

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Wednesday, 1 July 2026**

Nursing and Midwifery Council
10 George Street, Edinburgh, EH2 2PF

Name of Registrant: Clara Osariemen Osazuwa

NMC PIN: 19H2407E

Part(s) of the register: Nurses part of the register Sub part 1

Relevant Location: Leeds

Type of case: Misconduct

Panel members: Dave Lancaster (Chair, lay member)
Sophie Agolini (Registrant member)
Emma Foxall (Lay member)

Legal Assessor: Graeme Henderson

Hearings Coordinator: Fionnuala Contier-Lawrie

Facts proved: Charges 1, 2, 3, 4, 5, 6a, 8, 9, 10, 11, 12 and 13

Facts not proved: Charges 6b, 7

Fitness to practise: Impaired

Sanction: Striking-off order

Interim order: Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Ms Osazuwa's registered address by recorded delivery on 22 May 2026 and by email on 20 May 2026

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting would take place on or after 24 2026.

In the light of all of the information available, the panel was satisfied that Ms Osazuwa 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).

Details of charge

That you, a registered nurse:

1. On 11-12 September 2023:
 - a. Did not engage with a training session given by Colleague A:
 - b. In respect of the supervised medication round conducted by Colleague B:
 - i. Did not engage with it;
 - ii. Did not understand the importance of time critical medication.
2. On 26 September 2023:
 - a. Refused to follow Colleague D's (a band 6 nurse) instructions;

- b. Refused to undertake patient care.
3. On 18 January 2023:
 - a. Arrived for a shift half an hour late;
 - b. Said "I am not doing any work today" or words to the effect.
4. On 13 February 2023 spoke to Colleague E in an intimidating and/or confrontational manner.
5. On 14 February 2023 administered an excessive dose of Enoxaparin to a patient.
6. In relation to your actions at charge 5 you:
 - a. Attempted to dispose of the syringe used;
 - b. Demonstrated a lack of candour when questioned by Colleague A.
7. Your actions at charge 6a were dishonest in that you sought to conceal the excessive dose administered.
8. Took unauthorised absence from work on:
 - a. 12 September 2023;
 - b. 26 September 2023;
 - c. 31 March 2023;
 - d. 3 May 2023;
 - e. 2 June 2023.
9. In relation to your actions at charge 8(a), you stated to another member of staff that Colleague C had told you to go home.

10. Your actions at charge 9 were dishonest in that you knew Colleague C had not authorised your absence.

11. Failed to prepare patient notes as requested by Colleague F on the dates set out in Schedule 1.

12. On unknown dates, failed to answer patient call bells.

13. Failed to engage with your employer's Supporting Attendance policy.

Schedule 1:

12 October 2022

12 December 2022

13 December 2022

13 February 2023

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

Background

The NMC received a referral on 24 February 2023 from staff nurse Catherine Batley, of Leeds Teaching Hospitals NHS Trust (the Trust) raising concerns about Ms Osazuwa. The concerns had regard to Ms Osazuwa's clinical practice and attitude whilst working. It was alleged that Ms Osazuwa would not contribute to patient care, did not respond to call bells, did not collaborate with staff and she refused to undertake certain tasks.

Ms Osazuwa also allegedly failed to engage with required training sessions and staff saw her wearing EarPods whilst on shift.

Ms Osazuwa was supernumerary in her role and had been for some years. For various reasons, Ms Osazuwa was unable to get her competencies signed off. Gill Chapman, the local investigator, looked into various concerns raised about Ms Osazuwa.

Ms Osazuwa initially engaged with the internal investigations but failed to attend the conduct hearing on 28 May 2024 and has not engaged with the NMC.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Lorraine Benn: Senior Sister, St James University Hospital (The Hospital)
- Catherine Batley: Staff Nurse, Chapel Allerton Hospital (The Hospital)
- Gill Chapman: Head of Services for Trust's Staff Bank

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

Charge 1a and b

That you, a registered nurse:

On 11-12 September 2023:

- a. Did not engage with a training session given by Colleague A:
- b. In respect of the supervised medication round conducted by Colleague B:
 - i. Did not engage with it;
 - ii. Did not understand the importance of time critical medication.

