

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

Substantive Hearing

**Wednesday 18 June 2025 – Friday 20 June 2025;
Wednesday 25 June 2025; Friday 27 June 2025;
Tuesday 12 August 2025 – Friday 15 August 2025;
Tuesday 7 April 2026 – Friday 10 April 2026;
Thursday 7 May 2026 – Friday 8 May 2026;
Thursday 21 May 2026 – Friday 22 May 2026; Thursday 28 May 2026;
Friday 3 July 2026 (in-camera); Thursday 23 July 2026 (in-camera);
Friday 31 July 2026; Thursday 27 August 2026 – Friday 28 August 2026;
Friday 25 September 2026; Friday 23 October 2026**

Virtual Hearing

Name of Registrant:	Violet Innocent Iyoki
NMC PIN:	21J1262O
Part(s) of the register:	Registered Nurse - Mental Health (RNMH) 21 October 2021
Relevant Location:	Hexham
Type of case:	Misconduct
Panel members:	Sharon Laurence (Chair, Lay member) Hlupe Perpetua Knight (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	Sharmistha Michaels (18-20, 25, 27 June 2025) Nigel Mitchell (12-15 August 2025) Breige Gilmore (7 April to 23 October 2026)
Hearings Coordinator:	Emily Mae Christie
Nursing and Midwifery Council:	Represented by Nawazish Choudhury, Case Presenter (18 June 2025 – 25 September 2026) Mohsin Malik, Case Presenter (23 October 2026)

Ms Iyoki:	Present and represented by Neomi Bennett (Equality 4 Black Nurses)
No case to answer:	Charge 5
Facts proved:	Charges 1, 2, 3, and 4
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (12 months)
Interim order:	Interim conditions of practice order (18 months)
Final outcome:	FTP impaired - COP order

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, your representative, Ms Bennett, informed the panel that you waived your right to privacy [PRIVATE].

The panel determined that this should be recorded in the determination.

Decision and reasons on application to admit hearsay evidence of Mr Anthony Saiger and Patient E

The panel heard an application made by Mr Choudhury, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 of the *'Nursing and Midwifery Council (Fitness to Practise) Rules 2004'*, as amended (the Rules), to allow the hearsay testimony of Mr Anthony Saiger and Patient E into evidence.

In relation to Mr Saiger, Mr Choudhury submitted that he does not give direct evidence in relation to charges one to five. Along with Mr Saiger's witness statement, he provides three exhibits. The first is found at Exhibit AS/04 and is a medication management policy for the hospital. The second is found at AS/05 and is the administration of medication procedure. These documents are also found at Exhibits RT/27 and RT/28, and the witness who produces them will be called to give live evidence in due course. Mr Choudhury submitted that there would be nothing untoward in those documents being introduced because they are the actual policy documents from the hospital, and there would be nothing for Mr Saiger to add in terms of those policy documents.

Mr Saiger also introduces Exhibit AS/03, the disciplinary meeting notes from 24 April 2023. In attendance at this meeting were you, your UNISON representative, Mr Saiger, and a human resources representative of the hospital. Mr Choudhury submitted that there is nothing untoward about this document as it was produced under normal circumstances where a disciplinary hearing was chaired to address the allegations.

Mr Choudhury went on to make submissions in relation to the seven principles found in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Mr Choudhury submitted that the evidence of Mr Saiger is not the sole or decisive evidence in respect of any of the charges, however, it provides important background information that speaks to the charges. He submitted that Mr Saiger is the hospital director of Cygnet Healthcare (the Hospital), did not work alongside you, nor did he directly line manage you, and given the seniority of his position, there would be no reason for Mr Saiger to fabricate the evidence within his witness statement.

Mr Choudhury submitted that the charges are serious and would have a negative impact on your career were adverse findings made. However, if Mr Saiger's evidence were to be admitted, it would not be to your detriment as there are other witnesses being called to give live evidence, and they can be challenged on your behalf.

Mr Choudhury told the panel that the reason for Mr Saiger's non-attendance is due to a pre-booked holiday. He submitted that witnesses are warned to attend from 09:00, and considering the time difference, it would be inconvenient for Mr Saiger to make himself available from 04:00 whilst he is on holiday. He submitted that the NMC has made reasonable steps to secure Mr Saiger's attendance. Mr Choudhury referred the panel to an email dated 13 March 2025, where the NMC requested Mr Saiger to attend this hearing. This request was followed up by email on 13 March 2025, and 19 May 2025 where the hearing dates were confirmed. In response to the email on 19 May 2025, Mr Saiger informed the NMC that he would be away on holiday in the USA between 14 and 28 June 2025, and he would not be able to attend. Mr Choudhury submitted that this was a pre-booked holiday, and evidence was provided demonstrating his holiday was booked in November 2024.

Mr Choudhury submitted that you were informed in good time that this hearsay application would be made in relation to Mr Saiger. He referred the panel to an email dated 22 May 2025, when the NMC informed your representatives that Mr Saiger was unavailable and

asked if evidence could be read. On 2 June 2025, the NMC emailed your representatives requesting an update on your position regarding Mr Saiger's evidence. Further, on 16 June 2025, the NMC informed your representative that it would be making a hearsay application for Mr Saiger, and in a second email on this date, it attached the hearsay bundle. On 17 June 2025, the NMC sent another email confirming that a hearsay application would be made.

In respect of Mr Saiger, Mr Choudhury submitted that it would be fair and relevant for the witness statement to be introduced as hearsay evidence.

In relation to Patient E, Mr Choudhury informed the panel that the evidence of Patient E could be found in the following documents:

- Witness Statement of Ms Amy Dixon, paragraphs 9 to 12;
- Exhibits AD/03, and AD/04;
- Witness Statement of Ms Kelly Brown, paragraphs 4-6;
- Witness Statement of Mr Saiger, paragraph 5(b);
- Exhibit AS/03;
- Witness Statement of Ms Rachael Thompson, paragraphs 19 to 22; and
- Exhibits RT/16, RT/18, RT/19, RT/21, and RT/26.

Mr Choudhury submitted that Patient E's evidence is not the sole or decisive evidence of the charges. He submitted that there is no evidence to suggest that Patient E had a reason to fabricate their evidence, and there would be an opportunity to challenge the substance of their evidence, as Ms Dixon and Ms Thompson can be cross-examined on this.

Concerning the reason for Patient E's non-attendance, Mr Choudhury submitted that Patient E had not given consent for the Hospital to disclose their contact details to the NMC, so any reason for non-attendance cannot be considered. Additionally, he submitted

that, following his previous point, the NMC made as many reasonable steps as possible to engage Patient E.

Mr Choudhury submitted that you were only given notice of the hearsay application regarding Patient E on 17 June 2025, one day before this hearing started. He submitted that this is firsthand hearsay, and Ms Dixon and Ms Thompson can speak to this. He submitted that it would be fair and relevant to admit this as hearsay evidence.

Ms Bennett objected to the NMC's application to admit the witness statement of Mr Saiger and the evidence of Patient E as hearsay evidence.

Ms Bennett submitted that Mr Saiger is central to the case, and without live evidence, their statement cannot be challenged. Your challenge to Mr Saiger's evidence is that he chaired the disciplinary hearing leading to your dismissal, authored the disciplinary outcome letter, and referred the case to the NMC, which Ms Bennett submitted was retaliatory, with fabricated allegations in response to your protected disclosures regarding his conduct.

Ms Bennett explained why you oppose the application and referred the panel to your email, dated 27 January 2023, in which you expressed serious concerns about Mr Saiger's conduct. You stated that Mr Saiger made racially charged and defamatory comments, calling you a '*dangerous nurse who can administer medication to kill a patient*,' which Ms Bennett noted was inflammatory and racially coded, particularly since there has never been an incident in which you harmed a patient. Additionally, your email addressed errors made by other white nurses that were overlooked, while the label '*dangerous*' was never applied to them.

In this email, you also explained that you were blamed for a zopiclone medication error, which had nothing to do with you, and your only involvement was signing the book after the fact, which is standard practice. However, you alone were confronted, supervised, and threatened with disciplinary action. Ms Bennett clarified that the complaints in the email

demonstrate a broader pattern of being the only black international nurse remaining from her cohort, experiencing ongoing marginalisation and unequal scrutiny.

Ms Bennett submitted that Mr Saiger's witness statement must be tested through cross-examination, as you were scapegoated for a medication error you did not cause. She stated that Mr Saiger made discriminatory comments by calling you a '*dangerous nurse*'. Ms Bennett told the panel that Mr Saiger threatened your career and to report you to the Home Office. She argued that without cross-examination, you would lose the chance to challenge a witness whose motives, credibility, and impact on your employment and NMC referral are questionable. Additionally, she referenced Article 6 of the European Convention on Human Rights, highlighting your right to a fair hearing, which includes the right to challenge a witness against you when their credibility and motives are in question.

Ms Bennett submitted that the NMC's claims regarding Mr Saiger's pre-booked holiday do not excuse avoiding cross-examination in a fitness to practise hearing. She emphasised that Mr Saiger is not a minor witness and this hearing addresses procedural injustice, not just inconvenience. She asserted that time zones and holidays cannot bypass fundamental rights, and if the NMC considered Mr Saiger's evidence crucial, it should have scheduled the hearing accordingly.

Ms Bennett also countered the NMC's claims that Mr Saiger had no motive to fabricate evidence, stating that it is disputed because he made immigration threats and victimised her as a black nurse within his hierarchy. She argued that Mr Saiger's seniority is not a shield, but a risk factor. Furthermore, she stated that this issue is not about a job title, but rather involves Mr Saiger's conduct, which included weaponising the disciplinary process for his protection and using the NMC for retaliation.

Ms Bennett submitted that although Mr Saiger did not witness the clinical event, his referral and leadership of the disciplinary hearing laid the groundwork for the NMC's involvement in these allegations. She noted that Mr Saiger introduced key documents, including the disciplinary hearing notes, and that his evidence is crucial to the misconduct

narrative. Ms Bennett then addressed the Thorneycroft principles. While the NMC contends that Mr Saiger's evidence is not sole and decisive, she argued it is foundational, influencing internal decision-making and the referral, rendering it critical to the misconduct narrative.

Regarding the challenge to Mr Saiger's statement, she emphasised your disputes about the fairness of his disciplinary hearing, the legitimacy of the referral, and the truthfulness of the disciplinary outcome. She argued that Mr Saiger's evidence is not mere context; it reflects a contested and potentially fabricated process, with a clear motive to fabricate because a protected disclosure had just been made against him. The risk of reputational damage or scrutiny was high, making retaliation plausible and supported by the events' timing. The serious nature of the charges is significant. They could result in the loss of a career, raising, not lowering the threshold for procedural fairness. As charges become more serious, the need for cross-examination increases. Ms Bennett referred the panel to the case of *Ogbonna v NMC* [2010] EWHC 272 (Admin). In light of this, she submitted that the panel must refuse the NMC's hearsay application.

In relation to the NMC's application to admit the hearsay evidence of Patient E, Ms Bennett submitted that Patient E is the individual the NMC allege that you nearly administered the wrong medication to, however, there is no direct evidence of this.

She submitted that Patient E has withdrawn consent to give evidence, has not provided a signed statement, and did not authorise the NMC to rely on their account. They are the only central witness who can confirm or deny what happened. The remaining information consists of second-hand interpretations of what Patient E allegedly said, as recounted by Ms Dixon, Ms Thompson, and disciplinary notes from Mr Saiger, who is also absent. She referred the panel to Rule 31, arguing that this evidence is double hearsay and admitting it would be manifestly unfair. Patient E cannot be questioned, their credibility cannot be tested, and their comments cannot be clarified. Ms. Bennett submitted that the allegation is serious, contributing to your dismissal, leading to supervision, and now appearing before the panel without proper evidence.

