

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

**Substantive Hearing
Monday, 23 February – Friday, 6 March 2026
Monday, 9 March 2026 – Wednesday, 11 March 2026**

Virtual Hearing

Name of Registrant: Blessing Nneka Nwosu

NMC PIN: 22A13780

Part(s) of the register: Registered Nurse – Sub Part 1
Adult Nursing (Level 1) – 22 January 2022

Relevant Location: Leeds

Type of case: Misconduct

Panel members: Janet Fisher (Chair, Lay member)
Elizabeth Coles (Registrant member)
Dino Rovaretti (Lay member)

Legal Assessor: Ian Ashford-Thom

Hearings Coordinator: Petra Bernard (Monday, 23 February – Friday, 6
March 2026)
Elizabeth Fagbo (Monday, 9 March 2026 –
Wednesday, 11 March 2026)

Nursing and Midwifery Council: Represented by Simran Ghotra, Case Presenter

Miss Nwosu: Not present and unrepresented

Facts proved: Charges 1); 2a); 2b); 3; 4b); 4c(i); 4c(ii); 4d(i); 4d(ii);
4d(iii); d(iv); 5; 6; 7a); 7b); 7c); 8a); 8b); 8c); 9a);
9b); 9c); 9d); 9e); 10); 11); 12); and 13).

Facts not proved:

Charge 4a)

Fitness to practise:

Impaired

Sanction:

Striking-off order

Interim order:

Interim Suspension Order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Nwosu was not in attendance and that the Notice of Hearing letter had been sent to Miss Nwosu's registered email address by secure email on 22 January 2026.

Ms Ghotra, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Nwosu's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Miss Nwosu has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Nwosu

The panel next considered whether it should proceed in the absence of Miss Nwosu. It had regard to Rule 21 and heard the submissions of Ms Ghotra, who invited the panel to continue in the absence of Miss Nwosu.

Ms Ghotra referred the panel to the email from Miss Nwosu to the NMC dated 19 February 2026, which states:

'I am not attending

Meeting can proceed without me in it.'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised '*with the utmost care and caution*' as referred to in the case of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Miss Nwosu. In reaching this decision, the panel considered the submissions of Ms Ghotra, the written representation from Miss Nwosu, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *Jones and General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Nwosu;
- Miss Nwosu has informed the NMC that the hearing can proceed in her absence, which is indicative that she has received the Notice of Hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are due to attend today to give live evidence, seven others are due to attend this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022 and 2023;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Nwosu in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Nwosu's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Miss Nwosu. The panel will draw no adverse inference from Miss Nwosu's absence in its findings of fact.

Details of charge (as read)

Charge 1

That you, a registered nurse:

- 1) On or around 3 May 2022, disconnected the ventilator of a high C spine patient (Patient A) without clinical justification.
- 2) Failed to administer nimodipine in a timely manner:
 - a) on 15 May 2022 to Patient F;
 - b) on 5 July 2022 to Patient G.
- 3) On 19 June 2022, failed to escalate and/or or take appropriate action in relation to Patient B's lumbar drain, which had stopped oscillating.

- 4) On 23 June 2022,
 - a) failed to ensure that a patient who was at risk of falls was supervised;
 - b) without clinical justification, left an unknown patient on a bedpan for at least 2 hours;
 - c) In relation to Patient C:
 - i) failed to wean them off peripheral Norad medication as required;
 - ii) failed to monitor their blood sugar in a timely manner;
 - d) In relation to Patient D:
 - i) left medication unattended outside their bed space;
 - ii) failed to undertake observations with sufficient frequency;
 - iii) failed to take timely fluid balance of inputs and outputs or in the alternative failed to record the balance of inputs and outputs of fluid;
 - iv) retrospectively completed observation charts on their records to say observations were completed 2 hourly.
- 5) Your actions at 4d iv) were dishonest, in that you documented two hourly observations for Patient D when you knew you had only completed them five hourly.
- 6) On 5 July 2022, failed to ensure the administration of an antibiotic was witnessed and/or counter-signed by a 2nd nurse.
- 7) On 5 July 2022, in relation to Patient C:
 - a) failed to label multiple antibiotic infusions;
 - b) ran several incompatible infusions through the same cannula;

- c) failed to measure and/or record that you had measured the patient's nasogastric tube, prior to administering medication through it.
- 8) On 11 July 2022:
- a) failed to check the alarm volume on an infusion pump and/or monitor/ventilator.
 - b) Failed to titrate medication to achieve target parameters.
 - c) failed to check expiry dates on medication without prompting.
- 9) Between 14 and 15 August 2022, in relation to Patient E:
- a) Without clinical justification, prepared several infusions of medication simultaneously
 - b) failed to ensure a 2nd nurse witnessed the administration of one or more infusions
 - c) failed to label medication prior to obtaining a second signature
 - d) sought to replace an infusion of a controlled drug when it was not required
 - e) left a controlled drug unattended
- 10) On or around 3rd March 2023 failed to notify your employer that you had been made the subject of an interim order by the NMC.
- 11) Between approximately 3rd March to 3 April 2023, worked unsupervised on one or more occasions, in breach of your interim order.
- 12) Your action as set out in charge 10 above was dishonest in that you represented to your employer that your registration was not subject to conditions when you knew it was.
- 13) Your actions as set out in charge 11 above were dishonest in that you knew your registration was the subject of conditions.

Decision and reasons on application to amend Charge 1 (Day 3)

The panel heard an application made by Ms Ghotra to amend the wording of Charge 1.

The proposed amendment was to accurately reflect the evidence heard from Witness 3 on Day 2 of this hearing. It was Witness 3's evidence that, she did not know how the ventilator became disconnected, it would not have had to have been a deliberate act and could have accidentally been disconnected. It was submitted by Ms Ghotra that the proposed amendment would provide clarity and more accurately reflect the written and oral evidence of Witness 3.

Original charge

'That you, a registered nurse:

On or around 3 May 2022, disconnected the ventilator of a high C spine patient (Patient A) without clinical justification.

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

Proposed amendment

'That you, a registered nurse:

On or around 3 May 2022, ~~disconnected the ventilator of a high C spine patient (Patient A) without clinical justification.~~ **failed to take any or adequate steps when Patient A's ventilator had become disconnected.**

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

The panel accepted the advice of the legal assessor who referred it to Rule 28 of the Rules and *PSA v NMC & Jozi* [2015] EWHC 764 (Admin).

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Nwosu and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence of Ms 1 and Ms 2 (Day 4)

The panel heard an application made by Ms Ghotra under Rule 31, to allow the local written statements of Ms 1 and Ms 2 into evidence as hearsay. Ms Ghotra referred the panel to the cases of: *Thorneycroft v NMC* [2014] EWHC 1565 (Admin); *Ogbonna v NMC* [2010] EWCA Civ 216 and *Bonhoeffer v GMC* [2011] EWHC 1585 (Admin).

Ms Ghotra submitted that the local statements of Ms 1 and Ms 2 are not sole or decisive evidence but can be classed as supportive pieces of evidence. She submitted that the panel has heard evidence from Witness 5, who speaks to the relevant charges before it. She submitted that Ms 1 gives evidence of what was reported to her, what actions she had taken, and her recollection of what Miss Nwosu allegedly said when she was contacted. Ms Ghotra submitted that Ms 2's evidence relates to actions that were taken after the alleged incident took place.

In relation to the nature and extent of the challenge to the contents of the statements, she submitted that Miss Nwosu, although not in attendance at this hearing, could not initially recall at the local interview, exactly what had happened to the medication. Ms Ghotra submitted that there does not appear to be any suggestion that Ms 1 and Ms 2 had any reasons to fabricate their allegations. In relation to the seriousness of the charge and

taking into account the impact an adverse finding may have on Miss Nwosu's career, she submitted that the charges are serious and there may be an impact of an adverse finding in relation to the charge

Ms Ghotra submitted that it does not appear that any efforts were made to obtain formal witness statements from Ms 1 and Ms 2. However, she submitted that the panel may find this to be the appropriate decision. In terms of whether Miss Nwosu had prior notice or not Ms Ghotra submitted that the statements of Ms 1 and Ms 2 have been provided to Miss Nwosu for some time.

Ms Ghotra submitted that it is the NMC's position that it is fair to admit these two statements and they are relevant to what the panel is considering in this case.

She invited the panel to admit the hearsay statements of Ms 1 and Ms 2.

Panel decision

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

In reaching its decision, the panel applied the principles set out in *Thorneycroft*.

The panel gave the application serious consideration. The panel determined that Ms 1 and Ms 2's respective statements are not sole or decisive evidence; they are supportive of the specific allegations in relation to Charge 9.

In relation to any unfairness to Miss Nwosu, the panel considered that the unfairness was outweighed, in these circumstances by the duty of the panel to explore fully the issues in the case in the public interest.

The panel noted that Ms 1 and Ms 2's respective statements had been prepared in anticipation of being used in formal proceedings. In the preparation of this hearing, the NMC had indicated to Miss Nwosu that these statements would be provided to the panel as evidence. Despite knowledge of the nature of this evidence, Miss Nwosu made the decision not to attend this hearing or to challenge any of the evidence in writing.

In relation to the risk of fabrication, the panel was of the view that the statements have been obtained during a formal investigatory process, therefore the risk of fabrication is reduced. The panel determined that these statements address serious alleged conduct that took place on 14/15 August 2022, but which is not part of the current charge and therefore they provide wider contextual information relevant to these dates.

The panel considered whether Miss Nwosu would be disadvantaged by allowing the statements into evidence as hearsay. The panel considered that as Miss Nwosu had been provided with a copy of Ms 1 and Ms 2's respective statements and, as the panel had already determined that as Miss Nwosu had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine these witnesses were they to attend.

In these circumstances, the panel determined that the statements of Ms 1 and Ms 2 were relevant and that it would be fair to admit them as hearsay evidence. The panel was mindful that this would be hearsay evidence, and that it would consider what weight it deemed appropriate to give to the evidence when it reached the stage at which it would evaluate all the evidence before it.

The panel granted the application.

Decision and reasons on application to amend Charge 2b (Day 4)

The panel heard an application made by Ms Ghotra pursuant to Rule 28 of the Rules, to amend Charge 2b.

Ms Ghotra submitted that the proposed amendment was to accurately reflect the evidence heard from Witness 7 on Day 4 of the hearing. She submitted that Witness 7's evidence was, that it was Patient C and not Patient G, as currently alleged, to whom Charge 2b refers. Ms Ghotra submitted that the evidence still demonstrates that medication had not been administered at the time that it was due. She submitted that the underlying misconduct remains the same and the mischief is still the failure to administer the medication in a timely manner and that it is only the patient's anonymised name for the purpose of the charge that is being amended. It was submitted by Ms Ghotra that the proposed amendment would provide clarity and more accurately reflect the written and oral evidence of Witness 7.

Original charge

'That you, a registered nurse:

2b) on 5 July 2022 to Patient G.'

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

Proposed amendment

'That you, a registered nurse:

2b) on 5 July 2022 to Patient ~~G~~ C.

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

The panel accepted the advice of the legal assessor who referred it to Rule 28.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Nwosu and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Application to de-warn Ms 3 (Day 5)

Ms Ghotra made a request to de-warn Ms 3, who was warned to attend to give evidence as a witness today, 2 March 2026 and tomorrow, 3 March 2026. Ms Ghotra submitted that Ms 3's evidence, in the form of her witness statement dated 18 March 2025 and corresponding document, are not relevant to the charges in this case. She asked the panel to disregard the evidence it has read from Ms 3 and to continue the hearing without her evidence.

The panel accepted the advice of the legal assessor.

The panel considered Ms Ghotra's request. It was satisfied that Ms 3's witness statement and corresponding document are not relevant and do not speak to any of the charges. Accordingly, the panel agreed to Ms Ghotra's request and decided to de-warn Ms 3 and for her witness statement and corresponding document to be disregarded.

Decision and reasons on application to amend Charges 4c, 4d and 5 (Day 6)

The panel heard an application made by Ms Ghotra pursuant to Rule 28, to amend the wording in the stem of Charges 4c, 4d and the wording in Charge 5.

Ms Ghotra submitted that the proposed amendments can be made without injustice.

Ms Ghotra submitted that Witness 2, in her statement and oral evidence, stated that she could not recall who the patient was in the various incidents and that it was unclear which patients related to which incident. Ms Ghotra submitted that Patient C's records do not cover the date in question and Patient D's medical records have not been provided. Ms Ghotra further submitted that the charges remain specific to one shift on 23 June 2022, the underlying alleged misconduct remains the same and the patients' individual identities are not of the essence in respect of the alleged misconduct.

Ms Ghotra submitted that it is the NMC's position that there will be no prejudice in these amendments being made. She submitted that the proposed amendments would provide clarity and avoid the charges failing on a technical point.

Original charges

'That you, a registered nurse:

4) On 23 June 2022,

a) ...;

b) ...;

c) In relation to Patient C:

i) failed to wean them off peripheral Norad medication as required;

ii) failed to monitor their blood sugar in a timely manner;

d) In relation to Patient D:

i) left medication unattended outside their bed space;

- ii) failed to undertake observations with sufficient frequency;
 - iii) failed to take timely fluid balance of inputs and outputs or in the alternative failed to record the balance of inputs and outputs of fluid;
 - iv) retrospectively completed observation charts on their records to say observations were completed 2 hourly.
- 5) Your actions at 4d iv) were dishonest, in that you documented two hourly observations for Patient D when you knew you had only completed them five hourly.

