Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 July 2026 – Tuesday 21 July 2026

Virtual Hearing

Name of Registrant:	**Nadia Mohammed**
NMC PIN:	12I1915E
Part(s) of the register:	Registered Adult Nurse (Level 1) – 24 September 2012 Registered Midwife – 13 May 2015 Nurse Independent/ Supplementary Prescriber – 28 September 2018
Relevant Location:	Leeds
Type of case:	Misconduct
Panel members:	Rachel Carter (Chair, Registrant member) Jessica Read (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Monowara Begum
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Ms Mohammed:	Present and not represented at the hearing (13 July – 20 July 2026) Not present and not represented at this hearing (21 July 2026)
Facts proved by way of admission:	Charges 1, 2a and 2b
Facts proved:	Charges 2c, 2d, 3 and 4

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you a Registered Nurse:

Between 2019 and 2022 in relation to IV drip solutions:

1. Distributed or sold products to Company A [White Night London Ltd] without the permission of the manufacturer.

2. Created and/or allowed labels to be placed on vials:

a. Displaying a false lot number.
b. Displaying a false expiry date.
c. Displaying a list of ingredients which did not reflect the true ingredients contained within them.
d. Displaying the ‘Intravita’ name without their knowledge or permission.

3. Your actions at charge 2 were carried out with the intention of making the product appear to be of a higher value than it was.

4. Your actions at charge 2 were dishonest in that you knew you were distributing products with false information displayed on them.

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

Background

You were referred to the Nursing and Midwifery Council (NMC) on 20 July 2022 by Sarah Charpilloz (Ms Charpilloz), the company director of White Night London Ltd (White Night) providing mobile intravenous (IV) drips.

At the time of the alleged incidents, you and your husband, Jaazab Khan (Mr Khan), were the company directors for Ivitalise Ltd (Ivitalise) supplying IV treatments.

Ms Charpilloz was in a contractual relationship with Ivitalise for two years. A supply and profit share agreement was signed by Mr Khan (on behalf of Ivatilise) and Ms Charpilloz. You were also the named nurse for White Night.

On 8 July 2022, the contract between Ivitalise and White Night ended.

Following the termination of the contract, White Night contacted the manufacturer of the Ivitalise products, Intravita, directly to request a new pricing list and product list, following concerns regarding whether the supplier's name of the *'Wellness Myers'* product had changed. As a result of these enquiries, White Night sent Intravita a photograph of the bottle of IV nutrients that they were using with Ivitalise name on it, the label also stated, *'Manufactured by Intravita'*. On receipt of this photograph the chief executive officer (CEO) of Intravita International Ltd (Intravita), Vernon Otto (Mr Otto) confirmed that he did not recognise the label of the list of ingredients as one of their products.

The ingredients listed on the bottle were incorrect and included Hydroxocobalamin which is a prescription only medicine, a medicine not used in any product by Intravita. The label also listed amino acids which are high risk products and if used without preparatory health checks, could potentially cause serious health problems.

The only product supplied by Intravita to Ivitalise was named *'Wellness Myers'* which does not contain either ingredient and is the cheapest IV vitamin sold by the company. The

'Wellness Myers' label states *'PRODUCT NOT FOR RE-SALE'* and there was no agreement in place with you for re-sale of the product.

One bottle of *'Wellness Myers'* product was sold to you for £40. It was alleged that Ivitalise were selling the relabelled product to White Night for £87.15.

The label placed on the product and sold to White Night by Ivitalise appeared to be a more expensive product because of the different ingredients listed on the label which held a higher monetary value.

Mr Otto contacted you directly to ask you about the product. You in your emails denied distributing or selling products. You admitted relabelling the product to market it but denied changing the formula. You stated that the label referred to was from a misprint batch of labels which were not used. The stickers also showed what is alleged to be a fake lot number and expiry date not recognised by Intravita.

It was alleged by Mr Otto that the *'Wellness Myers'* product had been relabelled with a false list of ingredients in order for it to appear to be a more expensive product and to be sold to White Night at a higher fee.

The ingredients list on the Ivitalise bottle did not display the same ingredients that was present in the *'Wellness Myers'*. White Night had administered the product to customers believing the ingredients to be those on the label.

On 2 September 2022, you resigned as the company director.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you make full admissions to charges 1, 2(a) and 2(b).

The panel therefore finds charges 1, 2(a) and 2(b) proved in their entirety, by way of your admissions.

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

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

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

- Vernon Otto: CEO and shareholder of Intravita International Ltd

- Sarah Charpilloz: Director and founder of White Night London Ltd

You did not give evidence but provided the panel with written submissions which you supplemented with oral submissions.

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

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

Charge 2(c)

2. Created and/or allowed labels to be placed on vials:
    c. Displaying a list of ingredients which did not reflect the true ingredients contained within them.

This charge is found proved.

In reaching this decision, the panel considered the oral evidence of Mr Otto and Ms Charpilloz, the photographic evidence of the labels, the contemporaneous email correspondence and your recent 'witness statement bundle'.

The panel firstly considered the stem of this charge. It accepted that there was no evidence that you had personally created the labels or that you had applied them to the vials yourself. However, the panel was satisfied, on the balance of probabilities, that as a director of the company with a direct involvement in the delivery, stocking and administration of the product, you had *'allowed'* the labels to be placed on the vials. This matter will be discussed in further detail below. The panel also had regard to your admissions to charges 2(a) and 2(b).

The panel found the evidence of Mr Otto and Ms Charpilloz to be consistent, credible and reliable. Their oral evidence was mutually supportive and was also consistent with the objective evidence, including the photographs of the labels, the *'Record of orders'* between Ivitalise and Intravita and the contemporaneous email correspondence.

The panel considered the photographic evidence showing the list of ingredients displayed on the Ivitalise products and compared that list with the ingredients of the Intravita *'Wellness Myers'* product. It noted that the ingredients were largely different, and where there were some apparent matches, the quantities were also different.

The panel noted Mr Otto's oral evidence that the ingredients listed on the Ivitalise labels did not match the correct ingredients of the *'Wellness Myers'* product. This was supported by the contemporaneous emails between Eleanor Hartley (Ms Hartley), a registered nurse at White Night, and Mr Otto, dated 6 to 11 July 2022, in which concerns were raised that the products did not match. Intravita's response was that the product was not a true Intravita product as labelled.

The panel also accepted Ms Charpilloz's oral evidence that, throughout the period she received supply from Ivitalise, the labels on the products did not change. Her evidence undermined your suggestion that the issue was limited to a small number of erroneous labels or an isolated error affecting five labels.

The panel was satisfied that there was clear and cogent evidence from the labels that demonstrated a disparity between the ingredients displayed and the actual ingredients contained within the product. The panel found that this objective evidence was consistent with the witness statements and oral evidence of both Mr Otto and Ms Charpilloz.

The panel noted your admissions to charges 2(a) and 2(b). Although the panel did not have firm evidence that you personally created the labels, it was satisfied by your admissions that you certainly allowed labels containing incorrect information to be placed on the vials.

The panel also had regard to your latest 'witness statement bundle', in which you stated:

> *'The list of ingredients that appeared on the mislabelled vials was incorrect, it did not match the Wellness Myers formula. That is accepted…'*

Although you denied charge 2(c), the panel considered this to amount to an apparent acceptance that the ingredients displayed were incorrect.

Taking your admissions into account, namely that you created and/or allowed a false lot number and a false expiry date to be placed on vials, the panel found it more likely than not, that you would also have identified that the ingredients were wrong. Further, the panel felt that as a registered nurse, registered midwife and nurse prescriber, the checking of the contents of a medicine or product was your fundamental responsibility.

The panel therefore concluded, on the balance of probabilities, that you created and/or allowed labels to be placed on vials displaying a list of ingredients which did not reflect the true ingredients contained within them.

