Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
10-14, 17-21 and 24-27 November 2025, 1-3 December 2025
12 February 2026 and 17-18 March 2026

Virtual Hearing

Name of Registrant:	Glory Ogechi Nwachukwu-Udaku
NMC PIN:	22C0185O
Part(s) of the register:	Registered Nurse - Sub part 1 RNA: Adult Nursing, level 1 (2 March 2022)
Relevant Location:	Northallerton
Type of case:	Misconduct and lack of competence
Panel members:	Richard Weydert-Jacquard (Chair - Registrant member) Christopher Bithell (Lay member) Rashmika Shah (Registrant member)
Legal Assessor:	Hala Helmi (until 3 December 2025) Paul Hester (12 February 2026 onwards)
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter (until 3 December 2025) Represented by James Edenborough, Case Presenter (12 February 2026) Represented by Naa-Adjeley Barnor, Case Presenter (17 March 2026 onwards)
Mrs Nwachukwu-Udaku:	Present and represented by Anna Deery, Counsel, instructed by the Royal College of Nursing
No case to answer:	Charges 1.c, 1.d, 2.e and 3.f

Facts proved by way of admission:	1.a, 1.b (partial admission), 2.a, 2.d, 3.c, 5, 6.c, 7.a (partial admission)
Facts proved:	Charges 1.b (in its entirety), 1.f, 1.g, 2.c, 3.a, 3.d, 3.e, 4.a, 4.c, 4.d, 4.e, 6.a, 6.b, 6.d, 6.e, 7.a, 7.b and 8
Facts not proved:	Charge 1.e, 2.b, 3.b, 4.b and 4.f
Fitness to practise:	Impaired both by reason of lack of competence and misconduct
Sanction:	Striking-off order
Interim order:	Interim suspension order – 18 months

Decision and reasons on hearsay application pursuant to Rule 31

Before the charges were read, the panel was informed that NMC would be making an application to admit hearsay evidence which was contained in a 46 page hearsay bundle.

Mr Edwards made an application for all of the documents contained within the hearsay bundle to be admitted into evidence. He submitted that charges 1-5 relate to lack of competence, and that it is not uncommon for large amounts of documentation to be provided by people not called to give live evidence. Mr Edwards submitted that just because the author of the documents has not been called to give live evidence, it does not mean that it would be unfair to admit their documentary evidence. He submitted that a number of live witnesses will be attending the hearing to give evidence in respect of the charges.

Mr Edwards referred the panel to the case of *Ogundele v Nursing & Midwifery Council* [2013] EWHC 2748 (Admin). He submitted that hearsay evidence should not be rejected outright because the author of the document does not attend the hearing to give live evidence. Mr Edwards submitted that given the volume of evidence, it would be disproportionate to call every author of a document. He submitted that witnesses are being called, and you, through your representative, will have the opportunity to cross examine them. Mr Edwards therefore submitted that there would be little to no unfairness to you if all of the documents contained in the hearsay bundle are admitted into evidence.

In respect of Appendix 36, Mr Edwards submitted that it is accepted that this evidence is the sole and decisive evidence in respect of charge 3.e. He submitted that just because it is the sole and decisive evidence in respect of charge 3.e, it does not mean that it should be excluded from evidence. Mr Edwards submitted that this evidence goes to the heart of the case and forms part of a pattern of lack of competence.

Mr Edwards submitted that all documents contained within the hearsay bundle are relevant and it can safely be admitted and, after the panel has heard all of the evidence in this case, it can attach what weight it deems to be appropriate to it.

Ms Deery, on your behalf, submitted that the inclusion of the 17 documents in the hearsay bundle as highlighted, is disputed. She informed the panel that the NMC provided you with an exhibit bundle which included these disputed hearsay documents. Following this, at the request of the Royal College of Nursing (RCN), the NMC created a separate hearsay bundle.

Ms Deery referred the panel to the case of *The Professional Standards Authority for Health and Social Care v The nursing and Midwifery Council (Jozi)* [2015] EWHC 764 (Admin) and to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565*. Ms Deery submitted that all of the disputed documents have been created by people who are not attending the hearing to give live evidence. She addressed the panel on all of the disputed documents contained within the hearsay bundle.

Ms Deery submitted that given that the makers of the statements have not been called to give evidence, and that some of the authors are not identifiable, it is undeniable that you will not be able to fairly challenge their evidence. She submitted that there are no provisions in the hearing process that would mitigate against the unfairness and invited the panel to refuse the entire application.

The panel accepted the advice of the legal assessor.

Decision and reasons on hearsay application

In considering whether it was fair to admit the hearsay evidence, the panel was mindful of the following factors as set out in the case of *Thorneycroft* at paragraph 56:

> *1. 'Whether the statements were the sole and decisive evidence in support of the charges;*
> *2. The nature and extent of the challenge to the contents of the statements;*

3. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
4. The seriousness of the charge, taking into account the impact which adverse findings might have on N's career;
5. Whether there was a good reason for the non-attendance of the witnesses;
6. Whether the Respondent had taken reasonable steps to secure the attendance of the witness;
7. The fact that N did not have prior notice that the witness statements were to be read.'

The panel also had regard to the NMC Guidance on *'Evidence'* (Reference: DMA-6 Last Updated: 09/06/2025), and in particular, to the following set out under the section entitled *'Hearsay'*:

> *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

The panel considered each of the documents exhibited by Witness 1 separately. Before considering each of the documents separately, having regard to all of the information before it, the panel noted that the charges had not been read and it had not heard any responses from you, but that through your representative, you have objected to the 17 identified exhibits being admitted into evidence. The panel heard no evidence to suggest that any of the witnesses had fabricated their allegations. Furthermore, the NMC had not told the panel about any efforts taken to secure the attendance of any of the authors of the statements. Additionally, Mr Edwards submitted that the NMC had decided not to call all of the authors of the statements as it was not deemed necessary to do so in cases of lack of competence. The panel noted that in December 2024 you were made aware that the NMC seeks to rely on the hearsay evidence and you had prior notice of this application.

Exhibit 1.7 (Appendix 7 – Minutes and statements dated 23 March 2022) [First statement dated 23 March 2022 admitted] [Second (undated) statement not admitted]

The panel had sight of the handwritten statement dated 23 March 2022. It noted that it had been signed, and it contained information about specific alleged incidents. The panel considered that this was neither the sole nor decisive evidence in respect of any of the charges. The panel noted that this statement was relevant to the charges. The panel was of the view that whilst the maker of the statement has not been called to give evidence, other witnesses have been called who can speak to allegations of a similar nature. The panel determined that it was fair to admit this statement and determine what weight to attach to it after it had heard all of the evidence.

In respect of the second document contained within Appendix 7, the panel noted that it was unsigned and undated. Whilst it may be relevant to the charges, in the absence of any provenance, the panel determined that it would be unfair to you to admit this evidence. The panel therefore decided to reject the application to admit this evidence.

1.9 (Appendix 9 – Statement of Person 1 dated 26 April 2022) [Admitted]

The panel noted that whilst Person 1 has not been called to give evidence, their statement is not the sole or decisive evidence in respect of any of the charges. The panel also noted that this statement was signed and dated by an identified Healthcare Assistant (HCA). The panel considered that other witnesses who speak to allegations of a similar nature can be cross examined and have questions put to them by the panel. The panel therefore decided that it would be fair to admit this evidence and attach what weight it deems to be appropriate at a later stage of the hearing.

1.10 (Appendix 10 – Statements of Person 2 and Person 3 dated 26 April 2022) [Admitted]

The panel had regard to the statements of Person 2 and Person 3 and noted that the information contained within them was relevant to the charges. It noted that both statements were signed and dated. The panel considered that other witnesses who speak to allegations of a similar nature can be cross examined and have questions put to them by the panel. The panel therefore found that it would not be unfair to you to admit this evidence. What weight to be attached to this evidence will be determined by the panel once it has heard all of the evidence in this case.

1.13 (Appendix 13 – Statement of Person 4 dated 28 April 2022) [Not admitted]

The panel noted that the statement of Person 4 contained information which was not specific and did not go directly to any of the charges. The panel therefore found that it was unfair to admit this evidence as it was not relevant to any particular charge and you would not be able to properly challenge it.

1.17 (Appendix 17 – Email from Person 5 dated 1 May 2022) [Not admitted]

The panel noted that the email from Person 5 alleges general incompetence from the perspective of one of the consultant surgeons. The panel considered that this email was subjective and did not provide any specific information about why they drew their conclusions. The panel considered that whilst it may be relevant, given the imprecise nature of the opinions shared by Person 5 and their imprecise relation to the charges, that it would be unfair to you to admit it as you would be unable to challenge this.

1.19 (Appendix 19 – Statement of Person 6 dated 5 May 2022) [Admitted]

The panel considered that the information contained in Person 6's statement was relevant to the charges, and it was signed and dated. The panel considered that other witnesses who speak to allegations of a similar nature can be cross examined and have questions put to them by the panel. The panel was therefore of the view that it would not

be unfair to you to admit this evidence as you will have the opportunity to challenge this evidence.

1.20 (Appendix 20 – Statement of Person 7 dated 21 July 2022) [Not admitted]

Having regard to the content of Person 7's statement, the panel noted that the identity of the author was unclear, and it was not signed nor was there a name attached to it. Whilst the panel considered that this statement may be relevant, it would be unfair to you to admit it given the issues of provenance and verification.

1.23 (Appendix 23 – Email from Person 5 dated 20 August 2022) [Not admitted]

The panel decided to not admit this email for the same reasons as set out in 1.17.

1.24 (Appendix 24 – Email from Person 8 dated 15 August 2022) [Admitted]

The panel noted that the email from Person 8 contained specific allegations that were relevant to the charges. The panel noted that this statement was signed and dated. It considered that other witnesses who speak to allegations of a similar nature can be cross examined and have questions put to them by the panel. The panel was therefore of the view that it would not be unfair to you to admit this evidence as you will have the opportunity to challenge this evidence.

1.25 (Appendix 25 – Meeting notes from Person 5 and Person 9 dated 23 August 2022 and a record of a conversation dated 25 August 2022) [Meeting notes admitted] [Statement not admitted]

The panel noted that the meeting notes were signed and dated, and included information about allegations relating to infection control and patient safety. The panel considered that these meeting notes were relevant to the charges. The panel noted that you were present at the first meeting and aware of what was discussed during the meeting. The panel was of the view that it would be fair to admit the first part of the meeting notes.

The panel noted that the record of conversation between two individuals dated 25 August 2022 was unsigned and lacked any provenance. Whilst potentially relevant, the panel determined that it would be unfair to you to admit it given the issues of provenance and verification.

1.28 (Email from Person 10) [Not admitted]

The panel had sight of some text which appears to have been copied and pasted from an email and exhibited by Witness 1. The panel noted that this text does not include any information about who the author of the statement was, in what context it was provided and on what date the statement was written. Whilst Witness 1 will be attending the hearing to give live evidence, the panel considered that it would be unfair to you to admit it given the issues of provenance and verification.

1.30 (Appendix 30 – Statement from Person 11) [Not admitted]

The panel noted that this statement was made by a pastoral officer and considered that whilst it contained some potentially relevant contextual and background information, it did not relate specifically to any of the charges. The panel also noted that the statement was not signed or dated. Given the issues of provenance and identification, the panel was of the view that it would be unfair to you to admit this evidence.

1.36 (Appendix 36 – Statement from Person 12 dated 11 October 2022) [To be determined at a later stage)

During the panel's deliberations, it invited further submissions from the NMC on whether Person 12 had been requested to provide evidence at this hearing. After seeking instructions from the NMC, Mr Edwards informed the panel that the NMC had not made any efforts to secure the attendance of Person 12.

The panel requested that the NMC make enquiries about whether Person 12 would be able to attend the hearing to give live evidence. At the time of handing down, the panel

had no further information about whether Person 12 could attend to give live evidence. It therefore decided to revisit this part of the application at a later stage when it had been furnished with further information.

1.38 (Appendix 38 – Investigation meeting notes with Person 6 dated 11 November 2022) [Not admitted]

The panel noted that whilst the information contained within the investigation meeting notes is potentially relevant to the charges, they were not signed or dated. The panel also noted that the information was not the sole or decisive evidence in respect of the charges. Whilst this information was potentially relevant, the panel considered that it would be unfair to you to admit this document as it was unverified.

1.40 (Appendix 40 – Investigation meeting notes with Person 13 dated 11 November 2022) [Not admitted]

The panel decided to not admit this evidence for the same reasons as set out at 1.38.