In addressing the Thorneycroft principles, Ms Bennett submitted that it is decisive since the allegation relies solely on Patient E's statements, lacking contemporaneous complaints, clinical escalation, or corroborating documentation. Without Patient E, the charge collapses. She contended the allegation is contested, being untrue, unreliable, and procedurally unjust, as its source cannot be challenged. The NMC claims there's no reason Patient E would fabricate evidence; however, this cannot be tested, leaving open the possibility of misunderstanding.

Ms Bennett informed the panel that you were not aware of the hearsay application regarding Patient E until 17 June 2025, just one day before this hearing started. She submitted that this left inadequate time to prepare her submissions. She invited the panel to reject the NMC's application to admit the hearsay evidence from Patient E, deeming it unfair to you. If the panel considers admitting it, it should give it no weight due to its untested and double hearsay nature. She also requested that the panel formally dismiss the allegation regarding Patient E since there is no direct evidence, and the source of the allegation is absent.

Ms Bennett closed her submissions by inviting the panel to consider the following case law: *Professional Standards Authority v NMC* [2017] EWHC 70 (Admin); *El Karout v NMC* [2019] EWHC 28 (Admin); *Musonza v NMC* [2012] EWHC 1440 (Admin); and *Suddock v NMC* [2016] (High Court).

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

Mr Saiger

The panel first considered the application to admit Mr Saiger's witness statement as hearsay evidence. The panel determined that Mr Saiger's witness statement is relevant

but not the sole or decisive evidence supporting the charges. The panel noted that Mr Saiger bases his evidence on what was reported to him, as he was not present during the alleged incidents and did not decide what would happen with the patients.

The panel acknowledged the concerns raised by Ms Bennett about the alleged wider systemic issues surrounding Mr Saiger, including alleged racism and bias, as well as the challenge to Mr Saiger's credibility. Although it considered that Mr Saiger's evidence could not be tested, this alone is not sufficient to deny the application to admit hearsay. The panel noted that four witnesses would be giving live evidence and you would be able to cross-examine them.

The panel also took into account that the NMC could have done more to secure Mr Saiger's attendance, given he is on holiday and the NMC did not ask if Mr Saiger could attend remotely at a suitable time. However, the panel noted the legal advice, namely that this is not a reason for his evidence to be thrown out.

The panel was mindful that the charge is serious and if found proved, could significantly impact your career. Furthermore, the panel determined that you had received notice of the NMC's intention to make a hearsay application for Mr Saiger's witness statement to the panel since 22 May 2025.

In light of this, the panel decided that it would be fair to accept Mr Saiger's witness statement. It therefore determined to admit this into evidence as hearsay but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Patient E

The panel proceeded to consider the application to admit the evidence of Patient E as hearsay. It determined that Patient E's evidence is relevant, but not the sole or decisive evidence pertaining to the charge. The panel also took into account additional evidence,

including CCTV footage and the live evidence of Ms Dixon and Ms Brown, which would be presented in due course. It noted that these witnesses may be challenged, and the CCTV can be scrutinised.

It considered whether Patient E would have any reason to fabricate their evidence and concluded that there is no evidence either way. Furthermore, there could be many reasons for Patient E not giving consent for their details to be passed on to the NMC, and it considered that the NMC took reasonable steps to attempt to secure Patient E as a witness. The panel also noted that Patient E is vulnerable and that compelling them to attend as a witness could have had a detrimental impact on them.

The panel also considered that Patient E did not want to make a complaint, and it was Ms Dixon who made the complaint. Subsequently, the panel noted that Ms Dixon would be giving live evidence and could be challenged on this issue.

The panel was mindful that the charge is serious and if found proved, could significantly impact your career. The panel was mindful of the limited time you and Ms Bennett had to prepare for the hearsay application of Patient E having received notice of this the day before this hearing on 17 June 2025.

In all the circumstances, the panel determined that it would be fair and relevant to accept the evidence of Patient E as hearsay. It therefore determined to admit this into evidence as hearsay but noted that it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse:

1. On 12 June 2022 administered the incorrect dose of chlordiazepoxide to Patient A;
[Proved]

2. On 12 August 2022 dispensed approximately 20mls of clozapine for Patient D instead of the prescribed 4ml dose; **[Proved]**
3. On 10 January 2023 attempted to administer the wrong medication to Patient E and/or dispensed the medication using another patient's pot; **[Proved]**
4. On 10 January 2023 dispensed a 500mg co-amoxiclav (antibiotic) tablet that belonged to another patient instead of Patient G's prescribed 500mg amoxicillin; **[Proved]**
5. On 10 January 2023 dispensed zuclopenthixol for Patient H which was not prescribed to start until several days later. **[No case to answer]**

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

Background

The charges arose while you were employed by the Hospital, where you worked as a registered nurse from October 2021 until April 2023. The NMC received a referral from the hospital on 24 July 2023. It is alleged that on 12 June 2022, you were involved in an incident where incorrect medication was administered to a patient, and on 12 August 2022, it is alleged that you had a near miss in dispensing an incorrect dose of medication.

You received support to improve your practice through Cygnet's capability process and increased supervision. However, following the successful completion of the capability process, it is alleged that you made three similar errors on the night shift of 10 January 2023.

Following these alleged incidents, the Hospital conducted an internal investigation. At the conclusion of this investigation, you were invited to attend a disciplinary hearing on 24

April 2023. You were subsequently dismissed from the Hospital, effective from 25 April 2023, as confirmed on 26 April 2023.

Decision and reasons on application for adjournment

The panel heard an application from Mr Choudhury, under Rule 32, to adjourn proceedings until an agreed resuming date in order to call Mr Saiger to give oral evidence.

Mr Choudhury submitted that this application arises from the final answers given by Mr Jamie Kirk during Ms Bennett's re-examination, where he stated that Mr Saiger had said something along the lines of *'this person is now going to play the race card'* or words to that effect. Given that you are alleging racism and discrimination, Mr Choudhury submitted that these matters should be put to Mr Saiger, as he may wish to comment on or respond to the allegations.

Mr Choudhury submitted that granting an adjournment would serve the interests of justice, particularly as the case would have been part-heard in any event. He submitted that it would be fair and proportionate to grant this application, allowing the NMC to use the additional time to arrange for Mr Saiger's live evidence.

Ms Bennett submitted that in light of your objection to admitting the witness statement and exhibits of Mr Saiger as hearsay, she agrees with the application. Ms Bennett invited the panel to grant this adjournment in order to facilitate the live evidence of Mr Saiger.

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

The panel noted that this situation had arisen through no fault of either party.

The panel considered the general need for expedition in the conduct of fitness to practise proceedings, your interests, and the wider public interest. However, the panel determined that, in all the circumstances, given the case would be part-heard today an adjournment

would not cause any significant delays or prejudice to either party. If the application were granted, the remaining witness from the NMC would be Mr Saiger. The panel acknowledged that Mr Saiger's inability to give live evidence was solely due to his holiday. Considering that the case is scheduled to resume on a future date, it is possible that Mr Saiger may be available at that time, as his return from holiday is expected on 28 June 2025. The panel was of the view that Mr Saiger should be afforded the opportunity to respond to the allegations.

In light of this, the panel was of the view that, given the parties are entitled to a fair hearing and they have both agreed to the adjournment, it would be in the interests of justice and fairness to grant this application. Accordingly, the panel granted Mr Choudhury's request for an adjournment.

Decision and reasons for admitting Exhibit 11

During the cross-examination of Mr Saiger, an application was made by Ms Bennett to re-admit a bundle that had previously been received in error. Ms Bennett submitted that the bundle should be re-admitted as its contents were relevant to the matters being put to the witness. Mr Choudhury submitted that it is likely the bundle is relevant to your case and did not oppose this application.

Having considered the submissions of Ms Bennett and Mr Choudhury, the panel determined that the bundle is relevant to your case and therefore admitted it into evidence as Exhibit 11.

Decision and reasons on application of no case to answer

Following the conclusion of the NMC case, Ms Bennett made an application, pursuant to Rule 24(7) of the Rules, that there is no case to answer in respect of the '*Zopiclone Double-Dose Incident*', and the '*Patient E misidentification incident*' as well as the remaining charges. She submitted there is no real prospect of proving the facts or those

facts amounting to misconduct or current impairment. She provided the panel with written and oral submissions.

Ms Bennett referred the panel to the cases of *Ogbonna v NMC* [2010] EWCA Civ 1216, and *Suddock v The Nursing and Midwifery Council* [2015] EWHC 3612 (Admin) and submitted that where the investigative process is flawed, procedurally unfair, or the evidence is unreliable, the fair course is to halt these proceedings on the grounds that there is no case to answer on all charges. She submitted that in this case, the evidence has demonstrated that the referral process has been tainted by racial bias, exclusion, and deliberate omission of a protected act, which has made some of the allegations unsafe and others substantially weakened.

Ms Bennett submitted that the panel has heard that the only black manager was excluded from reviewing key CCTV footage without any operational reason, and that during the Hospital's investigation, no black or internationally educated colleagues were consulted; and that all witness accounts came from the same '*white management clique*'. She submitted that the Hospital's referral to the NMC included your passport, visa, birth certificate, police certificate, and TB records, which are irrelevant to the identified clinical concerns. Ms Bennett submitted that this framed you through a racial lens, as these documents would have never existed in the same form as a white British nurse's file. Further, she submitted that the referral form, as completed by Mr Saiger, stated 'No' in response to a question regarding if you had raised any complaints of bullying/harassment, which you had on 27 January 2023. Ms Bennett submitted that this was a protected act under section 27 of the Equality Act 2010, and the act of doing this has breached the fairness of each of the incidents charged in this case. Ms Bennett submitted that where the investigative process itself is discriminatory and procedurally flawed, the resulting evidence is inherently unreliable and incapable of meeting the Rule 24(7) threshold.

In relation to the Zopiclone incident, Ms Bennett submitted that in cross-examination, Mr Saiger accepted that the dose was administered by a different nurse and not yourself. However, this was omitted from the NMC referral. She submitted that referring you to the

NMC for something you did not do is an example of a charge with no evidential foundation.

In relation to the Patient E incident, Ms Bennett submitted that Patient E never named you and only referred to '*the dark-haired lady*'. She submitted that, as seen on the CCTV, other staff members with dark hair were on duty at the time. Ms Bennett submitted that Patient E had a history of making false allegations against other black nurses, and that there is no complaint or statement from Patient E. She submitted that the CCTV footage was reviewed selectively, with a black manager excluded from viewing it.

She submitted that the charges involving the '*zopiclone incident*' and Patient E should be dismissed, as there is no evidence that these incidents were investigated fairly as other white nurses were making the same errors but were not being referred to the NMC. Ms Bennett submitted that the weight of the remaining charges is seriously compromised as they all come from the same biased investigation that excluded black colleagues, relied on a closed clique, and omitted the protected act.

Mr Choudhury invited the panel to dismiss this application on the basis that it lacks merit. He submitted that the Zopiclone incident did not form part of the charges that the panel is required to determine, nor did it formally constitute part of the case presented to the panel by the NMC. He also submitted that charge 3 has been sufficiently pleaded and should be deliberated in the normal way. Mr Choudhury explained that he would address the evidence on all of the charges.