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Lorraine Benn, the Initial Fact Finding Proforma, the internal investigation report and the formal disciplinary investigation.

Charge 1a)

The panel first considered Ms Benn's NMC witness statement whereby she describes the incident:

"On the following day, 12 September, the trainer David Woellner came to the Ward in the afternoon and stated that he wanted to undertake some further one to one training with Clara, as he did not feel Clara was completely confident using the IV pumps. David was completely independent and did not know Clara personally. Nobody knew that he was planning to visit the Ward, but he took time out of his day to undertake some further training with Clara even though he was busy."

"A conversation then took place between David and Clara. I did not witness this at first as I was in the office at the time. Other members of staff reported to me that Clara was being rude to David, and kept turning her back to him whilst he was talking to her, and was not listening to what he was saying. Clara kept saying that he had already been signed off for IV's."

The panel was not supplied with an identification key but inferred that Colleague A was David Woellner

The panel also considered the internal initial fact finding proforma, dated 22 September 2023 which states:

"It had been noted from both MMPS and Trust Medical Device Trainer (David) in this meeting that you appeared to be asleep and were not engaged. So much so that the following day, David came for an assurance visit with you on the ward to see if you needed any further support."

"Clara confirmed she had been told this by David and Lorraine Benn Ward Manager on the day, but that she was not in the mood to engage, as she was distressed by the impromptu visit.....I asked for clarity by what Clara meant by not in the mood. Clara said she was anxious and was not prepared to engage when an appointment was not made"

The panel also considered the internal investigation report which states:

"You failed to engage with the Trusts medical devices trainer on the 11 and 12 September 2023 in that you:

- Were noted to be asleep and not engaged during the face-to-face medical devices training session on the 11 September 2023*
- Refused to engage in a medical device assurance visit on the 12 September 2023 and advised them that you 'were not in the mood'"*

Charge 1b)

The panel considered the witness statement of Ms Benn which states:

"The plan was for Clara to have undertaken a number of supervised medications round before she could be signed off to undertake them independently. Clara declined to engage with Hollie, and did not seem to understand the importance of time critical medication, which would have been part of the afternoon medication round."

The panel also considered the internal investigation report which states:

“You failed to engage with the Medicines Management Nurse in a supervised medicines round on the 12 September 2023, resulting in delays to the administration of time critical medication”

The panel was satisfied that there were various reports of Ms Osazuwa not engaging with training and medication rounds and that colleagues had attempted to help her and she refused. The panel was therefore satisfied that there was sufficient evidence to find Charge 1 proved in its entirety.

Charge 2a and b

On 26 September 2023:

- a. Refused to follow Colleague D's (a band 6 nurse) instructions;
- b. Refused to undertake patient care.

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Lorraine Benn, the Initial Fact Finding Proforma, the internal investigation report and the formal disciplinary investigation.

The panel first considered the witness statement of Ms Benn which states:

“Tanya [Colleague D] reported to me that once the handover for the morning had been completed, she informed Clara that she would assign her a bay of five patients, which would involve planning their care, attending the safety huddle and relaying any concerns to her. It was at this point that Clara became defensive and told Tanya that this was not what her role involved. Clara refused to do what Tanya had asked of her, and said that it was not her role to wash patients, and that she was not a support worker.

The panel also considered the internal investigation report which states:

“You did not contribute to the provision of patient care on the 26 September 2023 and instead sat in the staff room”

The panel also considered that the initial fact finding proforma and the formal disciplinary investigation confirmed the events of 26 September 2023.

The panel noted that Ms Osazuwa’s denied this allegation in the internal investigation.

The panel found that there was nothing which contradicts the account of Ms Benn and it was corroborated throughout the numerous investigation stages.

The panel therefore found this fact proved in its entirety.

Charge 3a and b

On 18 January 2023:

- a. Arrived for a shift half an hour late;
- b. Said “I am not doing any work today” or words to the effect.

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Catherine Batley, the Initial Fact Finding Proforma, the internal investigation report and the formal disciplinary investigation.