Handwritten statements of Person 14 and Person 15 [Admitted]

The panel noted that the statements of Person 14 and Person 15 contained information which is relevant to the charges. The panel also noted that both statements were signed and dated. The panel was of the view that the information contained within the statements can be tested and put to another witness who was present during the handover and who is attending to give live evidence. The panel therefore found that it was fair to admit both of these statements into evidence and attach what weight it deemed to be appropriate once it has heard all of the evidence in this case.

Details of charge (as read)

Whilst working at Woodlands Hospital between October 2021 and 10 February 2023 you failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse in that you:

1. Behaved in an unprofessional manner in that you

    a. On one or more occasions used your mobile phone during work time;
    b. On one or more occasions extended a coffee break or lunch break without permission and/or were not in theatres when you were expected to be;
    c. Walked in to Theatre 3 with coffee and a biscuit;
    d. Took a scalpel and was told to return it;
    e. On 26 April 2022 did not effectively assist the team to set up for a procedure;
    f. On one or more occasions was rude and/or argumentative and/or aggressive towards mentors who were attempting to provide training/advice;
    g. Participated in surgical procedures that you had no experience of without raising this with your mentor or a doctor;

2. Demonstrated poor record keeping in that you

    a. On 25 March 2022 used an abbreviated term to record a medical procedure in the theatre register book;
    b. On 07 April 2022 used an abbreviated term to record a medical procedure in the theatre register book;
    c. On one or more occasions pre-completed patient documentation before the patient procedure commenced;
    d. On one or more occasions did not amend documentation appropriately by crossing with a horizontal line and including date/time/your initials;
    e. On 23 August 2022 labelled a specimen as ‘gastroscopy’ rather than the documenting what the specimen was

3. Demonstrated poor infection control in that you;

   a. Demonstrated a poor clinical handwashing technique;
   b. Dropped a patch prepared for a procedure on to the trolley contaminating the sterile field;
   c. Punctured and/or intended to ‘tape up’ a perforated fluid bag
   d. Threw a hypodermic needle in a waste bin rather than a sharps bin;
   e. On one or more occasions de-sterilised yourself once scrubbed in when putting microscope handles on or leaning on an unsterilised trolley;
   f. Trailed the thread of a suture over an exposed area of a patient

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

   a. Did not consistently ensure the Phacoemulsification machine completes its cycle and / or is set up properly;
   b. Were unable to correctly term the layers of the skin;
   c. Were unable to mount blades on a knife;
   d. Was unable to inform the Surgeon that the instrument count was correct during a procedure;
   e. Were unable to mount a suture on a needle holder;
   f. Were unable to reliably set up a Theatre prior to a clinical list

5. On 17 August 2022 handed the keys to an operating theatre to a Healthcare Assistant and asked him to return them

Whilst working at Mount Vale Care Home

6. On 25-26 August 2022;

   a. Administered medication namely Lorazepam to Resident A when it was not prescribed to them;

b. Did not record in Resident A's medication administration record that you had administered Lorazepam;

c. Did not escalate Resident A's deteriorated condition by not escalating for further advice;

d. Removed Lorazepam medication prescribed to Resident B, in order to administer it to Resident A;

e. Did not record in Resident B's medication administration record that you had removed medication from the medication stock designated to them

7. On 26 August 2022 when discussing the Lorazepam medication administered to Resident A, you

a. Crossed out the entry you had made pertaining to this on the handover sheet;

b. told Colleague A that 'you would explain to the staff at hand-over that it was a mistake and say you did not give it'

8. Your conduct at Charge 7 above was dishonest as you intended to conceal that you had made a medication error by administering Lorazepam to Resident A.

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in respect of Charges 1-5 above, and your misconduct in respect of Charge 6 - 8.

Decision and reasons on application to hold parts of the hearing in private

Ms Deery made an application for parts of the hearing to be held in private. She informed the panel that there will be reference to matters relating to your health and personal circumstances which should be heard in private to protect your right to privacy. This application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Edwards, on behalf of the NMC, supported the application.

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

Having heard that there will be reference to matters relating to your health and personal circumstances, the panel decided to hear these parts of the hearing in private. It determined that any public interest in these matters being heard in public was outweighed by your right to privacy.

Decision and reasons on no case to answer application

After the NMC had closed its case, Ms Deery made an application of no case to answer in respect of charges 1.c, 1.d, 2.b, 2.e, 3.a, 3.f, 4.b, 6.d and 6.e. This application was made pursuant to Rules 24(7) and 24(8) of the Rules.

Ms Deery referred the panel to the case of *R v Galbraith* [1981] 1WLR 1039. She took the panel through each of the charges and set out the following.

Charge 1c

Ms Deery submitted that this charge falls under the second limb of *Galbraith*, namely that there is some evidence, but it is tenuous or inconsistent in nature. She submitted

that the only evidence presented by the NMC in support of this charge is the evidence of Witness 1, who was not a direct witness to the alleged events. Whilst Ms Deery accepted that hearsay evidence is admissible, she submitted that there is no evidence of who the staff members who allegedly reported their concerns were and there is no evidence of the circumstances in which the charge is alleged to have arisen. Ms Deery submitted that the evidence is very vague, it is overall weak and tenuous and, taking the evidence at its highest, the panel would not be able to find this charge proved.

Charge 1.d

Ms Deery submitted that this charge falls under the second limb of *Galbraith*. She submitted that the only evidence is provided by Witness 1, who was not a direct witness to the alleged incident. Ms Deery submitted that whilst it is accepted that hearsay is admissible, the evidence is very vague and tenuous in nature, and taken at its height, would not allow the panel to find this charge proved.

Charge 2.b

Ms Deery submitted that this charge falls under the second limb of *Galbraith*. She submitted that the only evidence that goes to this charge is the evidence of Witness 4 whose witness statement is inconsistent with her contemporaneous note. Ms Deery submitted that there is no direct evidence and that the evidence presented is tenuous and inconsistent. She therefore submitted that taking the evidence at its height, the panel would not be able to find this charge proved.

Charge 2.e.

Ms Deery submitted that this charge falls under limb one of *Galbraith*. She submitted that there is no evidence to support that you labelled a specimen incorrectly. Ms Deery drew the panel’s attention to the evidence of Witness 1, who refers to an alleged issue with the recording of a specimen. She submitted that even if the panel amended the charge to better reflect the evidence, the evidence, taken at its height would not allow the panel to find this charge proved.

Charge 3.a

Ms Deery submitted that this charge does not demonstrate a lack of competence. She submitted that this charge arose at the beginning of your mentorship and that you had not yet been taught the handwashing technique for working in the theatre. Ms Deery submitted that in Witness 3's evidence, it was accepted by her that she taught you how to do this and that she was confident that you were competent in handwashing for theatre after. Ms Deery submitted that lack of competence usually involves an unacceptably low standard of professional performance, judged on a fair sample of work, which could put patients at risk. She submitted that at the relevant time you had not been provided with the relevant training, and that even if this charge was found proved factually, it could not lead to a finding of lack of competence or impairment.

Charge 3.f

Ms Deery submitted that the second limb of *Galbraith* is engaged in this charge. She submitted that in Witness 3's evidence, she accepted that she had her back to the operating table and did not see what was alleged in this charge. Ms Deery submitted that the evidence in support of this charge was tenuous and inconsistent, and taken at its height would not allow the panel to find this charge proved.

Charge 4.b

Ms Deery submitted that the initial position is that there is no case to answer under limb 1 of *Galbraith*. She submitted that there is no evidence that you were unable to correctly term the layers of the skin. Ms Deery submitted that it is open to the panel to amend this charger to better reflect the evidence, and if this charge was amended, there would still be no case to answer. She submitted that lack of competence is an unacceptably low standard of professional performance, judged on a fair sample of work, which could put patients at risk. Ms Deery submitted that being asked an *"on the spot"* question about anatomy is not evidence of a lack of competence, and taking the evidence at its highest, could not lead to a finding of impairment or lack of competence.

Charge 6.d

Ms Deery submitted that this charge falls under limb two of *Galbraith*. She submitted that the only evidence in support of this charge is the evidence of Colleague A and Witness 6. She submitted that there is no documentary evidence to support the allegation and the evidence is tenuous. Ms Deery submitted that taking the evidence at its highest, it would not allow the panel to find this charge proved.

Charge 6.e

Ms Deery submitted that this charge falls under limb two of *Galbraith*. She submitted that the only evidence in support of this charge is the evidence of Colleague A and Witness 6. Ms Deery submitted that Resident B's MAR chart has not been provided and there is no documentary evidence to support this charge. She submitted that the evidence is tenuous and taken at its height would not allow the panel to find this charge proved.

In summary, Ms Deery submitted that it is recognised that at this stage the question is not whether the NMC had failed to discharge its evidential burden on the balance of probabilities. She submitted that the panel would not be able to find these charges proved and they should not continue to the next stage of the proceedings.

Mr Edwards submitted that the application is opposed in respect of all of the charges and made the following submissions in respect of each of the charges.

Charge 1.c

Mr Edwards drew the panel's attention to the evidence of Witness 1, which included a file note that was created at the relevant time. He submitted that Witness 1's role was to receive reports from members of staff and to act upon those reports where concerns were raised. According to Witness 1's evidence, a number of concerns were raised about you by staff which included what is set out at charges 1.a and 1.b. Mr Edwards

submitted that you have made admissions to charges 1.a and 1.b and it is accepted that these were legitimate concerns. He submitted that whilst Witness 1 is the only witness in respect of this charge, this does not mean that the panel should find that there is no case to answer and invited the panel to proceed with this charge.

Charge 1.d

Mr Edwards submitted that Witness 1, who gave live evidence at this hearing, also provided documentary evidence in support of this charge. He submitted that the evidence is not so tenuous as to find that there is no case to answer. Mr Edwards submitted that there is some evidence upon which the panel should consider that there is a case to answer.

Charge 2.b

Mr Edwards drew the panel's attention to the evidence of Witness 4, which included a local statement made at the time that this charge arose. He submitted that Witness 4 was clear in her evidence and submitted that her evidence was not tenuous. Mr Edwards invited that panel to find that there is a case to answer in respect of this charge.

Charge 2.e

Mr Edwards referred the panel to the evidence of Witness 1 which included evidence of a meeting that took place on 29 September 2022 which you attended and the concerns referred to in this charge were raised. He submitted that the evidence is not tenuous and there is a clear case to answer.

Charge 3.a

Mr Edwards drew the panel's attention to the evidence of Witness 3 and submitted that there is a case to answer. He submitted that demonstrating poor clinical handwashing technique is serious and is capable of amounting to a lack of competence and

impairment. Mr Edwards submitted that this charge should not be taken in isolation at this stage and invited the panel to find that there is a case to answer in respect of this charge.

Charge 3.f

Mr Edwards submitted that just because Witness 3 did not initially see the incident occur, this does not mean that the panel should find that there is no case to answer. He submitted that it does not matter that Witness 3 had her back turned at the time of the alleged incident, as she was there for the immediate aftermath and heard the interaction between the surgeon and you. Taking all of the evidence together, Mr Edwards submitted that there is sufficient evidence to find that there is a case to answer.

Charge 4.b

Mr Edwards drew the panel's attention to the evidence of Witness 4 and noted that she refers to layers of the abdomen rather than *'skin'* as set out in the charge. He submitted that this charge should not fail on a technicality and that the charge can be amended to properly reflect the evidence. Mr Edwards invited the panel to find that there is sufficient evidence to find a case to answer in respect of this charge.

Charge 6.d

Mr Edwards submitted that there is evidence to support this charge. He referred the panel to the evidence of Colleague A and Witness 6, both of whom were present during the handover. Mr Edwards submitted that their evidence is direct, consistent and is not tenuous. He submitted that there is no evidence that the witnesses fabricated their evidence and neither of the witnesses had anything to gain. He therefore invited the panel to find that there is a case to answer in respect of this charge.

Charge 6e

Mr Edwards submitted that whilst there is no MAR chart for Resident B, Colleague A and Witness 6 both gave evidence about this. He submitted that the absence of Resident B's MAR chart should not lead to a finding of no case to answer. Mr Edwards submitted that the evidence of Colleague A and Witness 6 was clear and credible and invited the panel to find that there is a case to answer in respect of this charge.

The panel accepted the advice of the legal assessor.

Decision and reasons on charge amendment

Before making its decision on the application for no case to answer, and in the light of the submissions made during that application, the panel invited submissions on any proposed amendments to the charges. The panel also noted that the preamble to charges 1-5 potentially related to a period of time in which you may not have been a registered nurse and invited submission on this matter.

