

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

**Substantive Hearing
4 – 15 November 2024
31 March 2025 – 17 April 2025
12 November 2025 (panel day only)
13 - 14 November 2025
1 – 12 June 2026
25 – 26 August 2026
12 October 2026**

Virtual Hearing

Name of Registrant:	Lan Sum Nancy Cheng
NMC PIN:	93K0122O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 30 November 1993
Relevant Location:	Harrow
Type of case:	Lack of competence/Misconduct
Panel members:	Patricia Richardson (Chair, Lay member) Katrina MacLaine (Registrant member) Alison Lyon (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Jumu Ahmed (4 – 10 and 12 - 15 November 2024, 31 March – 16 April 2025, 12 - 14 November 2025 & 1 – 12 June 2026) Samantha Aguilar (11 November 2024) Clara Federizo (17 April 2025)
Nursing and Midwifery Council:	Represented by Rowena Wisniewska, Case Presenter
Ms Cheng:	Present and unrepresented Not present and not represented (13 – 14 November 2025 & 1 – 12 June 2026, 25 & 26 August 2026, 12 October 2026)

Interpreter:

David Lin (4 – 8 November 2024)
Ludi Wu (11 – 15 November 2024, 31 March –
17 April 2025, 1 June 2026 (morning only))

Facts proved:

1(a), 1(b), 1(c), 2, 3, 4(b), 4(c), 4(d), 5, 6, 8

Facts not proved:

1(d), 4(a), 7

Fitness to practise:

Impaired

Sanction:

Striking-off order

Interim order:

Interim suspension order (18 months)

Details of charge

That you, a registered nurse between October 2021 and September 2022 and failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

- 1) Failed to work cooperatively with other colleagues by;
 - a) Screaming at colleague 1 [Vanessa Illes] whilst they were completing an ECG on a patient.
 - b) prevented Colleague 1 [Vanessa Illes] from giving a patient water; and
 - c) Shouted at colleague 1. [Vanessa Illes]
 - d) On a date unknown spoke with an unknown healthcare assistant in a loud voice.
- 2) On one or more occasion failed to listen to instructions and /or requests
- 3) On one or more occasion inappropriately argued with colleagues
- 4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;
 - a) patient discharge forms resulting in Colleague 3 [Ivy Togobo] completing them.
 - b) patients for admission to theatre, resulting in colleague 2 [Oluaseum Musa] having to take over the admission process for an unknown patient.
 - c) patients for admission resulting in Colleague 3 [Ivy Togobo] having to take over admission for an unknown patient.
 - d) patients for admission resulting in Colleague 4 [Sai Tawayaga] having to take over admission for an unknown patient.

5) On a date unknown whilst on the Day Surgery Unit put an unknown patients safety at risk by using the wrong wrist band before they went into theatre.

6) On a date unknown on Day Surgery unit failed to give a patient medication they needed before surgery.

7) On an unknown date unnecessarily asked an unknown patient to open wound dressing following a mastectomy when admitting them for a foot and ankle surgery.

8) On an unknown date failed to listen to a patient in pain.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Wisniewska, on behalf of the NMC, to make some minor grammatical/typographical amendments both to the introductory preamble paragraph to the Allegation and to Particulars 1(b), 1(c), 1(d), 2, 3, 4(b), and 6 of the charges.

It was submitted by Ms Wisniewska that the proposed amendments, set out below, would ensure accuracy and provide clarity:

That you, a registered nurse between October 2021 and September 2022 and failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

- 1) Failed to work cooperatively with other colleagues by;
 - a) Screaming at colleague 1 [Vanessa Illes] whilst they were completing an ECG on a patient.

b) prevented ~~ed~~ **ing** Colleague 1 [Vanessa Illes] from giving a patient water. ~~and~~
c) ~~Sshouted~~ **ing** at Colleague 1 [Vanessa Illes].
d) On a date unknown ~~spoke~~ **speaking** with an unknown healthcare assistant in a loud voice.

2) On one or more occasions ~~s~~ failed to listen to instructions and /or requests.

3) On one or more occasions ~~s~~ inappropriately argued with colleagues.

4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;

b) patients for admission to theatre, resulting in ~~C~~olleague 2 [Oluaseum Musa] having to take over the admission process for an unknown patient.

5) On a date unknown whilst on the Day Surgery Unit put an unknown patient's safety at risk by using the wrong wrist band before they went into theatre.

6) On a date unknown on **the** Day Surgery unit failed to give a patient medication they needed before surgery.

You did not object to the requested grammatical/typographical amendments.

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).

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

Details of charge

That you, a registered nurse between October 2021 and September 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

- 1) Failed to work cooperatively with other colleagues by:
 - a) Screaming at colleague 1 [Vanessa Illes] whilst they were completing an ECG on a patient.
 - b) preventing Colleague 1 [Vanessa Illes] from giving a patient water.
 - c) shouting at Colleague 1 [Vanessa Illes].
 - d) On a date unknown speaking with an unknown healthcare assistant in a loud voice.
- 2) On one or more occasions failed to listen to instructions and /or requests.
- 3) On one or more occasions inappropriately argued with colleagues.
- 4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;
 - a) patient discharge forms resulting in Colleague 3 [Ivy Togobo] completing them.
 - b) patients for admission to theatre, resulting in Colleague 2 [Oluaseum Musa] having to take over the admission process for an unknown patient.
 - c) patients for admission resulting in Colleague 3 [Ivy Togobo] having to take over admission for an unknown patient.
 - d) patients for admission resulting in Colleague 4 [Sai Tawayaga] having to take over admission for an unknown patient.
- 5) On a date unknown whilst on the Day Surgery Unit put an unknown patient's safety at risk by using the wrong wrist band before they went into theatre.

6) On a date unknown on the Day Surgery unit failed to give a patient medication they needed before surgery.

7) On an unknown date unnecessarily asked an unknown patient to open wound dressing following a mastectomy when admitting them for a foot and ankle surgery.

8) On an unknown date failed to listen to a patient in pain.

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

Decision and reasons on application to amend the charge

On day 15 of the hearing, having considered the evidence bundles and having heard oral evidence from 5 NMC witnesses, the panel raised an enquiry of the NMC in relation to the statutory ground of impairment alleged in your case. The panel noted that the referral to the NMC was on the basis of your lack of competence in that you had failed your probationary period because of concerns about your practice. However, the panel enquired as to whether some of the charges, that appeared to relate to your alleged behaviour, may more appropriately be considered as alleged misconduct, rather than a lack of competence.

In a private meeting with you, in the presence of Ms Wisniewska, the legal assessor explained to you the distinction between the statutory grounds of alleged impairment by way of misconduct as opposed to lack of competence.

On day 16 of the hearing, following the panel's enquiry, Ms Wisniewska applied under Rule 28(1)(a) of the Rules to amend the Allegation to include the additional statutory ground of misconduct as a route to impairment. She submitted that the NMC agreed that charges 1a), 1c), 1d), 3 and 8 are more about your alleged demeanour and behaviour rather than an issue of competence. Therefore, those charges would be more appropriately considered under the statutory ground of misconduct. She stated that the NMC did not propose to change the wording of the

particulars of the charges 1-8 in any way, only the wording in the preamble and the closing paragraph as follows:

~~'That you, a registered nurse between October 2021 and September 2022:
and failed to demonstrate the standards of knowledge, skill and judgement
and the standards of conduct required to practise without supervision as a
band 5 nurse in that you:~~

[...]

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence **in that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in relation to charges 1b), 2, 4a), 4b), 4c) and 4d), 5, 6 and 7; and by reason of your misconduct in relation to charges 1a), 1c), 1d), 3 and 8.'**

You disagreed with the application to amend the Allegation. You said that the alleged conduct as stated in the charges did not take place and that these are false accusations against you. You stated that your colleagues in the London Irish ward, where you were previously employed, had subjected you to bullying and harassment, and that it is those people who are guilty of misconduct, not you. You said that it would be unfair to add misconduct to the Allegation because it would mean *"making more false accusations"* against you, which you said would be against natural justice and in breach of your human rights.

The panel accepted the advice of the legal assessor and had regard to Rule 28 the Rules.

The panel took into account Ms Wisniewska's and your submissions. The panel was mindful that the application was made following an enquiry made by the panel and noted that Ms Wisniewska was unable to assist the panel as to the reason why the NMC had not initially considered some of the charges as possible misconduct. Further, the panel was also mindful that, in adding the ground of misconduct in

relation to some of the charges, it would in principle, under the NMC's legislation, have the power to impose a more severe sanction, that of a striking-off order, in relation to any misconduct established.

The panel first considered the merits of the case and the impact that the proposed amendment could have to both your case and the NMC's case. The panel noted that there is no application from the NMC to amend the factual charges faced by you. The only requested amendment is for misconduct to be considered an additional statutory ground to impairment because charges 1a), 1c), 1d), 3 and 8 concern your alleged interactions and behaviour towards your colleagues and a patient, as opposed to any alleged competency matters.

The panel next considered the fairness of the proceedings and whether the required amendment can be made without injustice. The panel was mindful that you are representing yourself in these proceedings and do not have the benefit of legal representation. It was reassured, however that any disadvantage in not having from legal representation was mitigated by the opportunity that you have had to discuss the matter in a lengthy private meeting with the Legal Assessor, in the presence of Ms Wisniewska, and the support you have had from the Chair and the Legal Assessor in the hearing itself.

The panel took into account that it had heard from five witnesses called by the NMC and is due to hear from 1 further NMC witness. It considered whether your cross-examination of the five witnesses so far would have been different if the statutory ground of misconduct had been alleged from the outset. The panel was satisfied that your cross-examination would not have been any different, particularly as each witness has been cross-examined by you at length and you had indeed asked about your behaviour and demeanour. Furthermore, you were also due to provide evidence to the panel as well as make your submissions.

Therefore, mindful of its duty to protect the public, the panel determined that amending the Allegation in the way proposed by the NMC would not cause unfairness and would be in the interests of justice.

It determined that it was fair and appropriate to allow the amendment, as applied for, to assist the panel in its deliberations by ensuring clarity and accuracy and better reflect the evidence. Also, the panel was of the view that the amendment was required in the public interest.

Details of charge (as amended)

That you, a registered nurse between October 2021 and September 2022:

1) Failed to work cooperatively with other colleagues by:

- a) Screaming at colleague 1 [Vanessa Illes] whilst they were completing an ECG on a patient. **[PROVED]**
- b) preventing Colleague 1 [Vanessa Illes] from giving a patient water. **[PROVED]**
- c) shouting at Colleague 1 [Vanessa Illes]. **[PROVED]**
- d) On a date unknown speaking with an unknown healthcare assistant in a loud voice. **[NOT PROVED]**

2) On one or more occasions failed to listen to instructions and /or requests.
[PROVED]

3) On one or more occasions inappropriately argued with colleagues. **[PROVED]**

4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;

- a) patient discharge forms resulting in Colleague 3 [Ivy Togobo] completing them **[NOT PROVED]**
- b) patients for admission to theatre, resulting in Colleague 2 [Oluaseum Musa] having to take over the admission process for an unknown patient. **[PROVED]**
- c) patients for admission resulting in Colleague 3 [Ivy Togobo] having to take over admission for an unknown patient. **[PROVED]**
- d) patients for admission resulting in Colleague 4 [Sai Tawayaga] having to take over admission for an unknown patient. **[PROVED]**

5) On a date unknown whilst on the Day Surgery Unit put an unknown patient's safety at risk by using the wrong wrist band before they went into theatre. **[PROVED]**

6) On a date unknown on the Day Surgery unit failed to give a patient medication they needed before surgery. **[PROVED]**

7) On an unknown date unnecessarily asked an unknown patient to open wound dressing following a mastectomy when admitting them for a foot and ankle surgery. **[NOT PROVED]**

8) On an unknown date failed to listen to a patient in pain. **[PROVED]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in relation to charges 1b), 2, 4a), 4b), 4c) and 4d), 5, 6 and 7; and by reason of your misconduct in relation to charges 1a), 1c), 1d), 3 and 8.

Background

You were referred to the NMC on 10 October 2022 by Royal National Orthopaedic Hospital NHS Trust (The Trust).

You were employed as an overseas nurse and started at the Trust in a Band 5 registered nurse position immediately on appointment as you already had your NMC PIN. You began work on the London Irish ward which is a 32-bed surgical ward. Subsequently, you had an induction and period of being supernumerary. Your period of supernumerary was extended initially as you did not feel you received a proper induction or supervision period as the ward was busy and carrying some vacancies. Concerns were then raised surrounding your competency, insight and accountability by the Trust. It was agreed you would have an extended period of supervision and closer mentor support. Your employer decided little progress had been made and an action plan was implemented from 25 January 2022 to 18 April 2022. This action plan was to help you focus on key aspects of nursing, knowledge and understanding

of the principles of care and included awareness and understanding of the NMC Code. [PRIVATE]

[PRIVATE].

On your return on 16 May 2022, you were moved to a Day Surgery Unit (DSU). Supervision periods were extended to ensure patient safety and fair opportunity for you to learn and succeed, however you worked most of the 11 months under supervision. On the Day Surgery Unit you showed minimum improvement or progress and the same behaviour issues remained which included '*poor team player, no ownership when concerns were raised*' at your final probation meeting your position was terminated by the Trust on 1 September 2022.

Hearing resumed on 13 November 2025

Decision and reasons on service of Notice of Hearing

Ms Cheng was not in attendance on the first day of the resuming hearing. Ms Wisniewska informed the panel that the Notice of Hearing letter had been sent to her registered email address by secure email on 8 October 2025.

Ms Wisniewska submitted that the NMC had complied with the requirements of Rules 11 and 34 of 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 resuming hearing, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Cheng's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Cheng

The panel next considered whether it should proceed in the absence of Ms Cheng. It had regard to Rules 21 and 34 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Ms Cheng.

Chronology

During the April 2025 tranche of this hearing, the panel had provisionally agreed dates that it would be available to complete this hearing. Ms Wisniewska had confirmed her availability; Ms Cheng had not. The hearing went part-heard on 17 April 2025, part way through Ms Cheng giving evidence on the facts. She had completed her examination in chief and was about to be cross examined by Ms Wisniewska.

Ms Cheng told the panel on 17 April 2025 (on the last day of the hearing before going part heard) that she was not available to attend the hearing in October or November, and that she was unable to identify any dates that she would be available during that period of time. In response to Ms Cheng's stated position, the panel told Ms Cheng that the hearing would resume when further dates have been agreed and directed that Ms Cheng provide the NMC with her dates of availability within 7 days.

On 1 May 2025, Ms Cheng emailed the NMC:

'After my carefully and consideration my next Availability time period, I will only available to have MS Team Zoom Meeting/ Hearing with Nursing and Midwifery Council_UK and Fitness of Practice Committee in March 2026. I am so sorry to response late as I have to think carefully all the possibility available time, the other full commitment and [PRIVATE].

I am apology as little late response my possible availability period with NMC_UK & Fitness of Practice Committee, at least, I am open, honest, transparent, reliable, integrity and professional for my decision.

Can you All parties kindly confirm to review my email and upgrade my availability period with NMC-UK in March 2026, please?

