Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 15 April 2026 – Friday, 17 April 2026
Monday, 20 April 2026 – Wednesday, 22 April 2026
Tuesday, 27 October 2026 – Thursday 29 October 2026

Virtual Hearing

Name of Registrant:	Catherine Inguyi Ngaira
NMC PIN:	00F1053O
Part(s) of the register:	Registered Nurse - Sub part 1 Adult nurse, level 1 (1 June 2000)
Relevant Location:	Merseyside
Type of case:	Misconduct
Panel members:	Graham Gardner (Chair, Lay member) Deborah Bennion (Registrant member) Shelley Hemsley (Lay member)
Legal Assessor:	Graeme Henderson
Hearings Coordinator:	Abigail Addai (April 2026) Fionnuala Contier-Lawrie (October 2026)
Nursing and Midwifery Council:	Represented by Denise Amaning, Case Presenter
Ms Ngaira:	Present and represented by Chuba Nwokedi, instructed by Royal College of Nursing (RCN)
Facts proved:	Charges 1, 2, 3, 4, 5, 7 and 8
Facts not proved:	Charge 6
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months with review)**

Details of charge

That you, a registered nurse, when providing personal care to Patient A:

1. On one or more of the dates and times set out in Schedule 1, while Patient A was receiving 110mg Morphine Sulphate per 24 hours via syringe driver, administered to Patient A or helped Patient A self-administer Morphine Sulphate tablets 30mg which had been discontinued.

2. Produced a handwritten MAR chart on which you recorded the said administration of Morphine Sulphate 30mg tablets to Patient A on one or more of the dates/times set out in Schedule 1, when on one or more of those occasions you had not administered or witnessed the administration of the medication.

3. On one or more of the dates and times set out in Schedule 2, administered to Patient A or helped Patient A self-administer Ramipril medication, which had been discontinued.

4. Produced a handwritten MAR chart on which you recorded the said administration of Ramipril to Patient A on one or more of the dates/times set out in Schedule 2, when on one or more of those occasions you had not administered or witnessed the administration of the medication.

5. Your action(s) at charges 1 and/or 2 and/or 3 and/or 4 were beyond the scope of your authority in providing personal care to Patient A in accordance with his care plan.

6. Your actions at charges 2 and/or 4 was dishonest in that you sought to create the misleading impression that medication had been administered at particular times when it had not been.

7. Were dishonest in that you stated that Patient A had self-administered medication when you had administered it.

8. Failed to inform Knowsley Clinical Commissioning Group ('CCG') and/or the District Nursing team that Patient A's needs as set out in his care plan had changed in that he now needed support with his oral medication.

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

Schedule 1

(1) 1 September 2020 at 09.00 and/or 21.00

(2) 2 September 2020 at 09.00 and/or 21.00

(3) 3 September 2020 at 09.00

(4) 4 September 2020 at 09.00

(5) 5 September 2020 at 09:00 and/or 21.00

Schedule 2

(1) Ramipril 2.5mgs:

(a) 1 September 2020 at 09.00

(b) 2 September 2020 at 09.00

(c) 3 September 2020 at 09.00

(d) 4 September 2020 at 09.00

(e) 5 September 2020 at 09.00

(2) Ramipril 5mgs caps:

(a) 1 September 2020 at 09.00

(b) 2 September 2020 at 09.00

(c) 3 September 2020 at 09.00

(d) 4 September 2020 at 09.00

(e) 5 September 2020 at 09.00.

Hearsay application

The panel heard a hearsay application by Ms Amaning, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31(1). She submitted that the NMC seek to rely on the evidence set out in the Safeguarding Report in order to pursue the NMC's statutory objective and the public interest in progressing hearings expeditiously.

Ms Amaning submitted that the hearsay application is for the admission of evidence of what Patient A told Nurse Karen Holland when she attended to him on 5 September 2020, which is seen in the Safeguarding Report. The alleged oral disclosure was subsequently repeated to Joanne McIver the day after and reflected in paragraph 13 of Holly Barton's evidence. To this end, the NMC submit that this evidence ought to be adduced.

Ms Amaning submitted that while she is making a global hearsay application in respect of the verbal disclosures made by Patient A to Karen Holland, and the subsequent hearsay accounts that appear in Joanne McIver's and Holly Barton's statement, she respectfully invited the panel to consider these separately.

Ms Amaning referred to the authorities of *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and *Mansaray v Nursing and Midwifery Council [2023] EWHC 730 (Admin)*. She then invited the panel to make a decision on the admissibility of

the evidence from the outset, rather than giving the evidence weight at the end of the evidential process.

