Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 16 November 2026 – Tuesday, 24 November 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Nneoma Stanhope Ubani-Ukoma
NMC PIN:	99I3678E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult nurse (level 1) 14 September 2002
Relevant Location:	Cardiff
Type of case:	Misconduct
Panel members:	Vanessa Rolfe (Chair, Lay member) Diane Gow (Registrant member) Kate Richards (Lay member)
Legal Assessor:	Jayne Wheat
Hearings Coordinator:	Eyram Anka
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Ubani-Ukoma:	Not present and unrepresented
Facts proved:	Charges 2a, 2b and 2d
Facts not proved:	Charges 1, 2c, and 2e
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**
Final outcome:	**FTP impaired - COP order**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Ubani-Ukoma was not in attendance and that the Notice of Hearing letter had been sent to Mrs Ubani-Ukoma's registered email address by secure email on 17 September 2026.

Mr Radley, 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 allegation, the time, dates, venue of the hearing and, amongst other things, information about Mrs Ubani-Ukoma's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons for proceeding in the absence of Mrs Ubani-Ukoma

The panel next considered whether it should proceed in the absence of Mrs Ubani-Ukoma. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to proceed in the absence of Mrs Ubani-Ukoma.

Mr Radley referred the panel to the proceeding in absence bundle. He drew the panel's attention to the attempts made to contact Mrs Ubani-Ukoma by telephone, which were subsequently discontinued as her telephone number was no longer available. Mr Radley

informed the panel that the NMC also undertook tracing enquiries in an effort to contact Mrs Ubani-Ukoma, but these had proved unsuccessful.

Mr Radley referred to the relevant authorities, including *R* v *Jones (Anthony William)*(No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

Mr Radley submitted that all reasonable efforts have been made to secure Mrs Ubani-Ukoma's attendance, particularly given the seriousness of the charges. He further submitted that there is a public interest in proceeding with the hearing. Mr Radley reminded the panel that Mrs Ubani-Ukoma has not engaged with these proceedings and that, consequently, there is no reason to believe that an adjournment would secure her attendance on some future occasion.

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.*

The panel decided to proceed in the absence of Mrs Ubani-Ukoma. In reaching this decision, the panel considered the submissions of Mr Radley and the advice of the legal assessor. It had regard to the factors set out in *R v Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted the following:

- Mrs Ubani-Ukoma has not made an application for an adjournment;
- The NMC has made considerable efforts to contact Mrs Ubani-Ukoma, including multiple attempts by telephone and email between June and November 2026;
- Mrs Ubani-Ukoma has not engaged with the NMC in relation to these proceedings and has not responded to any of the emails sent to her about this hearing;

- There is no reason to suppose that adjourning would secure Mrs Ubani-Ukoma's attendance at some future date;
- A number of witnesses are scheduled to attend over the course the 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 2024;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Ubani-Ukoma in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has not responded formally to the allegations. Mrs Ubani-Ukoma 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 Mrs Ubani-Ukoma'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 Mrs Ubani-Ukoma. The panel will draw no adverse inference from Mrs Ubani-Ukoma's absence in its findings of fact.

Details of charge (as amended)

That you a Registered Nurse:

At University Hospital of Wales:

1. On 6 April 2024 administered an extra dose of Atorvastatin to Patient F, over the prescribed amount. **[NOT PROVED]**

At Prince Charles Hospital:

2. Between 18 and 19 September 2024:

    a) Attempted to administer unprescribed Lactulose syrup to Patient A; **[PROVED]**

    b) Told Patient B that a cannula needed to be inserted for antibiotics when one was not required; **[PROVED]**

    c) Administered an extra dose of Thiamine to Patient C, over the prescribed amount;**[NOT PROVED]**

    d) Administered an extra dose of Carbocisteine to Patient D, over the prescribed amount; **[PROVED]**

    e) Administered an extra dose of IV medication Tazocin to Patient E, over the prescribed amount **[NOT PROVED]**

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

Decision and reasons on application to amend the charge

Mr Radley made an application to amend the spelling of the word ‘Carbocisteine’ in charge 2d. The proposed amendment was to correct a typographical error. Mr Radley submitted that Mrs Ubani-Ukoma would not be prejudiced if this amendment was applied.

‘That you a Registered Nurse:

At Prince Charles Hospital:

2. *Between 18 and 19 September 2024:*

   …

   d) *Administered an extra dose of Carbocisteine to Patient D, over the prescribed amount;*

   …

AND in light of the above, your fitness to practice is impaired through misconduct.'

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

In the panel's view, such an amendment is in the interest of justice. The panel is satisfied that there would be no prejudice to Mrs Ubani-Ukoma 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 accuracy.

Background

Mrs Ubani-Ukoma was referred to the NMC on 19 December 2024, by ACI Training and Consultancy Limited ("ACI Ltd"), the company that manages complaints on behalf her former employer, Day Webster Agency ("the Agency"). Mrs Ubani-Ukoma was employed by the agency and undertook agency and bank shifts at several Hospitals.

The referral concerns alleged medication errors involving Mrs Ubani-Ukoma in April and September 2024, whilst she was working agency shifts at University Hospital of Wales ("UHW"), which forms part of Cardiff and Vale Health Board. Mrs Ubani-Ukoma also

worked at Prince Charles Hospital (“PCH”), which forms part of Cwn Taf Morgannwg University Health Board (“the Health Board”).

The first incident is alleged to have occurred on 6 April 2024, whilst Mrs Ubani-Ukoma was working a bank shift at UHW. It is alleged Mrs Ubani-Ukoma administered an extra dose of Atorvastatin to Patient F, over the prescribed amount.

The remaining incidents are alleged to have occurred during a night shift at PCH between 18 and 19 September 2024. The clinical lead of ACI Ltd was subsequently informed of several medication errors alleged to have occurred during that shift. Specifically, it is alleged that Mrs Ubani-Ukoma:

- Attempted to administer unprescribed Lactulose syrup to Patient A;
- Told Patient B that a cannula needed to be inserted for antibiotics when one was not required;
- Administered an extra dose of Thiamine to Patient C, over the prescribed amount;
- Administered an extra dose of Carbocisteine to Patient D, over the prescribed amount; and
- Administered an extra dose of intravenous (IV) medication Tazocin to Patient E, over the prescribed amount.

Following these incidents, a strategy meeting was held between ACI Ltd and the Health Board, during which it was decided that the matters would not be investigated locally but would instead be referred to the NMC.

Panel directs the NMC to provide further documentation

On Day 3 of the hearing, 18 November 2026, Mr Radley identified that certain evidence had not been included in the exhibit bundle, namely the four outstanding Bennion Error Scoring System (BESS) forms relating to Patients B, C, D and E. He asked the panel to allow him extra time to obtain these documents.
The panel accepted the advice of the legal assessor.

The panel had regard to the NMC guidance on 'Directing further investigation during the hearing' (DMA-5), which states:

'When should a panel direct further investigation?

There are a number of reasons why a panel may direct us to carry out further investigations. These include:

- *New information has come to light that neither we nor the nurse, midwife or nursing associate have seen, which could undermine our case, support our case, or support the case of the nurse, midwife or nursing associate.*
- *The information currently before a panel is obviously incomplete or does not cover all the areas of concern. One example of this could be missing pages from patient notes, or from some other important document.'*

In reaching its decision, the panel noted that the documents had not been included in the evidence before it and considered that they may be capable of undermining or supporting the NMC's case or supporting Mrs Ubani-Ukoma's case.

The panel considered that the outstanding BESS forms should be made available to it. Accordingly, pursuant to Rule 22(5), the panel directed the NMC to provide the four outstanding Bennion Error Scoring System (BESS) forms relating to Patients B, C, D and E.

The panel was subsequently provided with the relevant BESS forms relating to Patients B, C, D and E on Day 4 of the hearing, 19 November 2026.

Application to admit the handwritten statements of Patients B, D, and E

Mr Radley made an application under Rule 31 to adduce the handwritten statements of Patients B, D and E as hearsay evidence.

Mr Radley referred the panel to the relevant considerations identified in the case of *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), namely:

1. Whether the statement is the sole or decisive evidence in support of the charges;
2. The nature and extent of the challenge to the contents of the statement;
3. Whether there was any suggestion that the witness had reason to fabricate their allegation;
4. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
5. Whether there was a good reason for the non-attendance of the witness;
6. Whether the regulator had taken reasonable steps to secure the witness's attendance; and
7. What prior notice did the registrant have that the witness statement would be read.