Mr Choudhury reminded the panel of the legal test found in the case of *R v Galbraith* [1981] 1 WLR 1039 and submitted that this test is meant for inherently weak or vague cases, which does not apply to this case.

Mr Choudhury went through each of the charges, highlighting the relevant evidence that speaks to each charge. He submitted that one of the key issues for the panel to consider is in relation to what, if any training, did you receive.

Mr Choudhury went through the NMC exhibit bundle, highlighting: your supervision records; your medication assessment records; and your controlled drugs assessment, dated 22 November 2022, which was during the time you were on a 12-week capability plan. Mr Choudhury submitted that he took the panel to these documents in detail as Ms Bennett has submitted that you are a newly qualified nurse and [PRIVATE], and therefore, these documents are something the panel should take into account when considering the seriousness, merits of the evidence, misconduct, and impairment when considering the credibility of this charge.

In his submissions regarding you being properly trained, Mr Choudhury referred the panel to the evidence of Mr Saiger, where these matters were addressed. Mr Choudhury submitted that you had the proper training, completed your preceptorship, passed the OSCE exams, obtained your NMC PIN, and all of the evidence the panel has heard throughout this case. He submitted that the suggestions made regarding you being an international nurse who recently qualified and [PRIVATE] is relevant context to misconduct and impairment, however, it is not a credible basis for the panel to find there is no case to answer.

Mr Choudhury moved on to address the panel on the documentary evidence and the quality of it that is before the panel for the purposes of the *Galbraith* test. He submitted that the NMC has produced a lengthy exhibit bundle to complement the witness statements in this case. He submitted that the exhibits are contemporaneous and speak to every charge. He outlined each of the documents before the panel, as well as referring the panel to the relevant page number from the transcript bundle of the previous sitting days, which contains the oral evidence of Witnesses 1, 2, 3, and 4.

Mr Choudhury submitted that all five charges taken both individually and cumulatively cross the threshold of seriousness, and that these are triable issues that the panel must consider. He submitted that there have been no significant inconsistencies arising from the cross-examination of the NMC's witnesses that would meet the *Galbraith* test.

Mr Choudhury submitted that whilst Ms Bennett's submissions surrounding racial bias should be taken seriously, these allegations have been unchallenged and ought to be an issue that the panel should test when making its decision on the facts of this case. He submitted that the panel are yet to hear your case and test your version of events.

In relation to Ms Bennett's written submissions, Mr Choudhury submitted that these mostly go towards the issues of misconduct and impairment and are not relevant for the purposes of the no case to answer application. He submitted that when someone alleges racism, there must be some evidence to support this; however, when you had been asked to do so by the hospital, you did not provide this, which caused difficulty for the Hospital to investigate this any further.

In conclusion to his submissions, Mr Choudhury invited the panel to dismiss this application on the basis that the evidence in this case passes the threshold and the panel should consider the charges in the normal way following the conclusion of the case.

Ms Bennett was given the opportunity to respond to Mr Choudhury's submissions. She submitted that this case is not about a pattern of genuine clinical concerns, but it is about a black, internationally educated nurse, who was the only one on her ward being overworked, underpaid, excluded from a fair investigation, and escalated to the NMC for matters that her white colleagues were either supported through or never accused of at all.

Ms Bennett reminded the panel that under 24(7) of the Rules, it must dismiss any charge where the evidence is too weak, speculative or tainted to be safely relied upon. She made submissions regarding your allegations of racial discrimination. Ms Bennett referred the panel to section 13 of the Equality Act 2010, and how racial bias from the witnesses directly impacts their credibility.

Ms Bennett reiterated her points made in her initial submissions regarding the circumstances surrounding each of the charges and how the investigation was conducted

in a biased manner, excluding black witnesses, and the evidence of the charges was decided upon by a *'narrow group of white senior staff'*.

Ms Bennett submitted that the charges are founded on inconsistencies, racialised assumptions and a process that excluded critical witnesses who may have told a different story, and that the racial imbalance would materially affect the panel's ability to make a fair and proportionate decision under Rule 24. In conclusion, Ms Bennett invited the panel to dismiss all charges.

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

The panel took account of the submissions of Ms Bennett and Mr Choudhury and the principles derived from *R v Galbraith* [1981]. The panel had sight of the NMC guidance, which stated:

'There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:

- 1. no evidence*
- 2. some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.*

The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account.'

The panel noted the following from *Galbraith*:

'(1) If there is no evidence that the crime alleged has been committed by the defendant there is no difficulty - the judge will stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.

b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'

In reaching its decision, the panel made an initial assessment of all the NMC evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer. It reminded itself that, at this stage, it was not making any findings of facts.

The panel took into account Ms Bennett's submissions regarding this case being racially motivated. However, the panel was of the view, that at this stage, there has been insufficient evidence presented before it to suggest that racial bias influenced the Hospital's decision to refer you to the NMC.

Charge 1

‘On 12 June 2022 administered the incorrect dose of chlordiazepoxide to Patient A’

The panel considered Exhibit RT/11, a BESS scoring report and your reflection, dated 22 July 2022. In your reflection, you admit to administering the incorrect amount of medication to Patient A and reflect on this medication error.

It also took into account the witness statement and oral evidence of Mr Kirk, who explained that you were the only nurse with the keys to the medication clinic and that when he checked the tablets, there was one less than there should have been. Other evidence before the panel includes Patient A’s Kardex, your training records, and your supervision records.

The panel was therefore satisfied that it had been presented with sufficient evidence to find the facts proved. It therefore concluded that there is a case to answer in relation to this charge.

Further, in consideration of rule 24(8), the panel determined that if this charge was found proved, there would be sufficient evidence to support a finding of impairment. Although administering an incorrect dose of chlordiazepoxide, on this occasion, did not cause Patient A serious harm, it may amount to serious misconduct. Therefore, the panel concluded that there is a case to answer in relation to this charge.

Charge 2

‘On 12 August 2022 dispensed approximately 20mls of clozapine for Patient D instead of the prescribed 4ml dose’

The panel took into account the witness statement and oral evidence of Ms Dixon, who has been a direct eyewitness to you allegedly administering 20mls of Clozapine into a measuring pot, rather than 4mls into an oral syringe.

In her oral evidence, Mr Saiger explained:

“In terms of side effects, it could be changes to the heart rhythm, such as tachycardia, changes to blood pressure, severe Constipation. Like I said, it's a very dangerous medication to overdose on.”

Similarly, Mr Saiger explained:

“Clozapine is a dangerous medication if overdosed, it can drop the white cell count and kill somebody pretty quickly.”

It considered the exhibits which included Patient D's Kardex, the Hospital's medication administration policy, and your training records. The panel also took into account the effects of an alleged overdose of clozapine and recalled evidence from Ms Dixon, 2, 4, and 5, who had all agreed that an overdose of this medication could cause serious harm to a patient.

The panel was therefore satisfied that it had been presented with sufficient evidence to find the facts proved. It therefore concluded that there is a case to answer in relation to this charge.

Further, in consideration of rule 24(8), the panel determined that if this charge was found proved, there would be sufficient evidence to support a finding of impairment. The panel determined that administering an overdose of clozapine could have caused serious harm, which could amount to serious misconduct. Therefore, the panel concluded that there is a case to answer in relation to this charge.

Charge 3

'On 10 January 2023 attempted to administer the wrong medication to Patient E and/or dispensed the medication using another patient's pot'

The panel considered the investigation meeting transcript dated 7 February 2023, and 15 February 2023. In the transcript you make an admission when you state the following:

'SHE ASKED WHY ANOTHER PATIENTS INITIALS WERE ON THE POT AFTER TAKING 2 TABLETS. I EXPLAINED THE POT WAS USED FOR A PREVIOUS PATIENT AND IN A RUSH I USED THE SAME POT'

The panel also took into account the CCTV evidence. This shows that Patient E takes the medication from the pot and then asks you something about the pot. It can be inferred from the CCTV that this was the correct medication, as the patient is seen taking a liquid medication, and an inhaler, which are both corroborated on Patient E's Kardex.

The panel considered the exhibits which includes the incident report form written by Ms Thompson, Patient E's Kardex, Patient F's Kardex, the documentation of the incident, your training records, and the Hospital's medication policies.

The panel also took into account the evidence of Witnesses 2, 3, and 5, who all spoke to the risks of dispensing medication in another patient's pot, and that management at the Hospital had sent out staff communications advising them against adopting this unsafe practice.

The panel was therefore satisfied that it had been presented with sufficient evidence to find the facts proved. It therefore concluded that there is a case to answer in relation to this charge.

Further, in consideration of rule 24(8), the panel determined that if this charge was found proved, there would be sufficient evidence to support a finding of impairment. The panel determined that attempting to administer the wrong medication and/or dispensing medication using another patient's pot could amount to serious misconduct. The panel heard that this occurred during COVID-19, and therefore, the risk of infection was increased. Therefore, the panel concluded that there is a case to answer in relation to this charge.

Charge 4

'On 10 January 2023 dispensed a 500mg co-amoxiclav (antibiotic) tablet that belonged to another patient instead of Patient G's prescribed 500mg amoxicillin'

The panel took into account the disciplinary meeting notes dated 24 April 2023, where you admitted to dispensing the incorrect medication but not administering it. It also considered the evidence of Ms Brown, who had completed the exhibited incident report. Additionally, the panel took into account that you admitted that you had not followed the Hospital's medication policy.

The panel was therefore satisfied that it had been presented with sufficient evidence to find the facts proved. It therefore concluded that there is a case to answer in relation to this charge.

Further, in consideration of rule 24(8), the panel determined that if this charge was found proved, there would be sufficient evidence to support a finding of impairment. The panel determined that dispensing an incorrect antibiotic to a patient may amount to serious misconduct. Therefore, the panel concluded that there is a case to answer in relation to this charge.

Charge 5

‘On 10 January 2023 dispensed zuclopenthixol for Patient H which was not prescribed to start until several days later.’

The panel considered what evidence it had in relation to this charge. It noted that Witnesses 2 and 3 mentioned this incident in their oral evidence, however, neither witness went into any detail of the incident, rather discussed why the medication was to be tapered. The panel also took into account that it had not been provided with any documentary evidence apart from a minor comment about this allegation in the investigation meeting notes, dated 23 January 2023, between Witnesses 2 and 3. Patient H's Kardex has not been identified, nor has their Kardex been presented to the panel to demonstrate their prescribed medication, and there is no incident report form to prove that this incident occurred.

Taking account of all the information presented by the NMC, the panel was of the view that there is insufficient evidence supporting this charge. Therefore, you have no case to answer on this charge.

Decision and reasons on facts

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

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

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

- Ms Amy Dixon: A registered nurse at the Hospital who assisted you with dispensing medication on 12 August 2022 and reported the incident involving Patient E on 10 January 2023.
- Ms Rachael Thompson: A registered nurse and your line manager at the Hospital, who completed the internal investigation at the material time.
- Ms Kelly Brown: A registered nurse and the nurse in charge at the Hospital during the night shift of 10 January 2023.
- Mr Jamie Kirk: A registered nurse at the Hospital and your supervisor at the material time, who reported the incident on 12 June 2022.
- Mr Anthony Saiger: A registered nurse and manager of the Hospital who conducted the disciplinary process at the material time.

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

- Mr Emeka Iregbulem: A registered mental health nurse who worked at the Hospital at the material time.

- Dr Franklin Eleazu: A specialist psychiatrist who worked at the Hospital at the material time.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Ms Bennett.