Ms Amaning submitted that the Safeguarding Report states that Patient A told Karen Holland that he had been having 30mg MST twice a day from his carer. The Safeguarding Report was then made two days after the alleged incident. She submitted that the verbal disclosures made by Patient A, contained within the Safeguarding Report contains hearsay insofar as what Nurse Holland was told by Patient A, and there is no statement from Patient A.

Ms Amaning submitted that the evidence is relevant as it goes towards charges 1 and 7. Secondly, Patient A passed away six days after the incident, therefore, there was no opportunity for a statement to be taken from him. In these circumstances, it would be fair to admit the evidence. Ms Amaning then had regard to *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* and referred to the criteria set out in paragraph 56:

i. *whether the statements were the sole and decisive evidence in support of the charges;*
ii. *the nature and extent of the challenge to the contents of the statements;*
iii. *whether there was any suggestion that the Witnesses had reasons to fabricate their allegations;*
iv. *the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
v. *whether there was a good reason for the non-attendance of the Witnesses;*
vi. *whether the Respondent had taken reasonable steps to secure their attendance; and*
vii. *the fact that the Appellant did not have prior notice that the Witness statements were to be read.*

Ms Amaning submitted that the verbal disclosure made by Patient A to Nurse Holland is not sole and decisive of charge 1, as the MAR charts show that 30mg of Morphine MST had been administered and signed for by you. There is also the account that you provided where you stated you had helped Patient A to get his oral medication as his mobility deteriorated. Additionally, the panel will hear from Holly Barton, who spoke to you after the incident. In respect of charge 7, the verbal disclosure may be considered sole and decisive because there is no statement from Patient A, as he passed away days after the incident. However, this evidence may be admitted and is not determinative of the issue of admissibility even if the verbal disclosure is sole and decisive on the issue, and *Thorneycroft* makes it clear that this does not mean the evidence must be excluded. Rather, the panel are able to carry out a careful balancing exercise and must be satisfied the evidence is demonstrably reliable or there is some other means of testing the evidence.

In respect of the second test, Ms Amaning submitted that you are legally represented in these proceedings. As such, your representative and the panel will have the opportunity to directly question Karen Holland, which will alleviate some of the concerns. Further, she submitted that there is no evidence to suggest that the verbal disclosure was fabricated. Instead, the disclosure was made and documented days after Nurse Holland was informed of the alleged incident. The subsequent disclosures made to both Joanne McIver and Holly Barton were also made promptly, namely the day after the incident (Joanne McIver) and two days after (Holly Barton).

Ms Amaning submitted that the charges are serious and any adverse findings could potentially have an impact on your career. However, the NMC have an overarching objective to protect the public. In respect of the sixth principle, she submitted that Patient A passed away before there was an opportunity to get a statement. As such, there are good and cogent reasons for Patient A's non-attendance. Ms Amaning further submitted that you had prior notice of these proceedings and the evidence contained, and were invited to two case conferences to discuss issues. However, you did not attend or return

the Case Management Form (CMF) which referred to the charges and the evidence the NMC would rely on.

In these circumstances, Ms Amaning invited the panel to admit the oral disclosure, submitting that it would be fair and relevant in this case.

Mr Nwokedi, on your behalf, invited the panel to refuse the hearsay application and submitted that it would be unfair and unreliable to admit the statements. He submitted the alleged statement made by Patient A, is not a witness statement and is a summary of a conversation recorded by Ms Holland. Further, you would not be able to cross examine Patient A because he has passed away.

Mr Nwokedi submitted that this case is based on the nuance of what it means to self-administer or assist with medication. He submitted that when Patient A was asked about the medication, he was going through toxicity, was in pain and was distressed and it is unclear what questions were asked of him at the time. Mr Nwokedi raised this point because he invited the panel to find that Joanne McIver's statement is not clear on whether she spoke to Patient A, or whether she was updated by Karen Holland. He also raised the same issues with regards to Holly Barton.

Mr Nwokedi referred to *Thorneycroft* and submitted that this evidence is not reliable because it was taken at a time when the patient was in pain. As such, any information elicited at the time cannot be said to be reliable. However, should the panel admit the statements as hearsay, he invited the panel to give the information minimal weight.

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. He also referred to the four 'relevant principles' set out in paragraph 45 of *Thorneycroft:*

> *1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*
>
> *1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*
>
> *1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*
>
> *1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.*

The panel gave the application in regard to the statements serious consideration and had regard to the test set out in *Thorneycroft* when making its decision.