Accordingly, the panel found charge 2(c) proved.

Charge 2(d)

2. Created and/or allowed labels to be placed on vials:
    d. Displaying the ‘Intravita’ name without their knowledge or permission.

This charge is found proved.

In reaching this decision, the panel considered the photographic evidence, the *‘Record of orders’*, the witness evidence of Mr Otto and Ms Charpilloz, and your ‘witness statement bundle’.

The panel was satisfied that the photographic evidence of the bottle label clearly displayed the Intravita name. In particular, the label stated, *‘Manufactured by IntraVita International’* and also states in red letters ***‘PRODUCT NOT FOR RESALE’***.

The panel also considered the *‘Record of orders’*, which showed that between August 2019 and June 2022, you had ordered a significant number of *‘Wellness Myers’* products and that your name was itemised on the order records under *‘statement name’*.

The panel accepted Ms Charpilloz's oral evidence that the label did not change during the period she received products supplied by you and that the products were supplied with the same labels throughout this period. The panel therefore rejected your account that the issue arose only in respect of five vials.

The panel considered Mr Otto's witness statement in which he stated:

> *'If the label was misprinted as stated in Nadia Mohammed's email, she does not offer any explanation as to why the label states 'Manufactuered by Intravita' and who placed this on the label. This should never have been placed on the Ivitalise Ltd label as the list of the ingredients on the label is not a product manufacturered by Intravita.'* [sic]

The panel also considered the following further evidence from Mr Otto's witness statement:

> *'On 13 July 2022, I replied to Nadia Mohammed and stated that there was no permission to relabel any of our products for distribution or marketing purposes. I asked that all Ivitalise products are recalled from the market and sent to Intravita.'*

The panel took into account your recent 'witness statement bundle', in which you stated:

> *'Looking back, I recognise that I did not fully understand how rebranding could be carried out safely or within the appropriate regulatory framework. I misunderstood the distinction between branding the outer IV saline bag and altering the manufacturer's product label, and I did not appreciate the professional and regulatory implications of that difference. My professional failing was not simply that I misunderstood those requirements, but that I failed to pause, question my understanding, seek*

clarification and independently verify that my understanding was correct before the product was supplied.'

Mr Otto's oral evidence was consistent with his witness statement. He accepted that there was no training on whether the products could be rebranded but said that it was obvious and pointed out that the label was clear. The panel also found his evidence to be consistent, credible and reliable. It was satisfied that Intravita had not given permission for its name to be displayed on the Ivitalise labels.

Having considered the evidence as a whole, the panel was satisfied, on the balance of probabilities, that you created and/or allowed the label bearing the Intravita name to be applied to the vials, and that this was done without Intravita's knowledge or permission.

Accordingly, the panel found charge 2(d) proved.

Charge 3

3. Your actions at charge 2 were carried out with the intention of making the product appear to be of a higher value than it was.

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence, the pricing evidence, the evidence of the ingredients displayed on the labels, the oral and written evidence of Mr Otto and Ms Charpilloz and your 'witness statement bundle'.

The panel first considered the evidence in relation to the supply and presentation of the products. It noted that your name appeared under *'statement name'* on the *'Record of orders'* for a significant number of *'Wellness Myers'* products. It also noted that the Ivitalise label displayed ingredients, including amino acids and other nutrients, which were not contained in the *'Wellness Myers'* product.

The panel then considered whether the false labelling made the product appear more valuable. It went onto consider Mr Otto's witness statement in which he stated:

> *'The Wellness Myers product that is sold by Intravita and was sold to Ms Mohammed does not contain any amino acids. As there are no amino acids in the Wellness Myers product it is the cheapest IV vitamin product that we sell. The label on the Ivitalise product, included in Eleanor Hartley's email, makes it appear as though it is a more expensive product because the label refers to more expensive nutrients as opposed to just having B vitamins.'*

Mr Otto, in his witness statement, goes onto state:

> *'The Wellness Myers product is the cheapest IV infusion on the market and it normally costs approximately £200. However, an Amino acid IV infusion is normally sold for around £300 or up to £350 in London.'*

Mr Otto, during his oral evidence, in response to Mr Malik, clarified that, *'the Wellness Myers product was not a POM, Prescription Only Medicine'* and that he *'didn't understand why Ms Mohammed would charge a prescription fee'.*

> *'However, a prescription is not needed for the Wellness Myers product as they are only nutrients and it is not a medicine.'*

The panel also considered the pricing evidence. It took into account the witness statement of Ms Charpilloz regarding the supply and profit share arrangement with Ivitalise, in which she stated:

> *'In relation to the price of the product, the supply and profit share agreement with Ivitalise Ltd stated:*

"<u>Products</u>

The Recovery IV drip:

● £43.58 (being 50% of the cost price to Ivitalise of £87.15)'

The panel also considered the following further evidence from Ms Charpilloz's witness statement:

'I discovered that the vials from Intravita actually cost £43. However, Nadia Mohammed had told me that the product cost them £87.15. This meant that I was paying the full price for the vial and splitting the profits with Ivitalise Ltd on top of this.'

The panel treated this part of Ms Charpilloz's evidence with appropriate caution as aspects of it were not fully supported in her oral evidence, in which she referred to having relevant conversations and exchanging emails with your husband, Mr Khan. However, the panel considered that her evidence nevertheless formed part of the wider evidential picture when assessed alongside the objective pricing and labelling evidence.

The panel took into account Ms Charpilloz's oral evidence that she had met you many times when you delivered products with your husband, and that you were present and helped when products were unboxed and stacked onto shelves. Furthermore, it accepted Ms Charpilloz's evidence that you had in your role as the nurse prescriber administered the product. The panel considered this evidence relevant to your level of involvement in the supply of the products and your awareness of the way in which they were presented.

The panel drew the inference that you were fully immersed in the company's activities, both as a director of the company and as the nurse prescriber. The panel noted your relationship with White Night, your role in the ordering and supply of products, and your presence during deliveries and handling of stock. In those circumstances, the panel was satisfied that there was evidence to suggest that you had a high level of involvement and were aware of the way in which the product was being presented and priced.

Having considered the evidence as a whole, the panel was satisfied that there was no credible alternative explanation for changing the labels and presenting the product as containing higher-value ingredients other than to make the product appear to be of a higher value than it was. The panel therefore found, on the balance of probabilities, that your actions at charge 2 were carried out with that intention.

Accordingly, the panel found charge 3 proved.

Charge 4

4. Your actions at charge 2 were dishonest in that you knew you were distributing products with false information displayed on them.

This charge is found proved.

In reaching this decision, the panel carefully considered the NMC guidance DMA-8 *'Making decisions on dishonesty charges and the professional duty of candour'* and the case of *Ivey v Genting Casinos UK Ltd* [2017] UKSC 67.

In considering your actual knowledge and belief at the time, the panel relied on the evidence that the false labelling was not an isolated incident. It noted Ms Charpilloz's evidence that the products supplied over the relevant period bore the same incorrect labels. The *'Record of orders'* also showed your name on the sales history from 2019 to 2022.

The panel further noted Ms Charpilloz's evidence that you were involved in delivering and stocking the vials. This supported the inference that you had sufficient opportunity to see and understand what information was displayed on the labels. In addition, you administered some of the vials over the time you were in partnership with White Night and

therefore would most certainly have seen and should have checked the ingredients list when giving the intravenous treatment.

Further, you admit creating and/or allowing a false lot number and a false expiry date to be placed on vials.