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

Charge 1

‘That you, a registered nurse, on 12 June 2022 administered the incorrect dose of chlordiazepoxide to Patient A.’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of you, Mr Kirk, and Ms Thompson.

The panel first considered the evidence from Mr Kirk. It found that Mr Kirk's evidence was reliable and consistent throughout both his written statements and his oral evidence.

The panel took into account how, in his witness statement, Mr Kirk sets out how the allegation came to light:

‘I worked the morning shift on 13 June 2022 and counted Patient A’s chlordiazepoxide medication before dispensing it. I noticed that there was one tablet less than what should have been there and that Ms Iyoki

administered Patient A's last dose during the night shift on 12 June 2022. Ms Lyoki did not check Patient A's titration chart to confirm the reduced dose of chlordiazepoxide that she should have administered. When I spoke to Ms Lyoki about it she stated that it was an accident. Patient A did not suffer any harm because of Ms Lyoki's error. I do not think that Ms Lyoki did this maliciously, it was an accident.'

The panel noted that Mr Kirk explained you were the only person with the keys to the clinic room on 12 June 2022. During cross-examination, Ms Bennett asked Mr Kirk whether the titration chart had recently been updated, which could be why the Kardex says '*please see the titration chart*'. Although Mr Kirk was not able to say with certainty whether you did or did not have access to the titration chart at the material time, he explained that if there was no titration chart, or the wrong titration chart was attached to the Kardex, there would have been more errors from other colleagues administering this medication, making the same mistake. Mr Kirk also explained that he discovered this error the following morning while checking the control book, noticing that there was one less tablet. Ms Bennett challenged Mr Kirk by asking him if his conclusions involved a degree of assumption, to which Mr Kirk explained that it would be unlikely that this medication error was not caused by you due to the control book showing a missing medication. He said that you were the only person with the keys to the clinic room and had signed the Kardex to indicate that you had administered the medication, so he did not think it was an assumption.

The panel also took into account the BESS scoring record, which was completed and signed by you and Mr Kirk on 17 June 2022. When asked about this in oral evidence, Mr Kirk was of the view that you accepted accountability for the incident as charged.

In the Managerial supervision record form dated 22 September 2022, it is documented that you and Mr Kirk discussed your medication errors. The form states '*I feel like this because of the errors I have made. The errors were not intentional, I have no confidence now.*' Further down the form, it is stated that you felt '*bad that these happened*' and that you stated that '*they were not intentional.*' The panel was of the view that this document

demonstrates that you were aware of making medication errors and that, had you not made this error, you would not have raised it in your supervision meeting.

The panel went on to consider Ms Thompson's evidence. Although Ms Thompson was not a direct witness to this charge, the panel found that she gave credible and consistent evidence as the ward manager who spoke with you about this incident on 17 June 2022.

In her witness statement, Ms Thompson explained:

'...I had a supervision meeting with Ms Lyoki to discuss the incident that took place on 12 June 2023 (sic). During the meeting Ms Lyoki was upset and remorseful and confirmed that she had administered Patient A the incorrect dose of chlordiazepoxide and confirmed that she had not read the special instructions on Patient A's Kardex.'

The panel was of the view that this was another instance demonstrating that you were taking accountability for the incident.

The panel took into account the supervision note dated 19 July 2022. It noted that although this evidence is hearsay about what was said between you and your supervisor, it corroborates the evidence of Mr Kirk and Ms Thompson, in that you took accountability for the incident.

The panel then took into account your evidence.

In your oral evidence, you explained that you had not received a proper handover and could not see a new titration chart; you only saw the old one, which you had used. You explained that you did not make an error in administering 10mg of chlordiazepoxide to Patient A because this was the dose on the titration chart, which you genuinely believed was the correct chart. You told the panel that the following day, when Mr Kirk drew your attention to administering the wrong dose to Patient A, you and Mr Kirk went to get the

correct titration chart, which was in the doctor's office. The panel noted that this conversation and the action to obtain the correct titration chart were never put to Mr Kirk or Ms Thompson in cross-examination.

In cross-examination of your evidence, you accepted that you had the keys to the clinic room and that you had a good working relationship with Mr Kirk. When asked about your admissions in the BESS scoring record, Ms Thompson's account of your conversation on 22 June 2022, and the supervision record, dated 19 July 2022, you explained that you were taking accountability; however, you wholly denied that you made any error.

In light of all the evidence before it, the panel accepted Mr Kirk's evidence as credible, consistent throughout, and corroborated by Ms Thompson's evidence. It found that your evidence was inconsistent with the other evidence before it. In all the circumstances, the panel found that, on the balance of probabilities, on 12 June 2022, you administered the incorrect dose of chlordiazepoxide to Patient A. Therefore, the panel found charge 1 proved.

Charge 2

'That you, a registered nurse, on 12 August 2022 dispensed approximately 20mls of clozapine for Patient D instead of the prescribed 4ml dose'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of you, Ms Dixon, Ms Thompson, and Mr Saiger.

The panel first considered the evidence of Ms Dixon. It found that Mr Dixon's evidence was reliable and consistent throughout both her written statements and oral evidence.

The panel took into account Ms Dixon's internal statement, which she made on 12 August 2022. It stated:

'At 09:45 staff nurses [You] and [Ms Dixon] were present in the medication clinic on Fisher ward. Staff nurse [You] was preparing morning medication for patient , [Ms Dixon] observed VI pour 20ml of liquid Denzapine (50mg/1ml). The correct dose is 4ml. [Ms Dixon] raised error with [You] who stated it was 20ml and pointed to the kardex stating 200mg. [Ms Dixon] explained drug calculation although VI did not appear to understand. [Ms Dixon] administered correct dose of liquid Denzapine to patient (4ml). Clinical manager DG notified by [Ms Dixon].'

The panel was of the view that this statement reflected Ms Dixon's account in her witness statement. In her oral evidence, Ms Dixon explained that she was in the medication clinic at the same time as you, administering another patient's medication, and she was not there to supervise you. She also explained that the reason she got involved was that she could see you pouring clozapine into a pot, and it looked like there was too much there. When asked further about this, Ms Dixon explained that it was not possible to measure a 4ml dosage of liquid medication in a pot, as the measurements on the pots start at 5mls. She explained that a syringe should be used to measure out 4mls. The panel noted that this was corroborated by the oral evidence of Ms Thompson, who also explained that the smallest measurement graduation is 5mls, so it would be very difficult to pour the liquid medication from the bottle into a pot accurately.

In considering the evidence of Ms Thompson, the panel also took into account how, in oral evidence, Ms Thompson explained that the procedure on the administration of medication states that only syringes should be used to dispense liquid medication and referred the panel to paragraph 2.27 of that policy. The panel reviewed this procedure, noting that it was called the *'Administration of Medication Procedure'*, issued in December 2020, and considered that at paragraph 2.27, it is stated:

‘2.27 If medication is in liquid form this should be offered to the individual in a dispensing pot to ensure the correct dosage. Oral syringes should be used to measure liquids. IV syringes should not be used for measuring oral liquids) unless they are disposed of immediately after measuring the dose.’

In light of this, the panel found that the evidence of Ms Dixon and Ms Thompson, that to measure out liquid medication you should have been using a syringe, was corroborated by the Hospital’s Administration of Medication Procedure.

The panel also considered the Hospital’s Medication Management Policy, issued June 2021, which explains the following at paragraphs 6.33 and 6.34:

‘6.33. For the purposes of this policy Cygnet, in line with the BESS tool, have defined a medication error as medication:

- ...
- *Wrong dose.*
- ...

6.34 Staff are to follow the medication error procedure for above medication errors and also clerical/dispensing errors and near misses.’

The panel found that, even though you had not administered the medication and were only in the process of dispensing it, per the hospital's medication management policy, this would have been considered a medication error as a dispensing error, which, per the policy, should be treated the same.

The panel then took into account your evidence. It noted that you explained that on the day of this alleged incident, you told the Hospital you were unwell and could not come in; however, you were made to come in anyway. You explained that your eyes were hurting

and that you couldn't see clearly. The panel noted that this was consistent with Ms Dixon's witness statement and oral evidence, in which she confirmed that you did say this.

The panel took into account that you explained you were in the process of dispensing the medication and measuring it in a cup when Ms Dixon stopped you to say it was wrong and that you should have been using a syringe. You explained that you were using a 5ml cup to measure the medication; however, the panel noted that this was not put to Ms Dixon or Ms Thompson in their oral evidence to confirm whether a 5ml cup existed. The panel found that this account was inconsistent.

In the disciplinary meeting notes dated 24 April 2023, Mr Saiger asked you about this incident, in which you are noted to have said, *'I gave a patient clozapine that was considered to be the wrong dose, I wasn't feeling that well, there was a nurse that was on the ward that pointed it out to me.'* The panel was of the view that this was a partial admission to this charge.

The panel was of the view that your evidence in relation to this charge was inconsistent. It determined that the evidence of Ms Dixon and Ms Thompson had been consistent and credible across both their contemporaneous exhibits through to their oral evidence. In light of this, the panel preferred the evidence of Ms Dixon and Ms Thompson.

In all the circumstances, the panel found that on the balance of probabilities, on 12 August 2022, you dispensed approximately 20mls of clozapine for Patient D instead of the prescribed 4ml dose. Therefore, the panel found charge 2 proved.

Charge 3

'That you, a registered nurse, on 10 January 2023 attempted to administer the wrong medication to Patient E and/or dispensed the medication using another patient's pot'

This charge is found proved on the second limb only.

In reaching this decision, the panel considered the charge in two limbs. It first considered whether, on 10 January 2023, you attempted to administer the wrong medication to Patient E. It then went on to consider the second limb, that on 10 January 2023, you dispensed Patient E's medication using another patient's pot.

In considering the first limb, the panel took into account the CCTV, your evidence, and the evidence of Ms Dixon and Ms Thompson.

The panel first considered the evidence of Ms Dixon, who had spoken to Patient E the morning after the alleged incident. In her witness statement, Ms Dixon explained:

'On 11 January 2023 I was working the morning shift and while speaking with Patient E she stated that she had been given the incorrect medication during the night shift. Patient E knew her medication quite well and I asked her how she knew it was the wrong medication and who was the nurse that administered the medication to her. Patient E described the nurse and it appeared to be [you].'

The panel also considered the incident form Ms Dixon completed on 12 January 2023, which stated:

'...Patient [E] stated she knew it was the wrong medication as the medication pot had her peers' initials wrote on and the medication looked different. Patient said she told [you] it was not her medication with [you] then apologising to her.'

The panel also took into account the evidence of Ms Thompson, which included her handwritten note of the conversation she had with Patient E. It is noted that when Patient E was asked what you had done after she told you that you had given her the wrong

medication, Patient E had said '*When [you] looked at them again [you] went and got [Patient E's] tablets.*'

The panel then considered the CCTV. The panel was mindful that the CCTV had no audio, so it could not corroborate whether Patient E's account was correct. It noted that Patient E had not provided evidence, and although a number of staff members were visible on CCTV, there was no evidence from any of them regarding what happened at the material time. The panel also noted that it was unable to see the colour of the medication in the pot, and that Patient E can be seen taking the medication before appearing to ask you a question.

In reviewing the CCTV, the panel took into account how Patient E presented at the time of taking her medication. It noted that Ms Dixon had explained that Patient E was familiar with her medication. In the CCTV, it appeared to the panel that Patient E accepted her medication and then took it. The panel also noted that the CCTV did not show the sequence of events as described by Patient E to Ms Thompson and Ms Dixon. In light of this, the panel was of the view that it was unlikely you had given Patient E the wrong medication, as she would have noticed before taking it.