The preamble to charges 1-5 currently reads as follows:

> *'Whilst working at Woodlands Hospital between October 2021 and 10 February 2023 you failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse in that you:'*

Mr Edwards informed the panel that the NMC issued your registration PIN on 2 March 2022. He acknowledged that some of the charges arose prior to you being registered with the NMC and directed the panel to Article 22(3). Mr Edwards submitted that Article 22(3) allows for there to be consideration of matters that arose before you received your NMC PIN. He submitted that the charges that arose before 2 March 2022 show a *"full picture"* of the alleged lack of competence. Mr Edwards submitted that the fact that you were not a registered nurse until 2 March 2022 does not affect the charges and no amendment to the preamble to charges 1-5 was necessary.

Mr Edwards made an application to amend charges 2.e and 4.b pursuant to Rule 28 of the Rules.

Charge 2.e as read:

> 2. *Demonstrated poor record keeping in that you*
>   e. *On 23 August 2022 labelled a specimen as 'gastroscopy' rather than the documenting what the specimen was*

The proposed amendment to charge 2.e was as follows:

> 2. *Demonstrated poor record keeping in that you*
>   e. *On 23 August 2022 labelled and/or recorded a specimen as 'gastroscopy' rather than ~~the~~ documenting what the specimen was*

Mr Edwards submitted that the proposed amendments better reflect the evidence in respect of this charge. He submitted that there would be no prejudice caused to you in allowing this amendment.

Charge 4.b as read:

> 4. *Demonstrated a lack of clinical knowledge and/or skills in that you;*
>   b. *Were unable to correctly term the layers of the skin;*

The proposed amendment to charge 4.b is as follows:

> 4. *Demonstrated a lack of clinical knowledge and/or skills in that you;*
>   b. *Were unable to correctly term the layers of the ~~skin~~ abdomen;*

Mr Edwards submitted that the evidence heard related to layers of the abdomen rather than layers of the skin. He submitted that this proposed amendment does not materially affect the case and it properly reflects the evidence. Mr Edwards submitted that the proposed amendment is both fair to the NMC and to you.

Ms Deery informed the panel that as an overseas nurse, you were required to pass the Objective Structured Clinical Examination (OSCE) before you could practise as a registered nurse. She told the panel that after you passed the OSCE on 22 February 2022, you received a your NMC PIN on 3 March 2022.

Ms Deery submitted that the preamble of charges 1-5 is open to interpretation and that it is a matter for the panel as to its interpretation of it. Mrs Deery submitted that in respect of charges 1.c and 1.d, the panel should consider the reading of the preamble and whether a duty has been established, and if so, whether it was breached. She submitted that if there was no duty on you prior to your NMC registration, then this further enforces the no case to answer application in respect of these charges. Ms Deery submitted that regardless of what the panel decide in respect of the reading of the preamble, charge 1.a remains fully admitted and charge 1.b remains partially admitted.

In respect of the proposed amendments to charge 2.e and 4.b, Ms Deery submitted that this application was not opposed.

The panel accepted the advice of the legal assessor.

In respect of the preamble to charges 1-5, the panel noted that no application to amend this had been made, and whilst it acknowledged that it could make an amendment of its own volition, it decided to consider whether there was a case to answer in respect of this in its deliberations. A consideration of the interpretation of the preamble will be decided at the facts stage.

The panel decided to allow the amendments to charges 2.e and 4.b as applied for. The panel was satisfied that the proposed amendments better reflect the evidence and ensure clarity and accuracy. The panel noted that this application was unopposed and considered that the proposed amendments did not materially change the charges. The panel therefore determined that it was in the interests of justice and fair to both parties to grant this application.

Charge 2.e now reads as follows:

> 2. *Demonstrated poor record keeping in that you*
>   *e. On 23 August 2022 labelled and/or recorded a specimen as 'gastroscopy' rather than documenting what the specimen was*

Charge 4.b now reads as follows:

> 4. *Demonstrated a lack of clinical knowledge and/or skills in that you;*
>   *b. Were unable to correctly term the layers of the abdomen;*

Decision and reasons on application for no case to answer

The panel had regard to Rule 24(7) and 24(8) of the Rules. It also had regard to the NMC's guidance entitled *'Evidence' (Reference:* DMA-6 Last Updated: 09/06/2025) in which the following is stated in the *'No case to answer'* section:

> *'There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:*
>
> 1. *No evidence;*
> 2. *Some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.*
>
> *The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account.*
>
> *Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard'*

The panel also had regard to the case of *Galbraith* which sets out the following:

> *'If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case. The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.*
>
> *Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

The panel first considered whether there was a case to answer in respect of the pre-amble to charges 1-5:

> *'Whilst working at Woodlands Hospital between October 2021 and 10 February 2023 you failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse in that you:'*

The panel accepted that you were a registered nurse from 2 March 2022. The panel noted that when you commenced employment at Woodlands Hospital (the Hospital), you had previously worked as a theatre nurse in a different country. The panel also had sight of a job description for the role of a Theatre Practitioner and details of the support you received to ensure that you met the standards required of a registered nurse in the UK. The panel considered that, at this stage, there is sufficient evidence to establish a

duty and to proceed with this preamble. Whether there has been a breach of this preamble is to be considered by the panel at the facts stage although the panel considered whether there was a case to answer in respect of the particulars below.

1.c

1. Behaved in an unprofessional manner in that you
   c. Walked in to Theatre 3 with coffee and a biscuit;

Having regard to all of the evidence before it, the panel noted that the only witness that has provided evidence in respect of this charge was Witness 1. The panel noted that Witness 1 had not directly witnessed what has been alleged in this charge, and there was no information about the context in which this is alleged to have occurred, or the position of the member of staff who reported the alleged concern. The panel was of the view that the evidence, taken at its highest, could not properly result in this charge being found proved. The panel therefore found no case to answer in respect of charge 1.c.

1.d

1. Behaved in an unprofessional manner in that you
   d. Took a scalpel and was told to return it;

The panel considered all of the evidence before it and noted that the only evidence in respect of this charge is the evidence of Witness 1. Whilst Witness 1 had attended the hearing to provide live evidence, the panel noted that she was not a direct witness to what had been alleged at this charge. The panel also found no evidence about the position of the member of staff who had reported their concerns or the context in which this charge was alleged to have occurred. The panel determined that the evidence in respect of this charge, taken at its highest, could not properly result in this charge being found proved. The panel therefore found that there is no case to answer in respect of charge 1.b.

Charge 2.b

2. Demonstrated poor record keeping in that you
   b. On 07 April 2022 used an abbreviated term to record a medical procedure in the theatre register book;

Whilst the panel accepted that the theatre register book had not been adduced in evidence, Witness 4 attended the hearing to give oral evidence. The panel also accepted that there were some inconsistencies in Witness 4's evidence. Nevertheless, the panel decided that the evidence was not so tenuous to justify a finding of no case to answer. The panel therefore decided to reject the application of no case to answer in respect of this charge and will proceed to consider it at the facts stage.

Charge 2.e

2. Demonstrated poor record keeping in that you
   e. On 23 August 2022 labelled and/or recorded a specimen as 'gastroscopy' rather than documenting what the specimen was

Having regard to all of the evidence presented in respect of this charge, the panel considered that it was of a tenuous character as there have been no direct witnesses to you allegedly having written this in the theatre register book. Furthermore, the panel did not have the theatre register book before it to confirm this entry. The panel therefore decided that the evidence, taken at its highest, could not result in this charge being found proved. Accordingly, the panel found no case to answer in respect of charge 2.e.

Charge 3.a

3. Demonstrated poor infection control in that you;
   a. Demonstrated a poor clinical handwashing technique;

The panel had regard to all of the evidence that had been presented in respect of this charge, and to the submission that a lack of competence and impairment could not be found in the circumstances. The panel had regard to the evidence of Witness 3 who attended the hearing to give live evidence. The panel also had regard to the documentary evidence. The panel considered that there was sufficient evidence that was not so tenuous as to justify acceding this application. The panel therefore decided to reject the no case to answer application in respect of this charge and consider it at the facts stage.

Charge 3.f

3. Demonstrated poor infection control in that you;
    f. Trailed the thread of a suture over an exposed area of a patient

The panel had regard to all of the evidence before it and noted that the only evidence in respect of this charge was provided by Witness 3. In Witness 3's evidence, she conceded that she did not see what has been alleged in this charge and only became aware of it because she overheard the surgeon raise their concerns. The panel found that the evidence in respect of this charge was tenuous and that, taken at its highest, could not properly result in this charge being found proved. Accordingly, the panel found that there was no case to answer in respect of charge 3.f.

Charge 4.b

4. Demonstrated a lack of clinical knowledge and/or skills in that you;
    b. Were unable to correctly term the layers of the abdomen;

The panel noted that Witness 4 was a direct witness to what has been alleged in this charge, and she provided oral and documentary evidence. The panel considered that the evidence was not tenuous in nature and that there is a case to answer in respect of this charge. Accordingly, the panel will proceed to consider this charge at the next stage.

Charge 6.d

6. On 25-26 August 2022;
   d. Removed Lorazepam medication prescribed to Resident B, in order to administer it to Resident A;

The panel assessed all of the evidence before it and noted that Colleague A and Witness 6 provided evidence in respect of this charge. The panel considered that this evidence was not so tenuous that taken at its highest, it could not properly result in this charge being found proved. Accordingly, the panel decided to proceed to consider this charge at the facts stage.

Charge 6.e

6. On 25-26 August 2022;
   e. Did not record in Resident B's medication administration record that you had removed medication from the medication stock designated to them

The panel assessed all of the evidence before it and noted that Colleague A and Witness 6 provided evidence in respect of this charge. The panel considered that this evidence was not so tenuous that taken at its highest, it could not properly result in this charge being found proved. Accordingly, the panel decided to proceed to consider this charge at the facts stage.

Details of charge (as amended)

Whilst working at Woodlands Hospital between October 2021 and 10 February 2023 you failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse in that you:

1. Behaved in an unprofessional manner in that you

   a. On one or more occasions used your mobile phone during work time; **[Proved by way of admission]**
   b. On one or more occasions extended a coffee break or lunch break without permission and/or were not in theatres when you were expected to be; **[Partially admitted] [Proved in its entirety]**
   c. Walked in to Theatre 3 with coffee and a biscuit; **[No case to answer]**
   d. Took a scalpel and was told to return it; **[No case to answer]**
   e. On 26 April 2022 did not effectively assist the team to set up for a procedure; **[Not proved]**
   f. On one or more occasions was rude and/or argumentative and/or aggressive towards mentors who were attempting to provide training/advice; **[Proved]**
   g. Participated in surgical procedures that you had no experience of without raising this with your mentor or a doctor; **[Proved]**

2. Demonstrated poor record keeping in that you

   a. On 25 March 2022 used an abbreviated term to record a medical procedure in the theatre register book; **[Proved by way of admission]**
   b. On 07 April 2022 used an abbreviated term to record a medical procedure in the theatre register book; **[Not proved]**
   c. On one or more occasions pre-completed patient documentation before the patient procedure commenced; **[Proved]**

d. On one or more occasions did not amend documentation appropriately by crossing with a horizontal line and including date/time/your initials; **[Proved by way of admission]**
e. On 23 August 2022 labelled a specimen as ‘gastroscopy’ rather than the documenting what the specimen was **[No case to answer]**

3. Demonstrated poor infection control in that you;

a. Demonstrated a poor clinical handwashing technique; **[Proved]**
b. Dropped a patch prepared for a procedure on to the trolley contaminating the sterile field; **[Not proved]**
c. Punctured and/or intended to ‘tape up’ a perforated fluid bag;**[Proved by way of admission]**
d. Threw a hypodermic needle in a waste bin rather than a sharps bin; **[Proved]**
e. On one or more occasions de-sterilised yourself once scrubbed in when putting microscope handles on or leaning on an unsterilised trolley; **[Proved]**
f. Trailed the thread of a suture over an exposed area of a patient **[No case to answer]**

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

a. Did not consistently ensure the Phacoemulsification machine completes its cycle and / or is set up properly; **[Proved]**
b. Were unable to correctly term the layers of the skin; **[Not proved]**
c. Were unable to mount blades on a knife; **[Proved]**
d. Was unable to inform the Surgeon that the instrument count was correct during a procedure; **[Proved]**
e. Were unable to mount a suture on a needle holder; **[Proved]**
f. Were unable to reliably set up a Theatre prior to a clinical list **[Not proved]**

5. On 17 August 2022 handed the keys to an operating theatre to a Healthcare Assistant and asked him to return them **[Proved by way of admission]**

Whilst working at Mount Vale Care Home

6. On 25-26 August 2022;

   a. Administered medication namely Lorazepam to Resident A when it was not prescribed to them; **[Proved]**
   b. Did not record in Resident A's medication administration record that you had administered Lorazepam; **[Proved]**
   c. Did not escalate Resident A's deteriorated condition by not escalating for further advice; **[Proved by way of admission]**
   d. Removed Lorazepam medication prescribed to Resident B, in order to administer it to Resident A; **[Proved]**
   e. Did not record in Resident B's medication administration record that you had removed medication from the medication stock designated to them **[Proved]**

7. On 26 August 2022 when discussing the Lorazepam medication administered to Resident A, you

   a. Crossed out the entry you had made pertaining to this on the handover sheet; **[Partially admitted] [Proved in its entirety]**
   b. told Colleague A that 'you would explain to the staff at hand-over that it was a mistake and say you did not give it' **[Proved]**

8. Your conduct at Charge 7 above was dishonest as you intended to conceal that you had made a medication error by administering Lorazepam to Resident A. **[Proved]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in respect of Charges 1-5 above, and your misconduct in respect of Charge 6 - 8.

