Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Meeting
Friday, 3 July 2026

Virtual Meeting

Name of Registrant:	Boodeo Nawah
NMC PIN:	05D0132O
Part(s) of the register:	RN1, Registered Nurse – Adult – 6 April 2005
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Pamela Johal (Chair, lay member) Fawzia Zaidi (Registrant member) Beverley Blythe (Lay member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Catherine Blake
Order being reviewed:	Suspension order (12 months, with review)
Fitness to practise:	Impaired
Outcome:	**Suspension order (6 months) to come into effect on 20 August 2026 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Mr Nawah's registered email address by secure email on 28 May 2026.

The panel took into account that the Notice of Meeting provided details of the review that the review meeting would be held no sooner than 29 June 2026 and inviting Mr Nawah to provide any written evidence seven days before this date.

The panel accepted the advice of the legal assessor.

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

Decision and reasons on review of the current order

The panel decided to impose a suspension order for a period of six months. This order will come into effect at the end of 20 August 2026 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 22 July 2024. This was reviewed on 1 July 2025 and an additional 12-month suspension order imposed.

The current order is due to expire at the end of 20 August 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, whilst employed by London North West University Healthcare NHS Trust

("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

1) *Did not demonstrate the required knowledge and/or skill and/or judgement in respect of medication management and administration (but not restricted to) one or more occasions set out within Schedule 1.*
2) *Did not demonstrate the required knowledge and/or skill and/or judgement in respect of documentation and record keeping (but not restricted to) one or more occasions set out within Schedule 2.*
3) *Did not demonstrate the required knowledge and/or skill and/or judgement in respect of communication with patients and staff (but not restricted to) one or more occasions set out within Schedule 3.*
4) *Did not demonstrate the required knowledge and/or skill and/or judgement in respect of safe handover of patients (but not restricted to) one or more occasions set out within Schedule 4.*
5) *Did not demonstrate the required knowledge and/or skill and/or judgement in respect of recognition and escalation of deteriorating patients (but not restricted to) one or more occasions set out within Schedule 5.*

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

…

SCHEDULE 1

1) *On an unknown date in 2020, you administered Phenobarbital to an unknown patient and did not know this was a controlled drug.*
2) *On 15 December 2020, in relation to an unknown patient:*
    a) *did not administer medication to said patient and/or*
    b) *signed to record that you had administered medication when you had not and/or*
    c) *left the medication unattended in a drawer.*

3) *On 16 February 2021, administered un-fractured heparin to an unknown patient when it was not prescribed.*
4) *On 17 February 2021, in relation to an unknown patient who was due to be transferred to another ward:*
    a) *failed to sign the drug chart following the administration of the IV antibiotic and/or*
    b) *failed to have a second checker present for the administration of the IV antibiotic*
5) *On 16 April 2021, did not know how to check whether a medication was in stock.*
6) *On 16 April 2021, did not administer medication to an unknown patient in a prompt manner and/or left the medication at the patient's bedside table.*
6) *On 16 April 2021, did not check an unknown patient's observations before administering medication.*
7) *On 7 May 2021, wished to undertake urinary catheterisation of an unknown patient without having the relevant training to do so.*
8) *On 7 May 2021, took 3 tablets of 2.5mg of Bisoprolol for a patient when the correct dosage was one tablet of 3,75mg of Bisoprolol.*
9) *On 19 May 2021, administered Co-Amoxiclav to an unknown patient who was allergic to penicillin.*
10) *On 19 May 2021, did not know that Co-Amoxiclav contained penicillin.*
11) *On 17 June 2021, prepared to administer Dalteparin, to an unknown patient who had been admitted with bleeding*
12) *On 7 June 2021, did not undertake observations of patients prior to administering medications without being prompted to so by a colleague.*

SCHEDULE 2

1) *On an unknown date in December 2020, did not complete a new admission booklet and/or make contemporaneous notes for a new patient.*
2) *Following the imposition of an informal action plan on 18 December 2020, did not:*
    a) *complete the medication assessment tool within the 4-week time frame and/or within the extension of two weeks.*

b) *complete the documentation training in respect of record keeping within the 4-week time frame and/or within the extension granted for a further two weeks.*
c) *complete the communication training for ELMS system within the 4-week time and/or within the extension granted for a further two weeks.*
d) *Did not produce a reflective account on the administration of Heparin by 22 March 2021.*