The panel considered your email to Intravita dated 12 July 2022, in which you stated:

> *'We feel that the director of Company As now disgruntled by this decision and has made false accusations. Company A have now hired a Doctor in the same manner to promote hangover cures for people under the influence and to purchase from Intravita.'*

The panel also considered your early response to the NMC to address the concerns, in an email dated 12 August 2022, in which you stated:

> *'This has come as a surprise to me since I stopped working with Sarah Charpilloz and it appears she is now disgruntled by this decision and is now making false allegations against me…'*

The panel considered these responses relevant to the explanation you gave to the NMC at the time and noted that this is inconsistent with your current position on the matter where you no longer advance that explanation.

The panel had regard to your 'witness statement bundle', in which you stated:

> *'Although I was a director of the company, my role was that of an Independent Nurse Prescriber. The day-to-day management of the business, including client relationships, supply arrangements, logistics and commercial decisions, was managed by my husband. My involvement was limited to my professional role as a nurse prescriber.'*

And went onto state, 'My professional responsibility was to prescribe safely and to ensure that the products I prescribed and supplied were accurately labelled before reaching the client. It is my failure in fulfilling that responsibility that I address in this statement.'

The panel noted your admissions to charges 2(a) and 2(b), however you did not accept the wider allegations that the ingredients were incorrectly listed or that the Intravita name was used without permission. It considered that there was no independent evidence supporting your alternative explanations, whereas the evidence of Mr Otto and Ms Charpilloz stating the level of your knowledge and involvement together with the objective evidence had been tested and was found to be credible and reliable.

The panel further considered your 'witness statement bundle' in which you stated:

'At the time the five vials were supplied to Company A, I did not know that the labels contained inaccurate information. I did not check the labels before the products were supplied, and I fully accept that this was a serious professional failing on my part. Had I identified the errors, I would not have allowed the products to be supplied. My failing was that I did not carry out the checks that I should have undertaken as the prescribing nurse.'

However, as a registered nurse, registered midwife and nurse prescriber, the panel found that you would have known the importance of accurate labelling and that labels on medicines should not be altered or changed under any circumstances.

The panel found that the first limb of the *Ivey* test was satisfied, in that, you knew you were distributing products with false information displayed on them.

In respect of the second limb, the panel was satisfied that ordinary decent people would regard such conduct as dishonest. The false information concerned the contents, origin

and presentation of products supplied to clients, and it had the effect of making the product appear different from, and more valuable than, it was.

The panel had no evidence before it to support your denials of these charges; it was just your words against what the panel heard in evidence from the two witnesses, Mr Otto and Ms Charpilloz, and you were able to cross examine both witnesses. It noted that you had resigned as the company director after concerns were raised to the NMC and your company closed soon after. In the light of all the evidence it has heard, the panel inferred that your actions at charge 2 were dishonest in that you knew you were distributing products with false information displayed on them.

Accordingly, the panel found charge 4 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct and impairment

Before hearing any submissions on misconduct and impairment, you gave evidence under affirmation.

You told the panel that you understand and accept the panel's decision. You maintained that your fitness to practice is not currently impaired. You have always accepted from the outset of these proceedings that you failed in your professional responsibility as the prescribing nurse for those products, that you did not check the labels before they reached the patients, you did not question the arrangements and that you did not apply the same standard of care and verification that you apply to every single day throughout the rest of your career.

You told the panel that you qualified as a registered nurse in 2012 and a registered midwife in 2015. You completed your independent prescribing qualification in 2018. You told the panel you have an otherwise unblemished career.

You told the panel that as a registered nurse, registered midwife and an independent prescriber, you understand that you did not meet the standards expected of you and that since the concerns were raised you have spent time reflecting.

You told the panel that your early responses in 2022 when the concerns were raised reflected a narrower understanding at the time. You said that you were initially focused upon resolving a commercial dispute. You have reflected honestly every year since and hold yourself to a higher standard. You have learnt that professional integrity is tested most where oversight is thin.

Since September 2022 you resigned as the director of the company with immediate effect and have had no involvement since. You told the panel that the business no longer exists and no longer trades in any form since that date.

You told the panel that on your return to the NHS practice since 2023, you made the decision to not undertake any independent prescribing. You have removed yourself entirely from that position of similar risk.

You told the panel you have completed further training specifically on fitness to practice and professional accountability. You have kept a reflective journal throughout the whole process of these proceedings, of how your understanding has now changed, and you have maintained your clinical CPD.

You told the panel that your colleagues during this period, including your professional midwifery advocate and senior midwives at Leeds Teaching Hospital (the Hospital) describe you as honest, reflective and consistently professional. One colleague in her testimonial, put before the panel, has stated that she trusts you implicitly and never had cause to doubt you. Another colleague has stated that the profession would suffer a genuine loss if you were removed from the register.

You told the panel that the business that gave rise to this case no longer exists. You are not in any commercial prescribing arrangement of any kind and have no intention of ever placing yourself in one. You told the panel that Ms Charpilloz, in her evidence, had told the panel that she had no concerns about your clinical practice. She had no complaints about the care you gave and had only received positive feedback from the patients that you treated directly during the period in question.

You told the panel you are not currently practising and are residing in the UAE at present and are the primary carer for your two young children. You said that there was therefore no risk to the public today.

You told the panel that if you are given the opportunity to return to practising, you are willing to do so with the supervision or support process the panel deems fit.

You told the panel to consider that the public confidence will be protected if the public can see a nurse who is taking full responsibility for her professional failings and who has spent four years demonstrating consistent, safe and reflective practise.

You told the panel you are not the same person you were between 2019 and 2022. You have spent many years reflecting honestly on your own judgement on what safe and accountable practise fully requires and how you respond when things are difficult. Your reflection has shaped how you have practised since and how you intend to practise going forward.

In response to questions by Mr Malik, you told the panel that you have been keeping up to date with the profession by embedding it into your everyday role and how important it is to remain accountable. You are the carer for two young children, so it is important for you to continue showing your children how important accountability is. You have kept up to date with the Ockenden report and how it is being implemented in today's practice in midwifery care. You are aware that changes are occurring specifically within the safety aspect of maternity services, more specifically in Leeds.

You told the panel that you have looked at opportunities for work in the UAE, but it is not something you are looking to do immediately as you are still the primary carer of your two children.

In respect of completing CPDs, you told the panel that you have been focused on preparing for this hearing and have done an online learning course by Simon Holborn (Mr Holborn) about fitness to practise and the importance of accountability.

In respect of your plans for the future, you told the panel that you plan to return to midwifery practice. You have not practised as a nurse since you qualified as a midwife. One of your roles within the business was as the independent nurse prescriber.

You said that the business Ivitalise no longer exists and that you are currently living in the UAE.

In response to Mr Malik's question as to where you are living, you told the panel you are living in Dubai. Mr Malik put to you that the company Ivitalise is trading in Dubai. You told the panel that it is not your company and it was purchased from your husband. You told the panel that the company name and logo had also been bought from your husband. You told the panel that you do not have any involvement in this company in Dubai.

In response to panel questions, you said that you understand that Ms Charpilloz said she felt deceived and lied to throughout the whole working relationship however you did not have any involvement in that your role was solely as prescribing nurse.

You told the panel that you understand the impact this may have had on Mr Otto and his company Intravita. Intravita is a reputable company in the UK, and the mislabelling and the misrepresentation had risks in tarnishing that name.

In response to panel questions, you told the panel that in respect of making the decision to refrain from independently prescribing, you had a discussion with Rebecca Musgrave (Head of Midwifery) at the time and you both agreed that she would be limiting your prescribing role on the e-system you have in the hospital. You told the panel that Ms Musgrave made the final decision and put that condition in place, if you were to return to midwifery.

You told the panel that the certificate you have provided in your 'witness statement bundle' is an e-learning course set by Mr Holborn. You told the panel Mr Holborn recommended you completed this course. You told the panel that the course represented 8-10 hours of CPD however, you completed it over two-three days ending on 6 July 2026.