Background

Charges 1-5 arose whilst you were employed by Woodlands Hospital (the Hospital). The Hospital is a 37 bedded hospital in which care is provided to NHS and private patients. Patients at the Hospital are treated for general surgery as well as ophthalmology, gynaecology and robotic hips and knees.

The Circle Health Group (the Group) employed and supported overseas nurses. As part of the Group's overseas project, following a successful interview you were supported in moving to England. When you arrived in England, the Group made you aware that you were expected to complete the OSCE and that this formed part of your employment conditions. Prior to commencing employment at the Hospital, you had previous experience of working in gynaecology surgical theatres and wards.

You commenced employment at the Hospital on 12 October 2021, and it was said that you were given time to familiarise yourself with the requirements of the role, as well as the policies and procedures. Prior to completing your OSCE, you were allocated a buddy who was a Healthcare Assistant. After you completed your OSCE on 22 February 2022 Witness 2, who was a registered nurse, was allocated to be your mentor. It was also said that you were supported and supervised by other registered nurses.

Concerns were raised about your conduct which included inappropriate use of your mobile phone and taking inappropriate and/or extended breaks. Concerns were also raised about your conduct and competence in the theatre which included alleged inadequate hand sanitisation and maintaining a sterile field in a theatre environment. It is also alleged that concerns were raised about your record keeping.

Following an alleged break down of the working relationship with your mentor, Witness 3 was assigned as a new mentor. It is alleged that your mentors found that you were

rude, and/or argumentative, and/or aggressive towards mentors who were attempting to provide training and advice.

On 27 January 2023, you were dismissed from your post at the Hospital.

Charges 6-8 arose when you were employed as registered nurse at Mount Vale Care Home (the Home). The Home provides residential care to residents who are frail and elderly and to some residents who have Dementia. The Home provides care to approximately 62 residents over two floors.

It is alleged that on the night shift of 25-26 August 2022, Resident A was agitated between 12:30am and 5am. It is alleged that at the handover on 26 August 2022, you said that you had administered half of a Lorazepam tablet to Resident A to whom this had not been prescribed. It is alleged that you said that you took the tablet from Resident B's medication supply.

Decision and reasons on facts

At the outset of the hearing, Ms Deery informed the panel that you made full admissions to charges 1.a, 2.a, 2.d, 3.c, 5 and 6.c. She also informed the panel that you made partial admissions to charges 1.b and 7.a.

The panel therefore finds charges 1.a, 2.a, 2.d, 3.c, 5 and 6.c proved in their entirety. The panel also found charges 1.b and 7.a partially admitted and will consider the disputed elements of these charges.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards, on behalf of the NMC and to those made by Ms Deery on your behalf.

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.

During its deliberations on the hearsay application, the panel decided that it would be assisted by hearing oral evidence from Person 12. The NMC made arrangements for Person 12 to give oral evidence during this hearing and the application to admit Person 12's evidence as hearsay fell away.

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

Witness 1:	Employed by Circle Health Group as a Clinical Services Manager for Theatre at the Hospital.
Witness 2:	Theatre Practitioner/Endoscopy Lead at the Hospital.
Witness 3:	Theatre Practitioner at the Hospital.
Witness 4:	Theatre Practitioner at the Hospital.
Person 12:	Ophthalmic Specialist at the Hospital.
Colleague A:	Registered Nurse at the Care Home.
Witness 5:	Registered Nurse at the Care Home.
Witness 6:	Care Practitioner at the Care Home.
Witness 7:	Frailty Nurse at Mayford House Surgery.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel took into account that you were of *‘good character’* and that this was relevant to you credibility and your propensity to act as alleged.

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

The following preamble applies to charges 1-5:

> *‘Whilst working at Woodlands Hospital between October 2021 and 10 February 2023 you failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse in that you:’*

In respect of this preamble, the panel determined that between October 2021 and 10 February 2023, in the context of your employment contract with the Hospital, you had a general duty to demonstrate the standards of knowledge, skill and judgement required to practise as a registered nurse. That panel will consider this preamble against each of the charges and particulars.

Charge 1.b.

1. Behaved in an unprofessional manner in that you

    b. On one or more occasions extended a coffee break or lunch break without permission and/or were not in theatres when you were expected to be;

This charge is found proved.

The panel noted that you accepted that on one or more occasion, you extended a coffee or lunch break without permission and/or that you were not in theatres when you were expected to be. The panel also noted that you did not accept that you behaved in

an unprofessional manner and it will therefore need to make a determination in relation to this element of the charge.

In your evidence you told the panel that you accepted that on two occasions, you were not in theatre when you were expected to be because you had a meeting with Witness 1, and on another occasion, you were having a meeting with the Royal College of Nursing (RCN).

In reaching this decision, the panel had regard to all of the evidence before it which included the oral and documentary evidence provided by Witness 1 and Witness 3. The panel noted that in her oral evidence, Witness 1 told the panel that if you leave the theatre, you need to inform your colleagues where you are going and why. She told the panel that unless you are on an authorised break or carrying out an approved task, you should not leave the theatre. Witness 1 said that everyone in theatre needs to be accounted for and colleagues must communicate where they are in case of an emergency. Witness 1 also told the panel that if she had a meeting with you, she would ensure that your colleagues were aware of it.

The panel had regard to Witness 2's local statement dated 28 April 2022 in which she stated:

> *'Glory had started the late shift on 26.04.22 @ 12:00 and was expected, as part of her role, to assist other members of staff to bring all the equipment into theatre 3 and to prepare for the afternoon ophthalmology list, starting @ 13:30. However, when I initially came around to theatre at approximately 13:05, following my lunch break, everyone that I asked ([Person 2], [Person 1], [Witness 2], [Person 16]) had not seen her recently. They stated that she had been there but had disappeared again (this is a recurrent problem). I had also been to theatre myself, preparing the microscope for use and to see what other preparations needed to take place, prior to the start of the lost, I had not seen Glory either. I was concerned as to her whereabouts, so I then went to ask [Witness 1] in her office if she had seen Glory, and she had not. It was also reported to me that she had not contributed to the setting up of theatres…*

I was also working with Glory in the ophthalmology list with [Person 17] on the evening list that same day. Unfortunately, [Person 17] had been delayed in the clinic therefore we were waiting in the anaesthetic area of Theatre 3 for her to arrive. Whilst we were doing this, Glory spotted her notebook on the side and said that she would put it in her locker. After approximately 10 minutes [Person 17] arrived to conduct the team brief, therefore I had to search for Glory once more. I went to the changing room to find her on her mobile phone.

This also took me back to a couple of weeks prior to that, when a similar situation had occurred for another list Glory was in with me. When it was time to perform the team brief, she was not there, I searched the department and called her and I could not find her, therefore, the team brief took place without her. She did appear in theatre 5 or 10 minutes into the start of the list, I explained that I could not find her anywhere for the team brief. Glory would not tell me where she had been when the team brief took place and when I had been looking for her.'

The panel found that Witness 2's witness statement and oral evidence was consistent with her contemporaneous statement. The panel accepted the evidence of Witness 2. The panel also noted that you accepted that on more than one occasion, you were not in theatres when you were expected to be. The panel therefore found that you on one or more occasions, were not in theatres when you were expected to be.

The panel considered that you had a duty to demonstrate the standards of judgement required to practise as a registered nurse which included ensuring that you were in theatres when you were expected to be. Having regard to the evidence of Witness 1, there was an expectation that you would be in theatres when you were expected to be, and if you were in a meeting, then this should have been communicated to your colleagues. The panel did not accept your explanation for being absent from the theatres, even if you were attending a meeting, you should have communicated this to your colleagues and in failing to do so, you behaved in an unprofessional manner.

Having regard to all of the above the panel found this charge proved on the balance of probabilities.

Charge 1.e.

1. Behaved in an unprofessional manner in that you

    e. On 26 April 2022 did not effectively assist the team to set up for a procedure;

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 2 and Witness 3. The panel also had regard to your evidence.

The panel had sight of Witness 2's local statement dated 27 April 2022 in which she stated the following:

> *'A few minutes later she very rudely shouted "why were you looking for me yesterday?, I was in theatre 3". I replied that everyone was looking for her to start the list and no one new she was. She then proceeded to verbally aggressively rant about her being in Theatre 3 all the time and had been setting things ready for the list. I know none of this to be true as I had set up for the list and she had been seen by other members of staff in the changing room on her phone. I also saw her coming out of the changing room door at 13:30 when she was supposed to have been in "theatre 3".'*

In her oral evidence, Witness 2 said that she had set up the theatre for the procedure on 26 April 2022.

The panel had regard to the evidence of Witness 3, in her witness statement she stated the following:

> *‘On 26 April 2022 Glory was asked to bring equipment into theatre to prepare for the surgery list. However Glory then disappeared and myself and other staff did not know where she was as it had been reported to me that Glory had not contributed to the setting up of theatre.’*

In her oral evidence, Witness 3 told the panel that she had set up the theatre.

In your evidence, you told the panel that you had been present in the theatre for the entire time. You said that at the relevant time, you were supernumerary and whilst you were comfortable in setting up the theatre for basic procedures, you could not set up for specialist procedures.

Having regard to all of the evidence the panel considered that it was unclear as to whether you had completed some of the set up for the procedure on 26 April 2022. The panel therefore found that that the NMC failed to discharge its evidential burden and found this charge not proved.

Charge 1.f.

1. Behaved in an unprofessional manner in that you

    f. On one or more occasions was rude and/or argumentative and/or aggressive towards mentors who were attempting to provide training/advice;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 2 and Witness 3. The panel also had regard to your evidence.

The panel had sight of Witness 2’s witness statement in which she stated the following:

‘I found Glory to be rude and aggressive in her demeanour and I have detailed these concerns in my statement []. This evidenced to me that Glory did not have the right attitude towards her learning and would become challenging towards myself and colleagues who were trying to support her.

Mentoring Glory was an extremely challenging experience. Despite spending a lot of time explaining things to Glory and the rationale behind practices, her attitude portrayed a lack of insight and awareness to situations. She would often argue with colleagues and surgeon [sic] in front of patients, displaying a dismissive attitude. This became frustrating as I was constantly repeating myself, even though I had tried various different ways of instruction and support, she often did not accept constructive criticism…’

The panel also had regard to the local statement of Witness 2 dated 27 April 2022 in which she stated the following:

‘A few minutes later she very rudely shouted “why were you looking for me yesterday?, I was in theatre 3”. I replied that everyone was looking for her to start the list and no one new she was. She then proceeded to verbally aggressively rant about her being in Theatre 3 all the time and had been setting things ready for the list. I know none of this to be true as I had set up for the list and she had been seen by other members of staff in the changing room on her phone. I also saw her coming out of the changing room door at 13:30 when she was supposed to have been in “theatre 3”. I quickly finished getting changed and left as I felt very uncomfortable being on my own with her.’