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

Proposed amendments

'That you, a registered nurse:

4) On 23 June 2022,

a) ...;

b) ...;

c) In relation to **a patient Patient C:**

- i) failed to wean them off peripheral Norad medication as required;
- ii) failed to monitor their blood sugar in a timely manner;

d) In relation to **a patient Patient D:**

- i) left medication unattended outside their bed space;
- ii) failed to undertake observations with sufficient frequency;

- iii) failed to take timely fluid balance of inputs and outputs or in the alternative failed to record the balance of inputs and outputs of fluid;
- iv) retrospectively completed observation charts on their records to say observations were completed 2 hourly.

5) Your actions at 4d iv) were dishonest, in that you documented two hourly observations for **the patient Patient D** when you knew you had only completed them five hourly.

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

The panel accepted the advice of the legal assessor who referred it to Rule 28.

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Nwosu and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy of the evidence.

Background

On 21 December 2021, having completed the NMC Observed Structured Clinical Exam (OSCE) boot camp, for international nurses, Miss Nwosu commenced work at the Neuro Intensive Care Unit (the Unit) at Leeds General Infirmary, within the Leeds Teaching Hospitals NHS Trust (the Trust).

Miss Nwosu's role was of a Clinical Support Worker, until she completed the OSCE and obtained her NMC PIN on 22 January 2022 and was then employed on the unit as a Band 5 Staff Nurse.

It is alleged that from January 2022 until August 2022, whilst in this post, Miss Nwosu made a number of medication errors and failures in her duties as a staff nurse. During this time Miss Nwosu completed a supernumerary period, mandatory training and demonstrated clinical competencies that allowed her to work unsupervised on the unit. She received intermittent clinical supervision from the Clinical Education Team and continuous support in the form of education days, online training and action planning.

Between 14-15 August 2022, a controlled drug was unaccounted for on the unit. In response to this incident, Miss Nwosu was interviewed during the local investigation which commenced in September 2022. She did not attend the disciplinary hearing that followed this investigation as she had resigned from the Trust.

On 13 December 2022 Miss Nwosu commenced work at Vicarage Court Care Home (the Home). Her role in the Home was of a general staff nurse, working nights.

The NMC received a referral on 10 February 2023 from the Hospital.

It is alleged that from 3 March 2023 to 3 April 2024, Miss Nwosu worked at the Home whilst an interim conditions of practice order had been made on her practice by the NMC. It is alleged that she worked in breach of this order, that she did so dishonestly, and that she had failed to inform the Home that her registration was subject to this order.

Following a disciplinary hearing at the Home, which Miss Nwosu attended, she received a final written warning on 3 April 2023. She continued to work at the Home as a care assistant.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence before it together with the submissions made by Ms Ghotra on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Nwosu.

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

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

- Witness 1: Home Manager at the Home, at the material time

- Witness 2: Sister on the Intensive Care Unit (ICU) and High Dependency Unit (HDU) at the Trust, at the material time

- Witness 3: Nurse in charge on the Unit at the Trust, at the material time

- Witness 4: Band 5 nurse on the Unit at the Trust, at the material time

- Witness 5: Clinical Educator on the Unit at the Trust, at the material time

- Witness 6: Senior Charge Nurse on the General ICU at the Trust, at the material time and Investigating Officer for the Trust investigation

- Witness 7: Senior Sister in the Hospital at the Trust, at the material time
- Witness 8: Clinical Practice Educator in the Unit at the Trust, at the material time

Before making any findings on the facts in this case, the panel considered the witness statements and documentary evidence provided by the NMC in conjunction with submissions made by Ms Ghotra.

The panel then heard and accepted the advice of the legal assessor, which included reference to the cases of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, *Dutta v GMC* [2020] EWHC 1974 (Admin), as well as NMC guidance Reference DMA-8 'Making decisions on dishonesty charges and the professional duty of candour'.

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

The panel, when considering Charges 1-8, had regard to a document called the '*New Starter Tracker*' which was completed contemporaneously by the Clinical Practice Educators to collect relevant feedback in order to identify specific training needs and to ensure they were addressed. The panel was of the view that this document was written with the intent of supporting Miss Nwosu and to make the support as specific as possible. Those making entries knew the importance of the accuracy of those entries and were under a professional duty to make accurate recordings. The panel was satisfied that this document was prepared in good faith.

The feedback informed another working document entitled '*Action Plan*' which was used to monitor interventions and to record improved practice. Miss Nwosu did not dispute the need for an Action Plan or its contents.

As such the panel found both the New Starter Tracker and the Action Plan to be relevant and useful documents because they evidence some of the concerns identified at the time and how they were addressed by Miss Nwosu's employer.

Charge 1

- 1) On or around 3 May 2022, failed to take any or adequate steps when Patient A's ventilator had become disconnected.

This charge is found proved.

The panel first considered whether there was any information available to discern the position taken by Miss Nwosu in respect of this charge. Witness 3, in an email to Witness 8 said that she had spoken to Miss Nwosu who had denied that the ventilator had been disconnected.

In reaching this decision, the panel took account of Witness 3's oral evidence and Witness Statement dated 23 May 2025.

The panel had regard to Witness 3's Witness Statement, which states:

'The patient in question was a patient who had sustained a high spinal cord injury...meaning the patient was completely dependent on a ventilator to maintain respiratory function.

I initially looked at the ventilator and noticed the patient was not receiving any ventilation as the ventilator had disconnected. I then looked at the patients monitor and noticed heart rate was reading 0 and blood pressure reading -0. I immediately reconnected the ventilator and called for help outside of the room...once ventilation was reestablished cardiac output was restored...'

In an email dated 6 May 2022 sent from Witness 3 to Witness 8, she describes the incident:

'...I spoke to Nneka after the event, she is adamant that the vent was not disconnected, although I'm sure it was, she tells me that it didn't happen. There were a couple of other issues over the night also...the patient did plug off at 6am and lost cardiac output for 5 mins, again I tried to talk to her about his requirement for regular suctioning, at the time there was no evidence this had been completed but she assured me it was done and just not yet ticked...'

The panel considered the evidence of Witness 3 and took account of her oral evidence. She clearly described how a ventilator could become disconnected and did not blame Miss Nwosu for the disconnection. Witness 3 was asked what Miss Nwosu was doing whilst she herself was reconnecting Patient A's ventilator, she replied she was in the room *'...stood doing nothing'*.

The panel found Witness 3 to be a credible and reliable witness whose evidence was aligned and consistent; from her first account in the email to Witness 8, to her NMC statement and her oral evidence. The panel was of the view that Witness 3 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to have been mistaken.

The panel had sight of Patient A's records which show Miss Nwosu's initials and signature indicating that she was the allocated nurse for Patient A on the night of 2 May 2022 to 3 May 2022. The records also showed that Patient A was completely dependent on the ventilator, which was consistent with Witness 3's evidence. The panel accepted Witness 3's evidence that Miss Nwosu was aware that she was the allocated nurse responsible for Patient A's care and that he was completely dependent on the ventilator.

Witness 3 described how you would be able to hear the rush of air where the disconnection had occurred and that you needed to reconnect the tubing at that point. The panel accepted Witness 3's evidence that Miss Nwosu did not even ask Witness 3, who was the Nurse in Charge on duty at the time for help when the alarm went off.

The panel was satisfied that Miss Nwosu had a professional duty of care toward Patient A to respond to the ventilator alarm, which was a fundamental aspect of nursing care, either by finding and fixing the disconnection or at the very least requesting help. The panel determined that Miss Nwosu had failed in her duty of care to take any or adequate steps when Patient A's ventilator had become disconnected.

The panel therefore finds Charge 1 proved.

Charge 2a)

- 2) Failed to administer nimodipine in a timely manner:
 - a) on 15 May 2022 to Patient F;

This charge is found proved.

In reaching this decision, the panel took account of Witness 8's oral evidence and Witness Statement dated 17 August 2023 and Supplementary Witness Statement dated 18 March 2025.

The panel had regard to the Datix missed nimodipine administration of 15 May 2022. The panel considered the Datix to be a professional record of events created on the day of the incident. The Datix also includes: *'Nimodipine dose was missed at 2am 15/5/22. On the prescription chart, the nurse's (NN) omission comment says 'patient was asleep'*. The panel determined from that document that Miss Nwosu was the named nurse allocated with the responsibility for Patient F and was under a duty of care toward him.

The panel had sight of the undated Reflective Account Form completed by Miss Nwosu. In answer to the question, *‘What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?’*, she wrote in response *‘missed dose of nimodipine’*. The panel considered that this document indicated that Miss Nwosu did not dispute this incident when she completed the reflection.

The panel determined that Miss Nwosu had failed to administer nimodipine to Patient F in a timely manner.

The panel therefore finds Charge 2a proved.

Charge 2b

- 2) Failed to administer nimodipine in a timely manner:
 - b) on 5 July 2022 to Patient C.

This charge is found proved.

In reaching this decision, the panel took account of Witness 8’s oral evidence, Witness Statement dated 17 August 2023, and Supplementary Witness Statement dated 18 March 2025. Additionally, Witness 7’s Witness Statement dated 17 May 2025 and the Datix she completed in respect of that shift.

The panel found Witness 8 to be a credible and reliable witness whose evidence was aligned and consistent, she recorded this incident in the New Starter Tracker after communication from Witness 7. The panel found Witness 7 to be consistent in her evidence and with the documentation. The panel found that Witness 7 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. The panel considered the nature of the incident to be memorable, and Witness 7 completed a formal

Datix to report this error, in these circumstances the witness was unlikely to have been mistaken.

The panel had regard to Patient C's Medical Administration Record (MAR) chart which showed that a dose of 30mg of nimodipine had been administered at 06:32 hours by another nurse. The MAR chart also showed that two 30mg doses of nimodipine were administered by Miss Nwosu at 10:14 hours.

The panel had regard to the Witness Statement of Witness 8, which includes

'I worked with Miss Nwosu on 5 July 2022 but only from 10:00 until 15:00...I was asked to take my own patients from 07:30 – 10:00 and 15:00 – 18:00. Various concerns about Miss Nwosu's practice were brought to my attention while I was not directly working with her. It was brought to my attention that Miss Nwosu had missed administration of time critical medication (nimodipine) on two occasions...Miss Nwosu had previously completed a reflection on nimodipine...'

Witness 8 in her supplementary witness statement explained:

'At paragraph 12 of my original statement, I mention the Registrant failing to administer nimodipine to patients. The missed nimodipine administration I was referring to occurred on the date written in paragraph 12, i.e. 5 July 2022, whilst the Registrant was not under my direct supervision...'

The panel had regard to the Witness Statement of Witness 7, who was the nurse in charge of the shift which includes:

'On 6 July 2022, I raised a datix regarding 2 incidents that occurred on 5 July 2022. One incident where the Registrant failed to sign for administering nimodipine...'

The panel had regard to the Datix record for Patient C which states:

'NN unfortunately had 2 Drug near misses whilst working on HDU yesterday. Firstly it was highlighted to Necka at 10.10am that she had not signed for her 08:00am nimodipine. Nnecka took it upon herself to then give the 08:00am nimodipine and 10am dose together without checking with a senior nurse or medic...' [sic]

The panel had sight of the Critical Care Nursing Assessment/Evaluation form which shows that the Nimodipine administration was changed to 30mg every two hours at 03:22 hours. Patient C's records clearly show that a dose should have been administered by Miss Nwosu at around 08:00 hours in line with the doctor's medical direction. This dose was not shown on the MAR chart, but a double dose is recorded as given by Miss Nwosu at 10:14 hours.

The panel determined that there was a duty for Miss Nwosu to adhere to the medications policy's *'right patient, right time'* practice. The panel determined that there was clear evidence that Miss Nwosu was the allocated nurse in charge of Patient C's care and responsible for administering his medications as directed.

As the nimodipine was given by another nurse at 06:32 hours, in adherence to the two hourly intervals as instructed by the doctor, this would indicate that the medication was required to be given at around 08:00 hours and not at 10:14 hours as given by Miss Nwosu. The panel determined that the doctors had given clear reasons to reduce the dose and to give the medication more frequently and it was clearly documented that the nimodipine was a time critical medication. Miss Nwosu had noted this in her reflection about the previous incident.

The panel determined that Miss Nwosu had missed the 08:00 hours dose and decided of her own volition to administer the 08:00 hours and 10:00 hours doses together at 10:14 hours.

The panel was satisfied that Miss Nwosu had a professional duty of care toward Patient C to administer medications safely, which is a fundamental aspect of nursing care. The panel determined that Miss Nwosu had failed in her duty of care to administer the nimodipine medication in a timely manner to Patient C.

The panel therefore finds Charge 2b proved.

Charge 3

3) On 19 June 2022, failed to escalate and/or or take appropriate action in relation to Patient B's lumbar drain, which had stopped oscillating.

This charge is found proved.

In reaching this decision, the panel took account of the Witness Statement and oral evidence of Witness 2 and corresponding documentation.

The panel also considered the contents of an email written by Witness 2 to Witness 7, which is undated but includes a reference to '*today(28/06/2022)*'. Witness 2 sent this email following two shifts as nurse in charge during which she supervised Miss Nwosu. The purpose of the email was to highlight training needs to the clinical practice educators so that they could intervene and address the issues.