Mr Radley also referred to the cases of *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin).

Mr Radley relied upon the witness statement bundle, the exhibit bundle, the evidence matrix and the oral evidence of NMC witnesses in support of his application.

Mr Radley submitted that Ms Madgwick, the Ward Manager who came on duty on 19 September 2024, had confirmed in her oral evidence Mrs Ubani-Ukoma's identity as the agency nurse in question. He stated that Mrs Madgwick also confirmed the patients Mrs Ubani-Ukoma had been responsible for during the shift. He submitted that Ms Madgwick stated that she had been alerted to the incidents following information provided to her concerning the Datix report completed by Ms Rachel Meredith ("Ms Meredith").

Mr Radley further referred to the oral evidence of Ms Meredith who stated that, upon coming on duty on 19 September 2024, she became aware that patients were angry about

the nurse who had cared for them. He stated that Ms Meredith confirmed to the panel that the handwritten patient statements, formed part of the Datix collated in relation to the incidents.

Mr Radley submitted that Mr Ben Durham ("Mr Durham"), in his oral evidence, had provided background information explaining why individual Datix reports had been produced following the initial Datix report which covered all the incidents involving the patients. Mr Radley also referred to Mr Durham's evidence concerning the scoring system, analysis of risk and the information received from patients who had made complaints to management staff.

Mr Radley referred the panel to the hearsay bundle which contains the initial referral and the patient statements. He submitted that Mrs Ubani-Ukoma had been made aware of the statements from an early stage and had therefore been afforded an opportunity to provide her response or defence.

Addressing the considerations identified in *Thorneycroft*, Mr Radley submitted that a number of concerns were raised by multiple individuals. He submitted that this is relevant to the panel's assessment of the credibility of the complaints.

In relation to the nature and extent of the challenge to the evidence, Mr Radley submitted that Mrs Ubani-Ukoma's account amounted to a denial of the charges and there has been limited challenge to the evidence advanced by the NMC.

Turning to the question of possible fabrication, Mr Radley referred to the evidence of Ms Amy Madgwick ("Ms Madgwick"), who had been asked whether there was any possibility that the patients had spoken to one another before reporting their concerns. He submitted that the patients were accommodated in separate bays and were apart from one another. He further submitted that this evidence is supported by the oral evidence of Ms Debra Broad ("Ms Broad").

In addressing the seriousness of the charges and the potential impact of adverse findings on Mrs Ubani-Ukoma's career, Mr Radley submitted that the events alleged to have

occurred on the ward between 18 and 19 September 2024 was concerning. However, he conceded that there is no evidence of harm to the patients or of any serious adverse outcome arising from the incidents.

In relation to reasons for the patients' non-attendance, Mr Radley submitted that the handwritten statements had been prepared by the patients at the time of the incidents. He explained that, with the passage of time and following the referral to the NMC, the patients had left PCH. The NMC had not subsequently approached them to obtain statements exhibiting their original handwritten accounts or to request supplementary statements providing further details of the incidents.

Mr Radley submitted that a proportionate approach should be taken when considering what further steps could have been undertaken. He invited the panel to consider the fact that the patients raised concerns with nursing staff at the time of the incidents.

Mr Radley acknowledged that no steps had been taken by the NMC to secure the attendance of the patients as witnesses. He accepted that this is difficult to surmount but invited the panel to consider the matter in the round, alongside the other relevant circumstances.

In relation to whether Mrs Ubani-Ukoma had received prior notice of the statements, Mr Radley submitted that she had been informed that the NMC intended to rely upon the patient statements. He explained that the statements had formed part of the initial referral and that the relevant bundle had been served on Mrs Ubani-Ukoma before the hearing. He submitted that Mrs Ubani-Ukoma had therefore been made aware of the evidence upon which the NMC intended to rely and had been afforded an opportunity to respond, or object to, that evidence.

Mr Radley confirmed that the handwritten statements were not properly exhibited and had simply been included with other documentation in the exhibit bundle. After further enquiry by the panel, Mr Radley confirmed that Mrs Ubani-Ukoma had not been informed that the NMC were seeking to admit these statements as hearsay evidence.

In concluding his submissions, Mr Radley invited the panel to consider the *Thorneycroft* factors as a whole, together with the corroborative evidence available and to assess the strengths and weakness of the evidence when determining the application.

The panel accepted the legal assessor's advice on the matters it should take into consideration when determining the application. This included reference to the cases of *Thorneycroft*, *El Karout*, *R (Ogbonna) v Nursing and Midwifery Council* [2010] EWCA Civ 1216 and *Mansaray*. Further, the advice included an explanation of Rule 31 which provides that, *'subject only to the requirements of relevance and fairness'*, a panel may accept evidence in a range of forms and circumstances, whether or not it would be admissible in civil proceedings.

Decision and reasons on application to admit the handwritten statements of Patients B, D and E

Patient B Statement

The panel considered that Patient B's handwritten statement is relevant, as it provides a direct account of the events shortly after they occurred and relate to charge 2b.

In considering the fairness of admitting the statement, the panel had regard to the factors identified in *Thorneycroft*.
The panel considered whether Patient B's statement is the sole or decisive evidence in support of charge 2b. The panel noted that it has heard potential corroborative evidence from Ms Broad, who directly witnessed the events. It also had regard to the evidence of Ms Meredith, who gave evidence that she had spoken with Patient B following the incident and recorded his account in her NMC witness statement dated 23 June 2026:

> *'Patient B said that the Registrant came to him with two Medication Administration Record ('MAR') charts. The Registrant wanted to give him antibiotics through intravenous therapy ('IV'). He told me that he refused this, as he knew that he was not on this type of IV medication but was on clotrimazole cream which is a type of*

antibiotic cream. Patient B was frustrated by this incident and the delay in getting his medication and broke medication drawer.'

The panel therefore determined that Patient B's handwritten statement is not the sole or decisive evidence in support of charge 2b.

The panel noted that Mrs Ubani-Ukoma is not present at the hearing and has not provided a statement specifically for these proceedings. However, the panel had regard to her local statement, prepared around the time of the incident in September 2024, in which she provided an account of the events. Mrs Ubani-Ukoma stated:

'while I was dealing with another patient the HCA went back to bed 3:3 and the patient said to her that he thinks he has antibiotic, the HCA did not ask me if I needed something, HCA decided on her own accord to call someone to put a cannula for the patient.

…

I went back to bed 3:3 that was when patient said HCA has called someone to put cannula for him. Hearing this I went out to look for the HCA to tell her to cancel the person she called for cannulation because the patient does not need it. The antibiotics was for his foot and not Intravenous. After few minutes as I was dispensing last medication for a patient. The staff for the cannulation turned up and I informed her that the patient did not require cannulation and I was not asked if the patient needed cannula before HCA called. I'm so sorry for wasting her time. Then she left.'

The panel considered that Mrs Ubani-Ukoma's account amounts to a challenge to the charge.

Turning to question of possible fabrication, the panel found no evidence before it to suggest that Patient B had fabricated his account. It noted that the incident occurred during Mrs Ubani-Ukoma's first shift on the ward at PCH and she was not previously known to the staff or patients.

The panel considered the circumstances in which the complaint arose, including Patient B's apparent frustration and the subsequent involvement of other individuals. It had regard to Ms Meredith's evidence concerning the layout of the ward, particularly the separation of the male and female bays by a solid wall, and her evidence that there was no reason for patients to have crossed paths.

The panel acknowledged the potential seriousness of the charges, particularly when considered in the context of a number of alleged medication errors involving several patients during a single shift. It was mindful of the possible consequences of adverse findings on Mrs Ubani-Ukoma's professional career.

The panel then considered the circumstances surrounding Patient B's non-attendance. It noted that the NMC did not take reasonable steps to secure his attendance and that no evidence has been presented to establish a good reason for his absence.

The panel further noted that, although Mrs Ubani-Ukoma was sent a copy of Patient B's handwritten account as part of the final exhibit bundle, the statement had not been properly exhibited. Furthermore, the panel considered that Patient B has not provided a witness statement specifically for these proceedings and that Mrs Ubani-Ukoma had not been expressly notified of the NMC's application to admit Patient B's handwritten statement as hearsay evidence without calling Patient B to give oral evidence.

In considering the overall fairness of admitting Patient B's statement, the panel noted that, during Ms Broad's oral evidence, it had been mindful of the explanation provided by Mrs Ubani-Ukoma in her local statement. The panel put Mrs Ubani-Ukoma's account to Ms Broad, who had witnessed the events, to ensure that Mrs Ubani-Ukoma's position was properly considered.