The panel had regard to the witness statement of Witness 3 in which she stated the following:

‘There are many role specific competencies that need to be achieved to a certain standard provided by Woodlands, which I needed to help Glory achieve. We would allocate any spare time after lists and sit down and talk through each competency, often, it was necessary to expand on and ask her many further

questions until a satisfactory answer was provided. She seemed to treat the whole exercise as a nuisance, and I felt that she lacked understanding in many aspects. I found this task challenging and felt that she did not always adopt the correct attitude. She would say to me that I asked her too many questions, encouraging me to simply sign off her competencies without treating them with the importance they deserve. I would set her a few simple tasks to do at home, which she did, as a method of making the answers more memorable for her. I tried to make our one- to-one time a fun element of her learning and to encourage her to adapt her fundamental nursing knowledge and practices to those required in theatres.'

The panel had regard to the Hospital's Fact-Finding Meeting notes dated 3 November 2022 in which *'Being aggressive and dismissive with other members of staff in theatre'* was one of the concerns raised.

In your evidence you denied this charge and said that you are not a rude or aggressive person. You said that you would ask questions but that this was not in a rude or aggressive manner.

Having regard to all of the evidence before it, the panel found the evidence of Witness 2 and Witness 3 to be consistent, credible and reliable. The panel therefore determined that it was more likely than not that on one or more occasions you were rude and/or argumentative and/or aggressive towards mentors who were attempting to provide training/advice. The panel also found that behaving in such a way was unprofessional and breached your duty to demonstrate the standards of judgment required to practise as a registered nurse.

Charge 1.g

1. Behaved in an unprofessional manner in that you

    g. Participated in surgical procedures that you had no experience of without raising this with your mentor or a doctor;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 2 and Witness 3. It also had regard to your evidence.

The panel had regard to Witness 2's local statement dated 28 April 2022 in which she stated the following:

> *'I was scrub practitioner for Cystoscopy list with two patients.*
>
> *For the first case I asked G Ogechi if she had done this procedure before. She said "yes, yes I have seen"*
>
> *I said I would set up the scope and talk her through it. I set up the scope explaining how each part works. I proceeded with the case. Once completed, Glory cleaned the scope, I then showed her how to pack it back in the tray. Someone else put the red cover back on and placed it in the sealed bag and into the hatch. (I honestly don't know which member of the team did this.)*
> *After the second case she said she thought it was a different procedure, a colonoscopy. I said we did not use bags of fluid for that procedure. When she described what she meant I determined she was talking about Venus procedures. I then said she must not say she has done procedures when she has not.*

The panel had regard to Witness 3's witness statement in which she stated the following:

> *'It concerned me further that Glory agreed to complete a surgical procedure despite knowing she had not attempted this before. This was an important aspect that I had reinforced with Glory during the signing off of her competencies. I had discussed similar scenarios at length with her where she agreed that she*

would never attempt to perform an aspect of surgery that she did not know about and that it was quite acceptable to admit this and to never work outside her scope of practice. One day I worked alongside Glory on an endoscopy list for [Person 18], consisting of colonoscopies. Prior to the session Glory informed me she had performed colonoscopies before when working with my colleague [Witness 2] and said that she was confident in her abilities to do this successfully. As the procedure progressed [Person 18] required a biopsy and Glory did not admit to me, until I questioned her that she had never actually taken a biopsy before and was prepared to go ahead and do this, despite never having used biopsy forceps and having no knowledge of how they worked. When Glory was questioned further by [Person 18] she only then admitted that she did not know what to do. This is a risk to patient safety and effective patient care.'

The panel heard oral evidence from both Witness 2 and Witness 3 which was consistent with their contemporaneous and witness statements.

In your evidence you denied this charge. You said that on both occasions there was a misunderstanding, and that this was as a result of there being different surgeons and their different methods of communication.

The panel found the evidence of Witness 2 and Witness 3 to be clear and consistent in respect of this charge. The panel therefore found that it was more likely than not that you participated in surgical procedures that you had no experience of without raising this with your mentor or a doctor. The panel considered that in not raising this, you could have potentially acted outside of the scope of your practice which was unprofessional. The panel therefore found that you failed in your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 2.b.

2. Demonstrated poor record keeping in that you

b. On 07 April 2022 used an abbreviated term to record a medical procedure in the theatre register book;

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 4.

The panel had regard to the witness statement of Witness 4 in which she stated the following:

> *'On 7 April 2022 when I was making an entry in the theatre register book I noticed, the entry made by Glory which said "EUA rectam and laying open of fistula in ano" when the procedure was actually and "examination under anaesthetic of rectum and laying open of fistula in ano"'*

The panel also had sight of Witness 4's local statement and noted that she did not mention you using an abbreviated term to record a medical procedure. In Witness 4's oral evidence, she confirmed that what is set out in her witness statement is correct.

The panel had regard to your evidence in which you said that this was not raised with you and could not recollect writing this.

The panel noted the inconsistencies in the evidence of Witness 4 and that she accepted that she had not directly witnessed you writing the entry. In addition, the panel had not been provided with the theatre register book and therefore could not independently verify that you had made the entry as alleged. Having regard to all of the evidence, the panel decided that the NMC had failed to discharge its evidential burden and found this charge not proved.

Charge 2.c.

2. Demonstrated poor record keeping in that you

c. On one or more occasions pre-completed patient documentation before the patient procedure commenced;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 2. It also had regard to your evidence.

The panel had sight of Witness 2's witness statement in which she stated the following:

> *'A scrub nurse is required to complete the care plan or WHO safety check list even when a patient has come to the Theatre from the anaesthetic room. I discussed and highlighted this to Glory on numerous occasions. – The WHO safety check list is a nationally recognised safety tool used within theatre environments to ensure the correct procedure is performed on the correct person. This is completed in three parts, firstly in the anaesthetic room prior to anaesthetic, secondly in Theatre prior to the operation and lastly at the end of the operation…'*

The panel also had sight of Witness 2's local statement dated 3 May 2022 in which she stated the following:

> *'she completes some of the care plan or WHO safety check list even before the patient has come into Theatre from anaesthetic room, despite this being highlighted and discussed on several occasions.'*

The panel heard oral evidence from Witness 2 which was consistent with her documentary evidence.

The panel had regard to your Performance Improvement Plans dated 3 and 6 May 2022 in which it was recorded that you started filling in the WHO (World Health Organisation) safety checklist and patient paperwork prior to the patient entering theatres.

The panel also had regard to your evidence in which you denied this charge and stated that it would not be possible to pre-complete this documentation. The panel bore in mind your evidence that the WHO checklist followed the patient through their journey. You explained that this started in the anaesthetic room and would only be completed finally in theatre once the procedure had begun, and consequently, could not be completed prior to a procedure.

The panel found that the evidence of Witness 2 was clear, consistent and reliable. It therefore found that it was more likely than not that on one or more occasions, you pre-completed patient documentation before the patient procedure commenced. The panel found that this demonstrated poor record keeping and breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 3.a.

3. Demonstrated poor infection control in that you;

   a. Demonstrated a poor clinical handwashing technique;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and Witness 3. The panel also had regard to your evidence.

The panel had regard to the witness statement of Witness 3 in which she stated the following:

> *'Nurses' perform a surgical scrub before they go into the surgery, this includes washing hands and forearms, donning a gown and putting on gloves. There is a specific way to wash our hands. The purpose of this is to promote patient safety*

and help to prevent contamination and infections.

In regard to her handwashing technique, I visited this area of concern on several occasions. Glory did not appear to have awareness of timing involved in the process and did not know about the different scrub solutions, what they contained and how to use each of them. Hand washing is a key part of being a scrub nurse.'

The panel also had regard to Witness 3's oral evidence.

In your evidence you told the panel that you felt quite confident in your handwashing technique but that the timings and solutions were different to what you were used to in your previous practice.

The panel found the evidence of Witness 3 to be clear, consistent and reliable. It considered that it was more likely than not that you demonstrated poor infection control in demonstrating a poor handwashing technique. The panel also found that you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 3.b.

3. Demonstrated poor infection control in that you;

    b. Dropped a patch prepared for a procedure on to the trolley contaminating the sterile field;

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 3. It also had regard to your evidence.

The panel had sight of Witness 3's witness statement in which she stated the following:

> *'On one occasion, after Glory had been working in this role for three months, she took a swab which had been used to clean a patient's unsterile eye area and dropped it intentionally onto her sterile trolley, because another one was needed. This is something that we would never do as it contaminates the sterile field. She had been containing unclean swabs like this in her gallipot for every case since she started in Ophthalmology; therefore I wondered why she had suddenly deemed this practice appropriate. The surgeon addressed her mistake when it occurred therefore I did not say anything further to Glory. I always strived to avoid too much additional confrontation in an attempt to foster a nurturing attitude and to promote an effective learning environment.'*

The panel also heard evidence from Witness 3 that it was accepted practice that if a sterile field is compromised, a drape can be used to cover the area.

In your evidence you accepted that you did drop a patch prepared for a procedure on to the trolley contaminating the sterile field, however maintained that this was by accident and that you covered the area with a drape to maintain the sterile field.

Having regard to all of the evidence before it, the panel considered that it was more likely than not that you dropped a patch prepared for a procedure on to the trolley contaminating the sterile field. However, the panel accepted your explanation that this was done by mistake and that you had taken appropriate remedial action thereafter. Therefore, the panel considered that you had not failed to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge not proved.

Charge 3.d.

3. Demonstrated poor infection control in that you;

    d. Threw a hypodermic needle in a waste bin rather than a sharps bin;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 3. The panel also had regard to your evidence.

The panel had sight of Witness 3's witness statement in which she stated the following:

> *'During surgery with [Person 19] I repeatedly corrected her practises and advised Glory of approaches to improve and reduce her mistakes. Examples include… and throwing hypodermic needles into the rubbish bag, as opposed to the sharps bin. Furthermore, if I highlighted an error to Glory she would deny any wrong doing, not admit accountability and often became argumentative.'*

The panel also heard oral evidence from Witness 3.

In your evidence you denied having thrown a hypodermic needle in a waste bin instead of a sharps bin, rather, you said that you dropped the metal lid of a vial on the floor and you could not find it.

The panel found that the evidence of Witness 3 was consistent, credible and reliable in respect of this charge. The panel therefore found that it was more likely than not that you demonstrated poor infection control in that you threw a hypodermic needle in a waste bin rather than a sharps bin. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 3.e.

3. Demonstrated poor infection control in that you;

e. On one or more occasions de-sterilised yourself once scrubbed in when putting microscope handles on or leaning on an unsterilised trolley;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Person 12 and Witness 2.

The panel had regard to the local statement of Person 12 dated 18 October 2022 in which she stated the following:

> *'Sometimes when Glory is scrubbed I have observed her de-sterilise herself and not realise. For example; when putting the microscope handles on, leaning on an unsterile trolley. I have had to point this out to her at which point she will question it before changing her gloves or re-gowning and gloving.'*

The panel also heard oral evidence from Person 12.

The panel had sight of Witness 2's witness statement in which she stated the following:

> *'…for example, she did not seem to grasp the basic concept of a 'sterile field' and would often desterilise herself or an area but deny doing so when challenged.'*
> In your evidence, you accepted that de-sterilising can happen and that when it did, you could change your gloves and keep the field sterile.

The panel found the evidence of Person 12 and Witness 2 to be consistent, credible and reliable. It therefore determined that it was more likely than not that you demonstrated poor infection control in that you, on one or more occasions, de-sterilised yourself once scrubbed in when putting microscope handles on or leaning on an unsterilised trolley. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 4.a.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    a. Did not consistently ensure the Phacoemulsification machine completes its cycle and / or is set up properly;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1, Witness 2, Witness 3 and Person 12. The panel also had regard to your evidence.

The panel had regard to the witness statement of Witness 2 in which she stated the following:

> *'For Cataract surgery we use a Phacoemulsification machine, this machine uses a tiny probe which is inserted into the eye and emits an ultrasound wave to soften and breakdown the lens so it can be removed by suction. When we are setting up for surgery we need to ensure this machine has to complete a set up system as test. Glory would be expected to maintain the sterile field. Insert a cartridge int the machine, follow on screen instructions to prime and run the test. When complete, attach tubes to Phaco hand piece, press button again to complete pressure test. Glory often did not follow the on screen instructions and disrupt the test cycle, causing the machine to 'error' and the process would have to start again, despite being shown and her demonstrating competence on a number of occasions. There was no consistency in her ability.'*

The panel also had sight of Witness 2's local statement dated 3 May 2022 and heard oral evidence from her.

In your evidence, you told the panel that the Phaco machine would often malfunction and that this was not as a consequence of your actions.

The panel heard evidence from Witness 1 and Witness 3, who both said that it was the only Phaco machine in the department and if it malfunctioned, then a service engineer would have been called. Witness 1 confirmed that a service engineer was not called and there was no record of them being called during the period in question.