I am looking forward to hearing from you All within 24 hours from 01/05/3035.'
[sic]

The NMC responded to Ms Cheng on the same day:

'The resuming dates were set at the last sitting in April. The panel have set the resuming dates as 12-21 November and 8-10 December 2025. As I have explained previously in response to your requests to postpone hearing dates, in order for us to consider any amendment or postponement to hearing dates, we need a reason as to why you cannot attend these dates. [PRIVATE] Failing that, we would oppose any application to postpone and invite the panel to proceed in your absence.'

On 25 May 2025, Ms Cheng emailed the NMC:

'[...]

I am respectful and honest to Nursing and Midwifery Council that I will be available to attend NMC-UK Hearing/ meeting via an invitation MS Team Zoom, with Fairness and Equal manner, as the following period:
1. 07/07/2025-20/07/2025 ((High possibility, I will be available to attend) or
2. 29/09/2025-12/10/2025, Please respectful to my sincerely and honest available time, please)

[...]

My unspeakable [PRIVATE] work experience from RNOH, NHS Trust some staff. False accusation with "Hearsay, Rumor, Gossip" [PRIVATE]. Thus, I will greatly appreciate it NMC-UK consider me sincerely proposal available time on 07/07/2025 to 20/07/2025) for the future meeting even I have full commitment for my other important event.

Can you please confirm to review my email within 12 hours from date 10/04/2025? I am looking forward to hearing from you soon.'

On 28 May 2025, the NMC responded:

'Your resuming substantive hearing is listed for 12 to 21 November and 8 to 10 December 2025. These dates were set by the panel and are based on availability. We are unable [sic] to change these dates. As I've previously explained, you are entitled to seek an adjournment of any hearing date. However, unless you are able to provide a reason as to why you cannot attend these dates, and evidence it with supporting documentation, the NMC will oppose any application. Is there a particular reason why you are unable to attend the set resuming dates?'

On 17 August 2025, Ms Cheng sent an email to the NMC:

'[...]

Urgent, I will not have time for any NMC-UK meeting/ Hearing until February 2026.

Please accept my honest apology. AC-2025_LON_001664_Nursing and Midwifery Council v Cheng'

On 18 August 2025, the NMC responded:

'I have previously explained, your substantive hearing is due to resume 12 to 21 November and 8 to 10 December 2025. These dates were set with you present at your last substantive hearing by the panel. Are you requesting a

postponement of these dates or are you content for the hearing to proceed in your absence? In order for us to consider any postponement of these dates in advance, you will need to provide us with a reason as to why you cannot attend these dates. You are entitled to make an adjournment application for the panel to consider, but without an explanation as to why you cannot attend the NMC will oppose any such application.'

On 22 August 2025, Ms Cheng sent another email to the NMC:

'In 2025 early of year to August 2025, this is my 4th time to inform Nursing and Midwifery Council UK, I have respectful and honest to inform Nursing and Midwifery Council UK, I will have have time available for any Nursing and Midwifery UK meeting/ Hearing. I will available after February 2026.' [sic]

On 22 August 2025, the NMC responded:

'I acknowledge receipt of your email reiterating that you will not be available for hearings until after February 2026. As you have not provided any reason as to why you are now unavailable for the agreed resuming dates in November 2025, we will be inviting the panel to proceed in your absence. I have clearly explained a number of times that in order for us to consider any agreed postponement, you need to provide us with a reason as to why your availability has changed. If you wish to make an application to the panel to adjourn the hearing in November then please provide Farhana and myself with your submissions at your earliest convenience.'

On 8 October 2025, the NMC served the Notice of Hearing on Ms Cheng informing her that the hearing was due to take place on 12 November and 13 – 21 November and 8 – 10 December 2025.

On 12 November 2025, in response to the email invitation to attend the hearing remotely by video conference, Ms Cheng said:

'A few months ago, I have informed all Nursing and Midwifery Council_UK whole team, Nursing and Midwifery Legal Team, [PRIVATE] and all your team, High Court of Justice, London, the honour Judge team, I would no time available to attend any Nursing and Midwifery Council or High Court of Justice UK meeting/Hearing in 2025. I have early informed all parties in 2025.

[...]

I am so sorry, I will unavailable to attend Nursing and Midwifery Council meeting/ hearing or High Court of Justice Meeting/ Hearing in 2025.

Be honest, I will unavailable to attend any Nursing and Midwifery Council_Uk and High Court of Justice Meeting/ Hearing before June 2026.

Can NMC-UK, [...], all NMC staff confirm to receive my email, within 24 hours from 12/11/2025, please?' [sic]

Submissions

Ms Wisniewska referred the panel to the NMC's email correspondence with Ms Cheng from May 2025. She submitted that Ms Cheng had considerable notice of this hearing and that we are due to hear Ms Cheng's cross examination evidence. She said that the hearing is at an advanced stage and to adjourn the hearing until 2026 would seriously affect the quality of the hearing. Ms Wisniewska further submitted that this application was being made in fairness not only to Ms Cheng but also to the NMC, and that the matter needs to be brought to a timely conclusion. She said that there is a clear public interest in considering these charges swiftly in order to protect the public and to maintain the public's confidence in the nursing profession as well as to the NMC as the regulator.

Ms Wisniewska invited the panel to proceed with the hearing in Ms Cheng's absence and further submitted that if the hearing was to adjourn, it would not make any more likely for Ms Cheng to attend on a future occasion.

In response to the panel's question as to why the NMC was of the view that Ms Cheng would not attend the hearing on a future occasion, Ms Wisniewska said that

there is no evidence that she wouldn't attend the hearing, but that she made that submission based on this situation today.

With regards to Ms Wisniewska's submission on the quality of the hearing being affected, she further stated that this was a general concern in relation to the proceedings generally due to the substantial delays and the time gaps. She submitted that if Ms Cheng started her cross examination in June 2026, this means that there is a considerable and significant gap since giving her evidence in chief which would affect the quality of the evidence.

Ms Wisniewska confirmed that the content of Ms Cheng's email correspondence dated 12 November 2025 can be inferred as an adjournment application.

The panel accepted the advice of the legal assessor who referred to the cases of *R v Jones (Anthony William)(No.2)* [2002] UKHL 5, *General Medical Council v Adeogba* [2016] EWCA Civ 162 and *CPS v Picton* [2006] EWHC 1108 (Admin).

Panel decision

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 *Jones*.

The panel has decided not to proceed in the absence of Ms Cheng. In reaching this decision, the panel has considered the submissions of Ms Wisniewska, the advice of the legal assessor and relevant NMC Guidance. It had particular regard to the factors set out in the decision of *Jones*, *Adeogba* (proceeding in absence) and *CPS v Picton* (adjournment) and had regard to the overall interests of justice and fairness to all parties.

The panel took into account that Ms Cheng does not have a representative, and is therefore representing herself. It also noted that English was her second language and she has required the services of an interpreter throughout the hearing. It accepted that the contents of her email communication of 12 November 2025

amounted to a request for an adjournment for the current hearing, a point which the panel noted was agreed by the NMC. The panel noted that Ms Cheng has been consistent since the last day of the previous hearing as to her unavailability for the current hearing dates. The panel is of the view that whilst she has not given full reasons as to why she is unavailable, she had implied in her email that it was due to [PRIVATE].

The panel was of the view that, whilst being in communication with Ms Cheng, the NMC did not take into account her consistently stated lack of availability for the dates which had been provisionally indicated by the panel. The panel noted that her availability on the provisional dates had never been confirmed by Ms Cheng. The NMC appears not to have explored alternative convenient dates for the attendance of all parties in light of Ms Cheng's unavailability, and had instead informed Ms Cheng that this listing was 'set by the panel'. This was an unfortunate misunderstanding as the dates had not been set (as repeatedly stated in the emails from the NMC). In fact, the dates had been provisionally agreed prior to Ms Cheng advising the panel on the last day of the hearing of her unavailability. Furthermore, despite Ms Cheng's emails to the NMC in May and August 2025 reiterating her unavailability, the NMC continued to proceed with the case and sent her the Notice of Hearing.

Following guidance in *Jones*, the panel determined that there was no indication from the communications from Ms Cheng to the NMC that she had voluntarily absented herself from this hearing or waived her right to attend.

The panel was of the view that the NMC's submission to proceed was limited as it focused on the efficient disposal of the case and the potential impact on the quality of evidence. The panel was mindful of its statutory duty to conduct matters expeditiously and accepted that it is in the wider public interest that allegations are resolved as swiftly as possible. However, in balancing the fairness to Ms Cheng and the NMC, the panel determined that it would be unfair to proceed in her absence.

The panel considered that both the panel and all parties had received the transcript from the previous hearings and had also taken full notes of the evidence heard

during the course of the hearing. This hearing relates to events that occurred in 2021-2022 and the panel has already heard all of the NMC evidence. Whilst the further delay in proceeding with the hearing may have some impact upon Ms Cheng's recollection of events, it was her application and no doubt she can use the documents already referred to as an aid. The panel was, therefore, of the view that another short adjournment would not cause a significant erosion to the quality of evidence, as submitted by the NMC.

Furthermore, the panel took into account that Ms Cheng has been fully engaged throughout the 24 hearing days so far. The panel is of the view that Ms Cheng's timely attendance on previous hearing days and her significant communications with the NMC, suggests that she will continue to engage with the process and to attend subsequent hearing days.

Before going part-heard in April 2025, Ms Cheng had concluded her examination in chief, and she was due to be cross examined from today. The panel was of the view that her cross examination was a central part of this process and key to the panel's decision making in relation to the charges. Similarly, the panel was of the view that hearing from Ms Cheng was important to enable it to make a fair, appropriate and proportionate judgement on impairment and sanction should the charges be found proved. The panel determined that it would not be able to mitigate any potential injustice if the hearing was to proceed.

The panel determined that the requirement for the expeditious disposal of a case must be weighed against the need to ensure the overall fairness of proceedings. The panel was of the view that the risks to Ms Cheng in being significantly disadvantaged by the panel proceeding in her absence under these circumstances outweigh the disadvantage to the NMC. Undoubtedly there will be cost and inconvenience caused to the NMC in re-listing this hearing, which is regrettable. It determined, however, that Ms Cheng's right to a fair hearing in being able to properly and sufficiently present her case - particularly because she is part-way through giving her evidence - outweighs that disadvantage. The panel was satisfied that the public would expect a registrant who is representing herself, who has attended her hearing for 24 days thus

far and wishes to continue to do so, be afforded the opportunity to finish presenting her case.

In these circumstances, the panel has decided not to proceed in the absence of Ms Cheng and to adjourn the hearing.

The panel directs that this hearing resumes on 1 – 12 June 2026 and Ms Cheng confirms her attendance within 7 days of receipt of this determination.

This will be confirmed to Ms Cheng in writing.

Hearing resumed on 1 June 2026

Decision and reasons on service of Notice of Hearing

Ms Cheng was not in attendance for the resuming hearing. The Notice of Hearing letter had been sent to Ms Cheng's registered email address by secure email on 7 May 2026.

Ms Wisniewska submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor. The panel also had regard to the NMC's guidance 'PRE-6' and the section called 'Notice of Resumed Hearing'. The panel was mindful that there was no minimum notice period required in relation to a resuming hearing.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Cheng'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 Ms Cheng has been served with the Notice of Hearing effectively.

Decision and reasons on proceeding in the absence of Ms Cheng

The panel next considered whether it should proceed in the absence of Ms Cheng. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Ms Cheng. She submitted that in Ms Cheng's email to the NMC on 1 March 2026, she said that she was unavailable in 2026 to attend any NMC hearing or meeting. She told the panel that the Case Manager had responded to Ms Cheng's emails on 23 January 2026, 23 February 2026, and 23 March 2026 querying as to why Ms Cheng was unavailable, to which Ms Cheng had not given a reason.

Ms Cheng in an email dated 1 March 2026:

'I am apology as I am and will be unavailable to attend any meeting/ hearing/ conference/ discussion in 2026.'

In response to the HC's invitation email to Ms Cheng on 29 May 2026, she responded on 30 May 2026:

'Apology. Unavailable any meeting in 2026. Sorry again. Please accept my open and honest sincerely answer from 2025, 2026.'

Ms Wisniewska submitted that it would not be appropriate to not proceed with the hearing as Ms Cheng has not provided the panel with a reason as to why she is unavailable in 2026 nor any evidence that she would be able to attend any future hearing. She further submitted that there is a general public interest in dealing with this matter as expeditiously as possible, particularly as this case has been going on for a period of two years.

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 *Jones*.

The panel has decided to proceed in the absence of Ms Cheng. In reaching this decision, the panel has considered the submissions of Ms Wisniewska, the representations from Ms Cheng, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties.

The panel noted that when the hearing adjourned in November 2025, Ms Cheng told the NMC:

*‘I am so sorry, I will unavailable to attend Nursing and Midwifery Council meeting/ hearing or High Court of Justice Meeting/ Hearing in 2025.
Be honest, I will unavailable to attend any Nursing and Midwifery Council_Uk and High Court of Justice Meeting/ Hearing before June 2026.’* [sic]

This hearing was scheduled in June 2026 to accommodate Ms Cheng’s availability as she stated that she would be available during this time. However, Ms Cheng has changed her position as she now stated that she will be unavailable in the whole of 2026.

The panel noted that the NMC Case Manager had emailed Ms Cheng on three occasions: 23 January 2026, 23 February 2026 and 2 March 2026, as to why she would be unavailable in the whole of 2026 but Ms Cheng did not provide any response.

In April 2025, Ms Cheng had concluded her evidence in chief and was due to be cross examined. The panel considered that during the course of the cross examination of the NMC witnesses, Ms Cheng had raised contextual matters relevant to her case. The panel took into account that Ms Cheng did not make an application for an adjournment or provide a reason as to why she was unavailable, in particular as she previously stated that she was available in June 2026. The panel

had no reason to suppose that adjourning, for the second time, would secure Ms Cheng's attendance at some future date. The panel also took into account that this hearing started in November 2024 and related to events that took place in 2021 and 2022. The panel is of the view that there is a strong public interest in the expeditious disposal of the case.

The panel accepted that there may be some disadvantage to Ms Cheng in proceeding in her absence, particularly as she was due to conclude giving her evidence through cross examination. However, in the panel's judgement, this can be mitigated. It was of the view that having already adjourned this hearing previously to give Ms Cheng an opportunity to attend, she has voluntarily absented herself and therefore waived her right to provide evidence or make submissions on her own behalf. The panel has an extensive hearing bundle comprising 8989 pages, this included approximately 3000 pages of evidence adduced by Ms Cheng, as well as notes of the contextual issues raised by Ms Cheng's contextual evidence throughout the cross examination of the NMC witnesses. In these circumstances, the panel is of the view that it can make allowance for the fact that her evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

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

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 Ms Wisniewska, and the evidence provided by Ms Cheng.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Mona Diamond ('Ms Diamond'): International Nurse Pastoral Facilitator at the Trust;
- Vanessa Illes (Colleague 1) ('Ms Illes'): Health Care Assistant (HCA);
- Oluaseum Musa (Colleague 2) ('Mr Musa'): Band 5 Registered Nurse at the Trust (Mentor to Ms Cheng);
- Ivy Togobo (Colleague 3) ('Ms Togobo'): Band 6 Ward Sister (Mentor to Ms Cheng);
- Chile Chikadza ('Ms Chikadza'): Ward Manager of the Day Surgery Unit at the Trust;
- Sai Tawayaga (Colleague 4) ('Ms Tawayaga'): Band 5 Registered Nurse at the Trust (Mentor to Ms Cheng);
- Cleone Gowers ('Ms Gowers'): Ward Manager for London Irish Ward the Trust.