Taking all this into account, the panel determined that, on balance, and in circumstances where it has heard from another witness who gave a direct account of the incident, it would be fair and relevant to admit Patient B's handwritten statement into evidence. It determined that appropriate weight to be attached to the statement will be assessed once it has heard and evaluated all the evidence before it. The panel acknowledged that

admitting the handwritten statement of Patient B when they have not been called to give evidence would likely lead to less weight being attached to it than if Patient B had produced a written statement and given evidence which could be tested by questioning. The panel therefore granted the application in respect of Patient B's statement.

Patient D Statement

The panel considered that Patient D's handwritten statement is relevant as the account had been obtained from Patient D shortly after the incident occurred. The panel noted that Ms Meredith confirmed this in her oral evidence. The panel further noted that the statement is dated and appears to have been signed, although the signature has been redacted.

In considering the fairness of admitting the statement, the panel had regard to the factors identified in *Thorneycroft*.

The panel considered whether Patient D's statement constitutes the sole or decisive evidence in support of charge 2d. The panel acknowledges that Patient D's handwritten account is the only direct account of events alleged at charge 2d. The panel noted that there is some other evidence before it, including the oral and documentary evidence of Ms Meredith, which corroborates Patient D's account. The panel therefore determined that Patient D's statement is not the sole or decisive evidence in support of charge 2d.

The panel noted that Mrs Ubani-Ukoma is not present at the hearing and has not provided a statement specifically for these proceedings. However, the panel had regard to her local statement, prepared around the time of the incident in September 2024, in which she provided an account of the events, denying charge 2d and challenging the evidence.

Turning to the question of possible fabrication, the panel found no evidence before it to suggest that Patient D had fabricated her account. It noted that the incident occurred during Mrs Ubani-Ukoma's first shift on the ward at PCH and she was not previously known to the staff or patients.

The panel had regard to the oral evidence of Ms Broad. She stated:

> "*4.4 and 4.1 were stood at the end of their beds, writing things down and talking to each other… they were distressed…"*

The panel had no evidence before it to suggest that the allegations had been fabricated. However, it noted that the evidence suggests that patients in bay 4 (Patients D and E) had conferred with one another.

The panel acknowledged the potential seriousness of the charges, particularly when considered in the context of a number of alleged medication errors involving several patients during a single shift. It was mindful of the possible consequences of adverse findings on Mrs Ubani-Ukoma's professional career.

The panel then considered the circumstances surrounding Patient D's non-attendance. It noted that the NMC did not take reasonable steps to secure Patient D's attendance and that no evidence has been presented to establish a good reason for her absence.

The panel further noted that, although Mrs Ubani-Ukoma was sent a copy of Patient D's handwritten account as part of the final exhibit bundle, the statement had not been properly exhibited. Furthermore, the panel considered that Patient D has not provided a witness statement specifically for these proceedings and that Mrs Ubani-Ukoma had not been expressly notified of the NMC's application to admit Patient D's handwritten statement as hearsay evidence without calling Patient D to give evidence.

Balancing all the factors, the panel concluded that it would not be fair to Mrs Ubani-Ukoma to admit Patient D's handwritten statement as hearsay evidence, in circumstances where there was no other direct evidence and no effort had been made to secure the attendance of the witness or obtain a formal statement from them. Accordingly, the panel refused the application.

<u>Patient E Statement</u>

The panel considered Patient E's handwritten statement is relevant, as it provided a direct account of the events shortly after they occurred and directly relates to charge 2e.

In considering the fairness of admitting the statement, the panel had regard to the factors identified in *Thorneycroft*.

The panel considered whether Patient E's statement constitutes the sole or decisive evidence in support of charge 2e. The panel acknowledged Patient E's handwritten account was the only direct evidence of the incident. No other witness who gave evidence was present. The panel determined that there is some corroborative evidence from Ms Meredith, both oral and documentary, confirming that Patient E had spoken to her about the incident. However, it also noted that neither Ms Meredith nor Mr Durham, in evidence, appeared to have been able to identify information supporting Patient E's account of the alleged medication error. Nevertheless, the panel determined that Patient E's statement is not the sole or decisive evidence in support of charge 2e.

The panel noted that Mrs Ubani-Ukoma is not present at the hearing and has not provided a statement specifically for these proceedings. However, the panel had regard to her local statement, prepared around the time of the incident in September 2024, in which she challenged Patient E's account. Mrs Ubani-Ukoma stated:

> *'The report wrote, patient in 4:1 says she had 2 intravenous medication, The patient did not have 2 iv medication.I went to the patient4:1asked her name checking drug chart and name band at the same time 'I explained to her that I will be administering IV tazocin as prescribed. I flushed the line first with normal saline and then transfuse iv/tazocin and I flushed with saline to prevent drug interaction and/orprecipitation. When I was about to leave. She said I only have one iv/tazocin, I replied to her that was what I administered but I flushed the line to keep it patent it was not another medicine.'*

The panel considered this information from Mrs Ubani-Ukoma directly challenges the account from Patient E.

Turning to the question of possible fabrication, the panel found no evidence before it to suggest that Patient E had fabricated her account. It noted that the incident occurred during Mrs Ubani-Ukoma's first shift on the ward at PCH and she was not previously known to the staff or patients.

The panel had regard to the oral evidence of Ms Broad. She stated:

> "*4.4 and 4.1 were stood at the end of their beds, writing things down and talking to each other… they were distressed…"*

The panel had no evidence before it to suggest that the allegations had been fabricated. However, it noted that the evidence suggests that patients in bay 4 (Patients D and E) had conferred with one another.

The panel acknowledged the potential seriousness of the charges, particularly when considered in the context of a number of alleged medication errors involving several patients during a single shift. It was mindful of the possible consequences of adverse findings on Mrs Ubani-Ukoma's professional career.

The panel then considered the circumstances surrounding Patient E's non-attendance. It noted that the NMC did not take reasonable steps to secure Patient E's attendance and that no evidence has been presented to establish a good reason for her absence. The NMC made no efforts at all to obtain a formal statement from Patient E or to call her to give evidence.

The panel further noted that, although Mrs Ubani-Ukoma was sent a copy of Patient E's handwritten account as part of the final exhibit bundle, the statement had not been properly exhibited. Furthermore, the panel considered that Patient E has not provided a witness statement specifically for these proceedings and that Mrs Ubani-Ukoma had not been expressly notified of the NMC's application to admit Patient E's handwritten statement as hearsay evidence without calling Patient E to give evidence.

Balancing all the factors, the panel concluded that it would not be fair to Mrs Ubani-Ukoma to admit Patient E's handwritten statement as hearsay evidence, in circumstances where there was no other direct evidence and no effort had been made to secure the attendance of the witness or obtain a formal statement from them. Accordingly, the panel refused the application.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Ubani-Ukoma.

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

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

- Emma Harris: Deputy Ward Manager in UHW
- Rachel Meredith: Manager on a Gastroenterology Ward at PCH
- Amy Madgwick: Senior Nurse for Specialist Medicine at PCH

- Ben Durham: Lead Nurse for Professional Practice and Quality Assurance at the Health Board

- Debra Broad: Healthcare Support Worker ("HCSW") at the Health Board

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

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

Charge 1

"That you a registered nurse:

At University Hospital of Wales:

On 6 April 2024 administered an extra dose of Atorvastatin to Patient F, over the prescribed amount."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, particularly Patient F's Medication Administration Record (MAR) chart, together with the oral evidence and NMC statement dated 6 June 2025 of Emma Harris' ("Ms Harris").

The panel took into account that Ms Harris was not a direct witness to the incident but was informed of it when she attended her next shift on 8 April 2024.

The panel had regard to Patient F's MAR chart, a contemporaneous document, which records the prescribed medication, dosage, frequency and time of administration. The panel noted that the chart contains a box for each prescribed dose to be signed upon administration. Each day is divided into four administration times: morning, midday, evening and bedtime. The MAR chart for Atorvastatin indicates that 20mg was to be administered in the morning and 20mg at bedtime. However, the panel took into account that a line has been drawn through part of the column, but not through the 'bedtime' box itself, making it unclear whether the bedtime dose had been discontinued.
The panel also had regard to an additional handwritten entry on the MAR chart stating, 'MOVED TO MORNING TO AID COMPLIANCE'. However, the panel observed that this entry is not accompanied by a signature identifying the person who made the amendment, nor is there a date indicating when the entry was made or when the change was to be implemented.