3) *Did not complete the mandatory training on ELMS within the 4-week time frame.*
4) *On 17th May 2021, did not complete a referral for an unknown patient on the internal referral system promptly.*
5) *On 20 May 2021, incorrectly recorded an unknown patient's observations in another patient's observation chart.*
6) *On 20 May, incorrectly recorded a patient's observation in another patient's file.*
7) *On 7 June 2021, incorrectly recorded the vital signs scores of an unknown patient in another patient's NEWS charts.*

SCHEDULE 3

1) *On 17 February 2021, when an unknown patient under your care was unwell and suffered a cardiac arrest, did not escalate to a senior colleague that the patient was unwell.*
2) *On 23 March 2021, did not undertake the following tasks during your shift without being prompted to do so by a colleague.*
    a) *making patients beds and/or*
    b) *undertaking personal care for patients and/or*
    c) *assisting patients with feeding.*
3) *On 10 April 2021, did not display a courteous manner towards patients.*
4) *On 7 May 2021, acted in a rude manner towards a patient's family and by telling them to "go go go" or words to that effect and gesturing with your hands.*
5) *On 10 May 2021, did not respond to an unknown patient who had requested assistance with pain relief.*

6) *On 13 May 2021, in relation to a patient who had specific food instructions, you failed to*
    a) *record those instructions in the patient's notes and/or*
    b) *handover those instructions to another colleague.*
7) *On 19 May 2021, did not help an unknown patient with their breakfast despite instructions from a colleague to do so.*
8) *On 1 June 2021, failed to tell colleague 1 that you were restricted from administering medications.*
9) *On 8 June 2021, disclosed the diagnosis and prognosis of an unknown patient to a family member despite the patient's instructions not to do so.*
10) *On 8 June 2021, did not attend call bells from patients without being prompted to do so by a colleague.*
11) *On 17 June 2021, did not offer assistance to a colleague when she was struggling to care for an unwell patient.*
12) *On 17 June 2021, did not introduce himself to patients and/or explain his role when administering medications to patient's*

SCHEDULE 4

1) *On 17 February 2021, in relation to an unknown patient under your care who was then transferred to a different ward, failed to:*
    a) *provide a handover detailing the care you had provided to the department and/or*
    b) *whether you had administered IV antibiotics to said patient.*
2) *On 6 April 2021, failed to handover to staff that:*
    a) *a doctor was attending to an unknown patient in his bay to undertake a chest drain on said patient.*
    b) *an unknown patient was experiencing severe headaches during the day.*
3) *On 7 May 2021, did not know why a patient had been admitted and/or their past medical history when handing over to a colleague.*

SCHEDULE 5

1) *On 17 February 2021, when an patient suffered a cardiac arrest, did not assist with and/or undertake CPR on the patient.*
2) *On 6 April 2021, failed to prioritise unwell patients according to their needs when carrying out observations*
3) *On 14 April 2021. Did not attend promptly to a patient who was ringing for assistance as they had low oxygen levels.*
4) *On 14 April 2021, did not know how to respond if a patient's MUST score was 1 or 2*
5) *On 17th May 2021, in relation to a patient on a catheter, failed to:*
    a. *notice that the patient's urine had turned pink and/or*
    b. *observe the patient hourly to check for signs of deterioration.*
6) *On 1 June 2021, did not prioritise the treatment of a patient with deranged electrolytes when instructed to do so by a colleague during handover.*
7) *On an unknown date in relation to a patient who was at risk of choking, did not sit a patient up before feeding them.'*

The first reviewing panel determined the following with regard to impairment:

'The panel noted that the original panel found that Mr Nawah had insufficient insight. At this meeting, the panel determined that there has been no evidence submitted by Mr Nawah to demonstrate that any insight has since been developed. The panel considered that he has not provided any reflection, nor has he demonstrated any understanding of the impact of his actions on patients or the wider profession. It also noted that there has been no communication directly from Mr Nawah since, and the only correspondence received was an email from his wife [PRIVATE].

In its consideration of whether Mr Nawah has taken steps to strengthen his practice, the panel noted that there was no evidence before it of any such steps being taken. Mr Nawah has not undertaken any relevant training, submitted any reflective work or shown any efforts to keep his professional knowledge up to date. Despite being advised of recommendations by the previous panel that could support his

remediation, he has not provided information to suggest that he has engaged with any of them.