The panel also heard Ms Cheng's evidence in examination in chief. Ms Cheng did not attend the hearing to start her cross examination evidence and conclude her evidence.

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

Charge 1

That you, a registered nurse between October 2021 and September 2022:

1) Failed to work cooperatively with other colleagues by;

a) Screaming at colleague 1 [Ms Illes] whilst they were completing an ECG on a patient.

This charge is found proved.

The panel first considered whether there was a duty on Ms Cheng, as a registered nurse, to work cooperatively with colleagues and took into account the terms of the 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. The panel determined that it is implicit within the terms in the Code that nurses are required to work cooperatively with colleagues, and considered this to be a fundamental tenet of nursing. The panel was therefore in no doubt that Ms Cheng was under a duty to work cooperatively with colleagues.

Furthermore, the panel had sight of the Trusts 'Local Induction Checklist' at the Day Surgery Unit which was signed by Ms Cheng and by Ms Chikadza, with the 'date of completion: 18/05/2022'. The panel considered that within the document, Ms Cheng had ticked as complete the reference to that *'I have read the Trust values and VAL-YOU Charter of Behaviours and understand what they mean is expected of me in my role as a staff member at the RNOH'* and *'I understand the standards of behaviour and performance I will be expected to demonstrate in my role'*, confirming that she understood the expectations of her in the role as a Band 5 nurse.

The panel then considered whether Ms Cheng had breached that duty by failing to work cooperatively with Ms Illes whilst she was completing an ECG on a patient.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Illes and Ms Chikadza, and the evidence provided by Ms Cheng.

The panel first considered the contemporaneous evidence relating to the incident.

In the Day Surgery Units (DSU) 'Feedback/Meeting Timeline', the panel noted that information therein was collated by Ms Chikadza from 16 May 2022 when Ms Cheng joined the DSU in order to provide a written summary of feedback gathered from her allocated mentors about Ms Cheng's overall progress. One entry read:

'06/07/2022

13:09 Concerns/Incident with patients

Overseen by Ivy: Concerns/Incident with patients. NC put back to supernumerary status

NC was allocated 10, 11, 12, 13, 14 patients. Vanessa asked NC if she needs help. Vanessa and student performing ECG on patient.

CC [Ms Chikadza] asked NC what happened with Vanessa, Vanessa told Nancy she is doing ECG on patient, NC open continues [sic: curtains] on patient. NC said to both patient and Vanessa to be quite [sic: quiet]. Student witness NC speaking to Vanessa harshly [...]

The panel went on to consider Ms Illes' witness statement, in which she wrote:

'5. There was one incident on the ward where I was showing a student how to use the ECG which I was trained in. [...] I was explaining to the student step by step how to use the machine. Nancy was opposite me with another patient and she could hear me. There was a curtain separating us and Nancy burst through it without asking permission. I was in the middle of performing the ECG and the patient was topless. Nancy was shouting asking me to stop making so much noise as her patient was getting annoyed but the patient told me they were fine and there was no issue. Nancy was screaming at everyone in the room.'

During Ms Illes' oral evidence, she told the panel:

'So when I was carrying out the ECG and she had pulled the curtain open, it was me and two students and the patient that I was doing the ECG on. She was screaming at us to be quiet and that we're making too much noise.'

[...]

'On that particular day with that incident, I don't know if you remembered Miss Cheng, but that you did scream and you did raise your voice. You may have not remembered it or you may have not thought of it to be screaming, but you did scream at me on that day and to other people that were in that situation.'

Ms Chikadza told the panel, during her oral evidence, that she did not witness this incident. However, she was the Ward Manager on the day in question, and wrote the minutes of the meeting after the incident took place in the DSU's Feedback/Meeting Timeline'. She also spoke to the patient who did not use the word 'screaming' but had complained about the way Ms Cheng's had spoken to other people.

The panel took into account the evidence provided by Ms Cheng in which she accepted that this interaction took place but that she was not screaming and that Ms Illes is lying about this. It was Ms Cheng's case that she had merely pulled the curtain and indicated using a courteous and appropriate hand gesture that they should be quiet as she was finding it difficult to concentrate. Ms Cheng also told the panel that, in her view, as Ms Illes was a Health Care Assistant (HCA), she was not qualified to undertake an ECG for this patient. She said:

'Doing an ECG is important for an operation, and if she's not a staff [registered nurse] she has no right to perform this work.'

The panel considered the definition of the word 'screaming'. It took into account the Cambridge dictionary definition:

‘to cry or say something loudly and usually on a high note, especially because of strong emotions such as fear, excitement, or anger [...]

The panel preferred the evidence of Ms Illes. It was of the view that Ms Illes’ oral evidence was consistent with her witness statement. It particularly noted that Ms Illes said that she and Ms Cheng had a ‘*good rapport*’ except on two occasions and therefore concluded that Ms Illes had no cause to fabricate her evidence.

The panel also considered the evidence from all of the NMC witnesses that Ms Cheng had a negative attitude towards HCAs in that she did not feel they were qualified to undertake certain roles and duties including teaching student nurses how to perform ECGs, and frequently kept asking for their job descriptions. The panel heard evidence from Ms Chikadza who told the panel that this duty was within Ms Illes’ role as an experienced HCA who was trained in this regard and that this was correctly done by her.

The panel was satisfied that Ms Cheng, on the balance of probabilities, had screamed at Ms Illes whilst she was undertaking an ECG on a patient. It was also satisfied that in acting in this way, Ms Cheng failed to work cooperatively with Ms Illes. It, therefore, found charge 1(a) proved.

Charge 1(b)

That you, a registered nurse between October 2021 and September 2022:

- 1) Failed to work cooperatively with other colleagues by;
 - b) Preventing Colleague 1 [Ms Illes] from giving a patient water

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Illes and Ms Chikadza, and the evidence provided by Ms Cheng.

The panel had regard to Ms Illes' witness statement, in which she wrote:

'6. There was another incident I can recall where a patient had come back from theatre and needed their vital signs checked which Nancy was doing. When patients come back from theatre we always give them water and something to eat. Nancy's patient had just returned from theatre and was gasping for water. Nancy was about to check their blood pressure but hadn't yet put the cuff on the patient. I asked Nancy to stop so that I could give the patient some water but Nancy was shouting that she needed to take the vital signs right away and dismissed the patient when they said they wanted the water first. I put the glass on the table and told the senior nurse what had happened.'

Ms Illes told the panel in her oral evidence:

'So when patient comes back from theatre, we normally do the vital signs and neurovascular checks.

As the patient was coming back onto the ward, she said straight away that I'm really thirsty, that I need some water and my mouth is really dry.

So normally what we do anyway, as nursing assistants as soon as the patients are coming in, we always bring them some water or a hot beverage, tea, coffee, hot chocolate. And then we asked them if they would, depending on the time of the day, if it was near to lunchtime, then we'd offer them their lunch. If it was still in the morning for breakfast, then we'd offer them some toast.

So I also asked the patient if she was ready to eat. And she also said yes, she was ready to eat. So I brought the patient a jug of water as well as a glass.

I pulled the glass and gave the water to the patient so she could have some water and Nancy was asking me to stop.

And she was just like, no, no. Like basically saying no, that the patient wasn't allowed to have the what I'm doing. I'm carrying out the blood pressure. With the patient then turned around, said. I just want a sip of water. The patient did have some of the water.'

In response to the panel's question, Ms Illes said:

'I went to give the glass of water to the patient and the patient was about to take the glass but Miss Cheng was saying that she needed to do the vital signs, so I put the glass on the table. So afterwards, the patient ... picked up the glass and she went to take a sip and put it back down. Then I had left and went back to the nursing station to tell the nurse in charge the incident that had happened.'

In response to the panels' question as to whether she was prevented from giving water to the patient, Ms Illes said:

'I was prevented. Yes. At the time, Miss Cheng was saying she wanted to do the blood pressure, which I understand is important for the progressions to be done, but the patient just wanted to take us like a couple sips of water before the blood pressure. So I was prevented at the time. But the patient did proceed to take a sip, and then I had then left the bedside. So I don't know what happened after that.'

[...]

I did initially pour it to give to the patient. I poured the cup to give to the patient and then I was told to stop. So then I just put the glass down in front of the patient. Patient took it up and then had a sip in and put it back down.'

In Ms Chikadza's witness statement, she wrote:

‘14. There was an incident where a Healthcare Assistant went to give a patient water and Nancy kicked off and didn’t allow the Healthcare assistant to give the patient water. I cannot recall the name of the Healthcare Assistant.’

In Ms Chikadza’s oral evidence, she told the panel that it was standard procedure for water to be given to the patient after they come out from surgery. She also said that the anaesthetists had also sanctioned that the patient should have water and this was on the drug chart. She also told the panel that, although she had not witnessed this incident, she spoke to Ms Cheng, Ms Illes and the patient afterwards to get their account. Ms Chikadza informed the panel that the account given by Ms Illes was consistent with that given by the patient who was very upset by the event.

During her examination in chief, Ms Cheng said that she felt it was more important to undertake the patients’ vitals before giving her water. She told the panel that Ms Illes, as a HCA should have sought her permission, as the registered nurse, before giving the patient water. Ms Cheng also told the panel:

‘I disagree, fake answer, Vanessa didn’t know it was my patient, she didn’t even know the patient, she couldn’t say the date, time, operation, or doctor [...].’

Ms Cheng also said:

‘even if the patient needs water, she should ask me’

The panel also noted from Ms Cheng’s evidence that she said *‘we had to do a physical assessment before they can have water, the HCA should listen to the nurse whether they can drink now or whether further assessment is required, the HCA must not override the nurse.’*

The panel considered from Ms Chikadza’s evidence that it was standard practice for HCA’s to provide patients with water as soon as they come out from surgery unless they are nil by mouth. Ms Chikadza advised that this patient had come back to the ward having been established as stable by the recovery team and that it was

appropriate and safe for her to drink water first before the blood pressure being taken.

The panel took into account the evidence provided by all of the NMC witnesses who stated that Ms Cheng often undermined HCAs and her attitude was that they should always seek permission and listen to the nurse.

The panel preferred the accounts of Ms Illes and Ms Chikadza over Ms Cheng's and could find no reason for them to fabricate their evidence.

The panel was satisfied that, on the balance of probabilities, Ms Cheng had prevented Ms Illes from providing water to the patient when it was requested. It was also satisfied that in acting in this way, Ms Cheng failed to work cooperatively with Ms Illes. It, therefore, found charge 1(b) proved.

Charge 1(c)

That you, a registered nurse between October 2021 and September 2022:

1) Failed to work cooperatively with other colleagues by;

c) Shouting at Colleague 1 [Ms Illes]

This charge is found proved.

The panel was satisfied that this charge is related to the same incident referred to charge 1(b).

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Illes and Ms Chikadza, and the evidence provided by Ms Cheng.

The panel had regard to Ms Illes' witness statement, in which she wrote:

'6. [...] Nancy's patient had just returned from theatre and was gasping for water. Nancy was about to check their blood pressure but hadn't yet put the cuff on the patient. I asked Nancy to stop so that I could give the patient some water but Nancy was shouting that she needed to take the vital signs right away and dismissed the patient when they said they wanted the water first [...].'

In response to the panel's question as to Ms Cheng's tone of voice during the incident with the water, Ms Illes said:

'It was a high tone of voice as in. She was very adamant that she needed to do the blood pressure right there and then, [...] As I said, it was like, no you. No, she can't have the water. Now I'm doing the blood pressure. No, you can't have it. So like that, very sharp and very like high. [...] It wasn't at a normal low tone. It was like a it was in a like, I don't want to say aggressive, but it was in a like a very stern and like ... yeah, like a stern like high tone [...] Her voice was definitely raised. And firm and stern and dismissive.'

Ms Chikadza told the panel in her oral evidence, that whilst she had not witnessed the event, she had been called because of the commotion and witnessed the patient complaining. She had spoken to the patient who was very upset because of the way Ms Cheng had spoken to her and to Ms Illes. Ms Chikadza confirmed to the panel that Ms Illes was allowed to provide water to the patient, and that it was sanctioned by the anaesthetist to be given to the patient once they returned to the ward from recovery.

The panel took into account Ms Cheng's evidence in which she said that Ms Illes' account of her shouting was fabricated, and that she did not shout at her, but used a hand gesture of facing her palms up. She told the panel:

'This hand gesture is used across the world ... it is not shouting ... she's been training for two years and she didn't know the hand gesture ... she already admitted that she's forgotten everything'

However, the panel also considered Ms Cheng's evidence to the panel in which she stated that she may be loud but that she was not shouting, and people misinterpreted her communication as shouting but it was her way of talking. The panel took the view that this appeared to contradict her early evidence that she had only used a hand gesture.

Having considered the evidence of Ms Illes which was supported by Ms Chikadza, the panel preferred their account of the incident to the contradictory account given by Ms Cheng in her evidence.

Therefore, the panel was satisfied that, on the balance of probabilities, Ms Cheng did shout at Ms Illes when she was providing water to the patient. It was also satisfied that in acting in this way, Ms Cheng failed to work cooperatively with Ms Illes. It therefore finds charge 1(c) proved.

Charge 1(d)

That you, a registered nurse between October 2021 and September 2022:

- 1) Failed to work cooperatively with other colleagues by;
 - d) On a date unknown speaking with an unknown healthcare assistant in a loud voice.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Mr Musa and Ms Cheng.

In Mr Musa's witness statement, he wrote:

'8. The second incident was regarding the way Nancy spoke with a Healthcare Assistant. I can't remember what it was about but I remember

witnessing it happening in front of patients. Nancy was speaking very loudly and I asked her to calm down and that we would discuss it later that day.'

Mr Musa, in his oral evidence, told the panel that he does not remember who this was about, what was said and who the HCA was. However, he expressed to the panel, his concerns in the way Ms Cheng communicated with the HCA's and also with himself.

Ms Cheng, in her evidence, told the panel that this did not happen and emphasised that there is no evidence as to who was involved and what this discussion was about.

This incident was not recorded in the Day Surgery Units 'Feedback/Meeting Timeline' and there was no other contemporaneous evidence or witnesses to support this charge. The panel, therefore, did not find that the NMC had discharged the burden of proof and found this charge not proved.

Charge 2

2) On one or more occasions failed to listen to instructions and /or requests.

This charge is found proved.

The panel first considered whether there was a duty upon Ms Cheng, as a registered nurse, to listen to instructions /or requests with regards to the Code of Conduct. The panel was in no doubt that the duty to listen to instructions and/or requests was implicit in the Code and accepted the submissions by the NMC that this duty included listening to feedback. The panel was satisfied that Ms Cheng was under this duty during the period of her employment in both the London Irish Ward and the Day Surgery Unit.