The panel first considered the witness statement of Ms Batley which states:

“I believe it was 18 January 2023, I remember Clara turned up for her shift at around 07:30am when we usually start at 07:00am”

“It was at this point that one other colleagues asked her if she wanted to take charge of bay one or bay two, to which Clara replied ‘I am not doing any work today’.”

The panel also considered the Initial Fact Finding Proforma, the internal investigation report and the formal disciplinary investigation which all corroborate Ms Batley’s statement of events.

The panel considered that Ms Benn was a credible witness, who’s statement was corroborated by several investigations and considered that there was no evidence which contradicted her account. The panel also noted that Ms Osazuwa did not deny that this event took place in her initial engagement with the internal investigations

The panel was therefore satisfied that it was more likely than not that this took place and found this fact proved in its entirety.

Charge 4

On 13 February 2023 spoke to Colleague E in an intimidating and/or confrontational manner.

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Catherine Batley.

The panel first considered the witness statement of Ms Batley which states:

“I was working on the same shift as Clara this day. Nurse Anju Matthew and student nurse Emma Hirst were completing a medication round together. As I walked back into the office where Anju was signing off Emma’s competency, Clara who was in the room shouted, ‘why don’t you ever sign me off?’ or words to that effect. Anju

and Emma were both shocked at the time and Clara was very intimidating and confrontational in her tone of voice towards them.....”

The panel considered that Ms Batley stated that the two colleagues who were present at the time, were both shocked at the intimidating manner in which Ms Osazuwa shouted.

The panel was satisfied that on the balance of probabilities, this charge is found proved.

Charge 5

On 14 February 2023 administered an excessive dose of Enoxaparin to a patient.

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Catherine Batley, the Initial Fact Finding Proforma, the internal investigation report, Datix report and the formal disciplinary investigation.

The panel first considered the witness statement of Ms Batley whereby she states:

“I did not witness this incident directly however I received a call from Anju Matthew who was in tears and very distressed, she told me that she was supervising Clara on a medication round on this shift and needed to retrieve something from the drugs trolley. Anju said she told Clara not to administer any medication until she returned, Clara would not have been able to anyway as she was under supervision. Anju said that when she returned, Clara had administered 100 iu of Enoxaparin to the patient when they were only prescribed 20 iu.”

The panel also considered that the internal investigation report, the formal disciplinary investigation, the Datix report and the fact finding proforma show that this medication error was investigated and proved.

The panel noted that Ms Osazuwa had admitted to this medication error in the investigation report.

The panel found that there was nothing to contradict the accounts of the nurse Anju Matthew and therefore found this charge proved.

Charge 6a

In relation to your actions at charge 5 you:

- a. Attempted to dispose of the syringe used;

This charge is found proved.

In reaching this decision, the panel took into account the NMC witness statement of Catherine Batley and the Initial Fact Finding Proforma.

The panel first considered Ms Batley's witness statement which states:

"Anju said that she saw Clara trying to dispose of the syringe and when she confronted her about it, she became very defensive and argumentative."

The panel also considered the complaint email which Ms Batley had sent to the NMC on 29 March 2023, which referenced this issue relating to the medication error and syringe disposal.

The panel found that Ms Matthew as referenced in Ms Batley's witness statement, was a direct witness to Ms Osazuwa disposing of the needle and this was corroborated in Ms Batley's concerns raised to the NMC. The panel therefore found this fact proved.

The panel noted however, although it found this fact proved, it was satisfied that it was normal practice to dispose of a syringe after use.

Charge 6b

In relation to your actions at charge 5 you:

- b. Demonstrated a lack of candour when questioned by Colleague A.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence it had before it.

The panel considered that this charge contained a typographical error. The colleague referred to in the evidence was Colleague E (Anju Matthew). In the event that the panel was minded to find the charge proved it would first have to amend the charge.

The panel considered the witness statement of Ms Batley who explained the events which took place, as told to her by her colleague Ms Matthew who witnessed them. It is said that when confronted with the drug error Ms Osazuwa became 'defensive and argumentative'.