In the circumstances, the panel found that there is no evidence to indicate that you gave Patient E the wrong medication. In light of this, the panel was of the view that the first limb of charge 3 was not proved.

In considering the second limb, the panel took into account the CCTV, your evidence, and the evidence of Ms Dixon and Ms Thompson.

The panel took into account the incident form Ms Dixon completed on 12 January 2023, which explained that Patient E had said '*the medication pot had [Patient E's] peers' initials wrote on*'.

The panel took into account the interview notes between Ms Dixon and Ms Thompson, who was the investigating officer. This interview took place on 12 January 2023, and in relation to this incident, Ms Dixon stated:

'[You] said that [you] had out [Patient E's] medication pot inside of [Patient F's] medication pot after [Patient F] had the medication and [Patient E] could see the initials through [Patient E's] pot. [You] said that this might have been why she thought the medication was wrong'

The panel also took into account the evidence of Ms Thompson, which included her handwritten note of the conversation she had with Patient E. It is noted that when Patient E was asked about a *'complication with some medications that happened on [10 January 2023] night shift'*, Patient E said *'Had [Patient F] on the bottom.'*

The panel also considered the CCTV. As before, the panel was mindful that the CCTV does not have audio. The panel noted that Patient E takes her medication and then asks you a question, which looks to be about the pot she had just taken her medication from. This is consistent with the account provided by Ms Dixon and Ms Thompson about Patient E's queries about the pot.

The panel then took into account your evidence. In the investigation meeting on 7 February 2023, Ms Thompson asked you about this alleged incident, to which you stated:

'NO, SHE [Patient E] ASKED WHY ANOTHER PATIENTS INITIALS WERE ON THE POT AFTER TAKING 2 TABLETS. I EXPLAINED THE POT WAS USED FOR A PREVIOUS PATIENT AND IN A RUSH I USED THE SAME POT, I CANT NOT RECALL WHO WAS IN THE CLINIC WITH ME'

The panel also took into account the email you sent to the NMC on 18 August 2023, where you stated:

'Question 9

What I would have done differently is used a different medication pot to dispense [Patient E's] medication instead of crossing out [Patient F's] name and using tat (sic) same pot to dispense for [Patient E].'

The panel considered that your oral evidence corroborated your account in the earlier investigation meeting note, as well as your email to the NMC on 18 August 2023. Furthermore, the panel was of the view that your account is also corroborated by Ms Dixon and Ms Thompson's evidence, in that you used a pot with Patient F's initials on it for Patient E's medication. The panel accept that you did not administer the medication incorrectly.

In light of this, the panel found that, on 10 January 2023, you dispensed Patient E's medication using another patient's pot. Therefore, the panel found charge 3 proved on the second limb only.

Charge 4

'That you, a registered nurse, on 10 January 2023 dispensed a 500mg co-amoxiclav (antibiotic) tablet that belonged to another patient instead of Patient G's prescribed 500mg amoxicillin'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of you, Ms Brown, Ms Thompson, and Mr Saiger.

The panel first considered the evidence of Ms Brown. It noted that Ms Brown was a direct witness to the alleged incident and was the person who reported it. The panel considered the following part of Ms Brown's witness statement, where she describes the incident:

‘...When Ms Lyoki potted the patient’s medication, I would double check it against the patient’s medication administration chart (Kardex). I was preparing another patient’s medication while Ms Lyoki potted Patient G’s medication.

I went to double check the medication that Ms Lyoki had potted for Patient G and when I checked it against Patient G’s Kardex I noticed that a white antibiotic tablet was dispensed instead of a capsule... We went through the mediation (sic) that Ms Lyoki had potted for Patient G and identified that Ms Lyoki had accidentally potted a 500mg co-amoxiclav (antibiotic) tablet that belonged to another patient instead of Patient G’s prescribed 500mg amoxicillin (antibiotic) capsule....

Ms Lyoki apologised for the mistake, and we discussed the importance of being mindful around the medication being dispensed.’

The panel took into account Ms Brown’s exhibited investigation meeting minutes, dated 23 January 2023. The panel noted that the recorded conversation was between Ms Brown and Ms Thompson, the investigating officer. Ms Thompson asked Ms Brown, ‘Once [Ms Brown] had shown [you] this, did [you] realise the mistake [you] had made?’ to which Ms Brown responded, ‘Yes she did, she apologised and we had a conversation about it. She reflected and we discussed the importance of being mindful around the medication being dispensed.’ Ms Thompson then asked, ‘Did the patient get the right medication?’, and Ms Brown answered, ‘Yes. It was a near miss – the medication wasn’t administered.’

The panel was of the view that Ms Brown was consistent throughout her written and oral evidence.

The panel noted that Ms Thompson exhibited the incident report form that was completed by Ms Brown. The incident form was completed on 12 January 2023, two days after the alleged incident, and Ms Brown states:

'All tablets correctly identified apart from one, box checked and discovered that the wrong medication was potted to the wrong person despite the medication being prescribed to individual patients with own labels and instructions on each of the boxes.'

The panel noted that this is a contemporaneous account of the incident, and although Ms Brown completed this form, Ms Thompson's evidence corroborated it. Ms Thompson also confirmed in oral evidence that patients have their own, separately labelled box in the Medication Room and can be admitted with their own stock of medication.

The panel took into account the evidence of Mr Saiger. It noted that in his witness statement Ms Saiger stated:

'On 24 April 2023 Ms Iyoki attended the disciplinary meeting with her union representative. I chaired the meeting and a member of staff from HR was present as a note taker. In regards to Patient G Ms Ikoyi accepted that she dispensed the incorrect antibiotic and acknowledged that she did not follow the Hospital's medicine administration process, by checking the patient's name against the medication box...'

The panel took into account your oral evidence. It noted that in your oral evidence, you explained that you had not worked on the ward before and that you thought the clinic room was not organised. You accepted that there was patient-labelled medication and that this was in a box labelled with the patient's name and administration instructions. You explained that you were conducting a walk-around with Ms Brown to understand the medication process and that the issue was only identified during the check-in, before the medication was administered to Patient G. You said that when the error was identified, it was rectified at that time.

When you were challenged about the conversation with Ms Brown, you denied that it ever happened and also denied apologising to Ms Brown for the error.

In the investigation meeting notes, dated 7 February 2023, which was a meeting between you and Ms Thompson, it was noted that you had said, *'ANTIBIOTIC – I DISHED MEDICATIONS, ONLY ONE ANTIBIOTIC IN CUPBOARD, OTHER NURSE KELLY BROUGHT THE CORRECT ANTIBIOTIC FROM ANOTHER CUPBOARD'*. Furthermore, the panel noted that in the disciplinary meeting notes, dated 24 April 2023, you had admitted to dispensing the medication incorrectly. When giving oral evidence, you accepted that you had admitted this in the disciplinary meeting. However, in your oral evidence, you denied that your signature at the end of the document was an admission to you having done something wrong, and that it was your way of engaging in the process at the time.

The panel was of the view that your oral evidence amounted to an admission. During your evidence-in-chief, you explained that the dispensing error had been identified whilst you were still in the medication clinic before the medication was administered. Then, in cross-examination, you accepted that you had admitted to making the dispensing error to both Ms Thompson in the investigation meeting on 7 February 2023, and to Mr Saiger in the disciplinary meeting on 24 April 2023.

The panel did not accept your explanation that, by signing the investigation meeting notes and disciplinary meeting notes, you understood your signature only to confirm receipt, attendance, or engagement with the process, rather than confirming the accuracy of the information recorded in those documents. The panel was of the view that the normal practice of signing meeting notes is to accept that the contents are a true and accurate reflection of what was said at that meeting. In light of this, the panel was of the view that you had admitted to dispensing the incorrect medication during the investigation meeting and the disciplinary meeting, and that the evidence regarding those contemporaneous admissions was credible.

Therefore, the panel found that on the balance of probabilities, on 10 January 2023, you dispensed the wrong medication to Patient G. In light of this, the panel found charge 4 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired.

There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Choudhury invited the panel to take the view that the facts found proved amount to misconduct. He outlined the specific parts of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) that you have breached, namely:

'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

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

To achieve this, you must:

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

...

19.3 keep to and promote recommended practice in relation to controlling and preventing infection.

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.'

Mr Choudhury submitted that whilst the breaches of the code by themselves do not indicate misconduct, together the charges found proved do cross that threshold. He submitted that the charges proved were not trivial matters; they related to fundamental aspects of medication administration whilst you were working as a registered nurse in a mental health hospital. Mr Choudhury submitted that, over an extended period, you failed to administer medication in accordance with the standards and procedures expected of you.

Mr Choudhury submitted that although no patients suffered harm from your actions, each of the charges found proved constituted a near miss. In particular, he submitted that in respect of charge 2 and Patient D, the risk factors associated with giving 20ml of clozapine were set out by the witnesses. However, although Mr Choudhury accepted that you had not administered the medication to Patient D, he submitted that this still constituted a very

serious near miss, and that there was potential for serious harm had the medication been administered.

In relation to charge 3, Mr Choudhury submitted that the panel heard at length from witnesses about the strict controls in place to avoid cross-contamination of medication, as well as the consequences associated with using another patient's pot, including that mistakes could be made. He submitted that the facts found proved at charge 4 go to the heart of two of the 'five R's'; right medication and right patient.

In light of this, Mr Choudhury invited the panel to find that your actions in the charges found proved amounted to misconduct.

Ms Bennett submitted that you respect the panel's finding of fact and do not seek to repeat the factual case already determined. She submitted that a clinical error, a breach of policy or practise falling below the expected standard of a registered nurse does not automatically amount to misconduct. Ms Bennett invited the panel to consider your state of mind, the circumstances in which it occurred, the actual and potential consequences, and whether it represented a serious departure from the standards expected of a registered nurse.

Ms Bennett submitted that your actions were not deliberate and that there is no evidence of you knowingly dispensing the wrong medication, administering an incorrect dose, or intending to harm a patient. She indicated that the panel's findings suggest these were inadvertent clinical errors and lapses in attention rather than intentional wrongdoing. Ms Bennett noted that you acknowledge these errors are unacceptable, recognise their potential risks, and accept that your practice fell below the required standard.

Ms Bennett addressed each of the charges. In relation to charge 1, she submitted that you accept the panel's finding. However, she submitted that the panel found that this incident was an accident and was not malicious; that you had just made an error. She invited the

panel to consider charge 1 as an isolated medication administration error involving inadequate checking of the titration chart, without malice or patient harm.

In relation to charge 2, Ms Bennett submitted that you acknowledge the seriousness of dispensing 20mls of clozapine and the possible consequences had the incorrect quantity been administered to the patient. However, she submitted that the error occurred whilst you were dispensing the medication inside the medication clinic, where Ms Dixon intervened. Ms Bennett noted that the panel had acknowledged that you were unwell, your eyes were hurting, and you could not see clearly, and that you had said this to Ms Dixon at the time. She submitted that you accept that you should have stopped and sought assistance, rather than continuing with dispensing the medication if your illness could affect safe medication preparation. She submitted that this was a failure of judgment. In light of this, Ms Bennett submitted that the error was corrected before the medication was administered, and there was no patient harm. She invited the panel to find that if it considered this charge amounted to misconduct, it should be limited to an inadvertent dispensing error.