There is no account of this incident from Miss Nwosu.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

Witness 2's Witness Statement includes:

'I reviewed the patient around 20:00 as they were going for a scan. At this point, Miss Nwosu did not mention anything untoward about the patient.'

At around 22:30, I went back to the patient and saw that the lumbar drain was not oscillating, which ... is required as an indication that the drain is working properly. ...When I looked at the patient's chart...it was recorded by Miss Nwosu that the drain had not been oscillating since 20:00 ... I asked Miss Nwosu when the drain had stopped oscillating, to which they said 20:00. I told Miss Nwosu that they should have informed the Nurse in Charge ("NIC") of this straight away due to the risk to the patient. If the lumbar drain is not working correctly, it could cause the patient to deteriorate rapidly or die as the CSF could build up again. The lumbar drain needs to be oscillating at all times. Miss Nwosu responded by saying 'well I am telling you now'. During the supernumery [sic] period, Miss Nwosu would have worked with patients that have lumbar drains in and would have been taught at the bedside how to care for them.'

Witness 2 in the email to Witness 7 outlined her concerns as follows:

'...I just have a few concerns regarding Nneka Nwosu from when I worked with her a few days ago..

19/06/2022 night shift

1. Told me her patient's Lumbar drain had stopped draining. I asked if it was oscillating to which she replied no. I asked her when did it stop oscillating to which she replied 8pm. It was 10.30pm at this point. When I said to her you need to inform the NIC straight away if a drain stops working and explained the importance, she replied with "well I am telling you now".

2. Didn't have any urgency with regards to anything going on with her patient who was going for a scan, a potentially blocked Lumbar drain...'

The panel had sight of Patient B's Adult Critical Care Observation Chart. It noted that there is a separate row to record if the drain is oscillating. Witness 2's evidence is consistent with this document. Witness 2 explained that there are three columns which represented three entries that should have been there for the hours 20:00 hours, 21:00 hours, and 22:00 hours. For these three columns the chart shows just a dash for the amount drained and does not show a tick to indicate that the drain was oscillating. The panel accepted Witness 2's evidence that Miss Nwosu was allocated to this patient.

The panel had sight of the lumbar drain management guidelines and accepted Witness 2's evidence that Miss Nwosu would have been familiar with these guidelines as part of her training. The panel had regard to the External Ventricular Drainage – Best Practice Guidelines and noted that '*CSF drainage must be observed at least hourly*'. Witness 2 stated that if the drain stopped oscillating action needed to be taken, either by identifying the problem and resolving it, or by asking for help.

The panel was of the view that Witness 2 was the nurse in charge overseeing Miss Nwosu and in her supervisory role asked her about Patient B's care. Witness 2's evidence was that she was not asked for help by Miss Nwosu in respect of this issue. When Witness 2 became aware of the problem she identified that the drain was under the patient and slightly kinked, and so she resolved the issue. The panel determined that Miss Nwosu had failed to escalate and/or or take appropriate action in relation to Patient B's lumbar drain, which had stopped oscillating.

The panel therefore finds Charge 3 proved.

Charge 4a)

4) On 23 June 2022,

a) failed to ensure that a patient who was at risk of falls was supervised;

This charge is found NOT proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel had regard to Witness 2's witness statement, which states:

'There was also an incident whereby Miss Nwosu left a patient, I cannot recall which patient, who was a falls risk, unattended. In the morning huddles, we always explain which patients are a falls risk so that all staff are aware. Miss Nwosu's patient was deemed a falls risk. I walked into the bay where the falls risk patient was and there was no one visible in there and Miss Nwosu was not in the bay. When Miss Nwosu came back into the bay, I informed them that the patient was left unattended...Miss Nwosu told me that they had let the nurse in the next

bed space know but when I spoke to this nurse (I cannot remember her name) they said Miss Nwosu did not.'

In the email from Witness 2 to Witness 7, she wrote:

*'...23/06/2022 I was supporting other new starters...
She left her falls risk patient unattended. When I informed that they need watching at all times and to let someone know if she is leaving the bay/ going behind a curtain, she said she let the nurse in the bedspace next to her know, but the nurse at the next bedspace said she didn't...'*

The panel was of the view that although Witness 2 clearly believed the nurse in the next bedspace it had seen no evidence to indicate why Witness 2 believed the nurse in the next bedspace instead of Miss Nwosu. Therefore, the panel could not evaluate for itself whether that colleague had been telling the truth.

The panel was of the view that whilst Patient B was a falls risk and there was a duty to ensure he was supervised, that duty would not mean that Miss Nwosu could not leave the patient for any reason, at times she would have to leave the bedspace to obtain essential medications or to take a break. Witness 2 explained to the panel that if she needed to leave the patient, she should have ensured a colleague was supervising the patient. The panel determined that the fact Miss Nwosu was not there when Witness 2 walked into the bay is not in itself conclusive of her failing in her duty. If she had, as she stated at the time, asked a colleague to supervise the patient then this would have been sufficient to discharge her duty. Therefore, the essential question is whether she had asked a colleague to supervise the patient.

The panel was not satisfied that the NMC has discharged its burden of proof to demonstrate that Miss Nwosu had not asked another nurse to take over in her absence.

The panel therefore finds Charge 4a not proved.

Charge 4b)

4) On 23 June 2022,

b) without clinical justification, left an unknown patient on a bedpan for at least 2 hours;

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations but she had also spoken to Miss Nwosu afterwards.

In the email from Witness 2 to Witness 7, she wrote:

*'23/6/2022 I was supporting other new starters...
Left patient on bedpan for 2 hours even after I asked her multiple times
to take him off it.'*

The panel had regard to Witness 2's Witness Statement, which states:

'Miss Nwosu left a patient, I am unable to recall who, on a bedpan. The patient had informed Miss Nwosu, as their nurse, that they needed the

toilet but were a falls risk so could not get out of bed. I happened to be in the bay at the time. The patient was, as a result, put on a bed pan. I had been called away to do other things around the unit and when I came back, I cannot recall after how long, the patient was still on the bed pan asleep. I had asked Miss Nwosu roughly three times to take the patient off the pan, which they said they would do, but every time (approximately three times) I came back they had not...Being on a bed pan for too long would not have been comfortable, would have created rings when sitting on the edge of it and could cause pressure sores to the patient.'

The panel considered the length of time the patient is alleged to have been left on the bedpan. The panel noted that the duration was long enough for the patient to have fallen asleep and that Witness 2 was an experienced Sister in the ICU/HDU environment which required very precise timings to be observed. It was the panel's view that she would have had an awareness of time and that when she said 'for two hours' this would not have been a random guess. Further, Witness 2 stated in her oral evidence *'if I said it I must have meant it'* when referring to the email she had sent to Witness 7.

The panel determined that Miss Nwosu owed a professional duty of care to the patient not to leave them on a bed pan any longer than necessary, due to the discomfort and risk of skin damage. The panel also heard from Witness 2 that 10-15 minutes on the bedpan would normally be clinically justified and if they hadn't used it by then you would remove it and try again later.

The panel determined that it was more likely than not the patient was left on the bedpan for two hours as Witness 2 had made the observation three times and had written the timing of two hours in their email to Witness 7, a Clinical Practice Educator shortly after the event. The panel therefore determined that Miss Nwosu had left an unknown patient on a bedpan for at least two hours without clinical justification.

The panel therefore finds Charge 4b proved.

Charge 4c)i

4) On 23 June 2022,

c) In relation to a patient:

i) failed to wean them off peripheral Norad medication as required;

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

The panel had regard to Witness 2's Witness Statement, which states:

'Another incident on this shift related to weaning a patient off medication. When doing the ward round with the doctors, the plan for this patient was to wean them off peripheral Norad. To do this, it needs to be chipped down (slowly turned down a few ml at a time)...Ms Nwosu was aware of this plan and acknowledged that they knew it when I asked after the ward round...However, every time I checked on the patient, the peripheral Norad was at the same rate...I asked Miss

Nwosu multiple times to wean the patient off the medication and they confirmed they knew how to do it. Eventually, I had to chip the medication down throughout the day myself as Miss Nwosu was not doing so.'

In the email from Witness 2 to Witness 7, she wrote:

'Plan for her patient was to wean peripheral Norad off. I informed her of this multiple times to which she acknowledged me. Every time I checked on the patient, she hadn't weaned any P. Norad, even after asking her to multiple times, so I ended up chipping it down and off during the day.'

Witness 2, in oral evidence, said that Miss Nwosu was allocated to two HDU patients on the date in question.

The panel had regard to the Guidance for peripheral Norad. The panel was of the view that Miss Nwosu was under a duty to the patient to follow the doctor's plan on the day in question. Miss Nwosu was aware of the plan, at the very latest after the first time she was told by Witness 2. The panel took account that Witness 2 had stated that she had asked Miss Nwosu multiple times to wean the patient off the peripheral Norad medication, that Miss Nwosu was told of the doctor's orders and that she confirmed that she knew how to do it.

The panel accepted Witness 2's evidence that Miss Nwosu had not reduced the dose on any occasions that she checked.

The panel therefore determined that Miss Nwosu failed to wean the patient off peripheral Norad medication as required.

The panel therefore finds Charge 4c)i proved.

Charge 4c)ii

- 4) On 23 June 2022,
c) In relation to a patient:
ii) failed to monitor their blood sugar in a timely manner;

This charge is found proved

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

The panel had regard to Witness 2's Witness Statement, which states:

'Another concern related to Miss Nwosu not taking blood sugars for a number of hours. The patient, I am unable to recall who, was on a continuous insulin infusion. Normally when a patient is on insulin, their blood sugar should be checked every one to four hours as insulin needs to be titrated dependent on the patient's blood sugar level. Miss Nwosu would have learnt this during their supernumerary period. If they did not know this, they could have asked another senior nurse... I went to check whether the patient's blood sugar had been stable on

VRIII (I cannot recall what time this was) and this patient had not had their blood sugars checked for seven hours...I discussed the importance of checking the levels, how often, the risks of a hypoglycaemic episode and about titrating insulin with Miss Nwosu but again she just shrugged.'

In the email from Witness 2 to Witness 7, she wrote:

'Didn't do a blood sugar on a patient with VRII [sic] for 7 hours. When discussing the importance of doing it more regularly, she came across as not being bothered(Attitude and body language).'

It was Witness 2's oral evidence that a patient's blood sugar monitoring would depend on what is on the patient's chart however it would normally be in the range of two to four hours and never seven hourly intervals. Witness 2 told the panel that it was something that would need *'keeping an eye on'*.

The panel determined that Miss Nwosu owed a professional duty of care to the patient to ensure that their blood sugars were checked with sufficient frequency to adjust the insulin infusion and avoid a hypoglycaemic episode. The panel accepts Witness 2's evidence that they had not been checked for seven hours and that this was not in a timely manner.

The panel finds that Miss Nwosu failed to monitor a patient's blood sugar in a timely manner.

The panel therefore finds Charge 4c)ii proved.

Charge 4d)i

4) On 23 June 2022,

d) In relation to a patient:

i) left medication unattended outside their bed space;

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

The panel had regard to Witness 2's Witness Statement, which states:

'...There was another incident whereby I saw Miss Nwosu had left medication by a patient's bed space on 23 June 2022. The patient was on a bed pan and had the curtains shut for dignity. There was medication outside of the bed space on a trolley. After medication is dispensed, it should be administered straight away to prevent anyone tampering with it (for example adding something to it or taking something out). I asked Miss Nwosu about this and they said they had got the medication out, so I knew they had left the drugs there...'

In the email from Witness 2 to Witness 7, she wrote:

'Left some medications on the side as her patient was on a bedpan, when asked what they were she told me nimodipine and something else that she couldn't pronounce. I asked her if it was fludrocortisone to which she said yes. I asked her if she knew what that was and she said" Yes, it's an anti-allergy". I said no it wasn't and explained what it was and then told her that if she doesn't know what a medication was then she should check what it is before she gives it. Again, just said ok and shrugged, giving off the impression she either wasn't bothered or didn't understand.'

The panel also heard from other witnesses who supported the system of a 'start to finish' medication process. The panel heard evidence from Witness 2 that if there were emergencies that perhaps the process would be interrupted however there were no emergencies at the time. The panel accepted Witness 2's evidence that there was no justification for leaving the medication unattended.

The panel determined that Miss Nwosu owed a professional duty of care to the patient to ensure that medication was not left unattended because of the risks associated with any tampering or mistakes that might occur.

The panel determined that it was more likely than not that Miss Nwosu left medication unattended outside the patient's bed space.

The panel therefore finds Charge 4d)i proved.

Charge 4d)ii

4) On 23 June 2022,

d) In relation to a patient:

ii) failed to undertake observations with sufficient frequency;

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

The panel had regard to Witness 2's Witness Statement, which states:

'...A few days later, when I wrote my email (below), I went back to the patient's chart to ensure that five hours was the correct amount of time observations had not been done for. I found that Miss Nwosu had filled in the observation chart to say they had been completed every two hours. I know they could not have completed these observations as I had seen the missing entries at 16:00 on the day, and because the saturations and blood pressure monitoring was not on the patient. Due to the patient taking off monitoring and trying to get out of bed, the SATS probe was not on the patient and the arterial line (invasive line in the arm that reads blood pressure) was not working. Miss Nwosu had no non-invasive blood pressure monitoring at their bed space, as I got it for them when I realised they had not completed observations.....but when I went back to the chart a few days later, all observations for the patient were filled in as if they had been done. My concern was that Miss Nwosu had recorded observations on the chart when the patient

was not being monitored. Miss Nwosu would not have known what the patient's observations had been during those five hours, yet had written some down...'