It noted that the Safeguarding Report features evidence of what Patient A is alleged to have said. However, there is also the live witness evidence of Karen Holland who will be able to speak to what Patient A said to her. In addition, there is her evidence of how Patient A presented to him when she visited him, namely that '*he was exhibiting signs of possible toxicity'*. This would potentially corroborate his hearsay account. Further the NMC

have provided a MAR Chart said to have been prepared and signed by you which, on one view, records you administering Morphine Sulphate tablets on the relevant date. In addition, there is evidence of what you are reported to have said when the matter was investigated by Kirsty Evans.

The panel noted that you do not accept that the MAR chart was a record of medicine that you administered, but the panel was unable to determine this factual dispute without first hearing evidence.

The panel considered that the hearsay evidence of what Patient A said is not the sole and decisive evidence in respect of Charge 1.

In light of the MAR Chart, the panel did not consider what Patient A is reported to have said as the sole and decisive evidence for Charge 7. The panel was of the view that the evidence can be challenged by way of cross examination.

The panel next had sight of your reflection, in which you agree to some elements of the Safeguarding Report. In these circumstances, the panel determined that the evidence is admissible and there is no reason to suspect that the evidence has been fabricated. The panel also determined that there was good reason for the non-attendance of Patient A as he subsequently passed away days after the alleged incident. It would be artificial to expect the NMC to have obtained a witness statement because Patient A had died prior to the referral to the NMC.

The panel was of the view that you were given prior notice of this application as the witness statements and exhibits will have been sent to your advisers, and you were given the opportunity to attend a case conference and fill out a Case Management Form. However, you did not attend the case conference or return the Case Management Form.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of what Patient A is alleged to have said, but

would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

On 23 December 2020, the NMC received a referral from NHS Knowsley Clinical Commissioning Group (the CCG). At the time of the incident, you were the Owner and Manager of the care provider Mossdel Healthcare Ltd ("the Company"). The Company had only recently registered with the Care Quality Commission (CQC) on 18 December 2019. As the Owner and Manager of the Company, you were aware that you were commissioned only to undertake tasks such as washing, dressing and making food for Patient A.

Patient A had a terminal diagnosis of metastatic pancreatic, lung and liver cancer and was at the time of the allegations living at home with his wife. You were also providing care to his wife at the relevant time.

On 13 August 2020, Patient A was admitted to Whiston Hospital and was subsequently discharged on 28 August 2020, with a package of care from Mossdel Healthcare commissioned to commence on 29 August 2020. The hospital discharge summary notes show that Patient A's previous prescription of morphine sulphate tablet (MST) was converted to 110mg of morphine via syringe driver, which was to be administered by a district nurse in his home. The discharge summary also notes that Ramipril was to be stopped due to acute kidney injury (AKI). When Patient A returned home with the Mossdel care package in place, it is alleged that you administered or helped Patient A to take the discontinued medication. It is also alleged that you created a Medication Administration Record (MAR), showing both the morphine MST- 30mg and Ramipril having been administered, which you signed on the dates found at schedules 1 and 2.

On 5 September 2020, Patient A was visited by Karen Holland who is a District Nurse. Nurse Holland attended upon Patient A; However, when Nurse Holland attended upon

Patient A, she believed he was exhibiting signs of opiate toxicity. Nurse Holland sought advice from the hospice and called an ambulance which led to a safeguarding referral being made.

Patient A was taken to hospital and on 11 September 2020, passed away. It is however highlighted that the cause of Patient A's death was confirmed as metastatic pancreatic cancer.

Decision and reasons on facts

When the charges were read at the start of the hearing you denied all of them. The NMC was required to prove all of its charges.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Amaning and by Mr Nwokedi. The panel took into account the fact that you are of good character. Whilst it had regard to the documents produced in the course of other investigations, it was not influenced by the decisions reached.

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:

- Karen Holland: District Nurse at Merseycare at the time of the concerns;

- Joanne McIver: District Nurse and Team Leader at Knowsley District Nursing at the time of the concerns;
- Kirsty Evans: Care Quality Commission (CQC) Inspector at the time of the concerns;
- Holly Barton: Social Worker at the Knowsley Multi-Agency Safeguarding Hub at the time of the concerns.

The panel also heard evidence from you under affirmation.

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 Mr Nwokedi.

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

Charge 1

That you, a registered nurse, when providing personal care to Patient A:

1. On one or more of the dates and times set out in Schedule 1, while Patient A was receiving 110mg Morphine Sulphate per 24 hours via syringe driver, administered to Patient A or helped Patient A self-administer Morphine Sulphate tablets 30mg which had been discontinued.

This charge is found proved.