You told the panel that in relation to the first Ockenden report, it is the safety aspect of the report and how the safety elements should be embedded into practice. You told the panel

that you have annually and in between your suspension, completed the emergency courses and completed all the mandatory training that is expected of you for your return to midwifery, however you do not have the certificates as in the UAE you do not have access to the NHS system. You have completed safe medication administration which was provided by the trust on their e-learning page, and have also completed an extended version.

In response to panel questions, you told the panel that you were aware that there was a company named Ivitalise operating in Dubai and that your husband had sold the brand name in Dubai before you moved there.

You told the panel that your company (Ivitalise) dissolved in 2022 and you went back to midwifery practice in 2023. Your husband received work opportunity in Dubai, and you moved there in July 2025. You told the panel you were working as a midwife from September 2022 until you resigned in 2025.

You assured the panel that you and your husband do not have any involvement in the Ivitalise company in Dubai in any capacity.

In response to Mr Malik's question, you told the panel that you can see on the website that the Ivitalise company in the UK is still active, however you do not have any business knowledge and it was your understanding that a strike-off was recommended but you are uncertain of what that means. You told the panel that you have not traded since September 2022 because you were unable to order from Intravita and therefore you had no supply.

Addressing the panel, on misconduct, Mr Malik invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the cases of *Roylance v GMC* [1999] UKPC 16, *Jackson J in Calhaem v GMC* [2007] EWHC 2606 (Admin), *Collins J in Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Khan v GMC* [2015] EWHC 301 (Admin).

Mr Malik submitted that your conduct fell short of the standards set out in 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). He submitted that your conduct falling short of the Code amounts to serious professional misconduct. He identified the specific, relevant standards where your actions amounted to misconduct. In particular, 10.3, 20.1, 20.2, 20.3 and 20.8.

Mr Malik submitted that the charges found proved are serious and involve dishonesty. He submitted that the dishonesty is directly linked to your professional practice and was a breach of trust. He submitted that your conduct, as detailed in the charges, falls significantly short of what would be expected of a registered nurse. He submitted that the areas of concern identified go to the heart of nursing practice, in particular, to act with honesty and integrity. He further submitted that the concerns are behavioural in nature which suggests an attitudinal issue.

Mr Malik submitted that the dishonesty was not a one-off incident, it occurred over a period of time. The panel have found that you were dishonest in that you knew you were distributing products with false information displayed on them. Mr Malik submitted that the misconduct is a serious departure from the Code, and he submitted that fellow practitioners would consider such a departure deplorable.

Mr Malik 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), *Yeong v GMC* [2009] EWHC 1923 (Admin) and *Silber J in Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Malik submitted all four limbs of the *Grant* test are engaged by the circumstances of this case.

Mr Malik conceded that there is no evidence before the panel that there was any harm to any customer, clients or patients as a result of your conduct. He submitted that your actions put patients at unwarranted risk of harm, in that by displaying a false lot number, false expiry date and a list of ingredients which did not reflect the true ingredients contained within the vials, had the potential to cause serious harm to clients. Mr Malik submitted that Ms Charpilloz was also caused psychological harm by your actions, as she stated in her oral evidence that she felt *'betrayed'* and *'scared'*.

Mr Malik submitted that in the absence of full insight and remediation, the risk of repetition and future harm remains.

Mr Malik submitted that your actions have brought the nursing profession into disrepute and you have breached fundamental tenets of the nursing professions by failing to promote professionalism. He submitted that there is a continuing risk to both public protection and the wider public interest due to your conduct. He further submitted that a finding of impairment is required to mark the unacceptability of the behaviour, to emphasise the importance of the fundamental tenet breached and to reaffirm proper standards.

Mr Malik referred the panel to the NMC guidance FTP-15 *'Insight and strengthened practice'* and your reflective statement in your 'witness statement bundle'.

Mr Malik submitted that charge 4, as found proved, indicates an attitudinal issue which is not easily remediable. He submitted that your insight is still developing, the concerns have not been remediated and therefore highly likely to be repeated by you. He submitted that there is no evidence that you have addressed or taken steps to address the concerns found proved and how your conduct impacted White Night and Ms Charpilloz.

Mr Malik submitted that you have failed to address the dishonesty aspect. He submitted that you have not reflected on that aspect of your behaviour which he submitted is a serious concern.

Mr Malik submitted that you have breached the duty of candour to be open and honest. He therefore submitted that a finding of impairment is necessary on public protection grounds as the misconduct in this case is serious and there remains a risk of repetition of the relevant misconduct. He further submitted that due to your lack of insight, lack of remediation and that the risk of unwarranted harm to patients remain, a finding of impairment is also necessary on public interest grounds. Mr Malik referred the panel to the NMC guidance DMA-1 *'Impairment'*. He submitted that your conduct has brought the nursing profession into disrepute and served to undermine public confidence and trust in the profession. You have not acted with honesty and integrity, and for those reasons, he submitted that your fitness to practise is currently impaired.

You told the panel to consider your 14-year professional career as a whole. You told the panel that nursing and particularly, midwifery practice has been the centre of your professional life. You deliberately chose to focus on your midwifery practice as you want to rebuild your professional confidence safely and responsibly. You told the panel that midwifery is the profession you love and hope to return to.

You referred the panel to your 'witness statement bundle' which highlights what you have learnt and the steps you have taken since September 2022. You told the panel that your CPD record demonstrates your understanding of honesty, integrity, accountability and maintaining public confidence. You referred the panel to your reflective journal within your 'witness statement bundle' which demonstrates your insight you have continued to develop over time.

You told the panel that although you do not accept the dishonesty allegation, you respect the panel's findings on this matter, your reflection has never been limited and that you have reflected deeply.

You told the panel you appreciate the distress it may have caused Mr Otto and Ms Charpilloz and understand their concerns that have been raised. You understand that discovering inaccurate labels can cause significant distress and the risk this has had on Ms Charpilloz's business as she had put her trust in you. You said that you understand that the labelling and the risk to Intravita had potential reputational damage.

You told the panel that you are genuinely apologetic for your professional failings which have impacted both Mr Otto and Ms Charpilloz directly.

In relation to whether you have attitudinal issues, you referred the panel to your testimonials which spoke to your honesty and integrity and reminded the panel that there were no concerns raised about your clinical practice by Ms Charpilloz.

You told the panel that if it finds that a restriction is needed on your practice then you accept conditions of practice and would fully engage with the conditions the panel consider are appropriate. You welcome the opportunity to continue to learn and to demonstrate safe practice and to rebuild the confidence in the profession and the regulator.

You told the panel that these proceedings have changed you profoundly. You cannot change what has happened but have worked very hard over the last four years to understand why it happened, how it affected others and how you can demonstrate these failings will never be repeated. You remain committed to returning to midwifery practice, and to practise safely and honestly.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *CHRE v NMC and Grant* and *Cohen v GMC*.

Decision and reasons 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.'*

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

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

> *'**10 Keep clear and accurate records relevant to your practice***
>
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
>
> ***10.3** complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
>
> ***14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place***
> *To achieve this, you must:*

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

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

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

<u>Promote professionalism and trust</u>

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

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

20.1 *keep to and uphold the standards and values set out in the Code*

20.2 *act with honesty and integrity at all times, treating people fairly…*

21.3 *act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care'*

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

In respect of charge 1, the panel found that your conduct involved a serious breach of trust. It noted that you admitted to charges 1, 2(a) and 2(b), and determined that those admissions demonstrated serious professional failings. In particular, you knew that products were being supplied to White Night without the permission of the manufacturer. This was not a minor or technical breach; it involved conduct which undermined the trust placed in you as a registered nurse, midwife and independent prescriber and also was a breach of trust between you and Intravita and White Night.