The panel took into consideration that, in the column dated 6 April 2024, there is a signature in the box labelled 'morning', which is unrelated to the charge. However, there is also a signature in the 'bedtime' box and when questioned about this signature during her oral evidence, Ms Harris told the panel, *"you get to know the nurses' signatures from working with them. I just know that wasn't the other staff nurse's signature and besides, this was the patient Mrs Ubani-Ukoma was assigned to".*

The panel is satisfied, on the basis of Ms Harris' evidence, that the signature in the 'bedtime' box is that of Mrs Ubani-Ukoma. However, the panel considered that the MAR chart did not clearly establish the prescribed frequency of administration of Atorvastatin on 6 April 2024, particularly in light of the line drawn partially through the column and the unsigned and undated amendment indicating that the medication had been moved to morning.

In these circumstances, although the panel was satisfied Mrs Ubani-Ukoma had signed the 'bedtime' box, it determined that there is insufficient evidence to establish, on the balance of probabilities, that Mrs Ubani-Ukoma administered an extra dose of Atorvastatin to Patient F, over the prescribed amount.

The panel therefore found charge 1 not proved.

Charge 2a)

"That you a registered nurse:

At Prince Charles Hospital:

Between 18 and 19 September 2024:

a) Attempted to administer unprescribed Lactulose to Patient A."

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, particularly the Datix incident form dated 3 October 2024, Ms Meredith's NMC statement dated 23 June 2026, Ms Broad's local statements and the oral evidence of Ms Madgwick and Ms Meredith.

Although Ms Meredith was not a direct witness to the incident itself, the panel accepted her evidence that she was the person to whom Patient A raised his complaint following the incident. The panel had regard to Ms Meredith's NMC statement dated 23 June 2026, in which she stated:

'Patient A told me that the Registrant had tried to give him a pot of fluid which I understood to be lactulose. Patient A said that he refused to take the medication.'

The panel further noted that Ms Meredith completed the Datix incident form and BESS report which details the error made. The panel considered Ms Meredith's written and documentary evidence to be consistent with the account she provided during her oral evidence. The panel concluded her evidence was reliable.

The panel also had regard to Ms Broad's contemporaneous local statements (DB/01 and DB/02). It noted that the two statements appear to have been written in different handwritings. The panel considered the explanation given by Ms Broad in her oral evidence when this discrepancy was put to her. Ms Broad explained that the first statement (DB/01) was written on 19 September 2024, following a long night shift, in the dark, without her glasses. She further explained that she had been asked to provide the second statement (DB/02) approximately a year later because the second page of her original statement had been misplaced. Ms Broad clarified that DB/02 is a continuation of DB/01 and had been written during the day, while she was wearing her glasses, was less tired and was not under time pressure.

The panel accepted Ms Broad's explanation for the apparent differences in handwriting between the two statements. It found her evidence concerning the circumstances in which the documents were prepared to be credible, noting that she had provided a consistently clear and detailed explanation, and that her evidence throughout was, in the panel's view, detailed and reliable.

The panel also had regard to Patient A's MAR chart, a contemporaneous document. It observed that, according to the information recorded on the chart, Lactulose was not prescribed to Patient A. The panel also noted that at the end of the chart, there is a table headed 'Omitted or Delayed Doses'. Within this table, there is an entry dated 18 September 2024, in which 'Lactulose' was recorded under the box labelled 'Medicine', and under 'Reason for admission' it says 'Declined' and under 'Action Taken' it says, 'Omitted Bowel open today'.

During her oral evidence, the panel asked Ms Madgwick whether it was unusual for medication that had not been prescribed to be recorded as declined. In response Ms Madgwick stated, *"yes it's very unusual as it suggests the nurse has asked the patient if they wanted it and the patient has said no."* Ms Madgwick went on to state, *"it was never prescribed and it was not on the medication chart".* The panel considered Ms Madgwick to have a good working knowledge of MAR charts and accepted her evidence in this regard.

Having considered the evidence before it, the panel determined that, on the balance of probabilities, Mrs Ubani-Ukoma attempted to administer unprescribed Lactulose to Patient A.

Accordingly, the panel found charge 2a proved.

Charge 2b)

> "That you a registered nurse:
>
> At Prince Charles Hospital:
>
> Between 18 and 19 September 2024:
>
> b) Told Patient B that a cannula needed to be inserted for antibiotics when one was not required."

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, particularly Patient B's Datix incident form, Patient B's handwritten statement dated 18 September 2024, Ms Broad's oral evidence, NMC witness statement dated 23 June 2026 and her local statement, Ms Meredith's NMC statement dated 23 June 2026 and Ms Ukoma's local statement.

The panel had regard to Patient B's handwritten statement which is a direct and contemporaneous account of the incident. In his statement, Patient B stated:

> *'On this night we had an Agency nurse on the ward.*
> *…*

She went to give me somepersons(sic) MEDS. She went on to request the people who put needles for meds to come and put a needle in my arm to put meds into my veins which was not needed…'

In considering Patient B's handwritten statement, the panel recognised that it is a first-hand and contemporaneous account of the incident. However, it took into account that Patient B was not asked to provide a formal witness statement for these proceedings by the NMC and was not invited to attend to give oral evidence. Consequently, his account could not be tested through questioning. The panel therefore determined that, while Patient B's contemporaneous statement is relevant, it cannot be afforded the same weight as the evidence of the witnesses that have attended to give oral evidence.

The panel also considered the evidence of Ms Broad, who was a direct witness to the incident. The panel took into account Ms Broad's local statement, in which she states:

'After that I heard a patient shouting in bay 3 I went to see what the problem was (3:3) states the agency nurse was arranging for a 'canula(sic) to be inserted into his arm' for an antibiotic. He added 'he didn't have any IV antibiotics, he's been taking them orally and the IV antibiotic was for the man in (3:2).'

In her NMC statement dated 23 June 2026, Ms Broad described what had occurred, stating:

'The Registrant instructed me to call the Medical Technical Assistant ('MTA') to insert a cannula, so the patient in bed 3 could take their antibiotics. The patient told her that he did not need a cannula as he took his medications orally. I told the Registrant that it was not my job to call the MTA and she needed to sort the situation as the patient also needed his nighttime medication to sleep. The Registrant refused.'

During Ms Broad's oral evidence, the panel put Mrs Ubani-Ukoma's version of events to her. In response Ms Broad stated:

“Its not in my job description, its for the qualified nurse to ring the MTA” [sic]

The panel found her account to be consistent, and she remained clear and resolute in her explanation, reaffirming her rationale on several occasions. The panel considered that her evidence is corroborated by Patient B’s handwritten statement and Datix incident report.

The panel also had regard to Patient B’s Datix incident form, completed by Ms Meredith, which provided a further account of the incident. The report states:

‘Patient asked to see me when i arrived on duty as he wanted to complain about the agency nurse the previous night. Patient states that the nurse tried to give him someone elses IV medication. Agency asked staff to call MTA up to ward to put in a venflon for IV Antibiotics on patient, Patient knew he wasn't on IV antibiotics so refused. On reviewing medication chart he was prescribed Clotrimazole cream as antibiotic only.’ [sic]

The panel further considered Ms Meredith’s NMC statement dated 23 June 2026, in which she described the incident as reported to her by Patient B. She stated:

‘The Registrant wanted to give him antibiotics through intravenous therapy (‘IV’). He told me that he refused this, as he knew that he was not on this type of IV medication but was on clotrimazole cream which is a type of antibiotic cream. Patient B was frustrated by this incident and the delay in getting his medication and broke medication drawer.’

The panel considered that although Ms Meredith had not witnessed the incident directly, she had spoken to Patient B about what had occurred on the morning following those events. Her account was recorded in the Datix report and was consistent with the evidence she subsequently provided in her NMC statement and during her oral evidence. The panel therefore considered Ms Meredith’s evidence to be credible.

The panel also noted that Ms Meredith’s evidence was consistent with Ms Broad’s account, particularly in relation to Patient B becoming frustrated to the extent that he broke

his medication drawer. The panel considered that this further supports the consistency of evidence concerning the incident.