In relation to charge 3, Ms Bennett submitted that this related to you using a different patient's pot to administer Patient E's medication, which you accepted was not acceptable and was done in a rush. You accept that this could cause confusion, undermine the patient's trust and increase the possibility of a medication error. However, Ms Bennett submitted that the panel's finding did not refer to the administration of the wrong medication and did not conclude that the medication was contaminated. She submitted that there was also no finding that Patient E suffered harm. Ms Bennett invited the panel to find that charge 3 may represent poor practice but does not reach the threshold of serious professional misconduct.

In relation to charge 4, Ms Bennett submitted that this was related to an inadvertent medication dispensing error which was identified before the medication was administered to Patient G. She submitted that the error was identified by Ms Brown, who described you accidentally potting the incorrect medication, and as soon as you realised, you apologised

and reflected on your error. Ms Bennett reminded the panel that this incident was recorded as a near miss and that the check-in safeguard had worked, preventing the medication from being administered to the patient. However, she accepted that this does not excuse your initial mistake, but it is relevant to the nature and seriousness of the conduct.

Ms Bennett submitted that the panel may consider its findings cumulatively. However, cumulative consideration must remain based on the precise facts proved. It must not transform the findings into something more serious than they were. She submitted that the panel's findings do not amount to four separate medication administration errors, nor do they demonstrate a pattern of deliberate wrongdoing. Ms Bennett submitted that the potential consequences are important, but the panel should not treat potential harm from medication that was never administered as though the patient had actually received an overdose or the wrong medicine.

In light of this, Ms Bennett submitted that the findings of the panel represent inadvertent clinical errors and poor medication practice; however, if considered proportionately, they do not cross the higher threshold required for serious professional misconduct. She submitted that if the panel is not with her on this point, then it should at least consider that charges three and four do not meet the required level of seriousness.

The panel heard and accepted the advice of the legal assessor, which included reference to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code, specifically:

‘1 Treat people as individuals and uphold their dignity

To achieve this, you must:

...

1.2 make sure you deliver the fundamentals of care effectively

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

To achieve this, you must:

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

...

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public’

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. Therefore, the panel considered each charge in turn.

Charge 1

The panel noted that this was an avoidable medication administration error arising from a failure to follow established procedures. Although you had administered the incorrect dose of medication to Patient A, no harm was caused to Patient A. However, the panel was of the view that safe medication administration is a fundamental aspect of nursing practice, and at the material time, you had been signed off as competent to administer medication. Although Patient A did not suffer harm, there was a potential risk of harm because you failed to follow the relevant policy and the instructions on Patient A's Kardex. In light of this, the panel determined that your actions amounted to misconduct in respect of charge 1.

Charge 2

The panel noted that this was a medication dispensing error. Although the medication was not administered to Patient D and no harm was caused, this was because Ms Dixon intervened while you were dispensing it. The panel found that dispensing five times the prescribed dose gave rise to a risk of serious harm, particularly given the risks associated with an overdose of clozapine. Had Ms Dixon not identified the error; Patient D could have come to serious harm.

The panel noted that you failed to follow the Hospital's medication administration procedure, which required you to use a syringe rather than a pot when dispensing this medication. The panel also considered that you had failed to follow the five R's, namely dispensing the right dose. The panel was of the view that safe medication dispensing is a fundamental aspect of nursing practice and that, at the material time, you had been signed off as competent to dispense medication. In light of this, the panel determined that your actions amounted to misconduct in respect of charge 2.

Charge 3

The panel noted that this incident involved your dispensing and administering Patient E's medication using another patient's pot. The panel found that your actions amounted to unsafe clinical practice, as there was potential for making a medication error, including administering medication to the wrong patient. There was also a risk of cross-contamination and associated infection control concerns. The panel found that this was a serious departure from the expected standards of a registered nurse. In light of this, the panel determined that your actions amounted to misconduct in respect of charge 3.

Charge 4

The panel noted that this was a medication dispensing error and that no harm was caused to Patient G because the error was identified before the medication was administered. However, the panel considered that this incident was a near miss and posed a potential risk of harm, as Patient G had been prescribed specific medication for a reason, and dispensing the incorrect medication could have resulted in Patient G receiving medication not prescribed for them.

The panel was of the view that your actions reflected a lack of due care and attention during the dispensing process. It also considered that you had failed to follow two of the five R's, namely dispensing the right medication for the right patient. The panel noted that you did not follow the Hospital's policies and procedures, including the requirement to ensure that medication was dispensed correctly and only when you were ready to administer it. It also noted that the error could have been avoided had appropriate checks been carried out, including checking the correct cupboard and identifying the difference between tablets and capsules.

The panel was of the view that safe medication dispensing is a fundamental aspect of nursing practice and that, at the material time, you had been signed off as competent to

dispense medication. In light of this, the panel determined that your actions amounted to misconduct in respect of charge 4.

Having considered each of the charges, the panel found that the proven conduct demonstrated a repeated pattern of careless and unsafe practice in relation to medication dispensing and administration. The panel was of the view that fellow members of the nursing profession would regard this as deplorable. In all the circumstances, the panel found that your actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Submissions on impairment

Mr Choudhury 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.

Mr Choudhury invited the panel to find that your fitness to practise is currently impaired on the grounds of public protection and public interest. He referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that limbs a, b and c of Dame Janet Smith's 'test' were engaged.

In relation to your current impairment, Mr Choudhury submitted that your misconduct was serious, breached fundamental tenets of the nursing profession, and is directly linked to your clinical practice. He referred the panel to your reflective piece, dated 31 July 2026. He submitted that in your reflection, you set out what you would do in a similar situation; however, you have not yet faced a similar situation at work, so it remains unclear how you would manage this.

Mr Choudhury submitted that your reflection accepts accountability and responsibility for your actions. However, he reminded the panel that you have not always accepted accountability and have tended to blame others for your actions. He reminded the panel that you also questioned the genuineness of your previous admissions recorded in contemporaneous documentation. Furthermore, he submitted that you had explained that the '*potting-up*' incident was an accepted practice in the hospital.

In relation to the training you have undertaken, Mr Choudhury submitted that you have, to your credit, undertaken some training, albeit not recently. He submitted that all of the training appears to be e-learning modules, and whilst they can be valuable, in-person training is of a different nature. Additionally, he submitted that the evidence of training is sparse and not as detailed as one may expect in this sort of case.

In relation to testimonials, Mr Choudhury submitted that you have provided some testimonials from 2024. However, he further submitted that there were no current testimonials from members of the profession who have recently worked with you. He submitted that there are no references where the author states that they are aware of the allegations or demonstrates that you have learned from your mistakes, and as such, there were no examples presented which speak to your current capabilities.

In relation to public interest, Mr Choudhury submitted that there is sufficient evidence to find that public interest grounds are also met. He reminded the panel of the NMC's overriding objective to protect and promote the health, safety and well-being of the public and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery profession and upholding proper professional standards.

Mr Choudhury submitted that a finding of impairment on public interest grounds is required because you failed to provide adequate care to patients in relation to medication errors and near misses, which breached fundamental tenets of the nursing profession. An ordinary and reasonable member of the public would expect a registered nurse to follow

proper medication procedures. He submitted that your actions fell significantly below the standard expected, which risks bringing the profession into disrepute, and that public confidence in the profession would be seriously undermined if a finding of impairment was not made in this case.

In light of this, Mr Choudhury invited the panel to find that your fitness to practise is currently impaired on the grounds of public protection and public interest.

You provided the panel with an impairment bundle, which contained the following documentation:

- Your reflective piece, dated 31 July 2026;
- Your conditions of practice, dated 8 August 2024;
- A testimonial from Mr Steve Robson, Home Manager of Kingsway Nursing Home (Kingsway), dated 25 July 2024;
- A medicines competency assessment with a practical and theoretical component, completed at Kingsway, signed by the Clinical Lead and dated 29 June 2024;
- A screenshot of your Virtual Learning Environment (VLE) containing a list of modules from the University of Suffolk, which includes a Medicines Management module;
- A training certificate from Medex, dated 27 August 2023, for completing the Safe Handling of Medicines course;
- A training certificate from Medex, dated 7 September 2023, for completing the Safe Handling of Medicines Level 2 course;
- A training certificate from Boots Care Learning, dated 29 June 2024, for completing the EMAR Knowledge Test; and
- A training certificate from Florence Academy, dated 18 March 2026, for completing the Medication Administration e-learning course.

In her submissions, Ms Bennett explained that you respect the panel's decision on misconduct. She then referred the panel to the cases of *CHRE v NMC and Grant*, and

Cohen v General Medical Council [2008] EWHC 581 (Admin), and the NMC guidance titled '*Impairment*' (DMA-01, last updated 28 January 2026).

In relation to Dame Janet Smith's '*test*' as set out in the case of *Grant*, Ms Bennett submitted that it is important to note that dishonesty is not engaged in this case. She submitted that the panel should take into account that it has not found that you deliberately harmed patients, and that there is no finding of malicious behaviour or concealment, although this does not diminish the importance of the medication concerns.

Ms Bennett submitted that the concerns can be addressed, as the issues in your case relate to medication administration, including checking, measuring, following titration instructions, choosing the correct medication, using the correct equipment, and paying proper attention, all of which can be taught, practised, assessed, and improved. She submitted that whilst the NMC have put some weight on you not accepting certain aspects of the case at the earliest stages, it is unfair for you to be criticised for simply defending an allegation. Ms Bennett referred the panel to NMC guidance, which states that denying some or all of the facts does not automatically mean a person cannot show insight.

Ms Bennett submitted that the NMC also noted that you had a tendency to blame others; however, she reminded the panel of the wider underlying context. She submitted that she is not suggesting that workplace treatment, race, workload, or any other factors remove your own responsibility as a nurse, but it would be unfair to describe everything she raised about her workplace as simply blaming others, especially given that there were witnesses who spoke to this. Ms Bennett reminded the panel of the oral evidence of Mr Kirk, Mr Iregbulem, and Dr Eleazu, and what they had told the panel about the wider workplace culture. She invited the panel not to treat your earlier concerns around race, lack of support, and differential treatment as proof that you were refusing responsibility, but rather to consider the wider context.

Ms Bennett referred the panel to your written reflective piece, dated 31 July 2026. She submitted that this demonstrates insight. You have explained that you understand your

professional responsibility, and that just because other nurses did something, such as pre-potting medication, does not mean that it was acceptable for you to do it when it went against the Hospital's policy and procedures. You also explained that the pressures, being on an unfamiliar ward, receiving a poor handover, feeling tired or unwell, may provide context, but do not remove your own professional responsibility for safe practice. You recognise that you must now stop, explain the problem, and seek support.

Ms Bennett submitted that there is evidence of how you would deal with a similar situation in the future. She referred the panel to your medicines competency assessment dated 29 June 2024. She submitted that this was a detailed competency assessment that included practical and theoretical components, including three medication rounds; patient identification; checking medication and doses against records and labels; liquid medication and syringe preparation; hygiene; medication errors and near misses; and when to ask for help or escalate. In light of this, she submitted that this competency assessment provides evidence that you were assessed whilst carrying out medication tasks. Ms Bennett also confirmed that the manager's comments on the document confirm that you scored well and passed the assessment. She submitted that this competence assessment demonstrates that you know how to handle a similar situation in the future.

Ms Bennett then referred the panel to your training certificates. She outlined the timeline for the training you undertook from August 2023 to March 2026. She submitted that these training courses included practical assessments, online learning, and academic study.