The panel first considered the contemporaneous evidence.

As context to the charge, Ms Chikadza provided an 'ACTION PLAN – carried forward from London Irish Ward', 'Date Objectives Agreed: 25/01/22 19.05.2022' which was put in place so that Ms Cheng was aware of specific individual objectives that she needed to work on. This included:

'3 To consistently establish and maintain effective communication with patients, colleagues and other members of the multidisciplinary team

For Nancy to use clear communication both verbal and written

For Nancy to use active listening and avoid interrupting when interacting with staff and patients [...]

The panel had regard to the document headed 'Meeting with Lansum "Nancy" Cheng' dated 16 May 2022 in which Ms Chikadza had outlined the expectation of the ward on Ms Cheng's first day on DSU and this had included the instructions:

[...] No use of mobile phone on ward – staff are not allowed to use mobile phone on the ward or at the nurses station. [...]

The panel also had sight of Ms Chikadza's email dated 16 August 2022, which stated:

'[...] At this point you were not listening or taking on board what I was saying as I noted that as I was trying to go through the document I just saw you all of a sudden getting up from your chair got your mobile phone from your pocket, wanting to leave the office saying "wait a minute" "wait a minute". At this time I stopped you and informed you that you are not allowed to record our meeting as it is not in the Trust policy and that I was stopping the meeting, this was now 18:56hrs. You went ahead and ran someone whom you informed me was your relative, you spoke in your own language, which I found was very unprofessional you then put the phone on speaker and said to me "what do you want me to do with this document, explain to my relative". At this time I never said anything and I left the office as this is not the normal Trust process

for the managers to have meetings with relatives regarding anything to do with their work [...]

In Ms Chikadza's Day Surgery Units 'Feedback/Meeting Timeline', the panel noted:

'[...] Another disturbing observation is that she tend to argue with her colleague and even the patients when she is corrected about anything. If she can learn how to stop talking over people and listen / take corrections constructively, her work experience with others will improve greatly.'

The panel went on to consider the documentary and oral evidence of Ms Diamond, Mr Musa, Ms Togobo, Ms Chikadza, and Ms Tawayaga. It also had regard to the evidence provided by Ms Cheng.

Ms Diamond, in her witness statement, wrote:

'6. The way Nancy conducted herself was unbelievable. I have never met another person that behaved like her. Nancy wouldn't listen from the first week and I told her that if she didn't listen then she wouldn't understand what I needed from her. There was constant talking and interrupting from Nancy. I told her that she would gain a lot more by listening. I said it is good to ask questions, but she needed to spend more time listening. It was an issue that she didn't grasp.

[...]

13. If Nancy was to look after elderly patients, they would be confused with the constant questioning and writing things down. I would be concerned if Nancy was to look after anyone I loved. I don't think she would personally hurt someone but there was a constant need for reassurance from other members of staff towards the patients this was informed to me via the ward staff. She spent a lot of time questioning and not listening [...]

[...]

16. I think I attended around 10 of Nancy's meetings in total and she would act very strangely. She wasn't listening and talking with analgise [sic] of how things were in China/Australia and that in the UK things aren't done properly and that the reason for her to come to the UK was to help with the epidemic and Queen and country [...]

The panel understood from the evidence given by Ms Diamond that she was not involved in any of Ms Cheng's clinical practice on the ward. Ms Diamond undertook a pastoral role for international nurses which included Ms Cheng. Her role was to help Ms Cheng to settle into the U.K. and support her to speak up for herself. Ms Diamond stated that she devoted considerable time to Ms Cheng in comparison to her support to other international nurses.

The panel also had regard to the evidence of Ms Chikadza, who in her witness statement, wrote:

'16. [...] I think it was to do with maybe her personality behaviour and not listening. Working with her was draining. Even for me having a meeting with her was draining and Nancy talked a lot but didn't listen would keep on interrupting.

17. I met with Nancy on the 5 August 2022 to go through her probation paperwork in preparation for her probation meeting, [...] This started the two-way discussion asking Nancy questions from the form and writing Nancy's responses. However, when it was my time to give feedback Nancy did not agree with the feedback I gave her, which was not surprising as Nancy does not like listening to what someone has to say or to take any advice.

[...]

20. The end of probation meeting was held on the 8 August 2022 [...] The meeting took around 4 hours and, in the end, even the RCN told Nancy to be quiet. Nancy was saying things that were not relevant. The RCN was trying to

speak with the chair and Nancy kept jumping in and not listening. Nancy needed to listen and then respond when it was the appropriate time to do so [...]

Ms Chikadza told the panel, in her oral evidence,

‘I spoke to her on a daily basis, she did not want to listen to anyone. It was very challenging to manage her.’

In Ms Gowers’ witness statement, she wrote:

‘6. [...] I noted there were issues with Nancy actively listening without interrupting, retaining and repeating/articulating information given [...]

[...]

16. [...] The concern of Nancy not actively listening, retaining and articulating information given was also raised by the Education Lead Nurse.’

Ms Gowers, in her oral evidence, told the panel that Ms Cheng would not listen to feedback and instructions, and that Ms Cheng would respond saying she has been a nurse for 30 years.

Mr Musa, during his evidence, told the panel that Ms Cheng would not listen to any of the guidance he put into place and that she would respond to him by stating that she has been a nurse for 30 years and ask him to just sign the competency booklet so she can pass her probation.

The panel considered that, throughout the course of evidence being given, all of the witnesses gave evidence that there was a concern about Ms Cheng’s ability to actively listen to instructions and feedback.

In Ms Togobo’s witness statement, she stated:

'10. Nancy is someone who doesn't listen and thinks she knows better as she would tell you that she had been working for 20 years in critical care [...]

In Ms Tawayaga's witness statement, she wrote:

'7. When you tried to explain things to Nancy, she would talk over you and I had to ask her to try and listen. I felt like she didn't like to listen when I was trying to provide feedback.'

The panel had regard to Ms Cheng's evidence, in which she told the panel:

'I disagree with all of the witnesses, I object'

In response to Ms Togobo's evidence, Ms Cheng told the panel:

'She's lying, she never taught me anything and she asked her questions and listened, I respected listened and answered her questions'

Ms Cheng also told the panel:

'I listened and I did it'

'I was signed off on the competency booklet, this showed I listened'

'I was competent after five days, why didn't they say anything for 9 months'

'If I was not listening, how come they [Mr Musa and Ms Togobo] sign the booklet'

Ms Cheng referred the panel to the numerous testimonials she had provided as evidence of her good character. She also said that *'people talked too fast, they had a strong accent and were too angry so she had needed to say please wait, she wasn't interrupting, they gave too much information in one go.'*

Ms Cheng also told the panel that if she failed to listen to instructions and /or requests, then she should not have been signed off on her competency work booklet by Mr Musa and Ms Togobo. Having had sight of Ms Cheng's competency work booklet, the panel noted that there was no specific competency relating to listening skills and saw no evidence that a competency of that nature had been signed off by any of her colleagues. However, it took into account that the competency booklet had evidence that Ms Cheng had been signed off on a number of competencies and it could be inferred that in order to have completed these competencies, she had been actively listening. The panel noted that Ms Cheng had been signed off as having completed a number of competencies within five days of starting her role at the DSU.

The panel took into account that Ms Cheng was on a probationary period for an extended period of time, had an action plan objective with a goal to actively listen, and it was therefore imperative that she listened attentively to instructions and feedback in order to improve on her performance and skills. The panel was of the view that despite having a number of her competencies having been completed, Ms Cheng had been told that there was an ongoing action for her to work on her listening skills. The panel considered that this action had been ongoing for a period of time and she had ample opportunity and support to improve this skill. The panel noted that Ms Cheng had not raised any issues of not understanding what people said to either Ms Gowers or Ms Chikadza as her line managers.

The panel considered that all six witnesses had been consistent in their accounts that Ms Cheng had persistently failed to listen to instructions and/or requests which they had corroborated with examples. The panel found no reason for them to fabricate their evidence.

The panel determined that there was strong evidence that, on the balance of probabilities, Ms Cheng failed to listen to instructions and /or requests. The panel therefore finds charge 2 proved.

Charge 3

3) On one or more occasions inappropriately argued with colleagues.

This charge is found proved.

The panel first considered the contemporaneous evidence.

Ms Chikazda, In the DSU's Feedback/Meeting Timeline, wrote:

'16/08/2022

[...]

Afternoon NC had Meeting with Ward Manager to go over the probation document as agreed at the adjourned meeting on 08.08.202, however could not proceed with the meeting as NC displayed unprofessional, concerning, intimidating behaviour and was ringing the relative to join the meeting.'

In the DSU's Feedback/Meeting Timeline, Ms Togobo wrote:

'15/08/2022

Ivy Togobo

16:55 (Meeting held in Ward Manager's Office)

How the day went?

NC is arguing about pt ratio and going on and on about it. IT explained to NC regarding the number of pts coming on the day and the acuity of pts we are receiving.'

The panel then considered the documentary and oral evidence of Ms Chikadza, Ms Gowers, Ms Togobo and Mr Musa. It also had regard to the evidence provided by Ms Cheng.

In Ms Chikadza's witness statement, she wrote:

'9. Issues started to arise shortly after Nancy joined the ward as staff were struggling to work with her and she didn't want to listen to any feedback. Staff were reporting that working with her was draining and stressing them out as they were scared to work with her. They were trying their best but would end up doing everything. Almost everyone working with Nancy came to me with concerns and how if they challenged her, she would kick off.'

In Ms Chikadza's cross examination, she said to Ms Cheng:

'[...] you were arguing with colleagues. Each time I try to get all of you in the office to resolve a conflict. So you have always been argumentative and it's been challenging to resolve any or mitigate any concerns and misunderstandings with colleagues.'

'[...] Almost on a daily basis, whenever you were on duty. There was always conflicts.'

'[...] I can give you an example, each time you are having a meeting with either myself or your supervisor says that to give you feedback. It's either there was an argument or you're trying to record. The meetings never got completed because you were always up doing something inappropriate or displaying inappropriate behaviours.'

[...] We are both sitting down facing each other, giving each other eye contact. I'm talking so that she speaks, but all of a sudden you just end up coming towards me. I felt intimidated and that's inappropriate and arguing that this is your opinion calling someone else. So I take that as an as an argument because you are raising your voice. I was increasing my voice. But you are raising your voice. And. Just disagreeing, talking over me so I felt intimidated in a small office. I just said to stop the meeting so things like that because we are talking on top of your voice and it's like you are shouting.'

Ms Chikadza was asked by the panel if Ms Cheng was disagreeing rather than arguing. She responded that to her *'disagreeing with a rationale is professional, but this was not the case with Ms Cheng who used an argumentative manner and was unprofessional'*.

Ms Togobo, in her witness statement, wrote:

'11. [...] She didn't pay attention to the patients and liked to argue a lot about everything [...]

Ms Togobo told the panel, in her oral evidence:

'All I can say, she's always arguing with me, but I cannot really [...] recall'

In cross examination, she said:

'[...], we are at work almost every day of our orals and sometimes it's difficult to recall the people that you work with, but I know that you are always arguing with us on the unit, especially when I have an care assistant or a nurse. Miss Cheng, can you do this for your patient or for a patient? Then [...] you start to argue.'

Ms Togobo was asked to clarify what she meant by arguing and confirmed she meant shouting in front of patients in a high tone.

Mr Musa, in his written statement, wrote:

'9. [...] Nancy was getting argumentative; this was the last issue I had with Nancy before saying I didn't want to work with her any longer as I was worried I was putting my NMC PIN at risk.'

The panel had regard to Ms Cheng's evidence when she said:

'I didn't argue with anyone or have any confrontation.'

The panel also considered her evidence that it may have been a misunderstanding and that *'Ms Chikadza was listening to gossip'*.

The panel noted that all of the witnesses called by the NMC were corroborative in relation to Ms Cheng demonstrating argumentative behaviour with her colleagues whilst working on the ward. The panel considered Ms Gowers oral evidence that: *'it may have been a misinterpretation of Ms Cheng's Asian voice and tone'*. However, the panel noted that the evidence provided by the witnesses as to Ms Cheng interacting argumentatively, appeared to coincide with incidents in which something had gone wrong, or when colleagues attempted to give her feedback, or an issue arose that she disagreed with.

The panel had regard to the consistency of the accounts given by the three witnesses and preferred their evidence.

The panel determined that, on the balance of probabilities, Ms Cheng had inappropriately argued with colleagues. This charge is therefore proved.

Charge 4(a)

4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;

a) patient discharge forms resulting in Colleague 3 [Ms Togobo] completing them

This charge is found NOT proved.

The panel first considered whether Ms Cheng was under a duty to manage her time effectively. The panel had sight of Ms Cheng's 'Action Plan – Carried forward from London Irish Ward, Date Objectives Agreed' 25/01/2022 19.05.2022' in which objective 2 was '*To be able to manage time effectively*'. Furthermore, the panel also had regard to the Code of Conduct which requires Ms Cheng, as a registered nurse, to be able to manage her time effectively. The panel was therefore satisfied that Ms Cheng was under a duty to manage her time effectively.

The panel first considered the contemporaneous evidence provided by the NMC. It noted from the DSU's Feedback/Meeting Timeline:

'12/08/2022

Ivy Togobo

[...] IT informed NC for them to discharged patients NC will say that she is going for lunch. IT have to discharge patients because all pts allocated was for injections and no TTAs and under local anaesthesia and minor procedures and wants to go home.'

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Togobo and the evidence provided by Ms Cheng.

The panel had regard to Ms Togobo's oral evidence in which she told the panel that in relation to the timeline for discharging patients that there is a need for a fast turnover but:

'it's not written that it must be at this certain time, but coming from based on my experience on the unit and how we see things on a daily basis.'

In response to panel's questions, Ms Togobo said:

'[...] But my issue there was when it's time to discharge a patient, that is when she wants to go for lunch and then by the time she returns, I've discharged the patient.'

The panel also had regard to Ms Cheng's evidence which was that she was not given a written guideline as to how long discharge forms should be and that this was all fabricated.

The panel also had regard to Ms Cheng's evidence of her competency booklet which referred to the competency at '2.8 Discharging a patient from the ward' dated October 2022. This competency had been signed as completed by one of her colleagues confirming that Ms Cheng understood and was able to discharge patients. The panel noted that this competency did not include an expectation of the time that should be taken to complete a discharge or the associated forms.

The panel was of the view that the NMC had provided limited evidence relating to the patients' discharge forms. It did not have any evidence before it as to how long Ms Cheng should have taken preparing the discharge forms, and what period of time was regarded as *'too long'*. It was also of the view that there was no evidence that the delay in preparing the discharge forms was due to Ms Cheng failing to manage her time effectively as opposed to having taken her lunch break or a comfort break. The panel considered that Ms Togobo's complaint related to Ms Cheng not being on the ward during the discharge period, rather than having taken too long to prepare the discharge forms as per the wording of the charge.

The panel therefore did not find charge 4(a) proved.