The panel also considered that the events themselves were investigated internally.

However, the panel noted that it is for the NMC to prove their case and this instance, did not provide sufficient evidence to show that Ms Osazuwa demonstrated a lack of candour when questioned by Colleague E.

The panel therefore found this charge not proved.

Charge 7

Your actions at charge 6a were dishonest in that you sought to conceal the excessive dose administered.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentation it had before it.

The panel considered the witness statement of Ms Batley who explained the events which took place, as told to her by her colleague Ms Matthew who witnessed them.

The panel also considered that the events themselves were investigated internally. The panel determined that although it found that Ms Osazuwa had disposed of the syringe, it could not find any evidence to show that she did so dishonestly. It would be normal practice to dispose of the syringe safely after administering an injection. There is nothing in the evidence which shows she sought to hide the syringe or dispose of it surreptitiously.

The panel therefore found this charge not proved.

Charge 8

Took unauthorised absence from work on:

- a. 12 September 2023;
- b. 26 September 2023;
- c. 31 March 2023;
- d. 3 May 2023;
- e. 2 June 2023.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Lorraine Benn, the internal investigation report, the formal disciplinary investigation and the Fact Finding proforma.

The panel first considered the witness statement of Ms Benn referring to an incident on 11/12 September which states:

“Shortly after this point, we discovered that Clara had left the Ward and did not tell anyone that she was leaving or when she would be returning. I made efforts to contact Clara, but I did not receive a response..... Clara did not return to the Ward at all for the remainder of the shift. This was an unauthorised absence..... Clara did not contact the Ward to say that she was okay until two days later. Clara then stated that she would be taking sick leave for a week.”

The panel also considered the witness statement of Ms Benn referring to an incident on 26 September which states:

“Tanya reminded Clara that this had already been agreed between her and myself, and that she would be undertaking the afternoon medication round. Clara then took herself into the staff room and stayed there, and refused to undertake any patient care”

The panel also considered that these unauthorised absences were referenced in the internal investigation report, the formal disciplinary investigation and the fact finding proforma.

The panel also noted that there were a number of attempts to engage with and contact Ms Osazuwa when her absence from work was unauthorised to which she did not respond to give explanation for her absence.

The panel found that there was sufficient evidence to show that the absences as stated in the charge, were unauthorised and therefore found this charge proved in its entirety.

Charge 9

In relation to your actions at charge 8(a), you stated to another member of staff that Colleague C had told you to go home.

This charge is found proved.

In reaching this decision, the panel took into account Lorraine Benn’s witness statement.

The panel considered Ms Benn’s NMC witness statement which states:

“Clara returned on 19 September. It was at this point that I spoke to her about what happened on 11 and 12 September. Clara said that I told her to go home on 12 September but that is not what happened. I told her to take a break and get a drink, and make a decision as to whether she wanted to undertake the

medication round as we could not delay the medication any further. I told Clara that I tried to contact her several times with no response.”

The panel also considered that Ms Osazuwa had stated that she had tried to contact Ms Benn several times, however Ms Benn had no missed calls or evidence to show this was the case.

The panel considered the evidence it had before it and found that it was more likely than not that Ms Benn had not told Ms Osazuwa to go home and therefore it found this fact proved.

Charge 10

Your actions at charge 9 were dishonest in that you knew Colleague C had not authorised your absence.

This charge is found proved.

In reaching this decision, the panel took into account Lorraine Benn’s witness statement.

The panel considered the witness statement of Ms Benn whereby she explains the incident.

The panel also considered that Ms Osazuwa had stated in Ms Benn’s witness statement that she had tried to contact Ms Benn several times, but there must have been an internet error. Ms Benn stated that she did not receive any missed calls or texts.

The panel was not satisfied that this was a misunderstanding on the part of Ms Osazuwa as she had displayed a pattern of behaviour with regard to taking unauthorised absences. The panel considered that Ms Osazuwa must have known that what she said was false and her actions would have been regarded as dishonest by the standards of ordinary decent people.

The panel was therefore satisfied that this was dishonest and as such, found this charge proved.