The panel found charges 2(c) and 2(d) proved and concluded that your conduct in charge 2 fell far below the standards expected of a registered professional. It determined that your conduct demonstrated a failure to act with the level of care, honesty, governance and professional judgement expected of a nurse, midwife and independent nurse prescriber. Your actions circumvented the traceability and other systems put in place to protect the consumers of the product, who were exposing themselves to risks by undergoing intravenous infusions.

In respect of charge 3, the panel determined that this went directly to your character, attitude and professional integrity. Nurses and midwives are expected to act honestly and professionally at all times, whether in clinical practice, business activity or any other setting connected to their professional status. The panel considered that your conduct represented a significant departure from those standards and amounted to misconduct.

Honesty is at the heart of professional practice and is the cornerstone of the public’s trust in the profession. Your conduct in putting your business needs above that of the people receiving the products for the purpose of financial gain strikes at the very heart of professionalism and undermines the trust which the public are entitled to place in the profession. Even though it was outside your day-to-day clinical practice, it showed a

disregard for the fundamentals of nursing practice and the standards of the Code. The two areas of your practice cannot simply be separated into two discrete parts.

Whilst considering your reflective journal written over the past four years, including an entry you submitted today, *'Journal Entry 6'* dated July 2026, the panel is concerned that you maintain a position that the charges against you amount to professional failings, mistakes and errors for which you show remorse. The reflections lack insight into the impact of the dishonesty that has been found proved, and with no alternative explanation for the ongoing dishonesty during a period of 18 months, the panel was satisfied that it represented a very significant departure from the Code and from the standards expected of a registered professional. It therefore amounted to misconduct.

The panel concluded that each of the charges in isolation amounted to misconduct. The conduct created a significant risk to public safety, was far removed from what is expected of a registered nurse and midwife, and would be viewed as very serious by fellow professionals.

The panel therefore found that your actions did fall seriously short of the conduct and standards expected of a registered nurse, midwife and independent nurse practitioner 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:28/01/2026) in which the following is stated:

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

Nurses and midwives 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 and midwives with their lives and the lives of their loved ones. To justify that trust, nurses and midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

In considering current impairment, the panel applied the principles in *Cohen* and *Grant*. It recognised that dishonesty can be difficult to remediate because it may indicate an underlying attitudinal concern. Although this conduct did not arise at any time in your midwifery role, the panel determined that it was directly linked to your professional practice in all settings, including your roles as a registered nurse, registered midwife and independent nurse prescriber.

The panel gave weight to the positive testimonials provided on your behalf. Those testimonials spoke highly of your honesty and integrity and indicated that there had been no concerns about your clinical practice in your midwifery role. The panel also noted that the testimonials were written by colleagues and staff who were aware of the charges. However, the panel considered that these positive matters did not address the full seriousness of the misconduct or the risks arising from it.

The panel accepted that you had demonstrated some remorse and had engaged consistently with the NMC. However, it considered that your remorse was limited because it focused primarily on professional mistakes, rather than the full extent of the misconduct, including dishonesty, lack of candour and the significant risk of harm to patients and members of the public.

The panel found your insight to be limited. Although your reflections addressed some failings, they did not sufficiently engage with the risk to public safety, the impact on the wider profession, or the consequences for Mr Otto, Ms Charpilloz, White Night's clients and others affected. As the only regulated healthcare professional connected to the company, the panel considered that you had a responsibility to ensure strict governance in relation to the supply, identification, labelling, storage and administration of Ivitalise products.

The panel was particularly concerned that you had not fully addressed the dishonesty or the duty of candour. Patients and clients receiving intravenous products were exposed to potential risks arising from incorrect labelling, uncertain product contents, storage requirements, allergens, adverse reactions and traceability. The panel considered that your reflections did not demonstrate a sufficient understanding of those risks or your own responsibility for them.

The panel noted that you had completed mandatory training and provided one certificate titled *'Understanding Fitness to Practise with The NMC'* dated 6 June 2026. However, it did not identify relevant training or other remediation which directly addressed the regulatory concerns, including dishonesty, governance, medicines management, patient safety, duty of candour and professional accountability.

The panel found that there were attitudinal concerns which had not been remedied and which would be difficult to remediate. Although you had stepped away from independent prescribing and said that you had resigned as a company director, the panel was not satisfied that this removed the risk. It considered that your insight remained insufficient in light of your failure to recognise that you acted in a dishonest way and, therefore, there remains a risk of repetition.

The panel concluded that all four limbs of the *Grant* test were engaged. It determined that your conduct placed patients and members of the public at unwarranted risk of harm. The risks arose from the relabelling and supply of intravenous products where the true

contents, storage requirements, allergens, potential reactions and traceability could not be properly assured. The use of false lot numbers created particular risks in identifying products and responding safely if concerns later arose, the use of false expiry dates allowed the potential for out-of-date medications to be administered intravenously, and most importantly, incorrect labelling of contents carries a very high risk to patient safety, particularly when administered intravenously.

The panel found that your conduct brought the professions into disrepute. Members of the public would not expect a registered nurse, midwife or independent nurse prescriber to act in this way. Your conduct undermined the trust and confidence that patients, colleagues and the public are entitled to place in registered professionals, particularly where honesty, integrity and patient safety are central to the role.

The panel found that you had breached fundamental tenets of the profession. In particular, your conduct was inconsistent with the obligations to prioritise people, practise effectively, preserve safety, and promote professionalism and trust. These breaches arose both from the risk of harm created by your actions and from the dishonesty involved.

The panel found that you had acted dishonestly. It considered that the conduct involved a high degree of planning and continued over a lengthy period until it was discovered and raised with the NMC. In light of your limited insight and insufficient remediation, the panel found that you remained liable to repeat the conduct in the future.

The panel considered that there was a clear dissonance between the account of your conduct within midwifery practice and your conduct within Ivitalise. It rejected any suggestion that professionalism applied only in a hospital or clinical employment setting. The panel considered that the standards of honesty, integrity, openness, patient safety and accountability applied across all areas of your professional life.

The panel found that your remorse did not extend to all aspects of the misconduct. You acknowledged making mistakes, but had not shown sufficient remorse or insight in relation

to the dishonesty, the misleading nature of your conduct, or the impact on patients, witnesses, businesses and public confidence.

The panel was not satisfied that you had demonstrated adequate insight into public protection. You had not fully acknowledged the serious risk created by incorrect labelling, the danger of allowing products to be supplied or administered without proper assurance as to their contents, or the potential consequences for those receiving intravenous products.

The panel also considered the duty of candour. It was concerned that patients and clients could not give properly informed consent if they did not know what products they were receiving or the risks associated with them. This further demonstrated the seriousness of the misconduct and the limited nature of your insight.

The panel was further concerned that you had not addressed the dishonesty element and had not been entirely transparent about your return to prescribing in your midwifery role. It considered that you allowed it to proceed on the basis that you had chosen not to prescribe, when in fact that decision had been made by the Head of Midwifery. The panel regarded this as misleading.

The panel also identified concerns about your account of the current position of the company. It considered that you had not been transparent about whether the UK company had closed or been dissolved and that it continued to trade in the same city in which you now reside, albeit it under different ownership. This reinforced its concern that you had not been entirely candid.

The panel had additional concern in relation to candour in that you failed to acknowledge the disparity between your statement about the labels being incorrect on only five vials of the product supplied by Ivitalise and the evidence that the panel heard that the labels were incorrect throughout the whole 18-month period.

The panel noted that you had admitted that you had not applied the standards required of you as a registered nurse in relation to charges 1, 2(a) and 2(b). It considered that the same applied to the remaining charges found proved. The panel concluded that you placed your own interests, and the interests of the business, above the safety and interests of the public and patients.