Charge 4(b)

4) On various dates from 16 May 2022, failed to manage your time effectively and

took too long preparing;

b) patients for admission to theatre, resulting in Colleague 2 [Mr Musa] having to take over the admission process for an unknown patient.

This charge is found proved.

The panel first considered the contemporaneous evidence. In the Day Surgery Unit's 'NC Progress to date' under 'Ward observations / experience on NC which have a negative impact on her colleagues and patients', the panel noted comments recorded by Ms Chikadza after Ms Cheng had been working on the ward for a 12-week period:

'NC struggles with admissions, her paper work is all over the place and easily get distracted with patients [...]

It also takes NC over 20 minutes to admit one patient and does and always forget the important admission steps such as; VTE assessment if completed, patients weight on the drug charts, still struggling with discharge process as well.'

The panel also took into account the documentary and oral evidence of Ms Diamond, Mr Musa, and the evidence provided by Ms Cheng.

Ms Diamond, in her witness statement, wrote:

'8. I never really had too much clinical input with her but there were two occurrences where I did as she was struggling with admissions. We have an admissions booklet with a risk assessment and care plans. The feedback I had was that Nancy was struggling with the booklet. Completing the booklet should take maybe 20 minutes but it was taking Nancy around an hour to complete. I was there to observe Nancy whilst she did the admission. We only managed one patient as Nancy bombarded me with questions. She would question why the booklet was asking for certain information. She was asking 'why' all the time and I had to explain it was a legal document created by the

hospital to admit people. There was a lot of unnecessary questions asking for rationale of why we were asking patients certain questions. This was done in front of the patients which was very inappropriate. I am not saying she shouldn't have asked questions but the amount she asked and their relevance was excessive and draining. Around 6 patients should have been admitted whilst doing the admission as supposed to just the one.'

Mr Musa, in his witness statement, wrote:

'5. The first incident involved the slow admission of patients. The day shift on the unit usually involves the admission of patients and preparing them for theatre [...] Nancy was to admit patients but she took a longer time than usual to do it. We needed to admit the patients quite quickly as there are other professionals that need to see the patients before they go into surgery.

6. The first patient Nancy was admitting took so long that I had to take over so that she could move onto the second patient. This was done because the patient was first on the theatre list and porters were ready to transfer the patient to theatre. There were around five patients for Nancy to admit and they should have taken around 15-20 minutes each but Nancy had already taken 45 minutes for the first patient before I took over. When I went to Nancy to check the second patient after I finished up with the other three patients, she was still admitting the second patient and it had been around an hour but I left her to finish the admission. I also noticed that Nancy asked a lot of questions that had already been answered. She went beyond what was required. An example was regarding the question we need to ask all patients about whether there are any skin problems on the body. The patient will tell us if they do and where it is. We do not need to ask more than that but Nancy was asking them when it happened, how it happened and once asked a patient to show her the wound so that she could examine it.'

The panel had regard to Mr Musa's local statement dated 15 June 2022:

'[...] She was very enthusiastic to work and thorough in admitting patients however she does take longer time with it because she kept repeating already asked questions which patients had answered [...]'

In his oral evidence, Mr Musa told the panel:

'Ms Cheng has a way of repeating questions that have already been answered [...] this is actually delaying the time [...] In this surgery unit, we have a booklet and guideline of what is needed but she [...] always goes out of it [...] this prolongs the admission process.'

Mr Musa told the panel that he had had to take over on one occasion as the porter was there and he needed to intervene to avoid delay in the theatre list. He had wanted to protect the theatre time and be on time, but that Ms Cheng was not concerned about that.

Mr Musa also told the panel that he had tried to help Ms Cheng, but when he did, she would respond by telling him that she has been a nurse for 30 years and so she was experienced.

During her evidence in chief, Ms Cheng stated that Mr Musa cannot recall exactly which day, location or patient details, and therefore it is not correct. She said that she disagreed with Mr Musa, and emphasised that it was Mr Musa who signed her to be competent in admissions in her competency booklet. During the course of her evidence, Ms Cheng said that she did not know about the time frame but always adhered to the 15-20 minute time frame when doing admissions.

The panel considered Ms Cheng's competency booklet and took into account that Ms Cheng was signed off as competent in relation to the admissions process by Mr Musa four days after joining the DSU and whilst she held supernumerary status. The panel concluded that this provided evidence that Ms Cheng knew the requirements of the admissions process. However, the panel noted that the wording of the competency '1.1 Admitting a patient to the clinical area' did not refer to the speed and proficiency of admitting patients and therefore this had not been part of Ms

Cheng's assessment when she was signed off as passing this competency. The panel had regard to the evidence that the ward was fast paced and that Mr Musa's evidence, that there were concerns about the length of time Ms Cheng took for admissions, was supported by other witnesses. The panel preferred his account.

In light of this, the panel determined that, on the balance of probabilities, Ms Cheng failed to manage her time effectively and took too long preparing patients for admission to theatre resulting in Mr Musa having to take over the admission process.

Charge 4(c)

4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;

c) patients for admission resulting in Colleague 3 [Ms Togobo] having to take over admission for an unknown patient.

This charge is found proved.

The panel first considered the contemporaneous evidence which included the DSU's Feedback/Meeting Timeline:

'10/08/2022

Ivy Togobo

Made a plan for the day and the number of patients we are looking after. NC & IT have 4 patients (Bed 1, 3, 4, 10).

Bed 1 – First on the list, NC started admitting patient at 07:10am.

7:30am NC was still admitting the first patient, after admission IT overseeing the admission booklet and papers however patient have only one wrist band and no weight on patient drug chart

[...]

Bed 3 – IT have to admit the patient because of the delays in admitting.'

The panel also had regard to the documentary and oral evidence of Ms Togobo and Ms Cheng.

Ms Togobo, in her witness statement, wrote:

'4. The first thing we do during a day shift on the unit is admission of patients. To do this we look at the theatre list and check the allocated patients according to the order they will go for their procedures. I worked with Nancy to ensure that patients were admitted in that order. She would do the first patient and I would do the second. When I finished the second, Nancy was still on her first and this happened a number of times. I got Nancy to go to the third and I would finish the first. The paperwork isn't huge, but it took Nancy a long time to complete. Theatre starts at 8am and so patients need to be ready as soon as possible as there are other professionals who need to see the patient before going to theatre.

[...]

7. Admissions should take around 10/15 minutes but Nancy's would go on for 40 minutes and I would find information missing from documents. It may have been that Nancy didn't understand the process, but this was covered in her orientation and paperwork. I found that sometimes Nancy talked to patients for a longer period but not concentrating on the admission process booklet which was all self explanatory [...]

In her oral evidence, Ms Togobo told the panel:

'I tell Miss Cheng that she needs to admit the first patient on the list whilst I move on to the second patient because I'm trying to get Miss Cheng to show

how fast paced the day surgery unit is so she will get familiar with the admission booklets. The paperwork that we use, but it gets to numerous times, Miss Cheng takes much longer time to admit the first patient.

I will first go to the second patient, admit the second patient. I will finish admission, admitting the second patient. I'll go to Miss Cheng, Miss Cheng is still on the first patient. And I've told Miss Cheng numerous times that she needs to be fast, even though she needs to take her time in admitting she still needs to be fast because of our theatre list.'

Ms Cheng referred the panel to her competency booklet on '1.1 Admitting a patient to the clinical area', in which Ms Togobo signed Ms Cheng as being competent in the admission process on 27 May 2022. The panel had regard to Ms Cheng's evidence in which she disagreed with Ms Togobo and said that she was not a good mentor to her. The panel took into account Ms Cheng's evidence that she had been signed off as being competent in the admissions process, nevertheless she went on to inform the panel that her mentor should have been working alongside her during patient admissions.

In addition, Ms Cheng said that she was never shown or told the admission policy for DSU. However, the panel noted the contents of the competency booklet which stated that Ms Cheng had an understanding of the admission process. Ms Cheng disagreed that it took her 40-minutes to complete the admission process as she checked her own watch.

The panel considered Ms Togobo's evidence that she told Ms Cheng about the 15-minute time frame to admit patients into the ward and that she signed the competency booklet as she was satisfied that Ms Cheng knew how to complete the admission process, as per Trust policy.

The panel had regard to evidence from all the other witnesses who were consistent in that Ms Cheng took long in admitting patients, and that unnecessarily repeated questions which delayed the process. The panel preferred the evidence given by Ms Togobo, as corroborated by other witnesses, to that of Ms Cheng's evidence and

determined that on the balance of probabilities, Ms Cheng failed to manage her time effectively and took too long preparing patients for admission to theatre resulting in Ms Togobo having to take over the admission.

Charge 4(d)

4) On various dates from 16 May 2022, failed to manage your time effectively and took too long preparing;

d) patients for admission resulting in Colleague 4 [Ms Tawayaga] having to take over admission for an unknown patient.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Tawayaga and Ms Cheng.

In Ms Tawayaga's witness statement, she wrote:

'6. Patients start arriving at 7am which is when the shift starts but sometimes they arrive before that so we come in at 6:30am although Nancy started at 7:30am. Patients should take roughly 15-20 minutes to admit but it was taking Nancy more than half an hour. I found that Nancy wasn't able to manage her time and was asking more questions than was necessary when going through the admissions booklet. She also spoke with patients in an abrupt manner. I had to stop Nancy several times to jump in and get the admission done as we were going to be late for theatre.'

In her oral evidence, Ms Tawayaga told the panel:

'I just found Ms Cheng, she wasn't able to manage her time well, she was asking more questions than necessary whilst going through the admission booklet and I had to come in and get the admission done [...]

and then there's certain things like when I'm trying to explain to Ms Cheng 'you're taking too long on the on that particular patient, please try' and [...] I would find that talking over me while I'm trying for her to listen and try to understand where I'm coming from, because the main reason is not to delay patients to theatre. [...]

During cross examination, she also told the panel:

'That's why I signed that you have [...] began to understand the admission process after having spoken to you, asking you to do what you're supposed to do correctly. That's why I signed. After all the reminding you to just don't take too long to a particular patient, try and go you time you work well. That is why I signed.

I was happy with your performance, but I have had to remind you to try and quicken your admission process.'

The panel had regard to Ms Tawayaga's evidence that she does not recall ever telling Ms Cheng that patients needed to be admitted in 15 minutes, but did tell her to speed up her work as patients needed to get to theatre.

The panel considered Ms Cheng's evidence in which she disagreed with Ms Tawayaga's evidence and initially said that she did not know about the 15 minute timeframe. Ms Cheng stated that she usually finished an admission in 10-15-20 minutes based on her critical care nurse experience but she had never taken 30 minutes. Ms Cheng also told the panel that the HCAs would not complete the preoperative assessments for her which means that she had to do them herself

which delayed her. Ms Cheng went on to challenge the credibility of Ms Tawayaga as a mentor stating that: *'she was a rude person, who caused the admission process to not be done properly because of the way she behaved.'*

Ms Cheng also said that there was lots of missing information in the booklet which was supposed to be completed by the pre-admissions team and was not, which is why it took her longer to complete the admissions booklet.

The panel had regard to Ms Togobo's evidence that it was not possible for the pre-admission information to not be completed in the booklet by the time the patient was admitted to the DSU and in any event, it was not Ms Cheng's duty to complete it. Furthermore, Ms Chikadza told the panel that Ms Cheng never raised the issue with her of the form not being completed during pre-admissions and Ms Cheng was not trained to complete those sections. In cross examination, Ms Chikadza stated that Ms Cheng had never reported to her that the HCAs were not assisting her with the admissions resulting in delays.

The panel found Ms Tawayaga to be a credible witness, and noted that she had tried to support Ms Cheng through the signing of the competency booklet for admissions and advising her as to how she could be more efficient during the admissions process. The panel preferred the account of Ms Tawayaga and could find no reason for her to fabricate her evidence.

The panel also had regard to evidence from other NMC witnesses of similar concerns being raised that Ms Cheng was taking too long to prepare patients for admission.

The panel determined that, on the balance of probabilities, Ms Cheng failed to manage her time effectively and took too long preparing patients for admission to theatre resulting in Ms Tawayaga having to take over the admission process. It therefore found charge 4(d) proved.

Charge 5

5) On a date unknown whilst on the Day Surgery Unit put an unknown patient's safety at risk by using the wrong wrist band before they went into theatre.

This charge is found proved.

The panel first considered the contemporaneous evidence which included the DSU's Feedback/Meeting Timeline:

'10/08/2022

Ivy Togobo

[...]

7:30am NC was still admitting the first patient, after admission IT overseeing the admission booklet and papers however patient have only one wrist band and no weight on patient drug chart.

Bed 10 – NC admitted the patient and still only one wrist band [...]

'12/08/2022

Ivy Togobo

[...]

IT have to inform NC to admit pt who are first on the list because NC went to Bed 5 who is 2nd on the list. Then NC went to admit Bed 2 who is 1st on the list. Nutrition screening not completed and HCA and IT went to checked pt before going to theatre and wrist bands are incorrect (one belong to different pt bed 3). Pt informed IT she did not want anyone to be in trouble.'

'15/08/2022 - Ivy Togobo

[...]

IT mentioned to NC that she gave a wrong wrist band to patient on 12.08.2022. NC denied it, IT took a copy of pt and show it to her.'

The panel also considered the 'Probation Appeal Hearing for Nancy Cheng' dated 18 October 2022 in which Ms Cheng provided written commentary which was included in the meeting notes in which she said that:

'Nancy answer: it was the only One time that Ms. Cheng put on a wrong label on the patient [...] It was a busy day, I did not check the first patient's label sheet with the correct patient's label detail. The ward clerk unintentionally put another patient's label sheet in that patient's file. I unintentionally missed the patient's label detail in one sheet [...] and put on the patient's wrist on such busy day.

When the Healthcare Assistant reminded me of the incorrect patient's label, I had apologized [sic] to that patient and double checked all the patient detail on the patient's label with that patient.

The patient accepted my sincere apology, and there was no further issue and No further complaint.

It was Only once the patient label was incorrectly placed, I had apologized [sic] to the patient and managed to correct the event at the time before pre-operation.'

The panel also took into account the documentary and oral evidence of Ms Togobo, Ms Chikadza, and Ms Cheng.

The panel had regard to Ms Togobo's witness statement:

'6. [...] Patients are supposed to have two identical wrist bands with their details but on one occasion Nancy had the wrong wrist band [...] When I told Nancy about it, she told me to 'shush' and not to tell anyone, but I had to be transparent as it was about patient safety [...]'

The panel was of the view that Ms Togobo was consistent in her oral evidence.

Ms Chikadza told the panel:

'I did observe one argument where there was a wrong wrist band put on the patient and [...] I just happened to get in there when Ms Cheng was questioning [...] the healthcare assistant [...]

Ms Cheng objected to Ms Togobo's and Ms Chikadza's evidence. She stated that it was not her responsibility to check the wristbands on the patients and it was for the nurse in charge, Ms Togobo, to check each patient's wristbands, which is the way it is done in Australia and Hong Kong. Ms Cheng told the panel:

'No such thing happened, because I did not put the wrong wristband. Why should I need to say shush?'