The original panel determined that Mr Nawah was liable to repeat matters of the kind found proved. Today's panel has received no new information to indicate any change in this position. In light of this, the panel determined that Mr Nawah is still liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the ground of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mr Nawah's fitness to practise remains impaired.'

The first reviewing panel determined the following with regard to sanction:

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Nawah's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mr Nawah's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the

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

The panel next considered whether a conditions of practice on Mr Nawah's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. However, it noted that Mr Nawah had previously been subject to a conditions of practice order, which included close supervision, at the time he committed the misconduct. Despite this, serious failings still occurred. The panel concluded that this indicated that conditions were not workable or effective and that the issues related to general lack of competence. Therefore, conditions would not be an appropriate or proportionate sanction in this case.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow Mr Nawah further time to fully reflect on his previous failings. The panel concluded that a further 12 months suspension order would be the appropriate and proportionate response and would afford Mr Nawah adequate time to further develop his insight and take steps to strengthen his practice.

In the absence of any new evidence of insight, remediation or engagement, and in light of the ongoing concerns regarding public protection, the panel concluded that a further 12-month suspension order with a review is the only appropriate and proportionate sanction at this time.

The panel also acknowledged that it could not impose a striking-off order at this stage, as Mr Nawah has not yet been suspended for a continuous period of two years.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of 12 months and that this would provide Mr Nawah with a further opportunity to engage with the NMC.'

Decision and reasons on current impairment

The panel has considered carefully whether Mr Nawah's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle. It noted that it has not seen any new material from Mr Nawah.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mr Nawah's fitness to practise remains impaired.

The panel has seen no information from Mr Nawah since the last review. The panel has no information that Mr Nawah has taken steps to strengthen his practice such as evidence of additional training in the areas of concern. There is nothing to suggest that he has taken any steps to maintain his nursing skills or knowledge in the period since the substantive suspension order was first imposed or last reviewed. It noted that Mr Nawah's lack of competence was extensive.

Further, the panel noted that the first reviewing panel found that Mr Nawah had not developed sufficient insight into his lack of competence. At this meeting, the panel had nothing from Mr Nawah to indicate that his insight has developed in any way since the substantive order was made or last reviewed.

The last reviewing panel determined that Mr Nawah was liable to repeat matters of the kind found proved. Today's panel has received no information that Mr Nawah's practice has in any way strengthened or improved since the last review. In light of this the panel determined that Mr Nawah is liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mr Nawah's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mr Nawah fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate given the lack of competence found proved, and the public protection issues identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the public protection issues identified, an order that does not restrict Mr Nawah's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'* The panel considered that Mr Nawah's lack of competence was to such an extent that a caution order would be inappropriate in view of the issues identified.

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

The panel next considered whether a conditions of practice on Mr Nawah's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order was not the appropriate order in this case. While the panel was satisfied that conditions of practice could be formulated to address the areas of concern, there is no information before it to suggest that Mr Nawah wishes to return to nursing, nor any information as to his current practice. The panel could therefore not be satisfied that Mr Nawah would engage and comply with conditions of practice.

The panel considered the imposition of a further period of suspension. It noted Mr Nawah has not provided evidence of remorse or reflection into his lack of competence, nor of steps taken to strengthen his practice. Mr Nawah has not engaged with the NMC or responded to requests for further information about his current situation since the imposition of the substantive order. The panel bore in mind that a striking-off order was not available to it at this stage as this is a lack of competence case and Mr Nawah has not yet been subject to a substantive order for two years.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of six months to allow time for Mr Nawah an opportunity to engage with the proceedings, or otherwise advise the NMC of his intentions, and for an expeditious review of the order before a panel with all sanctions available to it. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 20 August 2026 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mr Nawah's attendance at the review.
- A reflective piece using an established method commenting on how his lack of competence impacted on patients, the public confidence, and colleagues, and any causes and triggers of his lack of competence.
- Completed training on the internet or otherwise on medication administration, documentation and record keeping, communication and handover, and escalation of a deteriorating patient.
- His efforts to keep his knowledge of the profession up to date and his future intentions.

This will be confirmed to Mr Nawah in writing.

That concludes this determination.