In the email from Witness 2 to Witness 7, she wrote:

'...She didn't fill in a fluid balance for a SAH (that Drs were concerned about FB) for 5 hours or do observations on a patient for 5 hours (last done at 12pm, checked chart at 5pm). When informed of the importance of it she just shrugged. Also going back to the chart today (28/06/2022) she has now filled in those observations as if they'd been done 2 hourly...'

When Witness 2 was asked in oral evidence what a sufficient frequency would be, she said every two hours would be the standard unless a decision was taken to alter the normal pattern. The panel noted Witness 2's evidence was that there was a five-hour gap before Miss Nwosu made an observation of the patient. The panel was of the view that Witness 2 was particularly careful and went back to check the patient records before sending her email as she did not want to misstate the timings that she observed.

The panel determined that Miss Nwosu owed a professional duty of care to the patient to take frequent observations, in order to properly monitor the patient's condition, particularly in ICU/HDU where patients are very unwell and often unstable. Not taking any observations for five hours would not discharge this duty.

The panel accepted Witness 2's account and therefore determined that it was more likely than not that Miss Nwosu failed to undertake observations with sufficient frequency.

The panel therefore finds Charge 4d)ii proved.

Charge 4d)iii

4) On 23 June 2022,

d) In relation to a patient:

iii) failed to take timely fluid balance of inputs and outputs or in the alternative failed to record the balance of inputs and outputs of fluid;

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken. The panel took into account that Witness 2 had not only made her own observations, but she had also spoken to Miss Nwosu afterwards.

The panel had regard to Witness 2's Witness Statement, which states:

'There was a patient, I cannot recall which patient, who had a subarachnoid haemorrhage and doctors request these type of patient to have a fluid balance chart to document all input and output (for example any drinks, when they vomit or when they go to the toilet). It is important that these patients are in a positive balance ... as a high urine output can be indicative of a patient developing problems with the sodium level. I checked the chart at approximately 16:00 and noticed that Miss Nwosu had not filled in the fluid balance chart for five hours... This patient also had a catheter which needed to be emptied every two

hours but Miss Nwosu had not written any urine output for the last five hours nor tallied up the fluid intake for the day.'

In the email from Witness 2 to Witness 7, she wrote:

'She didn't fill in a fluid balance for a SAH (that Drs were concerned about FB) for 5 hours or do observations on a patient for 5 hours (last done at 12pm, checked chart at 5pm). When informed of the importance of it she just shrugged. Also going back to the chart today (28/06/2022) she has now filled in those observations as if they'd been done 2 hourly.'

The panel determined that Miss Nwosu owed a professional duty of care to the patient to follow the doctors plan and to take timely fluid balance of inputs and outputs and to record the balance of inputs and outputs of fluid on the fluid balance chart. This is particularly the case in ICU/HDU where patients are very unwell and often unstable.

The panel accepted the evidence of Witness 2 that there were no recordings on the fluid balance chart for 5 hours and in those circumstances found that those readings had not been completed. The panel further determined that there was no evidence to show that there were any exceptional circumstances that would explain why timely fluid balance inputs and outputs were not taken or recorded by Miss Nwosu.

The panel was satisfied that Miss Nwosu failed to take timely fluid balance of inputs and outputs.

The panel therefore finds 4d)iii Charge proved.

Charge 4d)iv

4d)iv On 23 June 2022,

In relation to a patient: retrospectively completed observation charts on their records to say observations were completed 2 hourly.

This charge is found proved.

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 2 and corresponding documentation.

The panel found Witness 2 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and oral evidence. Witness 2's evidence was also consistent with the documentation. The panel was of the view that Witness 2 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. The panel was further of the view that the nature of the incident was memorable and straightforward, and the witness was unlikely to be mistaken.

The panel had regard to Witness 2's Witness Statement, which states:

'...A few days later, when I wrote my email (below), I went back to the patient's chart to ensure that five hours was the correct amount of time observations had not been done for. I found that Miss Nwosu had filled in the observation chart to say they had been completed every two hours. I know they could not have completed these observations as I had seen the missing entries at 16:00 on the day, and because the saturations and blood pressure monitoring was not on the patient. Due to the patient taking off monitoring and trying to get out of bed, the SATS probe was not on the patient and the arterial line (invasive line in the arm that reads blood pressure) was not working. Miss Nwosu had no non-invasive blood pressure monitoring at their bed space, as I got it for them when I realised they had not completed observations.....My concern was that Miss Nwosu had recorded observations on the chart

when the patient was not being monitored. Miss Nwosu would not have known what the patient's observations had been during those five hours, yet had written some down...'

In the email from Witness 2 to Witness 7, she wrote:

'She didn't fill in a fluid balance for a SAH (that Drs were concerned about FB) for 5 hours or do observations on a patient for 5 hours (last done at 12pm, checked chart at 5pm). When informed of the importance of it she just shrugged. Also going back to the chart today (28/06/2022) she has now filled in those observations as if they'd been done 2 hourly'

The panel determined that Miss Nwosu owed a professional duty to complete patients' records accurately.

In her oral evidence Witness 2 was able to explain clearly how she discovered the observations had not been completed for five hours and that she had then fetched equipment for Miss Nwosu to enable her to take non-invasive readings. She then described that when drafting her email to the Clinical Practice Educators she went to check on the exact timings involved and discovered new entries where previously there were none. The panel accepted Witness 2's evidence and therefore finds Charge 4d)iv proved.

Charge 5

5) Your actions at 4d iv) were dishonest, in that you documented two hourly observations for the patient when you knew you had only completed them five hourly.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty as set out in *Ivey v Genting Casinos*. It had to determine what Miss Nwosu's actual state of mind was as to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary honest and decent people.

The panel also had regard to NMC guidance Reference DMA-8 '*Making decisions on dishonesty charges and the professional duty of candour*'.

The panel found that the observations on the patient's chart were not made at the time as Witness 2 had seen the blank spaces and further Miss Nwosu had not been able to do the observations as she had no means of measuring the oxygen saturation or blood pressure of the patient at the time. Therefore, she did not have any figures/readings to write down in the patient's records.

The panel then considered Miss Nwosu's state of mind at the time. The panel considered that Miss Nwosu had been told that she should have done the measurements and that her state of mind at the time was to record something on the chart to avoid getting into trouble. The panel was of the view that Miss Nwosu would have known that the purpose of the chart was to let other colleagues know the state of the patient's health at the time and to reveal any pattern in their condition through regular observations made by the nurses. The panel determined that Miss Nwosu was aware that she had not done what she was supposed to have done and was seeking to cover up her failures, which was the reason for her false recording.

The panel was of the view that there were very seriously ill patients in the unit at the time, patients who needed close attention paid to them. The panel concluded that Miss Nwosu had made the figures up. The panel was satisfied that Miss Nwosu had knowingly documented two hourly observations for the patient when she knew she had not recorded any for five hours. The panel determined that ordinary decent people would think that Miss Nwosu's actions were dishonest.

The panel therefore finds Charge 5 proved.

Charge 6

6) On 5 July 2022, failed to ensure the administration of an antibiotic was witnessed and/or counter-signed by a 2nd nurse.

This charge is found proved.

In reaching this decision, the panel took into account Witness 7's witness statement dated 17 May 2025, corresponding documents and oral evidence.

The panel found Witness 7 to be a credible and reliable witness whose evidence was aligned and consistent in her NMC statement and her oral evidence. The panel was of the view that Witness 7 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. In this case Witness 7 was giving evidence as to what they had been told by a colleague, 'the second checker', she had then satisfied herself and completed a Datix about the incident. In such circumstances the panel also asked itself if the account of the second checker could be relied upon; there was no suggestion that this person was fabricating their account or had any malice or unconscious bias. The panel considered that the nature of the incident was memorable and the second checker was unlikely to have been mistaken. The panel determined that Witness 7 had no ulterior reason for raising this incident about Miss Nwosu.

The panel was of the view that a Datix is a formal document that was prepared by Witness 7 in the line of her professional duty. This incident was investigated by a Sister in Adult Critical Care, who identified it as a training requirement for Miss Nwosu, and an Action Plan was to be implemented. The panel noted that the second checker does not appear to be Witness 7, however she was the nurse in charge at the time and had the duty to submit the Datix. She questioned Miss Nwosu about her mistake and reiterated the importance of

a second checker. The panel noted that this conversation with Miss Nwosu occurred at the time of the incident and that this evidence has not been challenged by Miss Nwosu.

In reaching this decision, the panel took account the Witness Statement of Witness 7, which states:

‘On 6 July 2022, I raised a datix regarding 2 incidents that occurred on 5 July 2022. One incident where the Registrant failed to sign for administering nimodipine and another in which the Registrant had administered antibiotics to a patient without a second checker.’

Datix completed by Witness 7 on 6 July 2022, states:

‘Secondly at 19:00 NN had asked a member of staff to double check her IV antibiotics that were due at 18:00. NN stated she had already thrown the empty ampules away but still wanted the nurse to sign the drug chart. The second checker nurse refused and asked her to make a fresh infusion up as she wasn't going to sign for something she had not seen. When the second checker went to the patients bedside to check the medication, she noticed that the patient already had her antibiotics running through and it became apparent that NN had already started the infusion without a double signature.’

The panel had regard to the IV Medication Good Guidance which details, amongst other things, the responsibilities of the second checker.

The panel had sight of the Injectable Medicines Code where it states:

‘3.2 General principles for intravenous administration

3.2.1 Within LTHT intravenous medicines must be prepared, checked and administered by two registered practitioners, unless they appear in the list in appendix 4.'

Appendix 4 was not relevant to this situation.

The panel had sight of Miss Nwosu's training records and took account that she had undergone several rounds of medication training and been successful in achieving her competency. The panel noted that this incident occurred months after Miss Nwosu had completed her supernumerary period and therefore, she would have been aware of the requirements.

Witness 7's evidence is that the second checker informed her that they were asked to sign but that they had refused as they had not witnessed the preparation of the medication. That they had told Miss Nwosu to re-prepare the medications so that they could witness the process but that instead Miss Nwosu had simply administered the medications without a second checker.

The panel was of the view that the second checker is responsible for undertaking the checks however it is Miss Nwosu's professional duty to the patient to obtain the second checker's signature and to ensure that the medications are witnessed and signed for. The panel was of the view that Miss Nwosu had failed in her duty to ensure that the medication was witnessed and countersigned by the second checker.

The panel accepts the account of events contained in the Datix and therefore that Miss Nwosu failed in her duty to ensure the administration of an antibiotic was witnessed and/or counter-signed by a second nurse.

The panel therefore finds Charge 6 proved.

Charge 7a

- 7) On 5 July 2022, in relation to Patient C:
a) failed to label multiple antibiotic infusions;

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness whose evidence was aligned and consistent from her NMC statement and her oral evidence. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00 hours. Her account in her statement, oral evidence and New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded contemporaneously and were discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8 stated in her Witness Statement:

'Miss Nwosu had also put up multiple antibiotic infusions for Patient C without labelling them. This meant no one else who needed to attend to the patient would know what was infusing.'

The panel had sight of the Injectable Medications Code where it specifies there is a requirement to label infusions:

'3.1.4 All medicines prepared for intravenous or subcutaneous infusion must be labelled at the time of preparation using the Trust approved yellow label to help distinguish between individual medicines. The label must include the following information:

- Name of patient, Unit or NHS number, and date of birth.*
- Ward or unit name.*
- Route.*
- Name and amount of medicine(s) added.*
- Name and quantity of the diluting fluid.*
- Date and time medicine prepared and date and time of expiry.*
This will be no longer than 24 hours unless specified.
- Signatures and the names of person preparing the medicine and where necessary the 'second checker'.*

The panel was of the view that Miss Nwosu and would have been aware from her training of the requirement to label the infusions and was under a duty to follow Trust and national guidelines and under a duty to Patient C to ensure safe medications administration.

The panel determined that Witness 8 had worked alongside Miss Nwosu on this day and was in a position of trust as a Clinical Practice Educator in supervising and developing new starters at the Trust; it accepted her evidence detailing the error made.

The panel determined that Miss Nwosu failed to label multiple antibiotic infusions.

The panel therefore finds Charge 7a proved.

Charge 7b

7) On 5 July 2022, in relation to Patient C:

b) ran several incompatible infusions through the same cannula;

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00 hours. Her account in her statement, oral evidence and the New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded contemporaneously and were discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8 stated in her Witness Statement:

'Miss Nwosu had also put up multiple antibiotic infusions for Patient C without labelling themThese infusions were also being run through one intravenous cannula at the same time and were not compatible with each other. This can cause issues such as an increase or decrease in the therapeutic effect of the medicines. Also, if the patient were to have

an unexpected allergic reaction to one of the drugs, it would be impossible to know which drug they had reacted to.'

The panel was of the view that Miss Nwosu was under a duty to follow Trust and national guidelines and under a duty to Patient C to ensure safe medications administration.

The panel determined that Witness 8 had worked alongside Miss Nwosu on this day and was in a position of trust as a Clinical Practice Educator in supervising and developing new starters at the Trust; it accepted her evidence detailing the error made.

The panel therefore finds Charge 7b proved.