'I do not agree this incident occurred, it's fake, no such happened, I didn't say shush'

However, during the cross examination of Ms Chikadza, Ms Cheng accepted that a discussion took place between her and Ms Togobo, and whilst she said she didn't say 'shush', she accepted that she put her finger to her mouth.

The panel considered the inconsistency in the accounts given by Ms Cheng during her evidence and noted that Ms Cheng had tried to lay the blame on the ward clerk and the nurse in charge. It took into account that Ms Togobo was a direct witness to this incident, and had reported it to Ms Chikadza, who joined shortly thereafter who also saw the wrong wristband on the patient. During her probation hearing, Ms Cheng had subsequently accepted that the incident had taken place.

The panel preferred the account of Ms Togobo and Ms Chikadza and could find no reason for them to fabricate their evidence.

The panel determined that, on the balance of probabilities, Ms Cheng put an unknown patient's safety at risk by using the wrong wrist band before they went into theatre. It therefore found charge 5 proved.

Charge 6

6) On a date unknown on the Day Surgery unit failed to give a patient medication they needed before surgery.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Togobo, Ms Chikadza, and Ms Cheng.

The panel first considered the contemporaneous evidence which included the DSU's Feedback/Meeting Timeline, the panel noted:

'12/08/2022

Ivy Togobo

Bed 3 - Anaesthetist called and spoke to IT [Ivy Togobo] and inform pt can have water up to 9:30am and IT asked regarding the pre-meds what time to give? However the anaesthetist was shocked that the pre-meds was not given. IT was informed by NC that anaesthetist will call and inform what time the pre-meds needs to be given but anaesthetist said to give the pre-meds immediately.'

The panel considered Ms Togobo's witness statement:

'9. There was an incident where anaesthetist told Nancy to give a patient medication they needed before surgery, but Nancy didn't tell me and when anaesthetist chased it up it hadn't been given [...]

Ms Togobo, in her oral evidence, told the panel:

'so when the anaesthetists come on the ward in that morning, when they will tell us they've prescribed a premedication for patient before going to theatre. So in this case, Miss Cheng was told to give a medication. At this certain time could be that same time, but I wasn't aware of that. The patient needed this medication. It was when the theatre manager calls the ward asking whether the patient's medication been given, it means they were ready for the patient to theatre, and when we checked or when I asked Miss Cheng, the medication wasn't given because premedication needs to be given by two nurses. In this instance, the medication wasn't given at all, and I wasn't aware of it.'

Ms Togobo said that she was “100% sure” that the anaesthetist had told Ms Cheng about the premedication because she received the call from the theatre manager asking whether that premedication had been administered by the nurse who was directly looking after that patient. She confirmed that the anaesthetist did not directly name Ms Cheng as the nurse who received that request, but that it was standard practice for the anaesthetist to look at the electronic board to see who would be the allocated nurse in charge of that patient, and then would make the request.

Ms Chikadza gave evidence of this incident in her oral evidence only. She confirmed to the panel that there was an incident with regards to Ms Cheng not administering the premedication for a patient and that the premedication had been prescribed on the drug chart. She also stated that she took the call from the anaesthetist with the concern, and that the anaesthetist would not leave anything to do with medication with the HCA.

The panel also had regard to Ms Cheng's competency booklet on '1.7 Medicines Administration', in which she was signed off as competent to safely administer medication to patients.

During examination in chief, Ms Cheng initially stated that the anaesthetist did not request for the premedication to be given to the patient at all and that no such thing had happened. Later in her evidence, she stated that the incident had occurred and that she did not receive that request for the premedication and it was the HCA who received that request and did not relay that request to a nurse. Ms Cheng then told the panel that she spoke to the anaesthetist when they came on to the ward who told her that the request was given to a HCA and they did not pass that request to her.

The panel had regard to the evidence of Ms Chikadza that the anaesthetist would not come onto the ward until the end of the theatre list and would not discuss medication with HCAs who wore different coloured uniforms to the qualified nurses so there could have been no confusion.

The panel was of the view that Ms Cheng's account was inconsistent and lacked credibility in this regard. The panel preferred the accounts given by the NMC witnesses and could find no reason for them to fabricate their evidence.

The panel determined that, on the balance of probabilities, it was more likely that Ms Cheng did fail to give a patient the premedication they needed before surgery.

Charge 7

7) On an unknown date unnecessarily asked an unknown patient to open wound dressing following a mastectomy when admitting them for a foot and ankle surgery.

This charge is found NOT proved.

The panel first considered the local statement made by Mr Musa dated 15 June 2022 in which :

'[...] She is quite comprehensive and extensive in her questioning skill but needs to master when and how to use the skill as a patient once opened her surgical dressing because she wants to know about the patient's skin condition though she claimed that the patient misunderstood her question [...]

It also took into account the documentary and oral evidence of Mr Musa and Ms Cheng.

Mr Musa, in his witness statement, wrote:

'9. The third incident involved admission of a patient that was due to have foot and ankle surgery. Before theatre we need to assess for skin conditions to check those areas. The patient had a wound dressing following a mastectomy and told Nancy this but instead of writing 'dressing to chest' the patient said that Nancy told her to open the wound dressing. When I asked Nancy about this she denied that she had asked the patient to open the dressing and that the patient did this on their own. Nancy was getting argumentative; this was the last issue I had with Nancy before saying I didn't want to work with her any longer as I was worried I was putting my NMC PIN at risk.'

During his oral evidence, Mr Musa informed the panel:

'[...] Because I was aware that the patient is having foot and ankle surgeries, so I did not expect the patient to inform me that Ms Cheng [...] asked about the skin and she informed me that, mentioned to me that, she had a mastectomy done with a dressing on it and Ms Cheng asked her to open it so she can see the wound. I called Ms Cheng concerning the matter and she told me that "no, that the patient removed it on her own" [...]

Mr Musa further explained in oral evidence that given the patient was having foot and ankle surgery and the location of the mastectomy dressing, if the dressing was

oozing Ms Cheng should have sought his advice or advice from a doctor and put a sterile dressing over the existing dressing rather than remove it. Mr Musa added that although he had not witnessed the discussion, or been called to assist by Ms Cheng, he had gone to the patient having seen Ms Cheng run from the cubicle. The patient reported that Ms Cheng had asked if there was any oozing, said she wanted to see the site and told her to remove the dressing. Ms Cheng told the patient in front of him that she did not ask and the patient said no and corrected her. Then Mr Musa had called the doctor and informed his manager.

The panel had regard to Ms Cheng's evidence. In an email dated 6 June 2022 to Ms Chikadza, Ms Cheng wrote:

'D. the bed 8 female patient's old dressing was removed under Right armpit. ([Mr Musa], RN concern). I explained to [Mr Musa], RN that the bed 8 female patient's felt sore Right shoulder and Right arm due to Old wound dressing when I recorded Skin Inspection Chart/ Turning Chart. As a professional Nurse, I suggested to inspect the wound dressing location on Right Should or Right arm. The patient's agreed to remove the Thick T-Shirt for Inspection the wound location. The patient felt the wound dressing was milder clear liquid oozing from Right Ampit [sic], the patient's hand contained some of wound dressing liquid. I walked outside to look for the Paper tissue for the patient. By the time, I recorded the patient's wound dressing on the Skin Inspection Chart/ Turning Chart record, the patient removed the old wound dressing. I informed [Mr Musa], RN about the patient removed the wound dressing from Right armpit [sic] and needed to have a sterile dressing before procedure. [Mr Musa], RN applied a sterile dressing for the patient.

Remark: To build open, honest, transparency, construction communication between with [Mr Musa], RN was very significant as the Teamwork. Thus, [Mr Musa] and I had a briefly discussion the patient's wound dressing after 15:25 on 06/06/2022. Therefore, there would No Misunderstanding, No miscommunication on 06/06/2022. [Mr Musa], RN and I shook [sic] the hands after our discussion about the patient's wound dressing.

The above is Factual and Truth Statement was recorded by N.CHENG, RN date 06/06/2022.'

The panel considered that Ms Cheng's evidence was that the patient had opened the old dressing of her own accord. She further stated:

'Mr Musa provided a corrupt story, that it was fake evidence in court, and hallucinations'

She also said: *'I have looked after over a thousand patient in a month [...] I do not remember such a patient [...] no such incident took place.'*

The panel considered that the suggestion made by Ms Cheng in her evidence that Mr Musa was fabricating his evidence was inconsistent with the account she has given in the email dated 6 June 2022 in which she appears to acknowledge that the incident did occur and that Mr Musa was present and that they discussed the patient's wound dressing and shook hands at the end of the incident. However, the panel had regard to the lack of evidence provided by the NMC of a witness present at the time of the discussion between Ms Cheng and the patient noting that Mr Musa was only able to give evidence of the discussion between the patient and Ms Cheng in his presence after the removal of the dressing and the dispute at that stage around whether Ms Cheng had or had not asked the patient to remove the dressing. The patient was not identified in the charge or present to give evidence, nor was the date of the incident specified and there was no entry on the DSU timeline/feedback. The panel therefore had no direct evidence that Ms Cheng had asked the patient to open the wound dressing and determined therefore that the NMC had not discharged its burden of proof and therefore found this charge not proved.

Charge 8

8) On an unknown date failed to listen to a patient in pain.

This charge is found proved.

The panel first considered whether Ms Cheng had a duty to listen to a patient in pain. It was of the view that the Code of Conduct requires nurses to deliver the fundamentals of care by providing assistance to patients without undue delay. It determined that Ms Cheng was under a duty to listen to and provide care and assistance for the patient in pain.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Gowers and Ms Cheng.

Ms Gowers, in her witness statement, wrote:

'7. There was one incident where Nancy was with me, and we were conducting the morning drug round for a patient. I had to leave Nancy with the patient for a moment and when I returned the patient was crying and told me they were in pain and needed to open their bowels but Nancy was not listening. Nancy was completely unaware and continued with putting the medication out and reading the instructions instead of attending to the patient. I told Nancy the patient was in pain and Nancy said she didn't realise she was. This wasn't the only time I noted that there were issues with Nancy being unaware of a situation [...]

Ms Gowers told the panel:

'This was when I was observing Miss Cheng doing a medication round. On this occasion we were at a patient's bedside and I had to excuse myself because I had to take a call. [...] when I came to attend to them they were crying and Miss Cheng was by the bedside still doing the medication round. And I asked the patient what was the issue. She said that she was asking for a bedpan and that the nurse Miss Cheng wasn't listening to her. And when I asked Miss Cheng what had happened, it appeared that she didn't realise that the patient was crying or that she had called the bell.'

Ms Gowers clarified that the patient was crying when she was entering the room, and confirmed that the patient was not crying when she left the room for her call.

In evidence, Ms Cheng informed the panel that she had been signed as competent in relation to pain medication and administration. She said that there were two patients who requested for pain relief on that day and for both patients she had administered pain relief. She said that the patient did not say that she was in pain, was not crying and did not request pain medication. Furthermore, the panel had regard to Ms Cheng's evidence accusing Ms Gower's of causing the patient pain. She said:

'So the only say was once Ms Gower came, she cried. The only reason is maybe Ms Gower's say something is upset her to make her cry. The only reason because why the patient in the bedroom was next to me less than about 6 inches. I don't see a reason she called a call bell when I was next to her [...]

If I was with that patient when the patient was in pain, how come the patient did not tell me and that is that ringing the bell? Unless the patients got mental problems [...]

And the patient did not tell me was in pain. Is it because of [Ms Gowers] causing her pain?'

The panel took into account that there was no other contemporaneous evidence.

The panel was of the view that Ms Gowers presented as fair, balanced, and proportionate when giving her evidence. It was apparent that she provided support to Ms Cheng during her time managing her on the London Irish Ward. It found Ms Cheng's suggestion as the possible cause of the patient's pain due to Ms Gowers action to be inappropriate and implausible. The panel preferred the evidence of Ms Gowers over Ms Cheng and found no cause for her to fabricate her evidence.

The panel considered Ms Gower's evidence that in the presence of Ms Cheng, the patient informed her that she was in pain and that Ms Cheng was not listening to her. In her oral evidence, Ms Gowers stated that the patient had pushed the call bell to request assistance whilst she was away from the patient having taken a telephone call. Upon her return she noticed that the patient was crying and that Ms Cheng '*was by the bedside, still doing the medication round [...] the patient told me she was wanting to use the bedpan but the nurse was not listening to her.*' The panel further considered Ms Cheng's account that she was not aware of the patient being in distress and that the patient had not told her that she was in pain. Because of the proximity of Ms Cheng to the patient, and the fact that the patient had pressed the call bell, together with Ms Gowers evidence that the patient had told her that she was wanting to use the bedpan but that Ms Cheng was not listening to her, the panel determined that this charge was proved on the balance of probabilities.

The panel determined that on the balance of probabilities, Ms Cheng failed to listen to a patient in pain. It therefore found this charge proved.

Allegations of bullying, harassment, discrimination and intimidation by Ms Cheng:

During her evidence in chief, as well as during her cross examination of the witnesses, Ms Cheng informed the panel that she was working in an environment where she was subjected to bullying, harassment, discrimination and intimidation throughout her time at the Trust and her position that the NMC witnesses have fabricated their evidence against her.

The panel considered Ms Cheng's representations that she was repeatedly harassed and bullied by colleagues in both wards, and explored this with all of the witnesses during their oral evidence.

The panel found that there was no evidence that this was the case. On the contrary, the panel found that Ms Cheng was well supported in both the London Irish Ward and the Day Surgery Unit over her eleven month extended probation period. The panel heard evidence that unusually the ward manager had acceded to Ms Cheng's request that she moved wards during her probationary period. The ward manager of

the DSU gave evidence that the purpose was to give her a fresh start in what was described as 'a calm, structured environment.' The circumstances on London Irish Ward had been challenging as it was during the Covid-19 pandemic. However, she was still given 1:1 support, had meetings on a regular basis with her line managers, was provided with an action plan with clear individual objectives, [PRIVATE] made to ascertain how she could be supported to improve her performance. Ms Cheng was also given extended supernumerary time and was given the opportunity to join a two-week skills workshop programme when the Trust recognised that she needed further input, despite Ms Cheng already being a qualified nurse. Upon her transfer to the DSU, Ms Cheng's action plan was continued, and she was supported by being mentored by two experienced nurses whose rotas were aligned with Ms Cheng's. The panel was of the view that this support was in addition to the comprehensive programme of pastoral care provided to all international nurses joining the Trust.

The panel was satisfied that all new staff were required to undertake a six month probationary period. However Ms Cheng due to the concerns raised, as detailed above, had her probationary period extended. The panel was not satisfied that she had been discriminated against in this regard.

The panel considered and accepted the evidence from all the witnesses who said that they each dedicated a significant amount of time and effort to provide support to Ms Cheng.

The panel also took into account Ms Cheng's responses, in an email to Ms Gowers dated 18/12/2022, about the Skills Programme where she expressed gratitude about the programme and Ms Gowers, and was appreciative of the opportunity:

'1. You are a very high professional Manager, Registered Nurse, Nurse Educator, Mentor, a Preceptor, a Coach, a Supervisor, an Assessor, a clear and methodogolist [sic] great trainer in my life with great compassion to the patients and the staff. Indeed, you are inspiration and my life, my nursing career as a Light house. You have opened my eye and my mind at new work place, London Irish Ward, RNOH NHS Trust, Since I joined as a new staff member, a Registered Nurse.'