Charge 11

Failed to prepare patient notes as requested by Colleague F on the dates set out in Schedule 1.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Catherine Batley, the internal investigation report, the formal disciplinary investigation and the Fact Finding proforma.

The panel first considered the witness statement of Ms Batley which states:

“On every occasion I worked with Clara, she would not write in the patient notes and I would have to complete them on her behalf.”

“I then sat down with her and spoke about how I personally plan my day and what I check for.....i thought this would be helpful for her.”

“Clara proceeded to just stare at me and did not undertake any work of her own.”

“I asked Clara to write some notes, and said that I would check them afterwards. When I approached her a short while later, her laptop was blank and, and she still had not moved from her chair”

“I am unsure whether Clara knew how to use the PPM+ notes system, but from my knowledge I never witnessed her completing anything on the computer system.”

The panel also considered Ms Batley’s email to the NMC from March 2023 stating her concerns about Ms Osazuwa, which included reference to lack of preparation of patient notes on the dates stated in Schedule 1.

The panel noted that the evidence it had before it shows that Ms Osazuwa had been given instructions on what to do on a number of occasions and did not respond or attempt to undertake the tasks.

The panel noted that Ms Batley had offered support on several occasions and Ms Osazuwa did not take this on or put it into practice.

The panel found that the evidence shows a pattern of behaviour whereby Ms Osazuwa is asked to do something and she does not do it.

The panel therefore found that it was more likely than not that this incident took place and found this charge proved.

Charge 12

On unknown dates, failed to answer patient call bells.

This charge is found proved.

In reaching this decision, the panel took into account Catherine Batley's NMC witness statement, her email to the NMC in March 2023, the internal investigation and the formal disciplinary investigation.

The panel first considered the witness statement of Ms Batley which states:

"On every occasion I worked with Clara, she would never answer a patient call bell on her own accord. I would often walk past the office or wherever Clara was at the time, and she would just be sat or standing there, whilst patient bells were clearly alarming."

"I would always need to remind Clara that the patient bells were alarming and prompted her to answer them."

“I witnessed other members of staff also asking Clara to answer the patient call bells.”

The panel also considered that Ms Batley’s concerns relating to Ms Osazuwa not answering patient call bells, can be seen in Ms Batley’s email to the NMC which included a number of concerns she had with Ms Osazuwa.

The panel found that there were a number of references to incidents whereby Ms Osazuwa would not answer call bells, which were witnessed by several colleagues.

The panel was satisfied that on the balance of probabilities, this charge is found proved.

Charge 13

Failed to engage with your employer’s Supporting Attendance policy.

This charge is found proved.

In reaching this decision, the panel took into account the internal investigation, the investigation outcome letter dated 31 May 2024 and the formal disciplinary investigation.

The panel considered the investigation report which reports a number of occasions whereby Ms Osazuwa failed to engage with her employer’s supporting attendance policy. This was confirmed in the investigation outcome letter dated 31 May 2024.

The panel noted that not only did Ms Osazuwa not engage with the policy, in some instances she even tried to negotiate her cooperation with being relieved of supernumerary status.

“Clara stated that if she was not going to undertake medications then she would go home. Emma advised Clara that if she left there would be consequences, but Clara left the ward anyway.....Upon Clara’s return, one of the matrons attempted to speak to her (Matthew Pinnock) about the past incidents that occurred. Clara did

not want to undertake her return to work meeting and declined to do so until she was taken off of her supernumerary period.”

The panel found that given the pattern of behaviour throughout, it had no reason to disbelieve the number of reports and witness statement regarding the lack of engagement in this instance.

The panel therefore found this fact 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 Ms Osazuwa 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, Ms Osazuwa’s fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

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

The NMC identified the specific parts of the Code which it considered have been breached:

Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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:

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

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

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.5 complete the necessary training before carrying out a new role

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

To achieve this, you must:

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

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

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care 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 and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The NMC submitted that it considers the misconduct to be serious as Ms Osazuwa's actions had blatant disregard for and disrespect of directions from managers, intimidating behaviour, clinical mistakes and dishonesty, unexplained absences, were a significant departure from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

The NMC required the panel to bear in mind its overarching objective to protect 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. The panel was referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Osazuwa's fitness to practise impaired on the grounds that all 4 limbs of the *Grant* test are engaged.