Charge 7c

7) On 5 July 2022, in relation to Patient C:

c) failed to measure and/or record that you had measured the patient's nasogastric tube, prior to administering medication through it.

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00 hours. Her account in her statement, oral evidence and the New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded

contemporaneously and discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8 stated in her Witness Statement:

'...Miss Nwosu had also administered medication down the patient's nasogastric tube, but there was no documentation to say that the tube had been measured prior to doing so. As per the enteral feeding policy ... we must measure the tube to check it is in the correct position both as part of the start of shift safety checks ... and again before putting anything down it. This is to ensure that feed and medication do not accidentally end up in a lung rather than the stomach...'

The panel had particular regard to the Action Plan where one of Miss Nwosu's learning objectives states: *'To follow the LTHT Enteral Tube Feeding Policy when caring for a patient with an enteral feeding including measuring and documenting length of NT tube prior to administration'*. The panel determined that this was discussed with Miss Nwosu at the time and documented accordingly in her Action Plan.

The panel noted that Patient C's records appear to be incomplete and do not contain any nasogastric tube records, however, it had sight of an example of the guidance of the Continuous feeds (feed runs 24 hours) NGT ongoing position checks, where it states that it should be measured every time anything is administered through the tube. The panel also had regard to the Trust's policy statement in the Guidelines for the Provision, Assessment and Management of Adult Critical Care Patients Requiring Enteral Feeding.

The panel was of the view that Miss Nwosu was under a professional duty of care to follow Trust and national guidelines and owed a duty to Patient C to ensure safe medicines administration.

The panel determined that Witness 8 had worked alongside Miss Nwosu on this day and was in a position of trust, it accepted her evidence detailing the error made.

The panel determined that Miss Nwosu failed to measure and/or record that she had measured the patient's nasogastric tube, prior to administering medication through it.

The panel therefore finds Charge 7c proved.

Charge 8a

8) On 11 July 2022:

a) failed to check the alarm volume on an infusion pump and/or monitor/ventilator.

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00 hours. Her account in her statement, oral evidence and the New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded contemporaneously and discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be

the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8 stated in her Witness Statement:

'On 11 July 2022, I worked a long day with Miss Nwosu. They completed their safety checks on an ICU patient without a prompt sheet, however they did miss some important checks, such as the alarm volume on an infusion pump and checking monitoring. I had to prompt Miss Nwosu on a few things so I gave them a prompt sheet [...] and encouraged them to use it. Otherwise, Miss Nwosu was on time with their observations, polite to patients and had good communication with relatives.'

The panel was of the view that these are clear, balanced, contemporaneous detailed accounts of what Miss Nwosu did well and not so well, the purpose of which was to be of assistance in her development. The panel found Witness 8's evidence to be helpful and specific. The panel determined that Witness 8 held a supervisory position and it was part of her role to supervise Miss Nwosu's practice. The panel determined that Witness 8 had no reason to fabricate her account.

The panel had regard to the Prompt sheet which details that as part of 'Daily Routine Checks & Jobs', '*checking Monitor & Ventilator alarms & settings*' is listed.

The panel was of the view that Miss Nwosu was under a professional duty of care to the patient to ensure that all of the daily safety checks were carried out and that the equipment being used was set up to protect the patient.

The panel was of the view that Witness 8 had supervised Miss Nwosu's practice and was a direct witness to the events detailed in her observations; it accepted her evidence and therefore the panel finds Charge 8a proved.

Charge 8b

8) On 11 July 2022:

b) Failed to titrate medication to achieve target parameters.

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00 hours. Her account in her statement, oral evidence and the New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded contemporaneously and discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8 stated in her Witness Statement:

‘Some concerns raised during this shift were around lack of titration of medication to achieve target parameters such as cerebral perfusion pressure and intracranial pressure. Target values are set by the doctors and we are required to act accordingly to achieve them where possible, for example by titrating the sedative or inotropic (blood pressure support) medications in order to try reduce the patient's intracranial pressure. I had to prompt Miss Nwosu to titrate the patient's noradrenaline (blood pressure support medication) according to the cerebral perfusion pressure target and prompt them to increase the sedation in an attempt to reduce the patient's intracranial pressure.’

The panel was satisfied that Miss Nwosu was the nurse allocated to the patient and that she was being supervised by Witness 8. The panel was of the view that Witness 8 had identified this to be a clinical issue and had included it as part of Miss Nwosu's Action Plan to support Miss Nwosu's development.

The panel was of the view that Miss Nwosu was under a professional duty of care to the patient to titrate medications in order to achieve target parameters, set by doctors, to protect the patient.

The panel considered Witness 8 had supervised Miss Nwosu's practice and was a direct witness to the events detailed in her observations; it accepted her evidence and the panel therefore finds Charge 8b proved.

Charge 8c

8) On 11 July 2022:

c) failed to check expiry dates on medication without prompting.

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's Witness Statement dated 17 May 2025, corresponding documents and oral evidence. The panel also considered the New Starter Tracker and the Action Plan as described above.

The panel found Witness 8 to be a credible and reliable witness. The panel was of the view that Witness 8 had no reason to fabricate her evidence, no malice or unconscious bias toward Miss Nwosu. Witness 8 was on the same shift as Miss Nwosu and was directly observing her from 10:00 – 15:00. Her account in her statement, oral evidence and the New Starter Tracker was consistent. Some elements recorded were not directly observed by Witness 8, but some were. All the incidents were recorded contemporaneously and discussed with Miss Nwosu in a meeting following the shift. They were then brought together in an Action Plan which was agreed with Miss Nwosu. The panel was of the view that in these circumstances the events described are unlikely to be the results of mistakes by those witnesses involved. The panel had sight of the Action Plan which was supportive of Witness 8's evidence. The panel was satisfied that the Action Plan was written to support Miss Nwosu in developing her practice and documented in a formal way.

Witness 8's stated in her Witness Statement:

'I supervised Miss Nwosu administering medication during this shift and asked them to recall the five R's (right patient, right drug, right dose, right route, right time), which they could. However, I did have to prompt them to check the expiry date on the medication as they did not do this for every medication administered'.

The panel was of the view that it is reasonable to conclude that Miss Nwosu would have known to check the expiry date of medications as it is a basic and fundamental part of nursing practice to check if it is safe to administer drugs to patients. The panel considered it would be second nature for a nurse to check the expiry dates as the 'right drug'

requirement implies that the medication has not expired and will therefore have the desired outcome and not be unsafe.

The panel determined that all forms of medication should have their expiry dates checked prior to administration in order to avoid errors.

The panel was of the view that Miss Nwosu was under a professional duty of care to the patient to ensure that she was not administering expired medications in order to protect the patient from harm.

The panel was of the view that Witness 8 had supervised Miss Nwosu's practice and was a direct witness to the events detailed in her observations; it accepted her evidence and therefore the panel finds Charge 8c proved.

Charge 9

The panel noted that the local Trust investigation, conducted by Witness 6, related to a missing syringe of Alfentanil (a controlled drug), it was never established what happened to this syringe and the panel was clear that although Charge 9 relates to the circumstances surrounding this incident, Miss Nwosu is not charged with any misappropriation of that syringe.

In reaching this decision on this charge the panel considered the weight to be given to the hearsay evidence of Ms 1 and Ms 2 who gave statements to the Trust investigation. Ms 1 confirms Witness 5's evidence that the syringe from 08:05 hours the previous day was shown to her by Witness 5 because it was the syringe still attached to the patient's equipment, and that Miss Nwosu, when contacted, '*confirmed that she changed the syringe on 14/8/2022 at 21:30*' on two occasions. Ms 2 confirms the actions she took, as Ward Pharmacist, when informed that a syringe of Alfentanil, a controlled drug, was missing. As such neither witness adds significantly to the relevant evidence available to the panel in respect of the charges.

The panel there finds Charge 9 proved.

Charge 9a

9) Between 14 and 15 August 2022, in relation to Patient E:

a) Without clinical justification, prepared several infusions of medication simultaneously

This charge is found proved

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 4, Witness 6 and corresponding documentation.

The panel also had regard to the notes of the Investigation Meeting dated 20 October 2022, which included Miss Nwosu's account of events. Miss Nwosu accepted that she should not have prepared all of the medications together and that the reason she did so was because she did not want to get caught out as she had the night before when one of her patient's infusions had run out. In her interview for the Trust's investigation Ms Nwosu accepted that her actions were not in accordance with the Trust's policy.

*'JB: Why did you feel the need to replace all the infusions at once?
Have you done this before?*

*NN: I haven't done this before, the patient had so much gone on
and I didn't want a problem with the infusions. I know this was
wrong and I'm so sorry about this.'*

Miss Nwosu's acceptance in this interview is confirmed in the evidence of Witness 4, who was supposed to perform the duties of the second checker for these infusions. Witness 4 stated in her witness statement:

'Miss Nwosu told me there were in fact three labels to sign as they were

preparing three medications in total for [Patient E], Alfentanil, Dexdor and another which I cannot remember (Dexdor and the other drug were not controlled drugs).'

...

'I did not have any concerns about this at the time and just signed the three labels. I can confirm that the labels did not have the patient's name on but I cannot recall whether the name of the drug was on the labels or not.'

The panel determined that Witness 4 was a reliable, credible witness whose evidence was consistent and straightforward. She gave a detailed account of events as she remembered them. The panel was of the view that she had no reason to fabricate or embellish her evidence and had no malice or unconscious bias toward Miss Nwosu. She had been spoken to shortly after the incident and had made a local statement which was consistent with her NMC statement and her oral evidence. Her detailed account and admissions to the Trust investigation clearly showed that she too had made errors. The panel did not consider that she was mistaken in her account as it was also supported by Miss Nwosu's admissions and therefore the panel accepted her evidence.

The panel also accepted the evidence of Witness 6, who was the independent Investigating Officer, as to the contents of the Trust investigation, as shown in the investigation report. The panel also accepted Witness 6's evidence as to the medication administration standards expected by the Trust as he was a senior experienced Charge Nurse in the General ICU at the Trust who had examined the Trust documentation as part of his investigation.

The panel determined that there is sufficient evidence to show that several infusions of medications were prepared simultaneously.

In respect to whether there was any clinical justification for doing so, Witness 6 in his NMC Witness Statement, signed on 5 June 2023, stated:

'It goes against all national and local rules to check out /administer three different infusions together...Each infusion should be checked individually as there can be serious consequences for the patient if the infusions are mixed up. In the rare event that all infusions were due at the same time, assistance would be sought form other staff members, so no two individuals were checking more than one infusion at a time to prevent misappropriation of infusions.'

When Witness 6 was asked if there could be a clinical justification for preparing several infusions of medication simultaneously, he was clear that there were too many risks in doing so. Specifically, his evidence was that Miss Nwosu's reason, given in interview, was not a clinical justification.

The panel was satisfied that Miss Nwosu owed a professional duty of care toward Patient E to administer medications safely which is a fundamental aspect of nursing care and that by preparing several infusions of medication simultaneously Miss Nwosu was not acting safely.

The panel there finds Charge 9a proved.

Charge 9b

9) Between 14 and 15 August 2022, in relation to Patient E:

b) failed to ensure a 2nd nurse witnessed the administration of one or more infusions

This charge is found proved

In reaching this decision, the panel took account of the Witness Statement and oral evidence of Witness 4, Witness 6 and corresponding documentation.

Miss Nwosu in her interview for the Trust investigation stated:

'JB: Did you check all the infusions together with the second checker?

NN: Yes, I did

JB: Where did you check the infusions?

NN: At the patient's bedside'

Witness 4 states in her Witness Statement:

'I did not witness Miss Nwosu putting the Alfentanil or other drugs into the patient's infusion. Controlled drugs do require the second person to witness the administration in an ideal world. However it was not the practice on our Unit during that time. This practice has since changed and we are all now second checking infusions and witnessing it from dispensing to administration.'

The panel had sight of the Trust's Controlled Drug Standard Operating Procedure, which states, in respect of controlled drugs:

'Procedure

6.1. Except on very rare occasions, two registered practitioners must always be involved in the administration of a controlled drug.

The general exceptions to this are:

- ▶ lone medical practitioners*
- ▶ midwives involved in a home birth*
- ▶ lone practitioners in the palliative care situation in the patient's home*
- ▶ the administration of the 'single signature' CDs listed in SOP reference CD 1.11 .*

These medicines, pregabalin, gabapentin, phenobarbital, temazepam and tramadol, have their own statement of controls,

and may be administered by a single registered practitioner. The same safety checks listed below still apply, but they are not witnessed by a second practitioner.

6.2. Both practitioners must be present during the whole of the administration process and both should check and witness:-

- The drug, form, route and dose prescribed*
- The drug name, formulation and strength selected from the cupboard*
- The preparation (e.g. drawing up) of the dose required*
- The identity of the patient*
- The administration to the patient; this MUST include witnessing the ingestion, injection or application'*
- The entry in the CD Record Book (CDRB - see below) or electronic register (areas using Omnicell cabinets)*
- The destruction of any surplus drug (e.g. part of an opened ampoule not used)*
- Balance remaining in the cupboard. Note that in areas using Omnicell, the balance is confirmed at the start of each transaction and this acts as the balance reconciliation.'*

The panel determined that Witness 4 was a reliable, credible witness whose evidence was consistent and straightforward. She gave a detailed account of events as she remembered them. The panel was of the view that she had no reason to fabricate or embellish her evidence and had no malice or unconscious bias toward Miss Nwosu. She had been spoken to shortly after the incident and had made a local statement which was consistent with her NMC statement and her oral evidence. Her detailed account and admissions to the Trust investigation clearly showed that she too had made errors. The panel did not consider that she was mistaken in her account as the events were straightforward and memorable.