The panel considered the NMC guidance DMA-1 and found that all three aspects were engaged: a continuing risk to public safety, the need to maintain public confidence in the professions, and the need to uphold proper professional standards. The panel found the misconduct to be serious. Your insight remained limited because it focused on mistakes rather than dishonesty, and on your role as a nurse prescriber within Ivitalise rather than your broader responsibilities as a registered nurse, registered midwife and independent nurse prescriber. The panel considered that your conduct demonstrated attitudinal concerns relating to honesty, integrity, openness and putting the needs of people receiving care first. It concluded that you had placed business and financial interests above patient safety and professional standards.

The panel concluded that a finding of current impairment was necessary on public protection grounds. It found that, if repeated, your conduct could expose patients and members of the public to unsafe or inadequately governed practice. The misconduct involved serious failings in the identification, labelling, supply and traceability of intravenous products, meaning those receiving them could not be assured of their contents, safety information or safeguards in the event of an adverse reaction. Given your professional status as a registered nurse, registered midwife and independent nurse prescriber, the panel considered these concerns particularly serious. It was not satisfied that your insight or remediation had sufficiently addressed the public protection concerns. The panel therefore found a real risk of repetition and that a finding of current impairment was required to protect patients and members of the public from future harm.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and

protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment was also required on public interest grounds, to mark the seriousness of the misconduct and its impact on public confidence in the professions and the regulator. It considered that the dishonesty, lack of candour and departure from professional accountability were fundamentally incompatible with the standards expected of a registered nurse, registered midwife and independent nurse prescriber. It concluded that an informed member of the public, aware of the facts and the panel's findings, would expect a finding of impairment to be made in order to declare and uphold proper professional standards. A finding was therefore necessary to maintain confidence in the nursing and midwifery professions and in the NMC as the regulator.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 4 June 2026, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. He submitted that the appropriate and proportionate sanction in this case is a striking-off order.

Mr Malik referred the panel the NMC guidance SAN-1 *'The purpose of and approach to sanctions'*.

Mr Malik submitted that the aggravating features of this case are as follows:

1. Abuse of position of trust
2. Lack of insight into failings
3. Conduct which put patients at risk of suffering harm

Mr Malik submitted that there are no mitigating features in this case.

Mr Malik next addressed the panel on the sanctions available to it. He submitted that this case is a dishonesty case and therefore is too serious to take no action or impose a caution order. He submitted that it would be neither proportionate nor in the public interest to take no further action. He submitted that this case is not at the lower end of the spectrum of impaired fitness to practise.

Mr Malik referred the panel to the NMC guidance SAN-2a *'Taking no further action'* and submitted that there are no exceptional features in this case that would warrant taking no further action and given the serious and potentially attitudinal nature of the concerns, this would not be sufficient to protect the public, maintain standards, or maintain confidence in the NMC as a regulator.

Mr Malik referred the panel to the NMC guidance SAN-2b *'Caution order'* and submitted that as there is no evidence that you have sufficiently remediated the concerns, there is still a risk of harm to patients. He submitted that as the conduct found proved is serious and relates to a potential attitudinal concern, and according to the NMC guidance is more difficult to put right, it cannot be said to fall at the lower end of impaired fitness to practise. Therefore, a caution order would not be sufficient to protect the public or satisfy the public interest considerations. He further submitted that you cannot practise safely and a more restrictive sanction would not be disproportionate.

Mr Malik referred the panel to the NMC guidance SAN-2c *'Conditions of practice order'*. He submitted that a conditions of practice order is more suited to case where there are clinical concerns and nurse can be supported to return to safe practice, however, there are no clinical concerns in this case.

Mr Malik submitted that a conditions of practice order would not be appropriate, as there are no areas of practice in need of assessment or training. The issue in this case is more fundamental, as the panel have found you to be dishonest by knowingly distributing products with false information displayed on them.

Mr Malik told the panel that although you have said that you will abide by conditions, there are no relevant or practical conditions that could be put in place to address the concerns or protect the public and maintain public confidence. As such the concerns are serious and cannot be addressed through conditions. Therefore, he submitted that a conditions of practice order is not appropriate in this case.

Mr Malik next referred the panel to the NMC guidance SAN-2d *'Suspension order'*. He submitted that the charges found proved are at the most serious end of the spectrum and do call into question your suitability to continue practising. He submitted that this case involves dishonesty which is more serious by the breach of trust involved. White Night were aware that you were a registered nurse and therefore trusted the information you gave. The products listed were more expensive than those included in the vials and a

financial gain was made from the higher price charged by Ivitalise. The vials were administered to clients without the knowledge of the true ingredients which caused a risk of harm patients who could have suffered reactions to ingredients not listed. Mr Malik submitted that the deception appeared to be premeditated as labels were created displaying false information, placed on vials and distributed.

Mr Malik submitted that this is a very serious case and falls within the category of a sanction for highest risk cases which could result in harm if not put right. He submitted that your insight is limited and therefore there is a risk to the safety of people using services if you were allowed to continue to practise even with conditions. He submitted that the concerns are not easily remediable and there is no evidence before the panel that you have taken steps to strengthen your practice or address your behaviour found proved.

Mr Malik submitted that the concerns in this case are serious and highlight a deep-seated attitudinal issue. He stated that the panel did find there is a risk of repetition.

Mr Malik submitted that having regard to these factors, temporary removal from the register would be insufficient to maintain public confidence and professional standards. He submitted that a suspension order is therefore not appropriate as the conduct in this case is incompatible with continued registration.

Mr Malik next referred the panel to the NMC guidance SAN-2e *'Striking-off order'*. He submitted that the nature and seriousness of your misconduct, calls into question your integrity and professionalism. He submitted that the trust and confidence in the profession can only be maintained by the imposition of a striking-off order. He submitted that in all the circumstances, a striking-off order is the only appropriate and proportionate order.

Mr Malik referred the panel to NMC guidance SAN-4 *'Sanctions for the highest risk cases'*. He submitted that this was not a one-off incident, and the concerns only came to light when they were raised by White Night. The panel heard that White Night had been selling the product for one and half years without knowing that the ingredients did not match the

label and therefore putting their clients at a risk of harm. Mr Malik submitted that this was not a matter of five vials being incorrectly labelled, the product was sold using incorrect labels for approximately 18 months.

Mr Malik submitted that there is limited insight or reflection from you and there is no evidence of remediation or that the concerns have been addressed. He submitted that your actions were a significant departure from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register.
He submitted that the public confidence in the profession cannot be maintained if you were not removed from the register.

Mr Malik submitted that the concerns in this case do raise fundamental concerns about your professionalism. The concerns are difficult to address or put right and constitute a serious breach of nursing standards and therefore a striking-off order is the appropriate sanction. He submitted that the public confidence in the profession could only be maintained by removing you from the register.

Mr Malik submitted that the findings in this 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. Therefore, he submitted that only a striking off order is the appropriate and proportionate sanction in this case.

Submissions on adjournment and proceeding in absence

On 21 July 2026, the panel received an email from Ms Mohammed requesting a short adjournment to allow her to seek independent legal advice and possibly obtain representation for the sanction stage. In her email she stated that she was *'finding the process emotionally and mentally exhausting, particularly given the seriousness of the NMC's application for a striking-off order'*.

Ms Mohammed did not attend the hearing on the morning of 21 July 2026. The hearings coordinator emailed her asking her to join and attempted to call the telephone number she had provided at the start of the hearing, but her phone was switched off. Mindful that she may have had other commitments, the panel allowed her until 10am to join. The hearings coordinator emailed Ms Mohammed to confirm the revised time and again attempted to call her, but her phone remained switched off.

When the hearing resumed at 10am, Mr Malik informed the panel that he would apply to proceed in Ms Mohammed's absence.