The panel also took account of Mrs Ubani-Ukoma's local statement, which directly contradicts Ms Broad's account of the incident. Mrs Ubani-Ukoma's account is as follows:

> *'while I was dealing with another patient the HCA went back to bed 3:3 and the patient said to her that he thinks he has antibiotic, the HCA did not ask me if I needed something, HCA decided on her own accord to call someone to put a cannula for the patient.*
>
> *…*
>
> *I went back to bed 3:3 that was when patient said HCA has called someone to put cannula for him. Hearing this I went out to look for the HCA to tell her to cancel the person she called for cannulation because the patient does not need it. The antibiotics was for his foot and not Intravenous. After few minutes as I was dispensing last medication for a patient. The staff for the cannulation turned up and I informed her that the patient did not require cannulation and I was not asked if the patient needed cannula before HCA called. I'm so sorry for wasting her time. Then she left.'*

The panel also considered that Mrs Ubani-Ukoma's account is contained within her local statement provided through the Agency following the incident, the date of which is unknown. It further noted that Mrs Ubani-Ukoma has not provided a formal witness statement for these proceedings and has not attended to give oral evidence. As a result, her account cannot be tested through cross-examination. The panel therefore attached limited weight to her statement.

Having considered the evidence as a whole, the panel preferred the evidence of Ms Broad which it found to be clear, consistent and corroborated by the contemporaneous accounts contained in Patient B's handwritten statement and the Datix incident form. The panel also took into account Ms Meredith's evidence, which it found to be credible and consistent with other evidence before it.

The panel concluded that, notwithstanding Ms Ukoma's differing account, the evidence is sufficient to establish, on the balance of probabilities, it is more likely than not that Mrs Ubani-Ukoma told Patient B that a cannula needed to be inserted for antibiotics when one was not required.

The panel therefore found charge 2b proved.

Charge 2c)

"That you a registered nurse:

At Prince Charles Hospital:

Between 18 and 19 September 2024:

c) Administered an extra dose of Thiamine to Patient C, over the prescribed amount."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, particularly Ms Meredith's NMC statement dated 23 June 2026, Ms Madgwick's NMC statement dated 23 June 2025, Patient C's MAR chart, Mrs Ubani-Ukoma's local statement and the oral evidence of Ms Meredith and Ms Madgwick.

The NMC had not provided the panel with a witness statement from Patient C, nor were they called to give evidence.

The panel had regard to Ms Meredith's NMC statement dated 23 June 2026, in which she states:

‘Patient C told me that he believed that he was given an extra dose of thiamine. When I looked at his medication chart, thiamine was prescribed three times a day, namely, the morning, lunchtime and evening. He said that he was given an extra dose prior to bed. This was not signed as being administered on his MAR chart, but he said he recognised the tablet. He said that he did not question this at the time but upon hearing other patients on the same bay have concerns about their medications, he said he realised that he had been given an extra dose.’

The panel noted that Ms Meredith’s oral evidence was consistent with her statement. It took into account that although Ms Meredith wasn’t present at the time of the incident, she had spoken directly to Patient C on the morning following the incident and accepted that she had faithfully recounted what Patient C told her.

The panel also had regard to Ms Madgwick’s NMC statement dated 23 June 2025, in which she states:

‘[Patient C] was given a dose of Thiamine, which is a Vitamin B1. Patient C said he was given a dose at bed time around 2200. It is administered orally, 100mg three times a day. Patient C had already had his three doses for the day. Patient C said he was then given an extra dose by the registrant at bedtime. His evening dose would have been given at around 1700.’

The panel took into account that Ms Madgwick did not witness the incident, nor did she speak directly to Patient C about it.

The panel further considered Patient C’s MAR chart. It noted that there are three signatures on the MAR chart: one in the row labelled ‘morning’, the second in the row labelled ‘midday’, and a third straddling the rows labelled ‘evening’ and ‘bedtime’.

During her oral evidence, Ms Madgwick was asked whether it was usual for a signature to straddle two boxes on a MAR chart. The panel acknowledged Ms Madgwick’s working knowledge of MAR charts. Ms Madgwick explained that it was unusual, as a nurse would ordinarily sign once for each administration of medication. She further explained that a

signature straddling two boxes would not necessarily constitute evidence of two administrations. Ms Madgwick went on to state, *"it is not clear from the chart…the fourth dose is only what the patient said"*. The panel accepted Ms Madgwick's evidence about the entries on this particular MAR chart.

The panel considered that the positioning of the third signature creates ambiguity as to whether it was intended to indicate that Thiamine had been administered in the evening or at both the evening and bedtime. The panel determined from the MAR chart that Thiamine was prescribed to be administered three times daily. It noted that the chart contained three signatures, which did not evidence that an additional dose had been administered.

The panel also took into account that, although Patient C had reported receiving an additional dose of Thiamine, there is no direct evidence from Patient C before the panel. His account had been relayed through Ms Meredith and Ms Madgwick. While the panel accept that Ms Meredith has faithfully recounted what Patient C had told her, it considered that the evidence, when assessed alongside the MAR chart, is insufficient to establish that an additional dose, above the prescribed amount had been administered.

The panel further noted that Mrs Ubani-Ukoma denied the allegation.

In light of the above, the panel concluded that the NMC has not discharged the burden of proof. It determined that the evidence is insufficient to establish, on the balance of probabilities, that Mrs Ubani-Ukoma administered an extra dose of Thiamine to Patient C, over the prescribed amount.

The panel therefore found charge 2c not proved.

Charge 2d)

"That you a registered nurse:

At Prince Charles Hospital:

Between 18 and 19 September 2024:

d) Administered an extra dose of Carbocisteine to Patient D, over the prescribed amount."

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, particularly Patient D's Datix incident form, Patient D's MAR chart, Ms Meredith's NMC statement dated 23 June 2026, Ms Broad's local statement and the oral evidence of Ms Madgwick and Ms Meredith.

The NMC did not provide a witness statement from Patient D, nor were they called to give oral evidence.

The panel accepted Ms Meredith's evidence that Patient D made a complaint to her when she arrived on duty on 19 September 2024, informing her that she (Patient D) believed that she had been given an extra dose of Carbocisteine. Following this complaint, Ms Meredith completed a Datix incident form which states:

> *'Patient asked to see me when i arrived on duty as she felt she had been given too many tablets last night prior to bed. She questioned the nurse but was told they were correct. On reviewing medication chart i note that an extra dose of Carbocysteine .75g was given and signed for by agency nurse even though its not prescribed for bed time.'* [sic]

The panel also had regard to Ms Meredith's NMC statement dated 23 June 2026, in which she reiterated Patient D's complaint and her subsequent review of the medication chart. She states:

> *'Patient D informed me that she believed that she was given too many tablets at night. She said that she queried this with the Registrant, who told her that this was*

correct. I then reviewed Patient D's medication and saw that the Registrant had signed for carbocysteine even though this was not one of the medications prescribed for Patient D for bedtime.'

The panel considered that Ms Meredith's account is consistent with her oral evidence. It accepted that, although Ms Meredith had not witnessed the administration of the medication directly, she had faithfully recounted the complaint made to her by Patient D.

The panel also had regard to Ms Broad's local statement, in which she stated:

'…and (4.4) Patient was crying and said she was given '15 tablets and she usually only takes 12, but instead of checking them she took them anyway not realising'

The panel noted that Ms Broad was present during the shift in question and spoke directly to Patient D at the time. It considered her evidence to be clear and consistent, noting that she reaffirmed her account during her oral evidence.

The panel further considered Patient D's MAR chart, which shows that, on 18 September 2024, there are signatures in the boxes for each part of the day; morning, midday, evening and bedtime. The panel noted that, although the signature in the 'bedtime' box is very faint it is nevertheless visible.

The panel also took into account Ms Madgwick's oral evidence, during which she confirmed the number of signatures recorded on the MAR chart. When questioned about the prescribed frequency of Carbocisteine, Ms Madgwick stated:

"The dose is morning midday and evening, here there are four signatures, one at bedtime which is one extra, which they [Patient D] weren't prescribed for"

The panel noted that Ms Madgwick's evidence, which it accepted as credible given her knowledge of MAR charts, confirmed that Carbocisteine was prescribed to be administered three times daily, namely in the morning, at midday and in the evening. However, the MAR chart contains four signatures, including one in the 'bedtime' box, despite there being no prescribed dose for that time.

The panel also considered that in Mrs Ubani-Ukoma's local statement, in which she referred to Patient D complaint and stated:

> *'…she said she was given extra dose of carbocysteine(sic) it was signed but not prescribed. All drugs I administered to 4:4 was prescribed on the drug when I gave it'*

The panel noted that Mrs Ubani-Ukoma's account is contained within her local statement provided through the Agency following the incident, the date of which is unknown. It further noted that Mrs Ubani-Ukoma has not provided a formal witness statement for these proceedings and has not attended to give oral evidence. As a result, her account cannot be tested through cross-examination. The panel therefore attached limited weight to her statement.