The panel was satisfied on the balance of probabilities that Witness 4's evidence was an accurate account of events rather than Miss Nwosu's simple assertion that she did have a second checker; Witness 4. Further, the panel found that a second checker was required for the Alfentanil as it was a controlled drug.

Witness 6 stated in his Witness Statement:

'...All infusions need to be removed and drawn up by two people but only controlled drugs need to be signed out...'

The panel was satisfied that Miss Nwosu owed a professional duty of care toward Patient E to administer medications safely which is a fundamental aspect of nursing care and that she should have ensured a second nurse witnessed the administration of the infusions.

The panel there finds Charge 9b proved.

Charge 9c

9) Between 14 and 15 August 2022, in relation to Patient E:

c) failed to label medication prior to obtaining a second signature

This charge is found proved

In reaching this decision, the panel took account of the witness statement and oral evidence of Witness 4, Witness 6 and corresponding documentation.

The panel was of the view that Miss Nwosu does not accept that the medication was not correctly labelled.

In the interview for the Trust investigation Miss Nwosu stated:

‘JB: Did you fill in the details on the additive labels prior to checking them?’

‘NN: Yes all of them’

In Witness 4’s interview for the Trust investigation, when asked if Miss Nwosu had completed additive labels in full when she checked the infusions, replied:

‘No, I just signed blank labels’.

The panel had regard to the Trust’s Injectable Medicine Code and its General Guidance on Injectable Therapy which requires labelling of medication in paragraph 3.1.4 as quoted above.

The panel determined that Witness 4 was a reliable, credible witness whose evidence was consistent and straightforward. She gave a detailed account of events as she remembered them. The panel was of the view that she had no reason to fabricate or embellish her evidence and had no malice or unconscious bias toward Miss Nwosu. She had been spoken to shortly after the incident and had made a local statement which was consistent with her NMC statement and her oral evidence. Her detailed account and admissions to the Trust investigation clearly showed that she too had made errors. The panel did not consider that she was mistaken in her account as the events were straightforward and memorable.

The panel was satisfied on the balance of probabilities that Witness 4’s evidence was an accurate account of events, rather than Miss Nwosu’s simple assertion that she did complete all of the details on the labels.

The panel was satisfied that Miss Nwosu owed a professional duty of care toward Patient E to administer medications safely which is a fundamental aspect of nursing care and that she should have labelled the infusions of medication prior to obtaining a second signature.

The panel determined that it was more likely than not Miss Nwosu failed to label medication prior to obtaining a second signature.

The panel there finds Charge 9c proved.

Charge 9d

9) Between 14 and 15 August 2022, in relation to Patient E:

d) sought to replace an infusion of a controlled drug when it was not required.

This charge is found proved

In reaching this decision, the panel took account Witness 5 and Witness 6's witness statements, corresponding documents and oral evidence.

Miss Nwosu in her prepared statement for the Trust investigation stated:

'After that, I rechecked my infusion and saw that the noradrenaline had almost finished so decided to make up all my infusions, so none runs out.'

In the interview for the Trust investigation she accepted that this course of action was wrong when she said

*'JB: Why did you feel the need to replace all the infusions at once?
Have you done this before?*

NN: I haven't done this before, the patient had so much gone on and I didn't want a problem with the infusions. I know this was wrong and I'm so sorry about this.'

Miss Nwosu attributed her mistake to the shift being extremely busy.

Witness 5 states in her Witness Statement signed 14 August 2023:

'Following handover, I did a full A to E assessment .. of the patient, safety checks and checked when the infusion pumps were due to expire. On doing so, I noticed that the Alfentanil [Patient E] was receiving via an infusion was due to expire at 08:00 so I asked another nurse, [Ms 4], to sign out another infusion with me, to replace the one due to expire. I noticed that on the prescription chart and controlled drugs book ...an infusion of Alfentanil was signed out for [Patient E] by Miss Nwosu and [Witness 4] at 21:30 On 14 August 2022 but this was not attached to the patient. The infusion attached to the [Patient E] was the syringe labelled as prepared on 14 August 2022 at 08:00.

Infusions are continuous and run for 24 hours. They are not prescribed for set times, for example at 21:30 or 08:00. The prescription covers multiple infusions and the nurse would sign out a new infusion when the previous one expires.'

The panel determined that Witness 5's evidence is consistent with the MAR chart for the patient which shows that an Alfentanil infusion was commenced at 08:05 hours the previous day and therefore it would not be expected that a new syringe would be needed at 21:30 hours.

Witness 5's evidence was that when she got to the patient's bedside there was Alfentanil left in the syringe prepared at 08:05 hours the previous day, which was still in progress. This evidence was supported by a photograph of the syringe which showed there was still a volume of medication in it.

The panel determined that Witness 5's evidence was reliable, credible, consistent and straightforward. The panel was of the view that she had no reason to fabricate or embellish her evidence, had no malice or unconscious bias toward Miss Nwosu. She had conducted a search for the missing syringe of Alfentanil and reported the matter to senior colleagues, she had taken photographs and, in her statement, gave a detailed account of those steps, as such it was unlikely she was mistaken. Her local statement was consistent with her NMC statement and her oral evidence and with the documents seen by the panel.

The panel determined that it was more likely than not Miss Nwosu sought to replace an infusion of a controlled drug when it was not required.

The panel there finds Charge 9d proved.

Charge 9e

9) Between 14 and 15 August 2022, in relation to Patient E:

e) left a controlled drug unattended

This charge is found proved.

In reaching this decision, the panel took account Witness 4 and Witness 6's witness statements, corresponding documents and oral evidence.

Miss Nwosu accepted during the Trust investigation that:

'As soon as I made up all the infusions, i kept them on the bedside locker (to be easily accessible to me and the nurse who would help look after the patient during break).....My fault here was that I made up all the medications and put them on a tray by the bedside locker which I later got to know was bad practice. I did it just to make my work easier which was still not an excuse.'

However, Witness 4 described the controlled drug being left unattended in the drugs room as well.

Witness 4 states in her Witness Statement:

'I looked over at the controlled drugs cupboard and saw all three of Miss Nwosu's drugs still below the cupboard in the open unattended. I do not know how long the drugs had been left unattended. Controlled drugs should not be left unattended so I brought them over to Miss Nwosu's patient's bed side.'

In oral evidence Witness 4 stated that she had a clear view of the medications and observed Miss Nwosu going back and forth dealing with someone in a side room and as such was leaving Patient E's bay.

Witness 6 states in his Witness Statement:

'Miss Nwosu admitted that they should not have drawn all the infusions up together and admitted they had left the drawn-up medications at the patient's bedside.'

The panel determined that Witness 4 was a reliable, credible witness whose evidence was consistent and straightforward. She gave a detailed account of events as she remembered them. The panel was of the view that she had no reason to fabricate or embellish her evidence and had no malice or unconscious bias toward Miss Nwosu. She had been spoken to shortly after the incident and had made a local statement which was consistent with her NMC statement and her oral evidence. Her detailed account and admissions to the Trust investigation clearly showed that she too had made errors. The panel did not consider that she was mistaken in her account as the events were straightforward and memorable.

The panel was satisfied on the balance of probabilities that Witness 4's evidence was an accurate account of events. It was consistent with Miss Nwosu's acceptance that she left a controlled drug unattended by the patient's bedside but went further in saying that the controlled drug was first left unattended in the drugs room.

The panel was satisfied that Miss Nwosu owed a professional duty of care toward Patient E to administer medications safely which is a fundamental aspect of nursing and that she should not have left a controlled drug unattended.

The panel there finds Charge 9e proved.

Panel direction for further evidence (Day 7)

Prior to deliberations on Charges 10, 11, 12 and 13, the panel of its own volition, made a direction under Rule 22(5) of the Rules requesting further evidence. It became apparent to the panel that the evidence the NMC had provided was limited, and that it may be assisted by further evidence in order to determine the facts.

The panel accepted the advice of the legal assessor which included reference to the cases of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin) and *Ruscillo v CHRE* [2004] EWCA Civ, as well as to Rule 22(5), which states:

'The Committee may of its own motion require a person to attend the hearing to give evidence, or to produce relevant documents.'

The panel proposed to direct that Ms Ghotra make efforts with the NMC to obtain documents in relation to Miss Nwosu's NMC investigation and the interim order hearing on 2 March 2023:

- Notice of Hearing and service documents
- Correspondence between the NMC and Miss Nwosu

The panel invited Ms Ghotra to make any comments in relation to the proposed direction. Ms Ghotra informed the panel that she would make enquiries with the NMC to obtain the documents requested. The panel went on to make the direction.

The requested documentation was duly provided and Ms Ghotra made submissions addressing the information provided.

Charge 10

10) On or around 3rd March 2023 failed to notify your employer that you had been made the subject of an interim order by the NMC.

This charge is found proved.

In reaching this decision, the panel took account of Witness 1's witness statement dated 30 November 2023, corresponding documents and oral evidence.

The panel considered that the charge would require Miss Nwosu to know that an Interim Order had been imposed. The NMC Code 23.3 is clear that she had a duty to inform her employer if she had her '*practice restricted or had any other conditions imposed*' once she knew that an interim order had been made. Therefore, the first step was to consider whether Miss Nwosu knew that the interim order had been made.

The panel heard evidence from Witness 6 that Miss Nwosu left the Trust after the investigation but prior to the disciplinary hearing.

The panel found Witness 1 to be credible and reliable, her evidence was consistent in her NMC Witness Statement and her oral evidence. The panel was of the view that Witness 1 had no reason to fabricate her evidence, and there was no evidence of any malice or unconscious bias toward Miss Nwosu. It was further of the view that the incident was

memorable, and Witness 1 took it seriously and acted quickly to address the issues raised, as such she was unlikely to be mistaken. Her evidence was unchallenged and Miss Nwosu did not appeal the final written warning that she received as a result of this incident.

Witness 1 stated in her Witness Statement:

'In December 2022, I interviewed Miss Nwosu for the role of nurse. During interview they told me that there had been a medication error in their previous role but did not say what the extent of the error was or that they had been dismissed. This made me think it was a simplistic error. Miss Nwosu told me that they had two medications and left them on the side. Miss Nwosu did not tell me they were controlled drugs. Miss Nwosu told me they had been called in by the Trust which employed them and 'told off' but said the reason for the error was that the Trust were asking them to work a lot and they were tired,Miss Nwosu did not go into much detail and was very matter of fact so I assumed that it was a matter concluded internally at the Trust. I had no reason to think anything different. In the application form for the nursing role, there is a section asking potential employees if they have a criminal record or are subject to any disciplinary or investigation. Miss Nwosu ticked no on this section.'

The panel considered the documents obtained from the NMC in respect of the investigation and the Interim Order hearing. The NMC sent two communications to Miss Nwosu, using the email address she had provided for her registration; the Notice of Hearing on 21 February 2023 and the Decision letter on 3 March 2023. This email address is still the nominated email address for correspondence with the NMC.

The panel had regard to Witness 1's Witness Statement in which she said that when she challenged Miss Nwosu on 3 April 2023 about not having informed her of the Interim

Order, Miss Nwosu said she had '*changed phones so did not have access to this*'. Even if the panel accepted that Miss Nwosu had changed phones it did not provide a clear reason why the email account could not be accessed in another way.

The panel determined that it was more likely than not that Miss Nwosu did have access to the correspondence via her emails and had accessed her emails between 21 February and 3 April 2023. On accessing her emails Miss Nwosu would have known about the NMC investigation and the Interim Order application; after the 3 March 2023 she would have seen the Interim Conditions of Practice Order and its terms.

The panel determined that it was more likely than not that Miss Nwosu was aware of the interim order at the time and failed to notify her employer that she had been made the subject of an interim order by the NMC.

The panel therefore finds Charge 10 proved.

Charge 11

11) Between approximately 3rd March to 3 April 2023, worked unsupervised on one or more occasions, in breach of your interim order.

This charge is found proved.

In reaching this decision, the panel took account of Witness 1's witness statement dated 30 November 2023, corresponding documents and oral evidence.

The panel accepted Witness 1's account. The panel was of the view that Witness 1 had no reason to fabricate or embellish her evidence and had no malice or unconscious bias toward Miss Nwosu. Witness 1 checked the Home's records and was then able to confirm how many shifts Miss Nwosu had worked between 3 March 2023 and 3 April 2023, which makes a mistake very unlikely. The panel took account that Witness 1 still employed Miss

Nwosu afterwards as a Health Care Assistant showing that she was not attempting to end her employment.

Witness 1 states in her Witness Statement dated 30 November 2023:

'Within a couple of days, Miss Nwosu came back to me with the full paperwork which was more in depth. I was concerned as Miss Nwosu had not been honest. The paperwork was dated around 3 March 2023 (I cannot be sure of the day but know it was March) and Miss Nwosu should have been honest from then. The Interim Order stated that Miss Nwosu could not work as a nurse alone, but because I was unaware of the Interim Order they had been working alone since they started in their role. Miss Nwosu had worked sixteen shifts alone in March 2023, since the IO was imposed.

...

During this meeting I read out the Interim Order to Miss Nwosu and their instant reaction was to ask if they still had a job, as they were on a sponsorship so their whole lifestyle was at stake. I asked why Miss Nwosu did not tell me and they said it was because they did not know.'