2. As a new country, a new work place, a new work system, a new system of policy and procedures, a group of new staff work around me, it is a challenge period for me. However, Yoi have opened your arms warm welcome and link me with different Department staff and our London Irish ward staff. Now, I will spend my time to identify surgical team Consultant, surgical team for better communication in order to advocate the patients Best Interest.

3. Thank you remind me, empower me and guide me to stand up and learn to voice out base on RNOH NHS Trust Value, Vision, mission and NMC_UK standard to be a professional, compassion and safe practice Registered Nurse [...].'

The panel considered that Ms Cheng's managers were willing to keep her as supernumerary for an extended period of time, despite the fact that it was a very busy ward.

Ms Cheng was enabled and advised by Ms Chikadza and Ms Togobo to use the 'freedom to speak up policy' and 'the resolution process' to raise any concerns she had with her line management.

The panel determined that it could find no evidence to support Ms Cheng's allegations of bullying, harassment, discrimination and intimidation. It determined that Ms Cheng was fully supported by the Trust and her colleagues. Furthermore, the panel was of the view that the NMC witnesses were credible and reliable, and that Ms Cheng often made it difficult for them to fully support her due to her unwillingness to listen and her resistance to constructive feedback. The panel found no evidence to suggest that they had fabricated their evidence.

The hearing resumed on 25 August 2026.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Cheng was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 25 June 2026.

Ms Wisniewska submitted that it had complied with the requirements of Rules 11 and 34.

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 and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Cheng'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 Ms Cheng has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Cheng

The panel next considered whether it should proceed in the absence of Ms Cheng. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Ms Cheng. She submitted that Ms Cheng had not provided a reason for her non-attendance and has voluntarily absented herself.

Ms Cheng sent an email to the NMC on 24 August 2026, in which she stated:

'[...] From 2025, I have Apology to NMC-UK, High Court of Justice, , I would be unavailable to attend any meeting, any hearing, any conference with NMC UK or High Court of Justice , London in 2026, 2027, 2028. 2029, 2030 [...]

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 has decided to proceed in the absence of Ms Cheng. In reaching this decision, the panel has considered the submissions of Ms Wisniewska and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones and Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Cheng has not made an application for an adjournment;
- In her email on 24 August 2026, Ms Cheng stated that she was not available for a number of years until 2030;
- Ms Cheng has not provided the panel with a reason as to why she is unavailable to attend the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Cheng in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent Ms Cheng, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated as it had heard Ms Cheng's perspective and contextual evidence when from her previous engagement in the hearing. Furthermore, the limited disadvantage is the consequence of Ms Cheng'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 has decided that it is fair to proceed in the absence of Ms Cheng and will draw no adverse inference from Ms Cheng's absence.

Fitness to practise

Lack of competence and/or misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts found proved amount to: a lack of competence in relation to charges 1b), 2, 4b), 4c) and 4d), 5, and 6 and/or misconduct in relation to charges 1a), 1c), 3 and 8, and, if so, whether Ms Cheng'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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, Ms Cheng's fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Submissions on lack of competence and misconduct

Lack of competence

The NMC has defined a lack of competence as:

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

Ms Wisniewska invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code:

Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

Ms Wisniewska identified the specific, relevant standards where Ms Cheng's actions amounted to a lack of competence. She submitted that by failing to reduce, as far as possible, the likelihood of mistakes, near misses or harm, not being aware how her behaviour affected or influenced other people, and failing to act as a role model breached 19.1, 20.3 and 20.8 in relation to all charges.

She submitted that in relation to:

Charge 1(b) – by preventing her colleague from giving water to a patient she had breached codes 1.2, 1.5, 8.1, 8.2, 8.5 by interfering with the care and recovery of patients.

In relation to charge 2 she had breached codes 1.2, 8.1, 8.2, 8.5, by impacting the delivery of care to patients, undermining the skills of her colleague, showed a lack of understanding of her role and expectations in care of the patient and interfered with the care of a patient.

In relation to charge 4 she had breached codes 1.2, 8.1, 8.2 and 8.5 by failing to work cooperatively with colleagues.

In relation to charges 5 and 6 she had breached code 1.2 by failing to deliver a fundamental part of care.

Ms Wisniewska submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that Ms Cheng was made aware of the issues around her competence?
- Is there evidence that Ms Cheng was given the opportunity to improve?

- Is there evidence of further assessment?

Ms Wisniewska submitted that the facts found proved in charges 1b), 2, 4b), 4c) and 4d), 5, and 6 show that Ms Cheng's competence at the time was below the standard expected of a probationary band 5 registered nurse.

Misconduct

Ms Wisniewska also identified the specific, relevant standards where Ms Cheng's actions amounted to misconduct.

In relation to charges 1a and c, she had breached codes 1.1, 1.2, 1.5, 5.1, 8.1, 8.2 8.5 and 20.3 and 20.8 by screaming and shouting at her colleague she had failed to respect other individuals, impacted patients perception as to how they were cared for, undermined the skills of a colleague, allowed her behaviour to negatively impact colleagues and patients and failed to act as a role model of professional behaviour.

In relation to charge 3 she had breached codes 8.1, 8.2, 9.3 and 20.6 by failing to work cooperatively, failing to respect the views and opinions of her colleagues in a professional way and breaching professional boundaries.

In relation to charge 8 she had breached codes 1.1, 1.2, 1.4, 1.5, and 2.1 by failing to listen to a patient.

Ms Wisniewska submitted that the facts found proved amounts to behaviour that does not reflect the standards expected of a registered nurse and therefore amounts to misconduct.

Submissions on impairment on both lack of competence and misconduct

Ms Wisniewska 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Misconduct

Ms Wisniewska submitted that limbs a, b and c are engaged for facts found proved for charges 1a), 1c), 3 and 8. She submitted that Ms Cheng's conduct had put patients at unwarranted risk of harm by shouting, screaming and arguing inappropriately with colleagues which could have negatively affected the care patients receive. In relation to charge 1(a), she submitted that Ms Cheng screamed and shouted at Ms Illes whilst she was undertaking an ECG for patient, which created a risk of distracting Ms Illes whilst undertaking the procedure. Ms Wisniewska also submitted that failing to listen to a patient in pain created a risk to the patient as pain is a warning sign that they need attention. She submitted Ms Cheng's misconduct had brought the nursing profession into disrepute. In addition, she submitted that Ms Cheng had breached all four of the fundamental tenets of the nursing profession, namely prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Lack of competence

Ms Wisniewska referred the panel to the NMC's guidance on 'Lack of competence' (Reference: FTP-2b, Last Updated 14/04/2021) which states:

'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk.'

Ms Wisniewska submitted that the charges found proved in relation to lack of competence, are wide ranging and breached a number of the fundamental tenets of the nursing profession, and therefore demonstrate an unacceptably low standard of professional performance which put patients at risk.

For both, the misconduct and the lack of competence, Ms Wisniewska submitted that Ms Cheng has not provided the panel with any evidence of the steps she has taken to strengthen her practice and to address the concerns, or any evidence of reflection, remorse or insight. Ms Wisniewska stated that Ms Cheng was liable to repeat the same behaviours. She therefore invited the panel to find Ms Cheng's fitness to practice impaired on both lack of competence and misconduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included: *General Medical Council v Meadow* [2007] QB 462 (Admin), *Holton v General Medical Council* [2006] EWHC 2960 (Admin), *R (on the application of Remedy UK Ltd) v General Medical Council* [2009] EWHC 2294 (Admin), *McDermott v The Health and Care Professions Council* [2017] EWHC 2899 (Admin), *Roylance v General Medical Council (No 2)* [2000] 1 AC 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Schodlock v General Medical Council* [2015] EWCA Civ 769, *Sawati v General Medical Council* [2022] EWHC 283 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin), and *Grant*.

The legal assessor also referred the panel to the NMC's guidance: 'Misconduct' (Reference: FTP-2a Last Updated 20/05/2026), 'Lack of competence' (Reference: FTP-2b, Last Updated 14/04/2021) and 'Impairment' (Reference: DMA-1, Last Updated 28/01/2026).

Decision and reasons on lack of competence

In accordance with NMC guidance FTP-2b, the panel considered whether there was evidence of an unacceptable low standard of professional performance judged on a fair sample of Ms Cheng's work, which could put people receiving care at risk.

It asked itself:

- 1) If it had been presented with a fair sample of Ms Cheng's work to be able to assess her standard - sufficient to assess her work over a period of time
- 2) How and to what extent she had breached the code in the proved charges

- 3) Whether Ms Cheng's performance was unacceptably low as expected of a probationary Band 5 nurse on a ward

The panel determined that the charges found proved established significant ongoing deficiencies in Ms Cheng's practice, in two wards with different line managers, colleagues, mentors and assessors, during the period of October 2021 to September 2022 across six themes, despite having supervision and support, which are:

- 1) Poor communication with colleagues
- 2) Lack of teamwork
- 3) Not listening to instructions or requests
- 4) Inability to provide core patient care such as ensuring timely completion of admissions and administering medication before patient went into surgery
- 5) Failure to mitigate risk and preserve safety by checking patient wrist band before surgical procedure
- 6) Lack of professionalism and accountability

The panel heard evidence that Ms Cheng had failed to undertake essential nursing duties during a lengthy period of time. The panel concluded that the types of concerns raised, the seriousness of those concerns and the number of examples of her work provided over the period in question represented a fair sample of Ms Cheng's work, sufficient for the panel to be able to assess her standard of work.

The panel went onto consider to what extent Ms Cheng had breached the Code in relation to the charges 1b), 2, 4b), 4c), 4d), 5, and 6.

In relation to charge 1(b), the panel determined that Ms Cheng breached:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

In relation to charge 2, the panel determined that Ms Cheng breached:

'8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times'

In relation to charges 4(b), 4(c) and 4(d), the panel determined that Ms Cheng breached:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

In relation to charge 5, the panel determined that Ms Cheng breached:

'8 Work co-operatively

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

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

To achieve this, you must:

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

In relation to charge 6, the panel determined that Ms Cheng breached:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

The panel bore in mind, when reaching its decision, that Ms Cheng should be judged by the standards expected of her as a probationary band 5 registered nurse, i.e. the position to which Ms Cheng had been appointed during October 2021 and September 2022, and not by any higher or more demanding standard, albeit she was qualified as a registered nurse, as per *Holton*.

The evidence presented established that Ms Cheng lacks the necessary knowledge, skills, and judgment expected of a probationary band 5 registered nurse.

The panel considered Ms Cheng's conduct was dismissive of colleagues, especially junior staff, she was disrespectful towards them and undermined their role and duties. Despite receiving substantial additional support and training, as well as holding an extended supernumerary status, she consistently failed to meet the required professional standards. Ms Cheng's performance remained below the competence expected of a probationary Band 5 nurse and had a direct impact on patients and the care provided to them placing them at risk of harm.

While there were some instances where the evidence suggested that Ms Cheng had met the competencies required, such as administering medication and patient admissions, these were not consistent and not representative of her overall performance. The panel had regard to the fact that Ms Cheng's competency booklet was not fully signed off by the end of her extended 11 month probationary period.

Reports from Ms Cheng's colleagues, mentors, line managers, assessors and pastoral mentor, as well as direct observations by her supervisors highlighted recurring and wide ranging deficiencies in her practice. Her underperformance occurred despite her operating under continuous supervision in a supernumerary capacity as well as extended supernumerary status, with no evidence of mitigating circumstances such as workplace pressures. The panel considered that in relation to charge 5, the risk of serious incident was only mitigated when the patient noticed that

the wristband was incorrect. Ms Cheng had not been open and honest when this incident occurred nor did she take responsibility for the error but rather requested Ms Illes keep the matter between themselves. During the hearing, Ms Cheng deflected the blame for this error onto others. This was despite Ms Cheng being made aware in her induction that DSU had a supportive culture of learning from mistakes.

The panel considered the questions posed by Ms Wisniewska during her submissions:

- 1) Is there evidence that Ms Cheng was made aware of the issues around her competence?

The panel was satisfied that there was evidence within the two action plans that were developed for Ms Cheng, the competency booklet that applied to her probation, notes from meetings with her line manager and mentors and oral evidence from witnesses that Ms Cheng had been made aware of issues around her competence on multiple occasions during her probationary period.

- 2) Is there evidence that Ms Cheng was given the opportunity to improve?

The panel was satisfied that there was substantial evidence from the evidence listed above, together with the supervision timeline details for DSU, that Ms Cheng was given the opportunity to improve across the 11 month extended probation period.

- 3) Is there evidence of further assessment?

The panel was satisfied that the competency booklet provided by Ms Cheng detailed where additional assessments were successfully completed, while others were yet to be signed off.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Ms Cheng's practice was unacceptably below the standard that one would expect of a probationary band 5 nurse acting in Ms Cheng's role.

In all the circumstances, the panel determined that Ms Cheng's performance demonstrated a lack of competence.

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 Ms Cheng's actions which took place during the course of her professional practice did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

In relation to charge 1(a), the panel determined that Ms Cheng breached:

'8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

In relation to charge 1(c), the panel determined that Ms Cheng breached:

'8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

In relation to charge 8, the panel determined that Ms Cheng breached:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that screaming, shouting and inappropriately arguing with colleagues and in front of patients, as well as failing

to listen to a patient in pain fell seriously short of the standards expected of a registered nurse. It considered that Ms Cheng should and did know how to behave appropriately, to treat colleagues and patients with respect, kindness, and compassion.

The panel concluded that Ms Cheng's conduct demonstrated a pattern of behaviour where she had not worked cooperatively and respectfully on multiple occasions which risked the efficiency and quality of care provided. For example, colleagues and managers had had to take time away from patient care and other responsibilities to deal with confrontations and patient complaints. The panel also had regard to the fact that delays in scheduled surgical procedures were only prevented by colleagues stepping in. On two occasions patients were put at risk by Ms Cheng not identifying errors in the pre-op preparation, and on another occasion, Ms Cheng had not been aware that the patient beside her was in pain and sought to blame the senior nurse. The panel considered that Ms Cheng's unprofessional behaviour had also negatively impacted on the environment for the ward staff and patients and resulted in senior management having to be involved. Furthermore, the panel noted that Ms Cheng's line manager, Ms Chikadza, described one occasion where she felt intimidated by Ms Cheng's behaviour when she had attempted to provide feedback.

The panel had regard to the fact that the breaches of the Code were wide-ranging and covered all four areas of the Code. The panel were of the view that the charges found proved would be regarded as deplorable by fellow practitioners and the public at large.

The panel found that Ms Cheng's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence and misconduct, Ms Cheng's fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

The panel determined that limbs a, b and c were engaged of the *test*.