Having considered the evidence as a whole, the panel found that there are four signatures on the MAR chart, notwithstanding that Carbocisteine was prescribed to be administered three times daily. The panel determined that this is supported by Patient D's complaint as recorded by Ms Meredith and Ms Broad, together with Ms Madgwick's oral evidence.

The panel therefore determined that, on the balance of probabilities, it is more likely than not that Mrs Ubani-Ukoma administered an extra dose of Carbocisteine to Patient D, over the prescribed amount.

The panel therefore found charge 2d proved.

Charge 2e)

> "That you a registered nurse:
>
> At Prince Charles Hospital:

Between 18 and 19 September 2024:

e) Administered an extra dose of IV medication Tazocin to Patient E, over the prescribed amount."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, particularly Patient E's Datix incident form, Ms Meredith's NMC statement dated 23 June 2026, Ms Madgwick's NMC statement dated 23 June 2025, Ms Broad's local statement, Mrs Ubani-Ukoma's local statement and the oral evidence of Ms Meredith and Ms Madgwick.

The NMC did not provide a witness statement for Patient E, nor were they called to give oral evidence.

The panel accepted the evidence of Ms Meredith, that she had spoken to Patient E on the morning following the incident. The panel had regard to the Datix incident form completed by Ms Meredith following her discussion with Patient E. It states:

'Issues with agency nurse overnight and medication. Patient asked to speak to me when i came on duty to inform me that she had received 2 doses of IV medication this morning. On questioning patient she states she had a bag of medication which she know is her antibiotics (Tazocin) then was given a slow injection. I asked if it could of been a flush but she states no it didnt look like a flush but she was still sleepy as had been woken up to give meds.' [sic]

The panel also had regard to Ms Meredith's NMC statement dated 23 June 2026, in which she provided a further account of Patient E's complaint. She states:

'Patient E informed me that she believed that she was given two doses of antibiotics via IV. When we administer antibiotics via an IV on the ward, we usually flush the line with saline pre and post dose.'

During her oral evidence, Ms Meredith was asked whether an inventory of Tazocin was maintained. She confirmed that no such inventory was kept. The panel accepted her explanation that although measures had been taken locally to establish whether Patient E had received an additional dose of Tazocin, she was unable to verify or substantiate Patient E's account.

The panel took account of Ms Meredith's oral evidence, in which she stated, *"this was one I was more doubtful about to be honest, but because of the instances I felt I had to put a Datix in, as the patient thought it had happened".* The panel considered that this reflects the uncertainty surrounding whether the flush was an infusion.

The panel also considered Ms Broad's contemporaneous handwritten local statement. It noted that Ms Broad was the HCSW during the shift in question and referred to Patient E's complaint in her statement:

> *'female bay complaining. (4.1) states she have been given too much medication.'*

The panel noted that Ms Broad's statement provides further evidence that Patient E had raised concerns about the medication she had received. However, the panel considered that this account does not establish whether an extra dose of Tazocin had been administered.

The panel also had regard to Ms Madgwick's NMC statement dated 23 June 2025, in which she describes the report she received from Ms Meredith concerning the incident and the steps taken to establish whether an extra dose of Tazocin had been administered to Patient E.

> *'When Rachel came in the morning, they looked through the disposed fluids, and couldn't find an additional bag for Patient E. It was unknown what medication was given. Patient E was reviewed by the medical team. There was no harm suffered, her observations remained stable and no adverse effects.'*

The panel concluded that, despite the steps taken to investigate Patient E's complaint, no additional bag of medication had been identified among the disposed fluids. It further noted that the additional medication allegedly administered could not be established.

The panel also took into account Mrs Ubani-Ukoma's local statement, in which she provided her account of this incident. She stated:

> *'The report wrote, patient in 4:1 says she had 2 intravenous medication, The patient did not have 2 iv medication.I went to the patient4:1asked her name checking drug chart and name band at the same time 'I explained to her that I will be administering IV tazocin as prescribed. I flushed the line first with normal saline and then transfuse iv/tazocin and I flushed with saline to prevent drug interaction and/orprecipitation. When I was about to leave. She said I only have one iv/tazocin, I replied to her that was what I administered but I flushed the line to keep it patent it was not another medicine.'*

The panel noted that Mrs Ubani-Ukoma's account is contained within her local statement provided through the Agency following the incident, the date of which is unknown. It further noted that Mrs Ubani-Ukoma has not provided a formal witness statement for these proceedings and has not attended to give oral evidence. As a result, her account cannot be tested through cross-examination. The panel therefore attached limited weight to her statement.

Having considered the evidence as a whole, the panel acknowledged that Patient E had reported receiving what she believed to be two doses of IV medication Tazocin. However, the panel considered that there remains uncertainty as to whether the second substance administered was an additional dose of Tazocin or a saline flush.

In light of the above, the panel determined that the NMC has not discharged the burden of proof. It concluded that that the evidence is insufficient to establish, on the balance of probabilities, that Mrs Ubani-Ukoma administered an extra dose of IV medication Tazocin to Patient E, over the prescribed amount.

Accordingly, the panel found charge 2e not 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 Mrs Ubani-Ukoma'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, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Radley provided written submissions which he supplemented with further oral submissions. His written and oral submissions are summarised below.

Mr Radley referred to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He also referred to the cases of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC2317 (Admin).

Mr Radley submitted that the facts found proved amount to serious professional misconduct. He referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified specific and relevant sections of the Code which he submitted were breached as a result of Mrs Ubani-Ukoma's conduct. Mr Radley also referred the panel to the NMC guidance on 'Misconduct' (FTP-2a).

Mr Radley submitted that Mrs Ubani-Ukoma's conduct in the charges found proved amounts to serious professional misconduct.

Mr Radley invited the panel to take the contextual factors into account. He submitted that, in this case, several patients had raised concerns regarding their medication, which appeared to have been ignored by Mrs Ubani-Ukoma. He further submitted that Ms Broad's escalation of the situation did not rectify the situation. He highlighted that Mrs Ubani-Ukoma's behaviour involved a number of patients across two hospitals. Mr Radley submitted that these factors are key to evaluating the contextual relationship between patient care, the medical practitioner, the effect on public protection and public perception of the profession.
Mr Radley submitted that, although the panel may take Mrs Ubani-Ukoma's previous practice history into account, certain behaviours are so serious, particularly where they concern patient safety, that they may in themselves overshadow previous performance.
Mr Radley submitted that the charges found proved are not simply breaches of a local disciplinary policy or minor concerns. Rather, they concern matters at the heart of and fundamental to nursing practice. These include a failure to recognise patient concerns regarding their medications, the impact on trust and confidence in the profession, reputational damage to the profession, an abuse of the trust between patients and professionals, and a failure to listen and work cooperatively with colleagues.

Mr Radley further submitted that the charges found proved represent failings directly relate to the standards of the nursing profession. He submitted that Mrs Ubani-Ukoma's conduct impacted seriously on patients. Accordingly, he invited the panel to find that Mrs Ubani-Ukoma's conduct in the charges found proved amount to serious professional misconduct.

Submissions on impairment

Mr Radley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Radley took the panel through the limbs of the test set out by Dame Janet Smith in her fifth Report to the Shipman Inquiry and set out in the case of *Grant*:

> *'Do our findings of fact in respect of the* (nurse's) misconduct …. *show that her fitness to practise is impaired in the sense that she:*
>
> 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.'*

Mr Radley submitted that the first three limbs of *Grant* are engaged in this case.

Mr Radley submitted that a finding of impairment is required for public protection as a result of the medication errors in the charges found proved and the effect of Mrs Ubani-Ukoma's conduct on patients and her colleagues.

Mr Radley reminded the panel that Mrs Ubani-Ukoma has not engaged with these proceedings. He submitted that although there is some evidence of training and reflection that the panel may find relevant, this has not been tested or expanded upon in any way. Mr Radley further submitted that Mrs Ubani-Ukoma's conduct in the charges found proved are so serious that it would impact public protection and the public trust and confidence in Mrs Ubani-Ukoma and the nursing profession as a whole.

Mr Radley argued that nursing standards such as candour, respect towards patients and their knowledge of their care and support of colleagues has been affected. He submitted that as a result of Mrs Ubani-Ukoma's conduct, Ms Broad would not work with her again.