The panel noted Ms Mohammed's earlier statement that the proceedings had been *'emotionally and mentally exhausting'* and decided to allow her further time, until 11am, to contact the NMC and re-engage with the hearing.

The hearings coordinator emailed Ms Mohammed to explain that the panel had given her until 11am to re-participate, after which it would hear Mr Malik's submissions on proceeding in her absence.

Ms Mohammed did not respond or otherwise engage by 11am.

Mr Malik in response to Ms Mohammed's application to adjourn submitted that the NMC strongly oppose adjourning these proceedings. He told the panel that this case was listed over a year ago and upon Ms Mohammed's request at the time, it was delayed.

Mr Malik told the panel that the NMC have already made submissions on sanctions and submitted that it would be extremely unfair on the NMC to adjourn at this stage.

Mr Malik reminded the panel that Ms Mohammed had indicated that she was willing to abide by any conditions, and the panel have heard the NMC submissions that conditions of practice is not appropriate.

Mr Malik invited the panel to have regard to the case of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and regard to the overall interest to all parties.

Mr Malik submitted that the NMC have put in a lot of work, and a lot of time has gone into listing this case and it would not be in the public interest to adjourn. He submitted that it is in the public interest for the expeditious disposal of this case and it would not be in Ms Mohammed's interest for this case to be delayed any further.

Mr Malik reminded the panel that Ivitalise is still currently active in the UK and has not been dissolved, which would allow Ms Mohammed to trade from that company. He reminded the panel that it had found a risk of repetition and a risk to the safety of the public. Mr Malik told the panel that Ms Mohammed has had a fair hearing and has had advice from the legal assessor.

Mr Malik submitted that Ms Mohammed is delaying the outcome. He reminded the panel that a company named Ivitalise is operating in Dubai, and the NMC and the panel are unaware of Ms Mohammed's role in the Dubai company.

Mr Malik in response to Ms Mohammed's request for seeking an adjournment in order to seek legal advice, submitted that she has had nearly four years to do so, and had made a conscious and informed decision to represent herself.

Mr Malik told the panel that the hearings coordinator had called Ms Mohammed on her Dubai phone number, however her phone was switched off, which he submitted is a total disrespect of the panel.

Mr Malik told the panel that Ms Mohammed has engaged throughout the regulatory process however, things have changed now because the panel have found all charges proved including the dishonesty charge, and have found her fitness to practise is currently impaired.

Mr Malik submitted that it is a delaying tactic by Ms Mohammed to buy as much time before being, what she may think might be a strike-off.

Mr Malik submitted that the panel should proceed in Ms Mohammed's absence. It has heard the NMC submissions and is aware of Ms Mohammed's position on sanction.

Mr Malik therefore invited the panel to proceed in the absence of Ms Mohammed.

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

Decision and reasons on adjournment

The panel reminded itself that its overarching duty was to ensure a fair hearing. In considering Ms Mohammed's application for an adjournment, the panel balanced fairness to her against the public interest, the interests of the NMC, the efficient disposal of the case, and the potential inconvenience to the panel, the NMC and the public.

The panel acknowledged that Ms Mohammed was distressed and that it was important to consider whether legal representation might assist her to put forward mitigation, insight or remediation. However, the panel noted that the application was made at a very late stage, during the sanction stage and after the NMC had already made submissions on sanction. It considered that, had the application been made before sanction submissions were delivered, the position may have been different. At this stage, however, the timing placed the NMC at a disadvantage and weighed against granting the application.

The panel also took into account Ms Mohammed's previous opportunities to obtain assistance and representation. It noted that she had previously received assistance from someone experienced in NMC matters and had arranged representation with them shortly before the hearing. The panel further noted that Ms Mohammed had represented herself effectively during the proceedings, including by engaging with and responding to NMC guidance.

The panel considered the history of the proceedings. Ms Mohammed had previously obtained a postponement, which had already delayed the case. It also noted that the proceedings had been ongoing since 2022 and that Ms Mohammed had been aware of both the proceedings and the NMC's position for a considerable period. In those circumstances, the panel considered there was a strong public interest in concluding the matter without further unnecessary delay.

The panel placed weight on Ms Mohammed's previous engagement. Up to day 7 of these proceedings, she had attended consistently and had responded promptly and appropriately to communications from the hearings coordinator. However, on the day of the application to adjourn, Ms Mohammed had sent an email but did not attend to explain her position or answer questions from the panel. The panel considered that her non-attendance, without sufficient explanation, was unhelpful and fell below the level of engagement expected from a registered professional in regulatory proceedings.

The panel was not satisfied that an adjournment would be likely to produce significant further mitigation, evidence of insight, or remediation that had not already been considered. It concluded that any potential benefit to Ms Mohammed was limited and did not outweigh the public interest in proceeding, particularly given the advanced stage of the hearing, the previous delay, and the inconvenience that a further adjournment would cause.

In all the circumstances, the panel concluded that an adjournment was inappropriate. For all of the reasons above, the panel rejected the application to adjourn the proceedings today.

Decision and reasons on proceeding in absence

The panel next considered whether it was fair, appropriate and proportionate to proceed in Ms Mohammed's absence. It had regard to the relevant NMC guidance, including CMT-8,

and reminded itself of the need to balance fairness to Ms Mohammed against the public interest and fairness to the NMC.

The panel noted that Ms Mohammed had engaged with the hearing throughout but had not attended on this occasion. Although she had sent a written request, she did not attend to explain her reasons, answer questions, or provide any further information. It did not consider that her written request, without attendance or further explanation, provided a sufficient reason not to proceed.

The panel also took into account the public protection concerns. It noted that Ivitalise appears to be a company trading in Dubai and that Ms Mohammed remained on the register as a nurse, midwife and independent nurse prescriber. It was concerned about the potential risk to the public if the case were delayed further, particularly given the uncertainty about her current work overseas and any ongoing connection with the company.

The panel considered that there was a strong public interest in the efficient disposal of the case. It was satisfied that proceeding in Ms Mohammed's absence was fair, appropriate and proportionate, particularly in light of her previous engagement, the absence of a sufficient explanation for non-attendance, the public protection concerns, and the need to conclude the matter without further delay.

The panel also reminded itself of section 23 of the Code, which requires registered professionals to cooperate with all investigations and audits. The panel considered that this duty reinforced the expectation that Ms Mohammed should engage fully with the proceedings, including attending to explain her position on seeking an adjournment.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction

imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- abuse of a position of trust, in that Ms Mohammed abused the trust between her and Intravita, White Night, Ms Charpilloz and the clients receiving care
- pattern of misconduct over a period of time, approximately 18 months
- placing people receiving care from herself and/or White Night at risk of harm
- lack of transparency, in that Ms Mohammed has not been fully open and honest during the process of this hearing
- limited insight into failings
- degree of premeditation

The panel also took into account the following mitigating features:

- early admission on charges 1, 2(a) and 2(b)
- some remorse shown

The panel recognised Ms Mohammed's engagement throughout this regulatory process other than today however, it felt this fell short of mitigation. It also took into account the very positive testimonials attesting to Ms Mohammed's honesty and clinical skills in her midwifery role but considered these fell short of mitigation as these were not relevant to the regulatory concerns.

The panel was of the view that the aggravating factors outweighed the mitigating factors in this case.

In reaching its decision the panel had regard to the NMC guidance SAN-4 *'Sanctions for the highest risk cases'*. It noted that the guidance states:

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

The panel first considered whether to take no action and was mindful that, in accordance with the NMC sanctions guidance, taking no further action is only to be considered in exceptional circumstances. It concluded that this would be inappropriate in view of the seriousness of the case. The panel considered that taking no further action would be wholly insufficient in this case. The misconduct involved serious and repeated dishonesty over an extended period, a breach of trust, risk to people receiving care, and limited insight. The panel therefore concluded that some form of sanction was necessary and that taking no further action would neither be proportionate nor sufficient to meet the public protection and public interest concerns.