The panel found that patients and colleagues were put at risk of physical and emotional harm as a result of Ms Cheng's lack of competence and misconduct. Ms Cheng's misconduct and lack of competence had breached all four of the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered the three questions in the case of *Cohen*, to determine Ms Cheng's current impairment:

- 1) Whether the conduct that led to the charge(s) is easily remediable.
- 2) Whether it has been remedied.
- 3) Whether it is highly unlikely to be repeated.

Regarding whether Ms Cheng's deficiencies are remediable, the panel considered Ms Cheng's shortcomings. The panel was of the view that these failings are capable of remediation, in theory. However, the panel considered that Ms Cheng has demonstrated a deep seated attitudinal concern, and noted that attitudinal concerns are more difficult to address. The panel had heard evidence from all of the NMC witnesses that Ms Cheng was difficult to work with, that she often argued and

shouted at colleagues, deflected the blame onto others and did not respond positively to feedback. Ms Cheng had been given a second opportunity when she was transferred to work at the DSU, at her request, where she demonstrated the same behaviours and attitude. The panel noted comments made by Ms Chikadza in her 'summary of concerns':

"its very challenging working with [Ms Cheng] on the ward, always got an answer and excuses for everything, no insight for patient safety, no insight of reflective practice"

The panel noted the requirement within the NMC's guidance to take into account whether the nurse has complied with the duty of candour and the requirements it places on professional practice when they consider issues of current impairment. Having accepted the accounts of witnesses in relation to Ms Cheng's response to errors and attempts to provide feedback on the standard of her practice, the panel had concerns about Ms Cheng's ability to be open and transparent, recognise her own limitations or take personal responsibility when things went wrong.

Regarding misconduct, Ms Cheng had also demonstrated a lack of respect for HCAs and questioned their roles and responsibilities, by asking for their job description and by telling them that she had been a nurse for over 30 years. Furthermore, Ms Cheng was insistent that all the allegations made against her were fabricated, 'fake' or because of unsubstantiated allegations of bullying, harassment and discrimination. The panel also had regard to the fact that Ms Cheng made unprofessional disparaging remarks to some of the witnesses within the hearing resulting in the panel Chair having to intervene.

The panel concluded that Ms Cheng demonstrated a deep seated attitudinal issue that could put people receiving care at risk of harm and also contrary to the values of respect of others, openness, and putting the needs of people receiving care first. The panel had regard to the NMC's guidance on misconduct (FTP-2a) where it refers to deep seated attitudinal issues and states: '*it is less likely that the nurse [...] will be able to remediate and take steps to address the underlying concerns*'. The panel concluded the misconduct established in Ms Cheng's case is not easily remediable.

The panel also took into account the NMC's guidance on 'Has the concern been addressed?' (Reference: FTP-16b, Last Updated 25/03/2026).

Ms Cheng has not provided the panel with any evidence of remorse, insight or reflection on the impact her behaviour had on her colleagues, patients, the profession and the wider public interest. While a large volume of material had been provided for the panel, the panel concluded that there was no reflective statement relating to the subject of the charges. Furthermore, Ms Cheng has not provided any evidence of relevant steps she has taken to address the concerns. The panel noted Ms Cheng provided the panel with evidence of training she had undertaken in Australia up to 2024 but none relate to the subject of the charges. Testimonials from patients and associates were provided between 2012 and 2017. The panel considered that whilst these were positive, they referred to a period of time prior to the allegations. The panel took into account what it considered to be very limited and qualified remorse shown by Ms Cheng following the incident relating to the wristband. The panel noted that this remorse was no longer present during the course of the hearing, in fact Ms Cheng emphatically denied charge 5 and attempted to blame others.

The panel concluded that Ms Cheng had not provided evidence to demonstrate that she had a comprehensive understanding of the harm or risk that her behaviour posed for patients, the damage to the public's confidence in the profession, how far her conduct or practice fell short of professional standards, or the need to take personal responsibility for problems without seeking to blame others or excuse her actions.

During Ms Cheng's attendance at the hearings, Ms Cheng refused to give any information to the panel, including her [PRIVATE] or status. Moreover, throughout the course of the hearing, Ms Cheng had also displayed the same behaviour of not listening, deflecting blame on others and an overall difficulty in communicating with her.

The panel was satisfied that Ms Cheng has not remedied her deficiencies or her misconduct overall. In light of this, the panel is of the view that there is a high risk of repetition and there remains a strong likelihood that her behaviour would have an impact on care provided to patients by her colleagues and the working environment. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered that a well-informed member of the public would reasonably expect a finding of current impairment, given the wide-ranging nature of the deficiencies and the misconduct found proved. Failure to find impairment would undermine public confidence in the profession and its regulatory processes. Consequently, the panel finds Ms Cheng's fitness to practice impaired on the grounds of public interest as well as public protection.

Having regard to all of the above, the panel was satisfied that Ms Cheng's fitness to practise is currently impaired on both lack of competence and misconduct grounds.

The hearing resumed on 12 October 2026.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Cheng was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 9 September 2026.

Ms Wisniewska submitted that the NMC had complied with the requirements of Rules 11 and 34.

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, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Cheng'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 Ms Cheng has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Cheng

The panel next considered whether it should proceed in the absence of Ms Cheng. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Ms Cheng. She submitted that Ms Cheng had not provided a reason for her non-attendance and has voluntarily absented herself.

Ms Cheng has not engaged with the NMC in relation to today's resuming hearing and, as a consequence, there was 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 has decided to proceed in the absence of Ms Cheng. In reaching this decision, the panel has considered the submissions of Ms Wisniewska and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Cheng has not made an application for an adjournment;
- Ms Cheng has not responded to the emails regarding the resuming hearing today;
- Ms Cheng has previously indicated that she would be unavailable to attend the hearing until 2030 and there is no reason to suppose that adjourning would secure her attendance at some date in the near future; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Cheng in proceeding in her absence because the panel will not have the opportunity to hear Ms Cheng's submissions in relation to sanction. However, this disadvantage is the consequence of Ms Cheng's decision to absent herself from the hearing, waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Cheng.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

In the Notice of Hearing, dated 2 October 2024, the NMC had advised Ms Cheng that it would seek the imposition of a conditions of practice order if it found her fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order is more appropriate in light of the panel's findings.

Ms Wisniewska referred the panel to the NMC's guidance on sanctions and submitted that the aggravating features include:

- Repetitive mistakes, which created risks to the safety of two patients in particular.
- A failure by Ms Cheng to accept advice, listen to colleagues, or follow instructions.
- A pattern of behaviour, as found by the panel, in which Ms Cheng did not work cooperatively and respectfully on multiple occasions, risking the efficiency and quality of care provided.
- A complete absence of insight: Ms Cheng has not submitted a formal reflective piece and has not demonstrated any insight during the course of these proceedings.
- Limited engagement with the proceedings: Although Ms Cheng engaged with a substantial part of the hearing and attended to question witnesses, she did not attend to give evidence herself, was not cross-examined as a result, and did not engage with the proceedings beyond the witness stage. Nor did she provide a good reason for her absence.

Ms Wisniewska submitted that the mitigating feature includes Ms Cheng having no previous NMC referrals.

Ms Wisniewska submitted that the NMC relies on the panel's own findings which underline the seriousness of Ms Cheng's lack of competence and misconduct. In relation to lack of competence, it includes:

- Poor communication with colleagues.
- Lack of teamwork.
- Not listening to instructions or requests.
- Inability to provide core elements of patient care, including ensuring timely completion of admissions and administering medication before a patient went into surgery.
- Failure to mitigate risk and preserve safety, including the failure to check a patient's wristband before a surgical procedure.
- Lack of professionalism and accountability.
- Underperforming despite continuous and extended supernumerary supervision, with no evidence of mitigating circumstances such as workplace pressures.

In relation to misconduct, this includes:

- Ms Cheng being dismissive of junior staff
- Disrespecting and undermining colleagues' roles
- Conduct which demonstrated a pattern of behaviour in which Ms Cheng did not work cooperatively and respectfully on multiple occasions, which risked the efficiency and quality of care provided — for example, colleagues and managers had to take time away from patient care and other responsibilities to deal with confrontations and complaints
- Conduct which put two patients at direct risk of harm
- Conduct which created a negative impact on the ward and on patients more broadly

Ms Wisniewska submitted that taking no action or a caution order would not be appropriate in the circumstances of this case.

Regarding a conditions of practice order, Ms Wisniewska submitted that conditions could not be formulated to address the concerns, to protect the public and meet the public interest. She submitted that the lack of competence identified by the panel, in particular the registrant's failure to listen to and follow instructions, does not lend

itself to being addressed through conditions. She submitted that there are no workable, relevant, measurable, and proportionate conditions capable of addressing either the lack of competence or the misconduct identified, namely: poor communication with colleagues; lack of teamwork; not listening to instructions or requests; inability to provide core patient care; failure to mitigate risk and preserve safety; and lack of professionalism and accountability.

Regarding a suspension order, Ms Wisniewska referred the panel to the NMC guidance on 'Suspension order' (Reference: SAN-2d, Last Updated 28/01/2026). She submitted that the charges found proved, regarding both misconduct and lack of competence, are towards the more serious end of the spectrum, and given the panel's finding of a lack of insight, a period of suspension would afford Ms Cheng the opportunity to develop insight and remediation that has not been evident to date. She said that the panel's determination clearly identifies risks to patient safety, in particular the lack of competence, the failure to listen to and follow instructions, and the direct risks posed to two patients. She submitted that although these are past events, they remain un-remediated, such that the risk persists. Furthermore, she submitted that the public's confidence could not be maintained if Ms Cheng was allowed to practise at this stage, and therefore a period of suspension is necessary. Ms Wisniewska further submitted that whilst Ms Cheng had engaged with substantial parts of these proceedings, she did not engage with the proceedings from the point at which she was due to give evidence, and she has shown no meaningful insight into her lack of competence or her misconduct.

Ms Wisniewska acknowledged that certain features of this case, such as the deep-seated attitudinal issues and the high risk of repetition, are features which might, in another case, support a striking-off order. However, having regard to the nature of the misconduct and lack of competence found proved, she submitted that a suspension order for a period of one year would be the appropriate and proportionate sanction.

Decision and reasons on sanction

Having found Ms Cheng'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 put people receiving care at risk of suffering direct harm for charge 5 and charge 8 and indirect harm by failure to listen to instructions and requests, or responding to the needs of patients
- A pattern of misconduct over a period of time
- Sustained lack of competence over a period of time despite supervision and support, and failure to acknowledge and engage with the support that was offered
- Ms Cheng initially engaged in the beginning of the hearing, however she failed to attend and engage in the hearing, without good reason, once the NMC case was completed resulting in no opportunity for Ms Cheng's evidence to be tested
- Absence of any insight making it difficult to address her concerns.
- Failure to work collaboratively with colleagues, supervisors, managers as well as undermining junior staff and making disparaging remarks.

The panel determined that there are no mitigating circumstances.

The panel noted that Ms Cheng was unwilling to provide the panel with any information as to her current employment or training, or information that would assist in understanding of any kind of mitigation or remediation.

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

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

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

The panel considered that Ms Cheng's actions were not at the lower end of the spectrum, and it found that there remains a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Cheng's practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Ms Cheng's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). The panel was of the view that conditions can be formulated to address Ms Cheng's lack of competence. However, because of Ms Cheng's deep seated attitudinal and behavioural concerns, as well as the nature and seriousness of Ms Cheng's conduct in two clinical settings with multiple members of staff, the panel determined that a conditions of practice order would not be appropriate in the circumstances. It also noted that the Trust had provided Ms Cheng with extensive supervision and support, and Ms Cheng did not respond positively or reach the expected standards of a probationary Band 5 nurse. The panel also took into account Ms Cheng's conduct with the witnesses during the hearing when she was present where she was dismissive of their experience and expertise of other nurses and displayed unprofessional behaviour. The panel concluded that these issues, along with Ms Cheng's complete lack of insight, suggested to the panel that Ms Cheng will not engage with any conditions that may be imposed. Therefore, the panel considered that there are no relevant,

proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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

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

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

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

The panel considered that the charges found proved in relation to lack of competence and misconduct and their finding on impairment were at the serious end of the spectrum. They covered all four tenets of the nursing profession and called into question Ms Cheng's suitability to continue practising. Whilst the panel acknowledged that the risks identified could be managed by Ms Cheng being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved and likelihood of repetition. Given Ms Cheng's lack of insight, lack of remorse, together with no evidence of training and development, and with deep seated attitudinal concerns, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

The panel noted that Ms Cheng has demonstrated deep seated attitudinal concerns and a lack of willingness to address the concerns. Ms Cheng was undermining and disrespecting multiple colleagues over a period of time in two different wards.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction as a result of the gravity of Ms Cheng's misconduct.

In considering a striking-off order, the panel had regard to the NMC Guidance on '*Sanctions for the highest risk cases*' (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case*'.

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

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*

- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel had drawn the distinction between the misconduct charges and the lack of competence charges. Looking at the misconduct charges, it related to a pattern of behaviour of arguing, shouting and screaming at colleagues, and a failure to listen to a patient in pain. The panel had found that this demonstrated deep seated attitudinal concerns. Ms Cheng has not provided any evidence of insight or her willingness to remediate the concerns.

In those circumstances, the panel determined that Ms Cheng's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Cheng's actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel was mindful that in accordance with Article 29(6) of the Order, the panel may not impose a striking-off order in relation to lack of competence impairment. The panel focused its attention on the misconduct at this stage. It considered that in the circumstances with the factual finding in relation to Ms Cheng's screaming, shouting and arguing with multiple colleagues on numerous occasions, the panel was in no doubt that there are deep seated attitudinal and behavioural issues on Ms Cheng's part and that such behaviour in the workplace is incompatible with her remaining on the Register. Ms Cheng had not provided any evidence of her willingness to try and remediate the concerns, particularly in relation to the deep seated attitudinal issues.

In taking into account the guidance on imposing a striking-off order, the panel was of the view that the charges do raise questions about Ms Cheng's lack of

professionalism during the incidents in question as well as throughout the proceedings. It was of the view that public confidence could not be maintained if she was not removed from the Register as Ms Cheng has not provided any evidence that she was willing to change her behaviour and the risk of repetition remained high. Ms Cheng has not provided any evidence of insight or reflection, and it determined that there was not a realistic prospect that she will gain insight into the matters found proved even after a period of suspension.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Cheng's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Ms Cheng in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is necessary in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Cheng's own interests until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that an interim suspension order is necessary and proportionate in order to protect the public and maintain the public interest over any appeal period. She submitted that this order should be imposed for a period of 18 months so as to allow sufficient time for any appeal to take place.

Decision and reasons on interim order

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

The panel was of the view that it was necessary to protect the public and maintain public confidence, given the seriousness of the findings which led to Ms Cheng's strike off from the register. It determined that it would be inappropriate to allow Ms Cheng to practise during the appeal window given the risks identified. The panel noted that if Ms Cheng does not appeal, the interim order will fall away once the substantive striking off order takes effect after 28 days. If Ms Cheng does appeal, the interim order will remain in place to ensure ongoing public protection.

The panel therefore imposed an interim suspension order for a period of 18 months as this was a realistic time to allow for any possible appeal to be concluded.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Ms Cheng has received the decision of this hearing.

That concludes this determination.