The panel had sight of condition 3 in the interim conditions of practice order:

'3. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of working on the same shift as, but not always directly observed by, another registered nurse.'

The panel noted that the interim order is clear in relation to supervision and observation.

The panel determined that Miss Nwosu had worked unsupervised on one or more occasions between 3rd March to 3 April 2023, in breach of her interim order.

The panel therefore finds Charge 11 proved.

Charge 12

12) Your action as set out in Charge 10 above was dishonest in that you represented to your employer that your registration was not subject to conditions when you knew it was.

This charge is found proved.

In reaching this decision, the panel had regard to the legal test for dishonesty as set out in *Ivey v Genting Casinos*. The panel bore in mind that it must first ascertain the actual state of the individual's knowledge or belief as to the facts. Once this has been established, the question of whether the conduct was honest or dishonest is to be determined by applying the objective standards of ordinary and decent people.

The panel determined, when finding Charge 10 proved, that Miss Nwosu was aware of the interim conditions of practice order. The panel accepted the submission of the NMC that by attending work and working unsupervised she was making a representation that she was entitled to do so.

The panel determined that by the standards of ordinary decent people, Miss Nwosu's actions were dishonest. Miss Nwosu was aware of the interim order imposed and the conditions were clearly set out. The panel therefore finds that Miss Nwosu was dishonest in that she represented to her employer that her registration was not subject to conditions of practice when she knew it was.

The panel therefore finds Charge 12 proved.

Charge 13

13) Your actions as set out in charge 11 above were dishonest in that you knew your registration was the subject of conditions.

This charge is found proved.

In reaching this decision, the panel had regard to the legal test for dishonesty as set out in *Ivey v Genting Casinos*. The panel bore in mind that it must first ascertain the actual state of the individual's knowledge or belief as to the facts. Once this has been established, the question of whether the conduct was honest or dishonest is to be determined by applying the objective standards of ordinary and decent people.

The panel determined, when finding Charge 10 proved, that Miss Nwosu was aware of the interim conditions of practice order. The panel accepted the submission of the NMC that by attending work and working unsupervised, in breach of the order she was making a representation that she was entitled to do so.

The panel determined that by the standards of ordinary decent people, Miss Nwosu's actions were dishonest. Miss Nwosu was aware of the interim order imposed and the conditions were clearly set out. The panel therefore finds that Miss Nwosu was dishonest in that she represented to her employer that she was entitled to work unsupervised when she knew that she was not.

The panel therefore finds Charge 13 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Miss Nwosu's 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, 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 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, Miss Nwosu's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Ghotra referred the panel to the terms of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) in making its decision. She identified the specific, relevant standards which the NMC suggest had been breached by Miss Nwosu and amounted to misconduct. She also referred to the cases of *Roylance v General Medical Council*_(No 2) [2000] 1 A.C. 311, *Calheam v GMC* [2007] EWHC 2606 (Admin) and relevant NMC Guidance (*FTP-2a*).

Ms Ghotra submitted that the conduct and failings in this case were not isolated incidents, took place over a period of time and are wide-ranging. She submitted that Miss Nwosu's actions posed a risk of harm to patients under her care whom she was responsible for. Ms Ghotra stated that it is expected that nurses act with honesty and integrity and keep accurate records, however, some of the facts found proved concerned matters relating to Miss Nwosu not keeping accurate records and doing so dishonestly. Further, Ms Ghotra submitted that the facts found proved in relation to dishonesty demonstrate a pattern of behaviour as they occurred over a period of time, on more than one occasion, and in separate settings.

Ms Ghotra submitted that Miss Nwosu's conduct indicates an underlying deep-seated attitudinal issue, which is difficult to address. She submitted that Miss Nwosu's behaviour demonstrated a significant departure from the principles of prioritising people, acting with honesty and integrity, promoting professionalism and trust in the profession, which the NMC say would be seen as deplorable by fellow practitioners. She submitted that the charges and behaviour in this case were sufficiently serious and amounted to misconduct individually and cumulatively.

Ms Ghotra invited the panel to take the view that the charges found proved amounted to misconduct.

Submissions on impairment

Ms Ghotra 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. Ms Ghotra referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and also referenced relevant NMC guidance (*FTP-15a*).

Ms Ghotra submitted that the following questions outlined in the case of *Grant* can be answered in the affirmative in respect of this case, in that Miss Nwosu:

- *Has in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
- *Has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or*
- *Has in the past committed a breach of one of the fundamental tenets of the profession and/or is liable to do so in the future and/or*

- *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

Ms Ghotra submitted that all limbs of the *Grant* test are engaged. She submitted that Miss Nwosu has acted and is liable in the future to act so as to put patients at unwarranted risk of harm. She stated that the panel's findings demonstrate that there were occasions where Miss Nwosu failed to administer medication and/or properly administer medication, carry out observations, and take appropriate action when a patient was deteriorating. Ms Ghotra submitted that these were fundamental aspects of nursing care and Miss Nwosu had repeatedly failed in her duty of care towards the patients she was responsible for, therefore putting them at unwarranted risk of harm.

Ms Ghotra submitted that Miss Nwosu actions fell significantly short of what is expected of a registered nurse and her actions are a serious departure from the standards expected of a registered nurse. She submitted that Miss Nwosu's actions and behaviour have brought the profession into disrepute and are likely to erode the trust and confidence of the public in the nursing profession.

Ms Ghotra submitted that nurses are required to promote professionalism and trust and her actions were serious and breached the fundamental tenets of the nursing profession. Ms Ghotra submitted that the panel have of course found Charges 5, 12, and 13 proved regarding Miss Nwosu having acted dishonestly. She submitted that Miss Nwosu is liable to act dishonestly in the future in light of the fact that it has been found that she acted dishonestly on more than one occasion, in two separate settings.

Further, Ms Ghotra submitted that there is no evidence of any reflection, training courses, or testimonials from any recent employment. There is no evidence to suggest that Miss Nwosu has taken any steps to adequately address the concerns or demonstrate insight or strengthened practice. Also, there were multiple instances of repeated misconduct despite Miss Nwosu receiving support from her employer and there are deep-seated attitudinal

problems which have not been addressed. Therefore, Ms Ghotra stated that the panel cannot be satisfied that Miss Nwosu's conduct is highly unlikely to be repeated, and a high risk of repetition remains.

Ms Ghotra also submitted that the concerns clearly constitute matters that are so serious that a finding of impairment is required to uphold professional standards. She submitted that if a finding of impairment were not made, public confidence and the trust in the regulatory process and the NMC as a regulator would be undermined.

For these reasons, Ms Ghotra submitted that a finding of impairment is necessary on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Calhaem v General Medical Council* and *CHRE v NMC and Grant*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* which defines misconduct as a '*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*'

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

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

'...1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

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

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

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

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

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

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

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

18.4 take all steps to keep medicines stored securely

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

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

20.2 act with honesty and integrity at all times, ... ,

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body...'

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

The panel considered whether the charges amounted to misconduct, first individually and then cumulatively within the area of concern.

The panel was satisfied that the following charges found proved would be regarded as a deplorable by fellow practitioners, was a significant departure from the conduct and standards expected of a registered nurse, and individually amounted to serious professional misconduct:

Charge 1

The panel had regard to its findings that on or around 3 May 2022, Miss Nwosu failed to take any or adequate steps when Patient A's ventilator had become disconnected. The panel was of the view that Miss Nwosu had a professional duty of care toward Patient A to respond to the ventilator alarm, which was a fundamental aspect of nursing care, either by finding and fixing the disconnection or at the very least requesting help which she failed to do.

Patient A was unable to breathe on his own and Miss Nwosu took no action to resolve the situation when his ventilator alarm was sounding. It was only when the nurse in charge entered the room and reattached the ventilator tubing that the patient's support with breathing was restored. Her inaction caused a serious risk of harm to Patient A.

Charge 2b

In relation to Miss Nwosu failing to administer nimodipine in a timely manner on 5 July 2022 to Patient C, the panel noted that this was the second incident regarding the same failure. It noted that having missed a dose at 08:00 Miss Nwosu had then administered a double dose of nimodipine, and she did not provide an explanation as to why she did so.

The panel also noted that Miss Nwosu's actions went directly against the doctor's orders and could have caused significant harm to Patient C. The panel considered this was an attitudinal issue rather than an issue of competency.

Charge 3

Miss Nwosu's failed to escalate and/or take appropriate action regarding Patient B's lumbar drain which had stopped oscillating and was not working properly. The panel noted that Miss Nwosu recorded that it was not oscillating but took no action for approximately two and a half hours. This was a serious failure in Miss Nwosu's duty of care and put Patient B at a real risk of serious harm.

Charge 4b

Miss Nwosu without clinical justification, left an unknown patient on a bedpan for at least two hours, despite being told three times by the nurse in charge to take the patient off. This represents Miss Nwosu's failure to care appropriately for the patient who would not have been comfortable and would have been at risk of pressure damage. This was a very basic task, and Miss Nwosu ignored the repeated instruction from the nurse in charge. The panel concluded that Miss Nwosu had not upheld the patient's right to dignity in this regard.

Charge 4c)i

This represents Miss Nwosu's failure to ensure that a patient was weaned off peripheral Norad medication in accordance with the doctors' treatment plan; despite being reminded multiple times by the nurse in charge who subsequently had to step in and complete this task herself. The panel noted that this would have been a straightforward action that required little time and that Miss Nwosu did not appear to be doing anything that prevented her from completing this task. Miss Nwosu put the patient at a real risk of

significant harm as they continued to receive medication at a higher dose than was clinically justified.

Charge 4c)ii

This represents Miss Nwosu's failure to monitor a patient's blood sugar in a timely manner when they were receiving an insulin infusion. The panel noted that the patient's blood sugar was not monitored for seven hours, which put the patient at a real risk of significant harm. The panel was of the view that monitoring patients in a timely manner is a basic requirement and a fundamental aspect of nursing particularly in HDU/ICU.

Charge 4d)ii and 4d)iii

The panel noted that observations on HDU/ICU are fundamental as the units care for patients who are very unwell, often unstable and need to be observed frequently. Miss Nwosu failed to carry out the necessary observations and recordings for five hours, leaving the patient vulnerable and at real risk of significant harm.

Charge 4d)iv and 5

These charges address Miss Nwosu dishonestly falsifying recordings in order to disguise her failure to carry out the necessary observations; thereby creating a false record of the patient's condition and potentially creating a dangerous situation where inaccurate records are relied upon to make future medical decisions.

Charge 6

This demonstrated Miss Nwosu's failure in ensuring that the administration of an antibiotic was witnessed and/or counter-signed by a second nurse. Miss Nwosu was challenged by the nurse she asked to be the second checker and reminded of the drugs policy and the safeguards that should be adhered to. Miss Nwosu then chose to ignore that reminder and

to administer the antibiotics without a second checker. The panel was of the view that this represented an attitudinal concern, and that Miss Nwosu had acted deliberately, ignoring rules in respect of safe medication administration.

Charge 7a, 7b, 7c

These charges deal with Miss Nwosu's fundamental failure to follow correct procedures to ensure safe medication administration; failing to label antibiotic infusions, risking serious mistakes being made; running incompatible infusions through the same cannula, risking the effectiveness and safety of these antibiotics and failing to measure the nasogastric tube before administering medication through it, risking aspiration. These failures demonstrated a disregard of clear guidance and process which would have been straightforward and familiar. This resulted in a real risk of significant harm to the patient.

Charge 8b

This charge relates to Miss Nwosu failing to act in accordance with the doctors' treatment plan to keep the patient's readings within parameters by titrating their medication. Despite Miss Nwosu working with a Clinical Practice Educator on that shift, she had to be reminded on every occasion to adjust the medications. The panel was of the view that this represented more than mere forgetfulness and was a disregard of the patient's medical needs.

Charge 9a, 9b, 9c, 9e

These charges relate to the administration of three infusions, including one of a controlled drug. Miss Nwosu disregarded the rules for safe medication administration, and particularly those dealing with the handling of controlled drugs. Three infusions were prepared at the same time, were not witnessed being administered by a second checker and were not labelled correctly. In addition, the infusions, including the controlled drug,

were left unattended in the drugs room and then beside the patient's bed. The panel noted that at the time of this incident Miss Nwosu had an action plan in place with a learning objective related to the administration of medicines. She was being supported and was aware of safe practice. Her disregard of that safe practice put patients at real risk of significant harm. The panel considered the repeated disregard of safe practice to represent an attitudinal issue.

Charge 10, 11, 12 and 13

The panel noted that Miss Nwosu was aware that her practice had been restricted by the imposition of an interim conditions of practice order on 3 March 2023, however, she failed to disclose the conditions to her new employer and practised unsupervised on more than one occasion. She continued to do so until her employer discovered the order during her regular PIN checks on 3 April 2023. This dishonesty led to Miss Nwosu practising unsupervised, therefore putting patients at real risk of significant harm.

The panel found that Miss Nwosu's actions in the following charges would not be considered as deplorable and did not individually amount to misconduct:

Charge 2a

The panel noted that the incident of 15 May 2022 had taken place approximately two months after Miss Nwosu's supernumerary period, and that she was still considered a new starter. It took into account that Miss Nwosu had explained she had failed to administer nimodipine, because Patient F was asleep. The panel was of the view that this was indicative of an error of judgement which required further training rather than misconduct.