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

'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel noted that a caution order does not restrict a registrant's practice and is generally suitable for cases at the lower end of the spectrum where the concerns are isolated, limited, and unlikely to be repeated. The panel concluded that this case was not at the lower end of spectrum. The misconduct involved dishonesty, a pattern of conduct over approximately 18 months, personal gain from a breach of trust, and a direct risk to

members of the public receiving care. In those circumstances, a caution order would not adequately protect the public, would not address the seriousness of the dishonesty, and would be insufficient to maintain public confidence in the profession or uphold proper professional standards.

The panel next considered whether to place a conditions of practice on Ms Mohammed's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). It reminded itself that conditions may be appropriate where the concerns are capable of being addressed by workable, measurable and proportionate conditions, including retraining, supervision or assessment.

The panel noted Ms Mohammed's stated willingness to comply with conditions. However, it concluded that the misconduct found proved was not primarily clinical in nature and was not capable of being remedied by retraining or supervision. The concerns arose from dishonesty, lack of transparency, limited insight and attitudinal issues. The NMC guidance recognises that dishonesty is an attitudinal concern which cannot easily be addressed by conditions, and that conditions are unlikely to be appropriate where the issue is deep-seated or relates to professional values rather than clinical competence.

The panel also considered that conditions would be impracticable in this case. The misconduct occurred outside Ms Mohammed's usual clinical role and arose from her position as a director and named nurse independent nurse prescriber within the company White Night.

The panel was not satisfied that there was an identifiable workplace setting or appropriate supervisor who could meaningfully oversee conditions directed at the misconduct found proved. It also considered that conditions would not sufficiently protect the public or satisfy the wider public interest, given the seriousness of the dishonesty, the risk to people receiving care, and the absence of meaningful remediation.

The panel therefore concluded that a conditions of practice order would be neither workable nor sufficient.

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

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional'*

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel recognised that a suspension order is a serious sanction and may be appropriate where the concerns are capable of being addressed and where a period of suspension would allow the registrant to develop insight, remediate the misconduct and demonstrate that the risk of repetition has reduced.

The panel carefully considered whether a suspension would be sufficient in Ms Mohammed's case, particularly in light of her engagement during much of the hearing, her admissions to charges 1, 2(a) and 2(b), some remorse, and the positive testimonials provided about her midwifery practice.

However, the panel concluded that the aggravating features significantly outweighed the mitigating factors. The misconduct was not a single isolated incident but a pattern of dishonesty over approximately 18 months. It involved a breach of trust, a degree of premeditation, personal or financial gain, and a direct risk to members of the public receiving care. The panel considered that these factors placed the case towards the more serious end of the spectrum and engaged the NMC guidance SAN-4 *'Sanctions for the highest risk cases'*, which states that honesty is of central importance to professional practice because of the high degree of trust placed in registered professionals.

The panel considered that several features identified in SAN-4 were present. These included personal or financial gain from a breach of trust, direct risk to people receiving care, premeditated, systematic or longstanding deception, and concerns relating to candour.

The panel also noted that Ms Mohammed had shown some remorse, but not in relation to the dishonesty itself. She had not demonstrated meaningful recognition that she had acted dishonestly, nor had she provided evidence explaining how similar conduct would be prevented in the future. Her reflections did not fully acknowledge the risks to patients, the impact on Mr Otto and Ms Charpilloz, or the wider impact on members of the public.

The panel took account of the positive testimonials, which attested to Ms Mohammed's honesty and clinical skills in her midwifery role. However, it considered that there was a significant disconnect between those testimonials and the misconduct found proved in her role as a director and named nurse independent nurse prescriber. The panel was not satisfied that the testimonials addressed the regulatory concerns, namely dishonesty, breach of trust, public risk and attitudinal issues. It therefore gave them limited weight in mitigation.

The panel concluded that a period of suspension would not be sufficient to address the seriousness of the misconduct or the ongoing risk. It had not seen meaningful insight or remediation in relation to the dishonesty, and it considered that the attitudinal concerns were not easily remediable. The panel was also concerned that Ms Mohammed was not currently in a position to strengthen her practice in a way that would address the specific concerns, given that the misconduct did not arise in an ordinary supervised clinical environment. In all the circumstances, the panel determined that suspension would not adequately protect the public, maintain public confidence in the profession, or uphold proper professional standards.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026).

The panel reminded itself that honesty is of central importance to professional practice because of the high degree of trust placed in registered professionals.

The panel found that Ms Mohammed's dishonesty was not isolated or spontaneous. It formed part of a pattern of conduct over approximately 18 months and involved premeditated, systematic and longstanding deception.

The panel identified several features in SAN-4 which were present. These included personal or financial gain from a breach of trust, a direct risk to people receiving care, and

premeditated or longstanding deception. It also considered that Ms Mohammed's conduct raised concerns about candour and transparency.

In the panel's view, the dishonesty went to the heart of the professional standards expected of a registered nurse, midwife and independent nurse prescriber, and caused serious harm to public confidence in the professions and in the NMC as regulator.

The panel acknowledged that Ms Mohammed had shown some remorse. However, it was concerned that she had not recognised that she had acted dishonestly and had not provided evidence explaining how such conduct would not happen again. It considered that the absence of meaningful insight and remediation in relation to the dishonesty reinforced the seriousness of the case and the ongoing risk to public protection, public confidence and professional standards.

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

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

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

The panel reminded itself that striking-off is the most serious sanction and is likely to be appropriate where a professional's actions are fundamentally incompatible with remaining on the register.

The panel concluded that the charges found proved raised fundamental questions about Ms Mohammed's professionalism, honesty, integrity and willingness to uphold the standards and values set out in the Code.

The panel considered that Ms Mohammed's conduct represented a significant departure from the standards expected of a registered nurse, midwife and independent nurse prescriber. Ms Mohammed's dishonesty created a genuine risk to members of the public receiving products and services from White Night. The panel considered that this type of dishonesty caused serious harm to the professional standard of honesty expected of registered professionals and was conduct that members of the public would find fundamentally incompatible with continued unrestricted membership of the profession.

The panel found there was a clear disconnect between the positive testimonials about her midwifery practice and her conduct in her role as a company director and the named nurse independent nurse prescriber. The panel therefore gave limited weight to the testimonials when assessing the regulatory concerns.

The panel had already concluded that a suspension order would not be sufficient. It was not satisfied that a period of suspension would allow Ms Mohammed to gain sufficient insight, remediate the dishonesty, strengthen her practice, or demonstrate that the risk of repetition had reduced. The panel considered that any lesser sanction would fail to protect the public, maintain public confidence in the professions and in the NMC, or uphold proper professional standards.

In all the circumstances, the panel determined that a striking-off order was the only sanction that was sufficient, appropriate and proportionate. It considered that this order was necessary to mark the seriousness of the repeated dishonesty, to send a clear

message about the standards expected of a registered nurse, midwife and independent nurse prescriber, and to maintain public confidence in the regulatory process.

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, midwife and independent prescriber should conduct themself, 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, midwife and independent nurse prescriber.

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He submitted that an 18-month interim order is required in this case to cover the eventuality of an appeal by Ms

Mohammed. He submitted that the substantive order will not come into effect until 28 days after the hearing and should Ms Mohammed lodge an appeal within the relevant period, the substantive order would not come into effect pending a resolution of the appeal. This would permit Ms Mohammed to practise without restriction during this time and would therefore fail to provide protection for the public or take account of public interest considerations.

Mr Malik submitted that an interim suspension order is required for a period of 18 months because it is likely to take that amount of time for the appeal to be heard.

Decision and reasons on interim order

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

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

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

That concludes this determination.