'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/their fitness to practise is impaired in the sense that S/He/They:

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The NMC submitted that limb a is engaged because Ms Osazuwa's actions put patients at unwarranted risk of harm. Failing to make patient notes creates a risk that another member of staff who needs to look back at a particular patient's notes for an update will not be able to find the necessary information. This can in turn impact on patient care. Failing to engage with and respond to training creates a risk of patients being exposed to inadequate care. Administering wrong dose of medication exposes patients to direct risk of serious harm. Not answering alarm bell calls exposes patients to potential risk of serious harm.

The NMC submitted that limb b is engaged because Ms Osazuwa's actions would shock a bystander should they learn of a nurse who did not engage with training, made clinical mistakes and attempted to conceal them, and who treated others in an intimidating manner.

The NMC submitted that limb c is engaged because through her actions Ms Osazuwa showed that she cannot be trusted to practise safely and kindly. She has breached the fundamental tenets of prioritising people, practising effectively, preserving safety and promoting professionalism and trust in the profession.

The NMC submitted that limb d is engaged because Ms Osazuwa acted dishonestly by attempting to hide the fact that she had administered the wrong dose of medication. Because of the lack of insight or awareness of the impact of her actions, it can be inferred that Ms Osazuwa is liable to behave dishonestly again in the future.

The NMC submitted that there is no evidence of insight, and Ms Osazuwa has not provided evidence of relevant training and strengthened practice.

The NMC considered that Ms Osazuwa is a continuing risk to the public due to her lack of insight and failure to undertake relevant training or having not had the opportunity to demonstrate strengthened practice through work in a relevant area.

For those reasons, it is submitted that her practice is currently impaired on the public protection ground.

The NMC considered there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Osazuwa's conduct engages the public interest because members of the public would be appalled to hear of a nurse failing to engage in necessary training, coming to work late and leaving work early or not turning up for her shifts, administering excessive dose of medication and then attempting to conceal this, ignoring patients call for help when they press the alarm bell, or acting in an intimidating manner towards colleagues. Such conduct severely damages and undermines public confidence in the nursing profession and the NMC as the

regulator.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance* in respect of misconduct and *Grant* in respect of impairment.

Decision and reasons on misconduct

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

The panel was of the view that Ms Osazuwa's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Osazuwa's actions amounted to a number of breaches of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

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:

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.5 complete the necessary training before carrying out a new role

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

To achieve this, you must:

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved show a range of serious failings, and that Ms Osazuwa's actions did fall seriously short of the conduct and standards expected of a nurse and, with the exception of charge 6a amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Osazuwa's 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.'

In this regard the panel considered the test approved by Mrs Justice Cox in the case of *Grant* in reaching its decision. In paragraph 76, she said:

'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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

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

The panel first considered limb a of the Grant test and determined that has been met in this case. The panel found that Ms Osazuwa's actions, namely in terms of the incorrect dosage of medication she administered, her refusal to comply with instructions and training and her complete disregard for prioritising patient care, meant there was substantial risk of patient harm in the past. In addition, although supernumerary at the time of the incidents, there would be a strain on colleagues' ability to practise safely, as they would have to cover for Ms Osazuwa. The panel also noted that there was nothing before it from Ms Osazuwa to show that this risk no longer remains.

The panel next considered limb b. The panel determined that this limb was also met as the charges are wide ranging in nature, including a lack of prioritising patient care, inability to follow instruction and clear deep-seated attitudinal issues. The panel found that a well-informed member of the public would be deeply concerned to hear of the actions of Ms Osazuwa as a registered nurse. The panel noted that her repeated unauthorised absences, lack of candour and picking and choosing on what tasks she would carry out, her lack of priority of care for patients would bring the reputation of the profession into disrepute.

The panel considered limb c. The panel found that this limb was engaged as the charges found proved, breached multiple fundamental tenets of the profession.