The panel found the evidence of Witness 1, Witness 2, Witness 3 and Person 12 to be consistent and reliable. The panel therefore found that it was more likely than not that you demonstrated a lack of clinical knowledge and/or skills in that you did not consistently ensure the Phacoemulsification machine completes its cycle and / or is set up properly. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 4.b.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    b. Were unable to correctly term the layers of the abdomen;

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 4. The panel also had regard to your evidence.

The panel had regard to the witness statement of Witness 4 in which she stated the following:

> *'On a date I cannot recall, I asked Glory to explain to me the layers of the abdomen. I was discussing these particular details as we were due into theatre, and I wanted Glory to be prepared for what the procedure entailed and for her to relay her basic understanding of the abdomen layers. When I asked, Glory was*

unable to tell me the name of the first layer and so I told her it was called “skin” I thought this may prompt her to recall the other layers of the abdomen. However, after I shared that the first layer was called skin I asked Glory what the next layer was called, she responded by saying “another layer”, I prompted to ask what another layer could be called she kept responding with “another layer”. Glory was not able to name the actual layers of the abdomen. There are three layers of the abdomen. This information is basic nursing knowledge.’

The panel also heard oral evidence from Witness 4.

In your evidence you told the panel that you were never asked this question and that you do know the layers of the abdomen. In your evidence you were able to recite the layers of the abdomen.

The panel noted that the only evidence presented to support this charge was the evidence of Witness 4. In the absence of any supporting evidence, such as this being listed on your Performance Improvement Plan, the panel found that the NMC had failed to discharge its evidential burden and found this charge not proved.

Charge 4.c.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    c. Were unable to mount blades on a knife;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 4. It also had regard to your evidence.

The panel had regard to the witness statement of Witness 4 in which the following was stated:

‘Glory and I then began scrubbing ourselves in preparation for theatre. While I was scrubbing alongside Glory I realised she was unable to mount the blade onto a knife handle correctly and unable to put sutures into the needle holders. Glory appeared to show a lack of understanding of how to do these tasks and needed my support. Again, as a theatre nurse this is a basic requirement and basic knowledge which I would have expected Glory to know.’

The panel also had regard to Witness 4’s local statement dated 28 April 2022 and your Performance Improvement Plan dated 3 and 6 May 2022.

In your evidence, you told the panel that there had been a change to policy and procedure and that you were expected to use forceps instead of hands to mount the blades on a knife. You said that everyone was requiring time to adjust to this change.

The panel noted that no evidence to support the change in policy had been presented. It found the evidence of Witness 4 to be consistent, credible and reliable in respect of this charge. The panel therefore found that it was more likely than not that you demonstrated a lack of clinical knowledge and/or skills in that you were unable to mount blades on a knife. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 4.d.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    d. Was unable to inform the Surgeon that the instrument count was correct during a procedure;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1, Witness 3 and Witness 4. It also had regard to your evidence.

The panel had regard to the witness statement of Witness 4 in which she stated the following:

> *'During the theatre procedure Glory demonstrated a complete lack of awareness as to what was going on around her. As a theatre nurse you have to inform the surgeon that the needle, swab and instrument count is correct. This is firstly done prior to surgery starting. A second count needs to be done upon the closing of the first layer. The surgeon needs to be informed that all is correct at this stage before continuing to close the following layers up to skin. A final count is then done at skin with the surgeon duly being informed that all is correct. A scrub nurse may commence an instrument count at any stage if she wishes. During the procedure Glory did not complete the instrument count.*
>
> *informed Glory of the hospital policy and relation to this and then verbally demonstrated the correct way of informing the surgeon. The surgeon confirmed that was correct and confirmed he needed to hear this at every stage of the procedure. Any this is basic nursing knowledge and Glory would have been expected to do this.'*

The panel also heard oral evidence from Witness 4.

The panel had regard to the evidence of Person 12 and Witness 3 which supported the evidence of Witness 4 in respect of this charge.

In your evidence, you told the panel that you know how to carry out a count and that you did it regularly in your previous job working as a nurse in Nigeria. You also said that at the relevant time, you were not working independently.

The panel accepted the evidence of Witness 3, Witness 4 and Person 12. It therefore found that it was more likely than not that you demonstrated a lack of clinical knowledge and/or skills in that you were unable to inform the Surgeon that the instrument count was correct during a procedure. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 4.e.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    e. Were unable to mount a suture on a needle holder;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to all of the evidence of Witness 1, Witness 3 and Witness 4. The panel also had regard to your evidence.

The panel had sight of Witness 3's witness statement in which she stated the following:

> *'I would repeatedly correct poor practice, suggest techniques for improvement and provide the necessary rationale to back up why we do things in a certain way. This would include the mounting of sutures onto the needle holder. She had observed this on countless occasions, and it was demonstrated to her by a surgeon on several occasions, whilst doing a case, but she seemed somewhat reluctant to adopt his advice.'*

The panel also had sight of Witness 1's witness statement in which she stated the following:

> *'It was fed back to me, whilst I was on annual leave. As I understand, Glory was in theatre and the surgeon had asked her to mount the needle the way he*

wanted. It is usual for the surgeon to advise the nurse how they would like the needle to be positioned and the nurse would be expected to continue placing the needle in the same position for all the patients.'

The panel had regard to the Witness statement of Witness 4 in which she stated the following:

'Glory and I then began scrubbing ourselves in preparation for theatre. While I was scrubbing alongside Glory I realised she was unable to mount the blade onto a knife handle correctly and unable to put sutures into the needle holders. Glory appeared to show a lack of understanding of how to do these tasks and needed my support. Again, as a theatre nurse this is a basic requirement and basic knowledge which I would have expected Glory to know.'

In your evidence, you told the panel that surgeons wanted sutures mounting on a needle holder in different ways and that they would show you how to do it in their preferred way.

The panel found the evidence of Witness 1, Witness 3 and Witness 4 to be consistent, credible and reliable. The panel therefore found that it was more likely than not that you demonstrated a lack of clinical knowledge and/or skills in that you were unable to mount a suture on a needle holder. The panel also found that in doing so, you breached your duty to demonstrate the standards of knowledge, skill and judgment required to practise as a registered nurse. Accordingly, the panel found this charge proved.

Charge 4.f.

4. Demonstrated a lack of clinical knowledge and/or skills in that you;

    f. Were unable to reliably set up a Theatre prior to a clinical list

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 2 and Witness 3. It also had regard to your evidence.

The panel heard evidence from Witness 3 who stated that you would regularly not be present during the preparation for the theatre list. The panel also heard evidence from Witness 2 who said that you were able to demonstrate that you could set up for theatre correctly but then you did not. The panel also heard evidence from both Witness 2 and Witness 3 that it was not one person's responsibility to set up for theatre and that it was a team effort.

In your evidence, you told the panel that you were able to set up theatre prior a clinical list. You accepted that at the relevant time, you were unable to set up theatre for specialist procedures.

The panel found that the NMC had failed to discharge its evidential burden in respect of this charge. The panel therefore found this charge not proved.

Charges 6-8

The following preamble applies to charges 6-8:

'Whilst working at Mount Vale Care Home'

Charge 6.a.

6. On 25-26 August 2022;

    a. Administered medication namely Lorazepam to Resident A when it was not prescribed to them;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A, Witness 5 and Witness 6. It also had regard to your evidence.

The panel had regard to Colleague A's witness statement in which she stated the following:

> *'I came into work as usual on the morning of 26 August 2022. I always get to work around 7.00am so I am ready for handover at 7.15am, Glory handed over to me, she went through the issues from the night shift with no concerns. Then she said to me that Resident A had been particularly noisy for long periods of time during the night and had been agitated, this was between 12.30am and 05.00am. Her next statement particularly shocked and concerned me. Glory said, "I made a nursing judgement that this lady needs something" (referring to Resident A). Glory went on to say "I gave Resident A half a Lorazepam tablet which I had taken from the medication supply of Resident B". I asked Glory to repeat herself, which she did. She was very confident and self-assured and repeated on three or four occasions that she had made a "nursing judgement".'*

The panel heard oral evidence from Colleague A.

The panel also had regard to the witness statement of Witness 6 in which the following was stated:

> *'I do day shifts, and on the morning of Friday 26 August 2022 I was at work and I was present at the morning handover at 7:15 am. [Colleague A] was the nurse in charge for that day shift and she was receiving the handover from Glory. At the handover Glory stated that during the previous night shift she had given Resident A half a Lorazepam tablet as the resident had been agitated and unsettled. Glory also stated that she had taken Lorazepam from Resident B to give it to Resident A.'*

The panel also heard oral evidence from Witness 6.

The panel also had regard to the hearsay documentary evidence of Person 14 and Person 15, both of whom were present during the handover and reported that they witnessed you saying that you had administered Lorazepam to Resident A. The panel gave some weight to this hearsay evidence as it was corroborated by the evidence of Colleague A and Witness 6.

The panel had regard to the witness statement of Witness 5 in which she stated the following:

> *'I do not recall a specific time but at some point during the night shift Glory came to the ground floor and mentioned to me that a resident has been agitated. Glory asked if she could give the resident some Lorazepam, I responded to Glory and said "yes, it's ok, if the are written up, then by all means give it to them". When I say "written up" this is nursing language and means that the resident has a prescription and therefore is prescribed the medication.'*

The panel also heard oral evidence from Witness 5.

The panel heard evidence from Colleague A who confirmed that Lorazepam had not been prescribed to Resident A. The panel also had sight of Resident A's MAR chart which showed that Resident A had not been prescribed this medication.

In your evidence, you denied this charge and said that there had been a miscommunication, and you had suggested that the GP be contacted to see if Resident A could be prescribed Lorazepam.

The panel considered that the direct evidence of Colleague A and Witness 6 was clear, consistent and reliable in respect of this charge. The direct evidence was also supported by Person 14, Person 15 and Witness 5. The panel found that given the number of witnesses who have given evidence that you said that you had given Lorazepam to Resident A, it was implausible that they had all misunderstood what you had said. Having regard to all of the evidence before it, the panel decided that it was more likely than not that on the nightshift of 25-26 August 2022, you administered

Lorazepam to Resident A when it was not prescribed to them. Accordingly, the panel found this charge proved.

Charge 6.b.

6. On 25-26 August 2022;

   b. Did not record in Resident A's medication administration record that you had administered Lorazepam;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A. It also had regard to your evidence.

The panel had regard to Colleague A's witness statement in which the following was stated:

> *'I asked Glory where she had detailed Resident A's MAR chart that she had given Lorazepam medication and Glory confirmed she did not update the MAR chart for Resident A.'*

The panel had sight of Resident A's MAR chart and noted that there was no record of Lorazepam being administered.

In your evidence, you told the panel that you did not make an entry as you did not administer Lorazepam to Resident A.

The panel accepted the evidence of Colleague A which was supported by Resident A's MAR chart. The panel therefore found that it was more likely than not that on the nightshift of 25-26 August 2022, after administering Lorazepam to Resident A, you did not make an entry in their MAR chart. The panel therefore found this charge proved.

Charge 6.d.

6. On 25-26 August 2022;

   d. Removed Lorazepam medication prescribed to Resident B, in order to administer it to Resident A;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A and Witness 6. It also had regard to your evidence.

The panel had regard to the witness statement of Colleague A and noted the following:

> *'Glory went on to say "I gave Resident A half a Lorazepam tablet which I had taken from the medication supply of Resident B". I asked Glory to repeat herself, which she did.*
>
> *…*
>
> *I went with Glory to count the Lorazepam medication for resident B, and I can confirm there was half a milligram missing. I rechecked the Lorazepam medication with a healthcare assistant [Witness 6] and we also found half a milligram missing.'*

The panel also had regard to Witness 6's witness statement in which she stated the following:

> *'Following the handover [Colleague A] took Glory into the treatment room and shortly after that Glory left. [Colleague A] then asked me to join her in counting the medication and we found 0.5mg of Lorazepam missing which was unaccounted for in the medication for Resident B.'*

The panel heard oral evidence from Colleague A and Witness 6. The panel also had sight of Resident B's MAR chart in which it was recorded that Lorazepam had been prescribed for Resident B and that it had not been administered for the two days prior.

Furthermore, the panel also bore in mind the evidence of Witness 6 that she had been asked by Colleague A to complete a medication stock check count of Resident B;s medication and they had found that 0.5mg of Lorazepam was unaccounted for. The panel had sight of Resident B's MAR chart in which both Colleague A and Witness 6 had signed confirming this stock discrepancy.