In relation to references, Ms Bennett accepted that you have not provided the panel with a 2026 reference from a senior colleague. However, she reminded the panel that this should not count against you, as there is no requirement to produce it.

In relation to the risk of harm, Ms Bennett submitted that you understand why this matters and that you have identified the possible consequences of your medication errors in your reflection. She submitted that you also appreciate the effects this may have upon colleagues and the wider team, as well as the public confidence. You recognised that

although the clozapine and antibiotics were stopped before administration, this does not excuse your original errors.

Ms Bennett submitted that the concerns have been addressed through e-learning training in medication administration, practical competence assessments, and a university-level medicines management study. Furthermore, you have provided a detailed reflection that identifies the risks and safeguards. In light of this, Ms Bennett submitted that a risk of repetition is highly unlikely.

Ms Bennet invited the panel to find that your fitness to practise is not currently impaired on the grounds of public protection, as you have evidenced your insight and remediation. Ms Bennett addressed the public interest. She asked the panel to consider what an informed member of the public would expect the NMC to do when a registrant has recognised the seriousness of their misconduct and addressed those concerns through reflection, insight, and strengthened practice. She submitted that whilst the public would expect the NMC to uphold professional standards once misconduct has been identified, they would also expect remediation to be recognised where the evidence supports it, as is the case here.

In relation to bringing the profession into disrepute, Ms Bennett submitted that the question for the panel to consider should be whether public confidence requires a finding that you remain impaired. She submitted that you have demonstrated a materially different position from that at the time of the material events. She submitted that the panel should consider not only what went wrong at the time, but also what you have done since, which would include recognising your insight and remediation, which would not undermine confidence in the nursing profession.

Ms Bennett submitted that although you have previously breached fundamental tenets of the nursing profession, your insight, remediation, and strengthened practice demonstrate that you are not liable to breach these in the future.

In conclusion, Ms Bennett invited the panel to find that your fitness to practise is not currently impaired on the grounds of public interest.

In response to panel questions, Ms Bennett explained that a positive example of putting your training into practice would be that when you worked for Kingsway, you noticed that a medication on a MAR chart was unclear, and rather than making an assumption, you stopped, checked the prescription, spoke to the second nurse on shift, and the matter was clarified with the patient's GP and the pharmacy before it was administered.

Ms Bennett explained that since September 2025, you have been actively seeking work as a registered nurse but have been unable to secure a nursing role that will accommodate the NMC's interim conditions of practice, particularly the requirement for another registered nurse to be available. Rather than leave healthcare altogether, you have continued working as a senior healthcare assistant to remain in a clinical care environment. Some of your responsibilities in your role included assisting with personal care, mobility, nutrition, and medication; monitoring residents' well-being; and maintaining accurate care records. You also provide some leadership and support and supervise new members of staff.

Ms Bennett informed the panel that in March 2026, you graduated from the University of Suffolk following completion of a master's in international nursing.

The panel accepted the advice of the legal assessor, which included reference to a number of relevant judgments, including *CHRE v NMC and Grant*, and *Cohen v GMC* [2008]; *PSA v (1) GMC (2) Uppal* [2015] EWHC 13 (Admin); and *Blakely v GMC* [2019] EWHC 905.

Decision and reasons on impairment

The panel went on to decide if, as a result of the misconduct, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

‘The question that will help decide whether a professional’s fitness to practise is impaired is:

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”

If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

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. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

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

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

The panel found that the first three limbs of Dame Janet Smith's 'test' were engaged in relation to the past. In relation to limb a, the panel found that although there was no direct harm caused to patients in your care, your misconduct put patients at a real risk of serious harm, given your repeated medication errors. In relation to limb b, the panel was of the view that due to your repeated medication errors, which although were near misses and did not cause direct harm to patients, brought the profession into disrepute as the public would expect a registered nurse not to make repeated errors and to learn from their mistakes. In consideration of limb c, the panel was of the view that safe medication dispensing is a fundamental aspect of nursing practice and that, at the material time, you had been signed off as competent to dispense medication.

Before considering whether you are liable in the future to put patients at an unwarranted risk of harm, bring the profession into disrepute, or breach the fundamental tenets of the profession, the panel considered the factors set out in *Cohen* [2008].

The panel first considered whether your misconduct was remediable. It took into account the NMC guidance titled '*Can the concern be addressed?*' (FTP-16a, last updated 27 February 2024). The panel found that the concerns are directly related to your clinical practice, specifically medication administration, and, as such, are remediable through strengthened practice. Furthermore, the panel noted that at the time of the concerns, you were struggling with the workplace culture and facing a number of difficulties as a result. Although this provided some context, the panel was of the view that it did not remove your professional responsibility for safe practice.

As the panel was satisfied that your misconduct is capable of being addressed, it went on to consider the NMC guidance titled '*Has the concern been addressed?*' (FTP-16b, last updated 25 March 2026).

The panel took into account your insight into the concerns. The panel considered your reflection, dated 31 July 2026, and noted that you have demonstrated an understanding of the potential risks associated with your misconduct in relation to each of the patients in the charges. The panel noted the following:

'Charge 1: Patient A

...

Although Patient A did not suffer harm, I understand that administering an incorrect dose could have caused excessive sedation, physical deterioration or other serious consequences.

Charge 2: Patient D

...

I recognise that the potential consequences could have been very serious had the incorrect quantity reached the patient.

Charge 3: Patient E

....

I understand that this was unsafe and could have caused confusion. A patient seeing another person's initials on a medication pot may believe that the medication belongs to somebody else. This may cause distress, reduce confidence in the nurse and lead the patient to refuse medication in the future.

Charge 4: Patient G

...

I must read the complete medicine name and compare it directly with the prescription and the label on the patient's individual medication supply.'

Furthermore, the panel took into account that in your reflection, you have demonstrated remorse and accepted responsibility for your actions. It noted the following:

'Pressure, an unfamiliar ward or medication room, an inadequate handover, lack of support, tiredness, illness or visual difficulty may provide context. However, they do not remove my duty to practise safely.

I have learned that when these factors are present, my responsibility is not simply to continue and try to complete the medication round. My responsibility is to stop, explain the safety concern, request assistance and not proceed until safe arrangements are in place.

One of my most important personal lessons is that stopping is part of safe nursing. I would now rather explain a delay in medication administration than create a risk by continuing without the correct information, equipment, concentration or support.

I am sorry that my practice created potential risks and caused concern. I am particularly sorry to the patients involved, their families, my colleagues and the wider nursing profession.'

The panel was of the view that your reflection has demonstrated good insight into the concerns, specifically where you have demonstrated remorse, explained your understanding of your professional responsibility, and set out what you would do differently in the future.

The panel then considered whether you have taken steps to strengthen your practice.

The panel considered the Kingsway competency assessment, dated 29 June 2024 and signed by the Clinical Lead. The assessment included both practical and theoretical components and showed that, at that time, you were deemed competent in medication administration. The panel considered this as positive evidence that you have taken some steps to strengthen your practice. However, the panel was of the view that, whilst positive, it did not demonstrate your current competency because you stopped working as a registered nurse in September 2025, and there has been no further assessment of your competency since.

The panel also took into account the testimonial from Mr Steve Robson, the home manager at Kingsway, dated 25 July 2024, which stated:

'... Violet has worked at Kingsway Nursing Home in Langley Park since 01/05/2024. She has worked alongside the Nursing team, who have supported her and supervised her with nursing duties including medication. Violet has settled in well and has completed all mandatory training, including the administration of medication and a medication competencies assessment. The competency assessment has been completed twice by 2 different nurses. Violet has scored well within the training and passed the competency assessment.'

Violet has also completed the Boots Pharmacy online medication training.

We pride ourselves at Kingsway in working together as a team, Violet has integrated into the team well and provides a caring and supportive approach to both Residents and their families and staff alike.

I am happy to welcome Violet to Kingsway and would hope that the restrictions to her practice can be lifted and that Violet can take a full and active role as part of the Nursing team...'

The panel found that this testimonial was a positive and encouraging reference and acknowledged that you have made strides in addressing and attempting to remediate the concerns. However, given that you have not worked as a registered nurse since September 2025, and the available evidence falls short of establishing that the concerns have been addressed, the panel considered that this testimonial did not demonstrate that you have fully strengthened your practice.

The panel took into account the four training certificates you provided related to medication administration and handling. The panel noted that all of these courses were completed online, with one completed in March 2026, two in September 2023, and the other in June 2024. Furthermore, the panel noted that there was nothing before it explaining what you were required to do in order to pass the course. It was of the view that, while undertaking training is a positive step towards strengthening your practice, the online courses were unlikely to have included a practical element, and most had taken place some time ago. Therefore, the panel concluded that the training certificates did not provide sufficient evidence that you had been able to fully strengthen your practice.

The panel noted Ms Bennett's submissions that you have recently graduated from the University of Sussex with a master's in international nursing. The panel noted that it appeared to have a screenshot of your VLE showing a module on medicines management. The panel was of the view that whilst this is an excellent academic achievement, it had nothing further before it about what that module entailed and how you have used this to strengthen your practice.

In light of all of this, the panel determined that whilst you have taken some steps to strengthen your practice, you have not sufficiently strengthened your practice to a level where the concerns have been fully remediated at this time.

The panel then went on to consider whether it was highly unlikely that your conduct would be repeated. The panel was of the view that, although you have demonstrated good insight into the concerns, given its finding that you have not sufficiently strengthened your practice to a level where the concerns have been fully remediated at this time, there remains a risk of repetition.

The panel returned to the test set out by Dame Janet Smith and considered whether you are liable in the future to act so as to put patients at an unwarranted risk of harm, to bring the profession into disrepute, or breach one of the fundamental tenets of the profession. The panel determined that although you have good insight into the concerns, as you have not sufficiently strengthened your practice to a level where the concerns have been fully remediated, you are liable in the future to put patients at an unwarranted risk of harm. As such, it further determined that you would also be liable in future to bring the nursing profession into disrepute and subsequently liable in future to breach the fundamental tenets of the nursing profession.

In all the circumstances, given that you have not sufficiently strengthened your practice to a level where the concerns have been fully remediated, and there remains a risk of repetition, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel then considered whether a finding of impairment on the ground of public interest was required. It bore in mind the NMC's overarching objectives: to protect, promote, and maintain the health, safety, and well-being of the public and patients; and to uphold and protect the wider public interest. This includes promoting and maintaining

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

The panel considered that your misconduct involved repeated medication errors and near misses. It was of the view that safe medication dispensing is a fundamental aspect of nursing practice and noted that, at the material time, you had been signed off as competent to dispense medication. The panel considered that members of the public rely on registered nurses to deliver safe care by exercising due care and attention and would not expect them to make repeated errors or fail to learn from their mistakes. The panel determined that your actions fell seriously short of the conduct and standards expected of a registered nurse, and that public confidence in the profession would be undermined if a finding of impairment were not made. Therefore, the panel found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order, and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Mr Choudhury informed the panel that in the Notice of Hearing, dated 2 May 2025, the NMC had advised you that it would seek the imposition of a conditions of practice order, if the panel found your fitness to practise currently impaired.

Mr Choudhury submitted that, in light of the panel's decision on impairment, making no order or a caution order would be inappropriate, and that making a suspension order or a striking-off order would be disproportionate in this case. As such, he invited the panel to impose a conditions of practice order for a period of 12 months.