Charge 4d)i

The panel noted that the medication was left outside of the curtains on a trolley by the patient's bed, but that there was no information about how long the medication had been

left there. The panel noted that the patient was said to be on the bedpan at the time the medication was left there and considered that this was not best practice. However it noted that some members of staff working in the unit did not always follow best practice in this respect. In these circumstances the panel did not consider this to be sufficiently serious to amount to misconduct.

Charge 8a

The panel noted that it was essential to check the volume on the alarms as they needed to be loud enough to be heard outside the patient's side room. Checking the volume of the alarm was one of the safety checks on a list that the nurse was required to fulfil at the beginning of their shift. However, the panel was of the view that checking the volume on an alarm was something that could be accidentally missed amongst other checks and did not necessarily demonstrate a deliberate act.

Charge 8c

The panel considered that checking expiry dates on medications was important and should happen on every occasion before medication administration. During this shift Miss Nwosu was checking the expiry dates on the IV medications but did not appear to realise she also needed to check all the other medications. This appears to have been a training need rather than a deliberate act.

Charge 9d

The panel considered that seeking to replace an infusion of a controlled drug when it was not required was not best practice and was potentially wasteful. However, this action did not put the patient at risk of harm and arose from Miss Nwosu mistakenly thinking that the infusion would need changing during her shift and therefore preparing the infusion in advance of the need. As such the panel considered this to be a mistake but not misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Nwosu's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

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

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 determined that all four limbs of the *Grant* test are engaged in this case. The panel found that patients were put at real risk of serious harm as a result of Miss Nwosu's misconduct as set out above.

The panel was satisfied that Miss Nwosu's misconduct had breached the fundamental tenets of the nursing profession, including promoting professionalism and trust and practising effectively. Further, it determined that confidence in the nursing profession would be undermined if the NMC, its regulator, did not find charges relating to dishonesty extremely serious. The panel was satisfied that Miss Nwosu's actions and omissions were serious including real risk of serious harm to patients and dishonesty and therefore had

the potential to significantly damage the reputation of the nursing profession and bring the profession into disrepute.

The panel had regard to the case of *Cohen v General Medical Council* and considered the following factors:

- Whether the misconduct is easily remediable;
- Whether it has been remedied; and
- Whether the misconduct is highly unlikely to be repeated.

The panel had regard to the NMC Guidance on FTP-15 '*Insight and strengthened practice*' and FTP-15a '*Can the concern be addressed?*'

‘Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.’

“It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice.”

Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents.

Examples of such concerns include:

- *medication administration errors*
- *poor record keeping*
- *failings in a discrete and easily identifiable area of clinical practice*
- *concerns about incidents that took place a significant period of time in the past, especially if the nurse, midwife or nursing associate has practised safely since they occurred.'*

The panel considered that the deliberate disregard of safe medication administration, the failure to monitor unwell and unstable patients, the failure to follow patients' treatment plans and the failure to protect patients when equipment issues arose demonstrated an attitudinal issue which is difficult to remediate. The panel particularly noted that a number of these incidents involved Miss Nwosu being asked or reminded repeatedly to do tasks but ignoring those instructions. In addition, the dishonesty in falsifying a patient's records and failing to disclose and abide by an interim conditions of practice order demonstrate a second attitudinal issue which is also difficult to remediate.

The panel also had regard to *FTP-15b 'Has the concern been addressed?'* and acknowledged that the events took place over a significant period of time whilst Miss Nwosu was considered a new starter, working in the HDU/ICU: a challenging working environment. Miss Nwosu had however been provided with significant support and training to perform her role and the many failings identified were fundamental aspects of that role. The panel looked for indications of insight from Miss Nwosu and noted that she had completed a reflection in respect of Charge 2a, however, the contents of that reflection were very limited and did not prevent the same error occurring within two months. Miss Nwosu had engaged with the Trust's investigation, into Charge 9, at the time, in interview she stated that her actions were wrong, that mistakes could affect the patient, and that she was sorry.

The panel also considered *FTP-15c 'Is it highly unlikely that the conduct will be repeated?'*

‘Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:

- ‘The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.*
- The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate’s behaviour, this may suggest that the risk of repetition in the future is reduced.*
- The nurse, midwife or nursing associate has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.*
- The nurse, midwife or nursing associate has engaged with us throughout our processes.’*

Regarding insight, the panel determined that Miss Nwosu had made some attempt addressing the concerns during the Trust local investigation. However, Miss Nwosu’s insight was extremely limited and did not address the identified risks such as how her actions and inaction put patients at a real risk of serious harm, how she would practise differently in the future and how this could have impacted negatively on the reputation of the nursing profession.

The panel carefully considered the evidence of any steps Miss Nwosu has taken to strengthen her practice. It had not been provided with any evidence of any relevant training or any testimonials. It therefore had no evidence that Miss Nwosu has undertaken any learning and applied that learning in practice to demonstrate that the concerns have been addressed, and that she can practise safely and effectively.

The panel considered that the charges found proved took place over a sustained period between May 2022 and April 2023, and they formed a pattern of misconduct. During this time Miss Nwosu received extensive support, including an action plan and direct supervision, in attempts to improve her practice. However, Miss Nwosu continued to make similar errors and failed to strengthen/improve her practice. The panel determined that the misconduct in this case also included dishonesty which is inherently more difficult to put right as it raises attitudinal concerns, which are difficult to remediate. As such, the panel could not be satisfied that it is highly unlikely that Miss Nwosu's misconduct would be repeated in the future. The panel finds that there is a high risk of repetition in this case with the attendant risk of unwarranted harm to patients in the future and that therefore a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required to mark the unacceptability of Miss Nwosu's misconduct and to uphold proper professional standards. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made in the specific circumstances of this case due to the serious and wide-ranging failings, significant risks, attitudinal issues and repeated dishonesty. Therefore, public confidence in the profession would be undermined without a finding that Miss Nwosu's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Nwosu's fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance documents which included *SAN-1*, *SAN-2*, *SAN-3* and *SAN-4* last updated on 28 January 2026.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Ghotra informed the panel that in the Notice of Hearing, dated 22 January 2026, the NMC had advised Miss Nwosu that it would seek the imposition of a striking-off order if it found Miss Nwosu's fitness to practise currently impaired. She referred the panel to the relevant NMC guidance.

Ms Ghotra suggested the following aggravating factors in this case:

- A pattern of misconduct over a period of time
- Extremely limited insight
- Vulnerability of the patients (who were level 2 or level 3)
- Deliberate breaches of the Code
- Dishonesty for financial gain

Ms Ghotra suggested the following mitigating factor in this case:

- Early admissions at a local level regarding some of the conduct against patient E

Ms Ghotra submitted that making no order or imposing a caution order would be inappropriate given the seriousness of the case, and that this case is not at the lower end of the spectrum of misconduct. Also, such orders would not protect the public or meet the public interest. She submitted that imposing a conditions of practice order would be inappropriate and insufficient given the nature of the conduct and the finding of the panel that Miss Nwosu had demonstrated attitudinal issues. Therefore, no relevant conditions could be formulated that would address the identified concerns.

Ms Ghotra stated that the NMC guidance on suspension sets out that a suspension order will be appropriate where the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional. She outlined the NMC's overarching objectives and submitted that a period of suspension would not be sufficient in this case. She submitted that Miss Nwosu has not engaged meaningfully in these proceedings, has not attended this hearing, did not provide or demonstrate any meaningful insight and has not shown any willingness to learn, engage, or reflect.

Ms Ghotra submitted that Miss Nwosu's conduct is fundamentally incompatible with remaining on the register. She submitted that a less severe outcome than a striking-off order would not satisfy the overriding objective of public protection or meet the public interest. Ms Ghotra submitted that the misconduct took place over a sustained period of time, forming a pattern of conduct. Also, there have been findings of repeated dishonesty raising attitudinal concerns and Miss Nwosu's failure to abide by fundamental duties of care to patients. She submitted that there is a high risk of repetition, and the public remains at a significant risk of harm. She submitted that the public's confidence in the profession would be undermined if the panel did not remove Miss Nwosu from the register. Ms Ghotra submitted that the conduct found proved falls far short of that expected of a registered professional.

For these reasons, she invited the panel to impose a striking-off order.

Decision and reasons on sanction

Having found Miss Nwosu's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which deliberately or recklessly put people receiving care at risk of suffering harm
- Deliberate breaches of the Code
- A pattern of misconduct over a period of time
- Extremely limited insight
- Vulnerability of the patient's receiving care (Level 2 and Level 3 patients)
- Dishonesty in falsifying patient records to cover up for failing to take necessary observations, potentially causing harm to the patient
- Dishonesty in failing to disclose an interim conditions of practice order to maintain employment

The panel also took into account the following mitigating features:

- Admissions of wrongdoing during Trust investigation in respect of Charge 9
- Completed a mandatory reflective account regarding Charge 2a
- Engagement with the clinical practice educators as a new starter

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case which involved the deliberate disregard of safe medication administration, the failure to monitor unwell and unstable

patients, the failure to follow patients' treatment plans, the failure to protect patients when equipment issues arose, dishonestly falsifying a patient's records and dishonestly failing to notify her employer of or abide by the terms of the interim conditions of practice order. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

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

The panel considered that Miss Nwosu's actions were not at the lower end of the spectrum of misconduct as they were very serious and involved repeated dishonesty. It also found that there is a risk to patient safety and the public interest. The panel therefore determined that a sanction that does not restrict Miss Nwosu's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place conditions of practice on Miss Nwosu's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026) in particular it noted the following matters which assist in determining whether conditions might be appropriate:

- *'...no evidence of deep-seated personality or attitudinal problems*

- *identifiable areas of the professional’s practice in need of assessment and/or retraining*
- ...
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- ...
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed...’*

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct found proved. The misconduct identified in this case involved a pattern of dishonesty, which evidenced attitudinal concerns that cannot be easily addressed through retraining. The panel considered that Miss Nwosu had already received extensive support and training which she did not respond to, and that she has not engaged with these proceedings. Also, the panel noted that Miss Nwosu had dishonestly continued her employment and practised as a nurse without supervision as she failed to disclose that she was under an interim conditions of practice order at the time. Therefore, the panel was not satisfied that Miss Nwosu would engage or comply with a conditions of practice order in any event. It concluded that the placing of conditions on Miss Nwosu’s registration would not adequately address the seriousness of this case or the attitudinal concerns identified. It was also of the view that conditions would not adequately protect the public or satisfy the public interest.

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

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

- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

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

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

Whilst the panel acknowledged that the risks identified could be managed by Miss Nwosu being temporarily removed 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.

The panel noted that this was not a single incident of misconduct but represented a pattern of conduct repeated over a substantial period of time. The panel determined that Miss Nwosu's dishonesty reflected deep seated attitudinal concerns. Furthermore, the

charges found proved are at the more serious end of the spectrum and call into question Miss Nwosu's suitability to continue practising as a registered nurse. They also involved a real risk of serious harm to patients. It noted that Miss Nwosu's last reflective piece was contained in the Trust investigation and addressed Charge 2. The panel was of the view that the reflection did not acknowledge the risk of harm to patients, how she would act differently in the future and/or the impact on the nursing profession.

The panel also took into account that it had extremely limited evidence of meaningful insight, and no remorse or remediation demonstrated with regard to the misconduct; it therefore determined there was a high risk of repetition. Given Miss Nwosu's lack of engagement, limited insight, together with no evidence of training and development, and her previous non-compliance with a conditions of practice order there was nothing before the panel to suggest that a period of suspension would mitigate the identified risks. The panel, therefore, determined that there is no realistic possibility that Miss Nwosu would address the concerns to such a level where she 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) in particular it noted the following regarding '*Cases involving dishonesty*':

- '*...deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- ...
- *personal or financial gain from a breach of trust*
- *direct risk to people receiving care*
- ...'

'Cases involving deliberate breach of an interim order'

'...If a professional deliberately doesn't comply with an interim or final order this can demonstrate a risk to the public. It is likely to be an aggravating factor and call into question whether they should remain on the Register, because it shows a disregard for the protections the Committee put in place and undermines the likelihood they will comply with any other sanction...'

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

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

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

The panel considers Miss Nwosu's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that Miss Nwosu's actions were serious, raising fundamental questions about her professionalism and willingness to uphold the standards and values of the Code. To allow her to continue practising would not protect the public

and would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel further noted Miss Nwosu's extremely limited insight and non-engagement with these proceedings. It was not satisfied that after any period of suspension that Miss Nwosu would gain sufficient insight. In any event, it noted the guidance in SAN-3 that:

'...where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight...'

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 Miss Nwosu's actions 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.

The panel noted the hardship such an order will inevitably cause on Miss Nwosu. However, this is outweighed by the public interest in this case.

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

This will be confirmed to Miss Nwosu in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of

this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Nwosu's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Ghotra. She submitted that the NMC is seeking the imposition of an interim suspension order for 18 months to cover any appeal period until the substantive suspension order takes effect.

Ms Ghotra submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

Decision and reasons on interim order

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

The panel was satisfied that an interim order is necessary for 18 months for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and the wider public interest to cover the 28-day appeal period and the duration of any appeal should Miss Nwosu decide to appeal against the panel's decision. The panel considered 18 months to be a realistic estimate as to how long an appeal would take to be resolved.

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

That concludes this determination.

This will be confirmed to Miss Nwosu in writing.