Mr Radley submitted that the concern is that Mrs Ubani-Ukoma has not demonstrated any acceptance of the impact her conduct had on patients and colleagues. He put to the panel that this will affect Mrs Ubani-Ukoma's ability to practice in the manner expected of a registered nurse. In these circumstances, he submitted that a finding of impairment is required in this case.

The panel put questions to Mr Radley.

The panel asked Mr Radley to clarify the basis of his assertion that Ms Broad would never work with Mrs Ubani-Ukoma again. In response, Mr Radley submitted that this was an inference drawn from Ms Broad's oral evidence. He also referred to the fact that Mrs Ubani-Ukoma had not returned to work as an agency nurse at the hospitals concerned. Mr Radley further submitted that, during her oral evidence, Ms Broad had demonstrated clear concern for the patients and the ward as a whole.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance, Nandi*, *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Khan v Bar Standards Board [2018] EWHC 2184*

(Admin), Benn v General Medical Council [2025] EWHC 87 (Admin), *Shodlok v General Medical Council* [2015] EWCA Civ 769), *Ahmedsowida v General Medical Council* [2021] EWHC 3466 (Admin) and *Giele v General Medical Council* [2005] EWHC 2143 (Admin).

Decision and reasons on misconduct

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 Mrs Ubani-Ukoma's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Ubani-Ukoma's actions amounted to multiple breaches of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively.'

*'**2 Listen to people and respond to their preferences and concerns***
To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively
2.6 recognise when people are anxious or in distress and respond compassionately and politely'

*'**3 Make sure that people's physical, social and psychological needs are assessed and responded to***
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages'

*'**8 Work co-operatively***

To achieve this, you must:

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

8.5 work with colleagues to evaluate the quality of your work and that of the team.'

The panel appreciated that breaching the Code does not automatically result in a finding of misconduct.

The panel considered that the charges found proved involve three medication related errors during a single night shift at PCH. This included attempting to administer an unprescribed lactulose syrup to Patient A and misinforming Patient B about needing a cannula for IV medication when one was not required. Mrs Ubani-Ukoma directed the HCSW on duty (Ms Broad) to arrange the procedure and Mrs Ubani-Ukoma went on to call the MTA to come to the ward to cannulate the patient. The third error involved Mrs Ubani-Ukoma administering an extra dose of Carbocisteine to Patient D, over the prescribed amount.

The panel considered that, although there is no evidence of actual physical harm to patients, Mrs Ubani-Ukoma's conduct had caused them distress and fear. The panel regarded these errors as particularly concerning given Mrs Ubani-Ukoma's experience as a registered nurse, including her previous experience in intensive care, high dependency, Accident & Emergency (A&E) settings, as outlined in her curriculum vitae (CV). The panel also took into account that the incidents occurred in the course of Mrs Ubani-Ukoma's professional practice, while she was providing direct care to patients.

The panel further considered that Mrs Ubani-Ukoma's conduct demonstrated a failure to work effectively and collaboratively with the HCSW on duty, particularly in relation to requesting Ms Broad to make arrangements for the insertion of a cannula, despite this falling outside Ms Broad's role. The panel also took account of Mrs Ubani-Ukoma's failure to respond appropriately to the wider patient safety concerns raised by Ms Broad.

Having carefully considered the circumstances of the case, and the nature and seriousness of the charges found proved, the panel concluded that Mrs Ubani-Ukoma's actions fell seriously short of the conduct and standards expected of a registered nurse. Accordingly, the panel determined that Mrs Ubani-Ukoma's conduct was sufficiently serious to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Mrs Ubani-Ukoma'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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) *...'*

The panel found that limbs (a), (b) and (c) of *Grant* are engaged in this case in relation to Mrs Ubani-Ukoma's past conduct. The panel determined that limb (d), which concerns dishonesty, is not engaged in this case.

In reaching this conclusion, the panel considered that Mrs Ubani-Ukoma's conduct involved three medication related errors affecting three different patients during a single night shift. In the panel's judgement, these failings placed patients at an unwarranted risk of harm.

The panel further determined that, by failing to uphold the standards of safe and effective nursing practice expected of a registered nurse, Mrs Ubani-Ukoma brought the profession into disrepute and consequently, breached the fundamental tenets of practising effectively and preserving patient safety.

In considering whether Mrs Ubani-Ukoma poses a risk in the future, the panel had regard to the factors set out in the case of *Cohen*:

- Is the behaviour easily remediable?
- Has it already been remedied?
- Is it highly unlikely to be repeated?

The panel determined that the concerns identified in the charges found proved are remediable. It considered that the concerns relate directly to nursing practice and therefore are amenable to further training, supervision and strengthening of practice. However, the panel had no evidence from Mrs Ubani-Ukoma, for the purposes of these proceedings, demonstrating insight into her misconduct or that she had strengthened her practice to address the concerns identified.

The panel acknowledged that Mrs Ubani-Ukoma had provided two training certificates dated 6 March 2024 and 24 June 2024. The panel noted that the training course of March 2024 on Intravenous Therapy included Medication Incidents, the Rights of Medicine Administration, Record Keeping and Documentation. However, it noted that both certificates predated the incidents giving rise to these proceedings and therefore does not demonstrate that Mrs Ubani-Ukoma undertook training to address the concerns identified.

The panel also gave consideration to the reflection contained within Mrs Ubani-Ukoma's local statement. However, it was not satisfied that this demonstrates insight or remediation, as the reflection was brief and very limited in scope. In particular, the panel had regard to the following passage from Mrs Ubani-Ukoma's statement:

‘Teamwork, communication and reassurance was very important to exercise on this shift and needs improving on. As a Registered Nurse, I will always look after patients in my care to the best of my ability at all times.’

The panel considered that although Mrs Ubani-Ukoma’s statement acknowledged the importance of teamwork and communication, it did not adequately address the concerns identified in the charges or demonstrate how she intended to prevent similar incidents from occurring in the future. The panel was therefore not satisfied that the reflection provided any evidence of insight or remediation.

The panel also had regard to the testimonial dated 14 January 2025, provided by a staff nurse who had previously worked with Mrs Ubani-Ukoma. However, it noted that the testimonial is not recent and does not specifically address the concerns arising from her misconduct. Accordingly, the panel determined that the testimonial does not assist in assessing whether Mrs Ubani-Ukoma has remedied her misconduct.

Taking these matters into account, the panel reviewed the *Grant* test and concluded that Mrs Ubani-Ukoma is liable in the future to place those receiving care at an unwarranted risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession.

Having considered the evidence before it, the panel is not satisfied that there is sufficient evidence to demonstrate that the underlying concerns have been adequately addressed. In particular, the panel have not been provided with any evidence of insight, a comprehensive reflection or remediation to be reassured that the misconduct would not be repeated. In these circumstances, the panel concluded that there is a high risk of repetition. Accordingly, the panel determined that a finding of impairment is necessary on public protection grounds.

The panel bore in mind the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that public confidence in the nursing profession would be seriously undermined if a finding of impairment were not made in this case. This is due not only to the public protection concerns identified, but also to the seriousness of the charges found proved, which include three medication related errors, affecting three different patients during a single night shift. The panel concluded that the nature of Mrs Ubani-Ukoma's misconduct, when considered alongside the risk of repetition, necessitates a finding of impairment on public interest grounds in order to uphold proper professional standards of conduct.

Having regard to all of the above, the panel was satisfied that Mrs Ubani-Ukoma's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that Mrs Ubani-Ukoma's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

Mr Radley provided written submissions which he supplemented with further oral submissions. His written and oral submissions are summarised below.

Mr Radley referred to the NMC guidance on *'The purpose of and approach to sanctions'* (SAN-1).

Mr Radley submitted that the aggravating features in this case are as follows:

- Failed to maintain professional standards by demonstrating unsafe medicines practice to patients
- Conduct that has significantly impacted patients for example:
    - Significant emotional distress
    - Lasting impact on their trust in healthcare
    - This makes patients reluctant to seek healthcare and extends the consequences beyond the incidents themselves
- Mrs Ubani-Ukoma's failings relate to a number of fundamental tenets of the nursing profession
- Other professionals would consider Mrs Ubani-Ukoma's behaviour deplorable
- The proven charges mean that the panel have determined that the behaviour has raised serious concerns
- Impact on the profession and the reputation of nurses has been brought into disrepute
- The panel found three of the limbs of the *Grant* test are engaged in this case
- Public protection and public interest are engaged
- Lack of engagement in the hearing and limited reflection/relevant evidence

Mr Radley submitted that the mitigating features in this case are as follows:

- No previous findings
- Some reflection and training
- Findings relate to a single shift

Mr Radley submitted that incidents of the nature found proved are viewed seriously, particularly as they occurred within a clinical setting and they relate directly to the treatment of patients. He reminded the panel that the incidents occurred in the workplace

and demonstrated failings in fundamental nursing practice which are at the heart of a caring profession, affecting colleagues and undermining the profession as a whole.