Mr Choudhury proposed that the panel impose the following conditions:

1. *'You must limit your nursing practice to a single substantive employer at the same place of employment. Such employment must be for a fixed term contract for no less than six weeks.*
2. *You must not be the sole registered nurse on duty at any time, you must work at all times on the same shift but not always directly observed by another registered nurse.*
3. *You must be directly supervised by another registered nurse at any time you are undertaking medications management, including dispensing and administering medication.*
4. *You must have meetings once a month with your mentor, supervisor or manager to discuss your medication management, including the dispensing of and the administration of medication.*
5. *You must obtain corresponding monthly reports from your line manager, mentor or supervisor outlining your medication management, including the dispensing and the administration of medication and provide these to your NMC case officer prior to any review hearing.*
6. *You must keep the NMC informed about anywhere you are working by:*
 - a) *Telling your case officer within seven days of accepting or leaving any employment.*

- b) Giving your case officer your employer's contact details.*
- 7. You must keep the NMC informed about anywhere you are studying by:*
 - a) Telling your case officer within seven days of accepting any course of study.*
 - b) Giving your case officer the name and contact details of the organisation offering that course of study.*
- 8. You must immediately give a copy of these conditions to:*
 - a) Any organisation or person you work for.*
 - b) Any employers you apply to for work (at the time of application).*
 - c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*
- 9. You must tell your case officer, within seven days of your becoming aware of:*
 - a) Any clinical incident you are involved in.*
 - b) Any investigation started against you.*
 - c) Any disciplinary proceedings taken against you.*
- 10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and/ or progress under these conditions with:*
 - a) Any current or future employer.*
 - b) Any educational establishment.*
 - c) Any other person(s) involved in your retraining and/or supervision required by these conditions.'*

Mr Choudhury submitted that the proposed conditions are specific to the facts of this case and are therefore proportionate and workable. Furthermore, he submitted that they are not

a suspension through an indirect route and outlined the reasoning for including each of the above conditions.

Following a panel question, Mr Choudhury explained that the first condition could be amended to include you being permitted to work for one substantive employer, which may be an agency, provided that any placement you undertake by the agency is for a period of at least 6 weeks.

Mr Choudhury reminded the panel that the needs of the public and the need to protect the wider public interest outweigh the needs of any individual practitioner.

Ms Bennett referred the panel to the screenshots of your applications for registered nursing roles. She outlined that the screenshots show two applications: one shows you had an interview on 17 August 2026 and that the application was withdrawn on 24 August 2026; and the other shows you were scheduled for an interview on 6 August 2026, but this was marked as unsuccessful on 11 August 2026. Ms Bennett submitted that these screenshots demonstrate that you have been actively applying for employment as a registered nurse.

Ms Bennett submitted that there is agreement with the NMC in that a striking-off order would be wholly disproportionate, and that a suspension order is not necessary. She went on to address the NMC's submission that a 12-month conditions of practice order would be appropriate.

She asked the panel to consider whether the concerns require your practice to be restricted at all, and if it does, then what the least restrictive and workable order is to address this. She reminded the panel that the purpose of a sanction is not punishment and should protect the public and maintain public confidence.

Ms Bennett invited the panel to consider a caution order. She submitted that a sanction must be determined in reference to where you are now, and the panel has found you have

good insight, remorse and an understanding of your professional responsibility. The panel has also noted that you have taken steps to strengthen your practice and has taken into account your positive testimonials. She submitted that the panel should consider whether the risks identified are ones that require a restriction on your practice or whether a caution is most appropriate. Ms Bennett reminded the panel that a caution order is a public sanction which marks the conduct as unacceptable, it remains on the register and would uphold professional standards. Furthermore, she submitted that this would not prevent you from obtaining work as a registered nurse.

If the panel were to conclude that some restriction remains necessary, Ms Bennett submitted that a conditions of practice order could be appropriate, but the panel should focus on the workability of the conditions. She challenged the NMC's submissions that conditions can make obtaining employment more difficult, but nevertheless, you should be able to secure employment. Ms Bennett referred back to her earlier submissions regarding your difficulty obtaining employment and explained that you have been unable to secure a nursing role that could accommodate your conditions, especially the requirement of direct supervision. She acknowledged that this difficulty could also be from the visa requirements.

Ms Bennett referred the panel to the NMC's guidance on conditions of practice and submitted that this is important, as it states that conditions must be relevant, proportionate, workable, and measurable. She submitted that the panel should impose the least restrictive conditions necessary to protect the public, and in doing so should not create any unnecessary barriers to you in obtaining new employment. She submitted that where supervision is proposed, the panel should consider the level of supervision that can actually be accommodated and assess whether the risk could be managed through a less restrictive condition.

Ms Bennett submitted that your existing conditions have made it difficult for you to obtain employment, and you could end up in the same position when this order is reviewed in 12 months' time, again, unable to produce the evidence that this panel needed to see. She

submitted that the NMC described the conditions as a route back to safe practice, which you agree with, but that route must be capable of being travelled.

Ms Bennett addressed the NMC's proposed conditions. She submitted that in relation to condition one, the panel should consider what the purpose of this condition is. She submitted that the panel should amend condition one to allow you to work for one substantive employer either permanently or on an appropriate fixed-term contract, and it should consider whether limiting you to one physical place of employment is necessary.

In relation to condition two, Ms Bennett submitted that the NMC has characterised this as preventing you from being the lead nurse or nurse in charge; however, it also includes a supervision requirement, which is very different. She submitted that this is what has caused you difficulty in obtaining employment. In relation to condition three, she submitted that this directly addressed the clinical concerns, and you are prepared to accept direct supervision whenever you undertake medication management. In light of this, Ms Bennett asked the panel to consider what additional risk requires you to be supervised at all times when you are already being directly supervised when undertaking medication management. Ms Bennett invited the panel to either remove condition two or amend it to just include that you may not act as the nurse in charge. She invited the panel to keep condition three in place as it directly addresses the identified concern and would improve the prospect of a future employer being able to accommodate this. She submitted that this is consistent with the NMC's own guidance on workability.

Ms Bennett submitted that there is no opposition to conditions four and five in principle, as they can serve as a useful evidential purpose. She submitted that there is no challenge to the standard notification provisions either. Ms Bennet submitted that the main ask of the panel is that the core employment and supervision conditions are drafted in a way that gives you a genuine prospect of obtaining employment.

In relation to the duration of the order, Ms Bennett submitted that 12 months should not become an arbitrary minimum period of restriction. She submitted that the NMC seeks 12

months to ensure that any employer can send reports; however, those reports cannot begin until you obtain employment. She submitted that if the panel considers 12 months appropriate because you may require time to secure employment, this should be made clear. She submitted that if you obtain employment and demonstrate your current competency sooner, then there should be a meaningful route to an early review.

Ms Bennett asked the panel to take into account the time you have already spent on an interim order.

In response to panel questions, Ms Bennett confirmed that since the interim conditions were imposed, you have made more than 40 applications that have been affected by the order. She submitted that you have explained that the restrictions, particularly the condition requiring you to work with another registered nurse on shift, have limited the roles that employers have been able to or willing to accommodate. Ms Bennett confirmed that you have been actively seeking employment as a registered nurse since September 2025 and have made 18 applications. The figure of 40 represents the broader period during which the conditions have affected your job search.

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

Decision and reasons on sanction

Having found your 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 judgment.

The panel took into account the following aggravating features:

- Your misconduct recklessly put patients at risk of harm due to your repeated medication errors;
- You breached sections of the Code; and
- Your actions constituted a pattern of misconduct over a period of time.

The panel also took into account the following mitigating features:

- The workplace presented a challenging culture at the time;
- You were a new international nurse and received little support from your employer;
- [PRIVATE];
- You have demonstrated good insight;
- You have demonstrated remorse for your misconduct; and
- You have made attempts to strengthen your practice.

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 determined that taking no further action would be neither proportionate nor address the identified risks to public protection and would not be in the public interest.

The panel next considered a caution order and had regard to the NMC guidance on ‘*Caution order*’ (SAN-2b, last updated 28 January 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 it had identified risks to patient safety, and therefore, a sanction that does not restrict your practice would not protect the public. Accordingly, the panel

determined that a caution order would be neither proportionate nor appropriate, and would not be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel had regard to the NMC Guidance on '*Conditions of practice order*' (SAN-2c, last updated 28 January 2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- ...
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel noted that it had identified specific areas of your practice in need of assessment and/or retraining, including medication management, including dispensing and administering, and that there was a realistic prospect that these concerns could be resolved with strengthened practice. It also noted that you are willing to further strengthen your practice in these areas. The panel was of the view that all of the above factors in SAN-2c are engaged in your case and determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case.

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

The panel was of the view that imposing a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. This is because the concerns are directly related to your clinical practice, and you need to be able to strengthen your practice to address them. A suspension would prevent you from doing this and would be unnecessarily punitive.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and send a clear message to the public and the profession about the standards of practice required of a registered nurse.

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

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to a single substantive employer, which may be an agency, provided that any placement you undertake by the agency is for a period of at least 6 weeks.
2. You must not be the sole nurse on duty or nurse in charge at any time.
3. You must be directly supervised by another registered nurse at any time you are undertaking medication management, which includes dispensing and administering medication.

4. You must meet with your line manager, supervisor, or mentor every month to discuss your performance and progress in relation to medication management, including dispensing and administering medication.
5. You must obtain a report from your line manager, supervisor, or mentor every three months regarding your performance and progress in relation to medication management, including dispensing and administering medication.

These reports must be shared with your NMC case officer in advance of any review of this order.

6. You must keep the NMC informed about anywhere you are working by:
 - a) Telling your case officer within seven days of accepting or leaving any employment.
 - b) Giving your case officer your employer's contact details.
7. You must keep the NMC informed about where you are studying by:
 - a) Telling your case officer within seven days of accepting any course of study.
 - b) Giving your case officer the name and contact details of the organisation offering that course of study.
8. You must immediately give a copy of these conditions to:
 - a) Any organisation or person you work for.
 - b) Any agency you apply to or are registered with for work.

- c) Any employers you apply to for work (at the time of application).
 - d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
9. You must tell your NMC case officer, within seven days of your becoming aware of:
- a) Any clinical incident you are involved in.
 - b) Any investigation started against you.
 - c) Any disciplinary proceedings taken against you.
10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:
- a) Any current or future employer.
 - b) Any educational establishment.
 - c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months. The panel determined that this length was proportionate, as it would give you time to obtain employment and strengthen your practice in medication management. Furthermore, the panel was satisfied that 12 months was sufficient to protect the public and satisfy the public interest.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing, the panel may revoke the order or any condition of it, confirm the order or vary any condition of it, or replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A written reflection about how you have implemented your development and understanding of the concerns regarding medication management, including dispensing and administering medication, in your current practice; and
- The reports you obtain from your line manager, mentor, or supervisor every three months.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Malik, on behalf of the NMC, submitted that an 18-month interim conditions of practice order is required to cover the period where you might make an appeal in this case. He submitted that an 18-month interim order is required, as this is the likely amount of time it would take for an appeal to be heard.

Ms Bennett submitted that there was no opposition to an interim order being imposed; however, this should not change the length of the substantive order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel took into account the seriousness of the facts found proved, and the reasons set out in its decision for the substantive order. This included the identified risks to the protection of the public and the wider public interest. In all the circumstances, the panel was satisfied that an interim order is necessary to protect the public and is otherwise in the public interest.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, as the panel have identified risks to public protection, and allowing you to practise unrestricted whilst the concerns have not been fully remediated, during a period where the sanction has not taken effect would not protect the public.

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

That concludes this determination.