You denied this charge and offered an explanation that you had administered Lorazepam to Resident B the previous night which you said you had discussed with Witness 5.

The panel found the evidence of Colleague A and Witness 6 to be clear, consistent and reliable. The panel preferred Colleague A and Witness 6's account as it had sight of Resident B's MAR chart in which there was no entry confirming that you had administered Lorazepam to them two days prior. Consequently, the panel considered your evidence to be inconsistent. Accordingly, the panel determined that it was more likely than not that on the nightshift of 25-26 August 2022, you removed Lorazepam medication prescribed to Resident B, in order to administer it to Resident A and that on the balance of probabilities that this accounted for the missing 0.5mg of Lorazepam from Resident B's medication stock. The panel therefore found this charge proved.

Charge 6.e.

6. On 25-26 August 2022;

    d. Did not record in Resident B's medication administration record that you had removed medication from the medication stock designated to them

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A and Witness 6.

The panel had regard to the witness statement of Colleague A in which she stated the following:

> *‘Glory went on to say “I gave Resident A half a Lorazepam tablet which I had taken from the medication supply of Resident B”. I asked Glory to repeat herself, which she did.’*

In her oral evidence Colleague A told the panel that you did not record in Resident B’s MAR chart that you had taken their medication stock to give to Resident A. Witness 6 also confirmed that she had seen Resident B’s MAR chart and you had not made an entry in it to say that you had taken their medication.

In your evidence, you told the panel that you did not make an entry in Resident B’s MAR chart as you did not take their medication supply for Resident A.

The panel found the evidence of Colleague A and Witness 6 to be consistent, credible and reliable. The panel had sight of Resident B’s MAR chart and noted that there was no record of Lorazepam being taken from their medication stock. The panel therefore found this charge proved on the balance of probabilities.

Charge 7.a.

> 7. On 26 August 2022 when discussing the Lorazepam medication administered to Resident A, you
>
> > a. Crossed out the entry you had made pertaining to this on the handover sheet;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A and Witness 6. The panel also had regard to your evidence.

The panel noted that you had made a partial admission to this charge, in that you accepted that you crossed out the entry, but you did not accept that you administered Lorazepam to Resident A.

The panel had regard to Colleague A's witness statement in which she stated the following:

> *'Glory had completed an entry on the handover notes, however, following our discussion that I told Glory this was unacceptable she scribbled this entry out on the handover sheet.'*

The panel had sight of the handover sheet in which an entry had been scribbled out, rendering it illegible. Furthermore, the panel noted under panel questions, that you accepted that you should have simply put one line through the entry, signed and dated it which you had not done, albeit you explained that you used it as a note to remind yourself about what you wished to say. The panel heard oral evidence from Colleague A which was consistent with her documentary evidence.

The panel found the evidence of Colleague A to be consistent, credible and reliable. The panel previously found that it was more likely than not that you administered Lorazepam to Resident A and discussed this with Colleague A. The panel preferred the evidence of Colleague A and considered that it was more likely than not that following a discussion about the inappropriateness of administering Lorazepam to Resident A, you crossed out the entry pertaining to this on the handover sheet.

Charge 7.b.

> 7. On 26 August 2022 when discussing the Lorazepam medication administered to Resident A, you

b. told Colleague A that ‘you would explain to the staff at hand-over that it was a mistake and say you did not give it’

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague A.

The panel had regard to Colleague A’s local statement dated 26 August 2022 in which she stated the following:

> *‘She also asked me that she will explain to the staff at hand-over that it was a mistake and say it was a mistake and she didn’t give it.’*

The panel also heard oral evidence from Colleague A which was consistent with her documentary evidence.

In your evidence, you denied this charge.

The panel found the evidence of Colleague A to be consistent, credible and reliable. The panel had regard to the context in which this charge arose and considered that it was more likely than not that after realising that you should not have administered Lorazepam to Resident A, you told Colleague A that *‘you would explain to the staff at hand-over that it was a mistake and say you did not give it’.* The panel therefore found this charge proved.

Charge 8

Your conduct at Charge 7 above was dishonest as you intended to conceal that you had made a medication error by administering Lorazepam to Resident A.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it.

In determining whether your actions were dishonest, the panel had regard to the NMC Guidance on *‘Making decisions on dishonesty charges and the professional duty of candour’* (Reference: DMA-8 Last Updated 06/05/2025) which sets out the following factors that need to be considered:

- *‘what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*
- *whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *whether there is evidence of alternative explanations, and which is more likely.’*

Having been informed by Colleague A that your actions in taking Lorazepam from Resident B to administer to Resident A were unacceptable, the panel considered that your actions in scribbling out your entry on the handover sheet so it was no longer legible, and seeking to retract what you had said during the handover, were an attempt to conceal what you had done. The panel was of the view that after your conversation with Colleague A, you would have known that you had incorrectly administered Lorazepam to Resident A, and in attempting to conceal that you had, the panel considered your actions were deliberate to hide what you had written and said.

In respect of alternative explanations, the panel had no other plausible or reasonable explanation for you crossing out the entry and seeking to retract what you had said during the handover. These two actions, in the panel’s view, demonstrated an intent to conceal.

The panel had regard to the test as set out in the case of *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67*. As set out above, the panel determined that you knew that you had administered Lorazepam to Resident A when you should not have and you attempted to conceal that you had. The panel considered that in light of your knowledge, you conduct was dishonest by the standards of ordinary, decent people.

The panel therefore found this charge proved on the balance of probabilities in respect of charge 7.

Interim order

As this hearing did not complete within the allocated dates, and as this matter will be relisted to be completed at a later date, the panel invited representations on whether it was necessary to make an interim order pursuant to Rule 32(5).

Mr Edwards, on behalf of the NMC, made no application for an interim order.

Having heard that the NMC deemed that this panel did not need to consider an interim order, this hearing adjourned.

[This hearing resumed on 12 February 2026 for one day and the panel handed down its decision on fitness to practise when it resumed on 17 March 2026]

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 lack of competence 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

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

Mr Edenborough invited the panel to take the view that the facts found proved amount to misconduct. He submitted that the charges are directly linked to your clinical practice and the standard of care provided. In respect of the charge of dishonesty and your

behaviour towards colleagues, Mr Edenborough submitted that these are serious and invited the panel to consider whether there is evidence of a deeper attitudinal issue.

Ms Deery referred the panel to the cases of *Roylance v General Medical Council* (No2) [2000] 1 AC 311 and *R (on the application of Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin). She submitted that the question of whether the charges amounted to misconduct is a matter for the panel.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Mr Edenborough invited the panel to take the view that the facts found proved amount to a lack of competence. He submitted that whilst it is accepted that you had moved into a different professional environment with different culture and practices, there were a broad range of failures on numerous occasions which amounted to lack of competence.

Ms Deery referred the panel to the NMC on *'Lack of Competence' (Reference FtP-2b)*. She submitted that a registrant's specialism needs to be taken into account and that the panel needs to have regard to the relevant procedures, policy and guidance in determining lack of competence.

Ms Deery informed the panel that when the charges arose, you were a newly qualified nurse in the UK, having previously practised as a registered nurse in Nigeria. She told the panel that you had previously specialised in gynaecology theatre wards and when you moved to the UK you faced significant challenges. Ms Deery submitted that you felt unsupported and you were not provided with specific training. She submitted that in May 2022, two months after you had passed your OSCE, you were signed off on all of your

competencies. She submitted that as a newly qualified nurse in the UK, you were not provided with specific and adequate training and there was a lack of support.

Submissions on impairment

Mr Edenborough 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).

Mr Edenborough referred the panel to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026). He submitted that all of the charges go to public safety in a clinical context and that by virtue of the clinical context and risk a finding of impairment is required to protect the public. Mr Edenborough submitted that taking into account all of the charges that have been found proved, including dishonest, a finding of impairment is required in the wider public interest to mark the seriousness of the misconduct and maintain public confidence in the profession.

Ms Deery submitted that your fitness to practise is not currently impaired. She invited the panel to have regard to the contextual and personal factors. Ms Deery drew the panel's attention to your bundles of documents and submitted that you have demonstrated considerable insight, provided evidence of training and supportive testimonials.

Ms Deery informed the panel that you have been working for an Agency either as a care assistant or senior care assistant since November 2024. Ms Deery told the panel that your employer is aware of the NMC proceedings and they have been supportive of you. As part of your role as a care assistant, Ms Deery informed the panel that you give medication in accordance with care plans, adhere to record keeping policies and are involved in discharges. She submitted that no concerns about your clinical practice or behaviour have been raised in any other employment in the UK or in Nigeria. Ms Deery

submitted that in all of the circumstances, it is unlikely that the same or similar situation would occur again. She submitted that if a finding is not made, there is no risk to the public and a finding of impairment is not required in the public interest.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to the NMC Guidance and a number of legal authorities.

When determining whether 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 panel was of the view that in respect of charges 6, 7 and 8, your actions fell significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.2** 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*

***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

***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*

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*

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care 13.2 make a timely referral to another practitioner when any action, care or treatment is required*
13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

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*
14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

16 Act without delay if you believe that there is a risk to patient safety or public protection
To achieve this, you must:
16.2 *raise your concerns immediately if you are being asked to practise beyond your role, experience and training*

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*

__18.3__ make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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…

The panel acknowledged that a breach or breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in failing to escalate concerns about Resident A and taking medication from Resident B and administering it to Resident A when it was not prescribed to them was unsafe and had the potential to cause harm. The panel also considered that in failing to complete the records accurately for both residents the course of action you had taken was a serious departure from the standards expected.

The panel was of the view that your actions following the administration of medication that was not prescribed to Resident A was serious as you sought to conceal what you had done. The panel found that the sequence of events as set out in charges 6, 7 and 8 were serious, deliberate and fell significantly short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on lack of competence

Having found charges 1.a, 1.b, 1.f, 1.g, 2.a, 2.c, 2.d, 3.a, 3.c, 3.d, 3.e, 4.a, 4.c, 4.d, 4.e and 5 proved, the panel went on to consider, whether these amount to a lack of competence and, if so, whether your fitness to practise is currently impaired.

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 had regard to the NMC Guidance on *'Lack of Competence'* (Reference: FTP-2b Last Updated: 14/04/2021) which sets out the following:

> *'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'*

In assessing lack of competence the panel also took into account that in *Holton v General Medical Council* [2006] EWHC 2960 (Admin) the standard to be applied is that applicable to a post which a professional had been appointed to and the work they were carrying out taking into account any speciality in that post.

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

Charge 1.a. The panel was of the view that using your phone at work was a behavioural issue and therefore it did not amount to lack of competence.

Charge 1.b. The panel considered that taking breaks without permission was a behavioural issue and it therefore did not amount to lack of competence.

Charge 1.f. In being rude, argumentative and aggressive to mentors, the panel considered that this was a behavioural issue which did not fall within the parameters of lack of competence.

Charge 1.g. The panel was of the view that in participating in surgical procedures that you had no experience of without raising this with your mentor or a doctor amount to lack of competence. The panel was satisfied that there was sufficient support and supervision available to you.

Charge 2.a. The panel was of the view that using an abbreviated term to record a medical procedure on one occasion did not amount to lack of competence taking into consideration that you were a new nurse in the UK and the error was not exceptionally serious.

Charge 2.c. The panel considered that as you pre-completed patient information on more than one occasion it was unsafe practice and an unacceptably low standard, this amounted to a lack of competence.

Charge 2.d. The panel was of the view that whilst you did not amend documentation appropriately, in the context of this case, namely that it happened only on one occasion and was not repeated, it did not amount to a lack of competence.

Charge 3.a. The panel noted that as you were working in a specialist and aseptic environment you were expected to use proper handwashing techniques. The panel heard evidence from witnesses who said that they provided support in ensuring that you were aware of proper handwashing techniques and despite the support provided, you did not meet this competency. The panel therefore found that this charge amounted to lack of competence.

Charge 3.c. Whilst the panel acknowledged that you taped up a fluid bag on one occasion, the panel considered that this was exceptionally serious and amounted to lack of competence.

Charge 3.d. The panel was of the view that disposing of sharps inappropriately was hazardous and exceptionally serious and amounted to lack of competence.

Charge 3.e. The panel considered that in de-sterilising yourself in the theatre this amounted to lack of competence. You were provided with significant support and mentoring in an attempt to ensure you were competent in sterilisation and had in-fact been signed off as competent.