Mr Radley submitted that the concerns raise fundamental questions about Mrs Ubani-Ukoma's professionalism and her approach towards patients and colleagues. He argued that there is a need to protect the public from the risks arising from Mrs Ubani-Ukoma's conduct and to prevent damage to public confidence in the nursing profession. It was Mr Radley's submission that these concerns would not be adequately addressed were Mrs Ubani-Ukoma permitted to practise unrestricted.

Mr Radley submitted that taking no further action or imposing a caution order would not be appropriate, having regard to the nature and seriousness of the charges proved in this case.

Mr Radley submitted that, given the particular circumstances of this case, a conditions of practice order would be the most appropriate sanction, as conditions could be formulated to address the concerns relating to public protection and public confidence in the profession.

Mr Radley referred to the NMC guidance on '*Sanction'* (SAN-1), which sets out that a suspension order may be appropriate in cases where the misconduct is not fundamentally incompatible with continuing to be a registered professional. Mr Radley submitted that the NMC's overarching objective of protecting the public and maintaining public confidence in the profession could be satisfied by a less severe sanction. He therefore submitted that a suspension order would not be appropriate in this case.

Mr Radley referred to the case of *Bolton v Law Society* [1994] 1 WLR 512 and stated that this case illustrates the principle that the reputation of the profession is more important than the fortunes of any individual member.

Mr Radley submitted that, in the circumstances of this case, the concerns arising from Mrs Ubani-Ukoma's conduct could be adequately addressed a conditions of practice order, whilst satisfying the requirements of public protection and the wider public interest.

Mr Radley invited the panel to consider the following conditions:

- Undertaking training and guidance in relation to medication management
- Supervised by one employer, albeit it can be through an agency

The panel put questions to Mr Radley.

The panel asked Mr Radley to identify the evidential basis for his submission, under aggravating features, that Mrs Ubani-Ukoma's conduct had significantly impacted patients in term of having a lasting impact on their trust in healthcare. In response, Mr Radley referred to Ms Broad's evidence, particularly her account of discussions that took place between patients following the incidents and the fact that patients chose to report their concerns. He also referred to Patient B's actions in breaking his medication drawer, which he submitted was a clear demonstration of Patient B's frustration. Mr Radley explained that he had drawn an inference from this evidence that the incidents would have had a lasting impression on patients involved.

The panel also asked Mr Radley to explain his assertion that Mrs Ubani-Ukoma's conduct has had a significant impact on patients, making patients reluctant to seek healthcare. In response, Mr Radley submitted such experiences were likely to be discussed with family members and friends and, as a consequence, could prevent people from wanting to visit a particular hospital or wanting to be on a particular ward.

The panel sought clarification from Mr Radley regarding the reference to a striking-off order and the case of *Bolton* in his written submission. In response, Mr Radley explained that he had included the case of Bolton to illustrate the need to balance Mrs Ubani-Ukoma's interest against those of the profession as a whole. He submitted that, in cases involving serious misconduct, notwithstanding the impact that a sanction may have on the registrant, the importance of upholding the reputation of the profession may outweigh the interests of the individual registrant. He maintained that public confidence in the profession is of paramount importance.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Ubani-Ukoma'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 recklessly puts people receiving care at risk of suffering harm
- Multiple breaches of the Code
- Three occurrences on one night shift
- Failure to attend hearings, or to engage in the Fitness to Practise (FtP) process, without good reason
- No evidence of insight or remorse
- Failure to work collaboratively with colleagues, namely Ms Broad the HCSW on duty
- Patients were caused fear and distress

The panel also took into account the following mitigating features:

- A single night shift at one hospital
- No previous regulatory findings

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would not protect the public, be proportionate or 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 Mrs Ubani-Ukoma's actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Ubani-Ukoma'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 placing conditions of practice on Mrs Ubani-Ukoma's registration would be appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*

- *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 found that the concerns arising from the charges found proved are remediable. Although the panel has made a finding of misconduct, it considered that the nature of the concerns which relate to areas of clinical competence lends itself to a conditions of practice order. The panel is satisfied that there are identifiable areas of Mrs Ubani-Ukoma's nursing practice which require retraining, particularly in relation to medicines management.

The panel determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case, whilst ensuring public protection. Such conditions would also afford Mrs Ubani-Ukoma an opportunity to undertake further training and demonstrate strengthened practice within a supervised working environment.

The panel had regard to the NMC guidance SAN-2d and considered whether a suspension order would be appropriate. The panel determined that, whilst it recognises the seriousness of the concerns, it does not consider them to be so serious that they could only be addressed by temporarily removing Mrs Ubani-Ukoma from practice. The panel is satisfied that the risks identified could be adequately managed through a conditions of practice order. It therefore determined that imposing a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Ubani-Ukoma's case.

Having regard to the matters it has identified above, the panel concluded that a conditions of practice order will protect the public, mark the importance of maintaining public

confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

Balancing all of these factors, the panel determined that a conditions of practice order is the appropriate and proportionate sanction in this case.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must limit your nursing practice to one substantive employer. If this is an agency, any placement must be for a minimum of three months.
>
> 2. You must not engage in drug administration unless supervised by a registered nurse of band 6 or above (except in life threatening emergencies). This supervision must consist of:
>
>   - Checking medication charts accurately
>   - Dispensing medication
>   - Administering medication
>   - Signing medication charts
>   - Noting and escalating any concerns relating to drug administration
>   - Completing relevant records accurately

3. You must meet with your line manager or supervisor every month to discuss and review the following:

    - Checking medication charts accurately
    - Dispensing medication
    - Administering medication
    - Signing medication charts
    - Noting and escalating any concerns relating to drug administration
    - Completing relevant records accurately
    - Collaborative working with colleagues

4. You must provide a report from your line manager or supervisor to your NMC case officer at least 7 days in advance of any review hearing or meeting. This report must include reference to the following:

    - Checking medication charts accurately
    - Dispensing medication
    - Administering medication
    - Signing medication charts
    - Noting and escalating any concerns relating to drug administration
    - Completing relevant records accurately
    - Collaborative working with colleagues

5. You must keep the NMC informed about anywhere you are working by:

    a) Telling your case officer within seven days of accepting or leaving any employment.

    b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:

    a) Telling your case officer within seven days of accepting any course of study.

    b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:

    a) Any organisation or person you work for.

    b) Any agency you apply to or are registered with for work.

    c) Any employers you apply to for work (at the time of application).

    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:

    a) Any clinical incident you are involved in.

    b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a) Any current or future employer.

    b) Any educational establishment.

    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Ubani-Ukoma has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by Mrs Ubani-Ukoma providing:

1. An in-depth written reflection addressing the following:
    - The contributing factors that led to the events of the 18 to 19 September 2024;
    - The human factors that were in effect; and
    - Reflections on any relevant training undertaken (as per bullet point 3).
2. Evidence that you have kept your knowledge and skills up to date
3. Updated training courses in:
    - Drug administration;

- Communication and collaboration with colleagues;
- Record keeping; and
- The impact of human error on herself, colleagues, patients, family and the wider community on the reputation of the profession.

This will be confirmed to Mrs Ubani-Ukoma in writing.

Interim order

As the conditions of practice 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 Mrs Ubani-Ukoma's own interests until the conditions of practice sanction takes effect.

Submissions on interim orders

Mr Radley made an application for an 18-month interim conditions of practice order to cover the appeal period. He submitted that without an interim order, Mrs Ubani-Ukoma would be able to practise unrestricted if an appeal is lodged in relation to these matters. Mr Radley submitted that the application is made on the grounds of public protection and in the public interest for the same reasons as the substantive order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel had regard to the NMC guidance on *'Interim orders after a sanction is imposed'* (SAN-6). 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. It determined that an order is necessary to protect the public in light of

the panel's earlier findings as to seriousness and risk to the public. Given the nature of the findings and the aggravating features identified, serious damage would be caused to the reputation of the profession if no order were imposed. The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for the time that may be taken before an appeal can be heard. Not to do so would be inconsistent with the sanction imposed.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Ubani-Ukoma is sent the decision of this hearing in writing.

That concludes this determination.