The panel then considered limb d and found that as it found charge 9 proved, which related to dishonesty, claiming she had been told to go home when she clearly had not and knew she had not, was satisfied that this limb was also engaged.

The panel then considered the factors set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin) and determined that the charges found proved, reflect deep-seated attitudinal issues with Ms Osazuwa's practice and although the issues could be remediable under certain circumstances, due to the lack of engagement with the NMC, the panel had no information to suggest that Ms Osazuwa has shown insight or taken any steps to rectify the issues.

The panel found that due to the multiple opportunities to receive help and Ms Osazuwa not taking them, as well as the lack of insight shown, the risk of repetition of the behaviour is high.

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

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

The panel determined that a finding of impairment on public interest grounds is required because a member of the public would be appalled to hear of Ms Osazuwa's misconduct and therefore, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Osazuwa's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Osazuwa's 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 Ms Osazuwa off the register. The effect of this order is that the NMC register will show that Ms Osazuwa 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.

Representations on sanction

The NMC submitted that a 12-month suspension order would be proportionate in this case.

The NMC submitted that suspension would be the appropriate sanction due to the attitudinal and behavioural nature of the concerns raised, and one instance of dishonesty, this was misconduct that impacts upon the reputation of the profession. In order to maintain public confidence in the profession a signal should be sent to both Ms Osazuwa and the wider profession that such conduct and behaviour should not be accepted. The NMC submitted that a period of suspension would be an appropriate sanction; given the repetitive nature, pattern of behaviour and lack of awareness/insight, a suspension for a period of 12 would be appropriate.

The panel noted that on 8 April 2026 a previous panel met and adjourned a substantive meeting of this case on the basis that proper notice had not been given.

That panel expressed a concern that as of January 2026 the NMC had changed its Sanctions Guidance. In particular SAN 3 'Deciding between suspension and strike off' states the following:

- *Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't*

usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.,

This panel was concerned to note that this issue had not been addressed.

The NMC submitted the following aggravating factors:

- Seriousness: Serious concerns which may result in harm/based on need to promote public confidence in nurses
- The medication error involved a controlled drug, and the amount administered versus the amount prescribed was a large difference and posed a significant risk harm to the patient
- The repetitive nature of the misconduct
- The lack of engagement from Miss Osazuwa during both the internal investigation proceed and NMC investigation process.
- No evidence of insight.

The NMC also submitted the following mitigating factors:

- No actual harm caused to patients

Decision and reasons on sanction

Having found Ms Osazuwa's 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 panel had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated failings over a long period of time
- Wide range of failings
- Failure to take on any of the support offered
- Non engagement from the conduct meeting onwards, with her employer

- Non engagement with the NMC
- Any matters of dishonesty
- Complete absence of insight

The panel also took into account the following mitigating features:

- Reference to health issues. however there was no evidence before the panel to substantiate these or how it would have affected the conduct in the charges

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

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

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

The panel considered that Ms Osazuwa’s misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Osazuwa’s practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on Ms Osazuwa’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). Having found that there were clear attitudinal issues, complete lack of insight and that the panel had nothing to show she

would cooperate with the NMC should it impose conditions of practice and having regard to the nature and seriousness of Ms Osazuwa's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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

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

The panel considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Ms Osazuwa's lack of engagement, lack of insight, lack of remorse, together with no evidence of training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

The panel also considered SAN-3 and noted that although the NMC bid was a suspension order, given the complete lack of engagement and absence of insight from Ms Osazuwa, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on '*Sanctions for the highest risk cases*' (Reference SAN-4 Last Updated: 28/01/2026). 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 found that the charges found proved were wide ranging, over a period of time and the fact that it has no evidence of insight or remediation from Ms Osazuwa, her actions were a significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Ms Osazuwa's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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 matters it identified, in particular the effect of Ms Osazuwa's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case. In particular it saw no reason to depart from SAN-3.

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

This will be confirmed to Ms Osazuwa 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 Ms Osazuwa's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that Ms Osazuwa's fitness to practise is impaired on a public protection basis, an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

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 allow for the appeal period.

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

That concludes this determination.