Charge 4.a. The panel was of the view that in failing to ensure that the machine was used correctly on a number of occasions despite receiving support and training amounted to lack of competence.

Charge 4.c. The panel considered that being able to mount a blade was a basic requirement of a nurse working in a theatre. In failing to achieve this competency after receiving support the panel found that this amounted to lack of competence.

Charge 4.d. The panel was of the view that being able to inform the surgeon of an instrument count was a basic requirement of a nurse working in a theatre. The panel noted that concerns about your competency in this area were raised on more than one occasion and was an unacceptably low standard. The panel therefore found that this charge amounted to lack of competence.

Charge 4.e. The panel heard evidence from three witnesses who said that you were unable to mount a suture on a needle holder on a number of occasions despite support and training being provided. The panel was of the view that this was a basic skill required by the role of a theatre nurse and amounted to lack of competence.

Charge 5. The panel considered that giving the key for an operating theatre to a Healthcare Assistant on one occasion was not exceptionally serious and did not amount to lack of competence.

Taking into account the reasons given by the panel for the findings of the facts and the reasons set out above, the panel has concluded that your practice fell significantly

below the standards expected of a theatre nurse and amounted to lack of competence in respect of charges 1.f, 1.g, 2,.c, 3.a, 3.c, 3.d, 3.e, 4.a, 4.c, 4.d and 4.e.

The panel also found that in relation to lack of competence, parts 1.2, 6.2, 8.5, 10.1, 13.4, 16.2, 19.1, 19.3 and 20.1 of the Code had been breached.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct as found in charges 6, 7 and 8, 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 occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel found that your lack of competence placed patients undergoing treatment in the theatre at an unwarranted risk of harm. The panel also found that in using Resident B’s medication for another resident, this placed them at a risk of harm as this depleted the stock of medication for Resident B which may have resulted in the medication not being readily available when needed. In giving Resident A medication that was not prescribed for them, you practised beyond your role as a nurse and therefore you placed them at an unwarranted risk of harm as you did not know how it would interact with any other medication or whether it was safe for them.

Dishonesty and preserving patient safety are a fundamental tenets of the profession. The panel was of the view that in administering medication to a resident without a prescription followed by your failure to be candid about your actions represented a serious departure from professional standards, and as a result, you brought the profession into disrepute.

The panel was of the view that as lack of competence is clinical in nature it is possible to address this through training. The panel went on to consider whether the misconduct found is capable of remediation. The panel considered that whilst the dishonesty found occurred in relation to one incident and was initially opportunistic, it then persisted and you made considerable and pre-meditated efforts to cover up that you had wrongly administered Resident A medication that had not been prescribed. Evidence of this premeditation included attempting to erase your written entry and stating to a colleague that you would inform the rest of the team that you had not given the medication. Consequently, the panel considered that when you became aware that you should not have given this medication, you sought to conceal your actions rather than ensuring patient safety through transparency in the care you provided and through your duty of candour. The panel further considered that the charges relating to misconduct raised potential deep seated attitudinal concerns about honesty and accountability. The panel acknowledged that whist not impossible, dishonesty and attitudinal concerns are inherently difficult to remediate.

The panel went on to consider whether you had remediated your misconduct and addressed your lack of competence.

The panel had regard to your reflective statement and considered that your insight into your lack of competence and misconduct was limited. The panel noted that whilst you are entitled to maintain your defence to the charges at the impairment stage, some two months have elapsed since the decision on facts was handed down providing you with an ample opportunity to provide a detailed reflection. The panel considered that you have shown some remorse for your actions, you have not reflected in any sufficient detail, including within the abstract, on the potential severity of the impact of your

actions on patients/their safety, colleagues' ability to safely care for resident or the wider public confidence and trust in the nursing profession.

The panel noted that you have provided some evidence of training and positive testimonials. The panel noted that the training courses that you have undertaken do not go directly to specific concerns of this case and there was no evidence of how you have implemented any learning or how you would change your practice in the future. The panel was not satisfied that you have addressed the lack of competence or misconduct identified.

Having regard to all of the above, the panel considered that there is a risk of repetition and that you are liable to place patients at an unwarranted risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession and act dishonestly in the future. 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.

In respect of the lack of competence, the panel determined that a finding of impairment was required to uphold professional standards and the public would be concerned if a nurse who lacks competence was able to practise without restriction. The panel also determined that given the seriousness of the misconduct which involves dishonesty and potential attitudinal concerns, the public would be concerned if a finding of impairment was not made. The panel therefore determined that a finding of impairment is required on public interest grounds to maintain public confidence in the profession and the regulator.

Having regard to all of the above, the panel determined that you are not able to work safely and effectively without restriction. The panel therefore found your fitness to

practise is currently impaired on public protection and public interest grounds in respect of your lack of competence and misconduct.

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 have 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 careful regard to the NMC Guidance (References: SAN-1, SAN-2 *(2a-2e) SAN-3, SAN-4* all last updated: 28/01/2026).

Submissions on sanction

Ms Barnor informed the panel that the original NMC sanction bid was for a suspension order, however given the panel's findings, she submitted that the sanction bid is that of a striking-off order. She provided the panel with some factors of the case that were aggravating and mitigating in her submission.

Ms Barnor submitted that the misconduct in this case is particularly serious and falls into higher risk concern as set out in the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference: SAN-4 Last Updated: 28/01/2026). She submitted that a professional who has acted dishonestly will always be at risk of being struck off the NMC register and that when a registrant has deliberately breached the professional duty of candour by covering up when things have gone wrong, especially if this presented a risk of harm, is the type of case most likely to require consideration of a striking-off order. She submitted that your actions are fundamentally incompatible with you being a registered nurse and that the most appropriate and proportionate sanction is that of a striking-off order.

Ms Deery submitted that her primary submission was that a conditions of practice order would be the most appropriate and proportionate order. She submitted that if the panel was not minded to impose a conditions of practice order, then a suspension order would be the most appropriate and proportionate order. Ms Deery submitted that a striking-off order would be wholly disproportionate in the circumstances.

Ms Deery addressed the panel on the principle of proportionality and highlighted some factors that were mitigating in her submission. She submitted that you have worked safely and effectively, without restriction or concerns as a care assistant and senior care assistant since November 2024. Ms Deery submitted that you have completed relevant training courses and kept your nursing knowledge up to date.

Ms Deery provided the panel with some information about your personal circumstances and the challenges you faced both personally and professionally when you came to work in the UK. She submitted that when the charges arose, you were not supported by a nursing mentor or buddy, and you were not given any specific training.

Ms Deery submitted that when considering all of the charges that have been proved together, it is accepted that they are serious, but not at the most serious end of the spectrum. She submitted that the charges arose between 3.5 and 4 years ago and that you have not worked as a registered nurse since February 2023. Ms Deery submitted that you do not need a further period out of practice or a further period of time to reflect and to show insight.

Ms Deery submitted that in all of circumstances a striking-off order would be wholly disproportionate and a lesser sanction would be more appropriate.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the 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 factors:

- Your conduct placed Resident A and Resident B at a risk of suffering harm through acting beyond the scope of your practice and by seeking to conceal that you had administered unprescribed medication.
- Whilst your dishonesty was initially spontaneous, it persisted and became premeditated in an attempt to conceal what you had done.
- You have demonstrated limited insight into your conduct.

The panel also took into account the following mitigating factors:

- You made six full and two partial admissions to the charges at an early stage.
- There is some evidence of training that you have completed.
- At the relevant time, you faced significant personal challenges.
- Some positive testimonials (although not from any current or recent employers or colleagues).
- When the charges arose, you were in a challenging period of transitioning from practising in Nigeria to the UK.

In considering whether there were any further mitigating factors in this case, the panel had regard to the remorse and apologies you have expressed in your reflective statement. The panel noted that your remorse is focussed on the lack of competence, and in respect of the misconduct charges, you refer to a shortfall in your communication skills rather than an acceptance of your dishonest conduct. The panel also noted Ms Deery's submissions that you were not supported by a mentor or buddy when you started working at the Hospital. The panel did not accept this as a mitigating factor as it heard evidence from your colleagues and management at the Hospital who said that you were provided with support. The panel also had regard to Ms Deery's submission that you have practised *'safely and effectively'* as a care assistant, however no evidence was provided to substantiate this.

Whilst the panel acknowledged the pressures you may have been under, it was of the view that this does not justify or mitigate against any of the conduct or behaviour found.

The panel first considered whether to take no action and noted that this is only appropriate in cases where a finding of impairment has been made solely to uphold professional standards and when a registrant has demonstrated an exceptional level of remediation and insight. The panel found that your practise is currently impaired on both public protection and public interest grounds, and that your level of insight is limited and there is no evidence of remediation. The panel therefore found that taking no further action would neither protect the public nor uphold public confidence in the profession.

The panel next considered a caution order which is only appropriate if there is no risk to the public or to people using services. In the NMC Guidance on 'Caution order' (Reference: SAN-2b) Last Updated: 28/01/2026) the following is set out:

> *'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 the misconduct in this case is particularly serious and was not at the lower end of the spectrum of impaired fitness to practise and would be inappropriate in view of the seriousness of the case. As the panel found that there is a risk to patient and public safety, it determined that a sanction that does not restrict your 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 order on your 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). The panel noted that the charges found proved in relation to lack of competence are clinical in nature and therefore a

conditions of practice order would potentially be appropriate and address those concerns. However, having found that there is evidence of deep-seated personality and attitudinal problems and having regard to the nature and seriousness of your misconduct, 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 in respect of the misconduct found.

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 as stated:

- *'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 also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension and considered the following list of circumstances that 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.*

Whilst the panel acknowledged that the risks to the identified risks to the public could be managed for a time by temporary removal from the Register, it 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 your limited insight and limited evidence of training and development and the attitudinal nature of your misconduct, the panel considered that there is no realistic possibility that you would address the concerns to such a level where you could return to practise safely.

In this particular case, 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).

The panel found that you administered medication to a vulnerable resident to whom it was not prescribed. When you were informed that this was not appropriate, instead of upholding your duty of candour and prioritising patient safety, your initial and spontaneous dishonesty evolved into pre-meditated dishonesty in that you attempted to conceal what you had done which placed Resident A at a risk of harm. Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'* which is likely to require consideration of a striking-off order.

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?*

Honesty and integrity are fundamental tenets of the nursing profession and in attempting to conceal that you had given an unprescribed medication to a vulnerable resident you placed them at a risk of harm. In the panel's view, your behaviour and conduct raise fundamental questions about your professionalism.

Given that you did not uphold your duty of candour and your behaviour is indicative of a deep-seated and harmful attitudinal concern, the panel considered that public confidence in the profession and the NMC as its regulator could not be maintained if you were not removed from the Register.

As set out previously, the panel found that you have failed to meaningfully reflect on your conduct and develop your insight to the extent that public safety, public confidence in the profession, and professional standards could be maintained.

The panel was mindful that despite you having a significant period of time since the incident, and thereafter since the handing down of facts, to develop your insight you have not. Having regard to the seriousness and nature of your conduct and behaviour, and to your limited insight, the panel determined that there is no realistic prospect that even after a period of suspension, you would have gained insight or strengthened your practice to reduce the risks identified.

Your conduct and behaviour were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your conduct and behaviour were so serious that to allow you to continue practising would not protect the public and 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 effect of your conduct in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

In balancing all of the factors, the panel had regard to the financial hardship this order would cause. However, the panel considered that your interests were outweighed by the need to protect the public, promote confidence in the nursing profession and declare and uphold proper professional standards.

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.

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.

Submissions on interim order

Ms Barnor submitted that an interim suspension order for a period of 18 months is necessary to protect the public and to maintain public confidence for the appeal period. She submitted that not imposing an interim order would be inconsistent with the panel's earlier findings.

Ms Deery submitted that an interim order is not necessary to protect the public or to uphold public confidence. She submitted that an interim suspension order should not be an automatic decision in every case where a striking-off order is imposed. Ms Deery submitted that the risk of repetition is low, the charges arose 3.5-4 years ago, and you have demonstrated some insight and completed training and learning. She submitted that you have been working as a carer and there have been no concerns raised. Ms Deery submitted that as there is no real risk to those receiving care, and that the substantive order will address the public interest, whilst an interim order may be desirable, it is not necessary.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

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. Having already determined that a striking-off order is necessary to protect the public and to satisfy the public interest in this case, to not impose an interim suspension order to cover the appeal period would be inconsistent with its earlier findings. 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.

This will be confirmed to you in writing.

That concludes this determination.