In reaching this decision, the panel noted that it was not a matter of controversy that the prescription for 30mg morphine sulphate tablets had been discontinued by the time Patient A returned home. The panel accepted that you would not have known this as the administration of medicine was not part of your remit.

As such it was not within your remit to create a MAR chart, particularly as you would have no means of knowing whether or not any of the medicines in Patient A's home had been discontinued.

You would have been aware that Patient A was being administered medication on a syringe driver, which was the responsibility of the district nurses who visited twice a day.

In reaching its decision the panel took into account Kirsty Evans witness statement which reads:

> *'The Registrant [you] told us that Patient A was self-medicating following his discharge from hospital on 28 August 2020. I understand that Patient A was deemed to have capacity, and was able to manage his own medication. This was confirmed in his assessment so there was no issue there. However, the Registrant told us that four days following discharge, Patient A was struggling to get to the kitchen to get his medication, so he asked the Registrant to help him by handing him his medication. This escalated on day five with asking the Registrant to put his medication in a pot for him. We asked the Registrant very specifically, in her own words, what she did to support Patient A with his medication. The Registrant said that there was one occasion where she got the medicine from the kitchen, popped the tablet out of the packet and put it into a pot. She then handed it to Patient A. The Registrant said that on other occasions the Registrant had put the medication into the pot and left it for Patient A to take himself later.'*

Kirsty Evans reiterated this conversation when giving oral evidence to this panel. She confirmed the conversation had taken place with you when her and a colleague had visited the Company offices to conduct an inspection after these concerns had been raised. She said your actions in *'popping'* medication from its packaging, "*does break away from the care plan".* Although her notes of the meeting are no longer available, she informed the panel that her witness statement was based on her contemporaneous notes.

The panel found that Kirsty Evans statement was corroborated by other evidence including Karen Holland's assessment of Patient A's condition. There was a telephone conversation between yourself and Holly Barton on 11 September 2020. Holly Barton said that you admitted that you *'put the medication in a pot for Patient A to take'* and *'followed his instruction despite this not being part of the care plan'.* While the panel heard evidence that the telephone line was not clear, it saw nothing to contradict the evidence obtained by Holly Barton.

Karen Holland was also told by Patient A that his carer (you) had administered his medication. However, the district nurses were not aware that Patient A was taking his discontinued medication. Furthermore, she found on that date a completed and signed MAR Chart stating that MST had been administered. In the panel's view, this concern was so great that Karen Holland told Joanne McIver at the district nurse safety huddle the following day, which prompted Joanne McIver to advise Karen Holland to complete a Safeguarding Report. While the evidence contained within the document is hearsay evidence of what Patient A said, the panel determined it was credible as it had been produced two days after the incident and was consistent with your admissions and the documentary evidence of the MAR chart. The Safeguarding Report also details a conversation with Patient A's partner where she confirmed that despite Patient A being on a syringe driver, he would request for more medication, and you would administer it to him. Whilst this is also hearsay evidence, it provides further corroboration of the NMC's case.

In response to the concerns, you sent an undated letter which stated the following:

'During my visits, I would place Mrs. Patient A [Patient A's wife] medication in a pot, while Patient A , preferring to manage his own, would request me to hand him his medications. On the third day he requested to be reminded of the pending completion of one of his medicines.'

In oral evidence, you maintained that you did not put Patient A's medication in a pot and handed all of his medicine to him in a Tupperware. However, the panel heard evidence from a number of witnesses who said that once you had popped the medication from the packaging, you are administering. Further, two witnesses, stated that you admitted to placing medication in a pot. As such, the panel concluded that it is more likely than not that you had administered the medication to Patient A. The panel considered that your use of the word pot meant that you had potted medicine for consumption. It did not consider that *'pot'* meant that you placed all of the medicine, unopened, in a large Tupperware. The panel understands the use of the word 'pot' to be consistent with the method the public would visualise unpackaged medication being handed to a patient for taking.

The panel next had regard to Patient A's MAR Chart. The panel could think of no other reason for you creating a Medicine Administration Record unless you intended to administer medicine to Patient A. The panel was of the view that you believed this document was important, given that you had amended the legend to include further details. While you maintain that you created the MAR Chart as a reminder to Patient A that his dexamethasone was reducing on day seven, the panel considered this explanation to be highly unlikely. If this were the case, then the document which would have been produced, would only deal with the dexamethasone. Indeed, the panel was of the view that if this was merely a reminder in respect of that sole medication, there would be no need to list all the other medication, and that another method of reminding would be more appropriate.

As a registered nurse, you would have been well aware that by creating a MAR chart, you assumed responsibility for providing Patient A with the medicine set out in that document.

The panel therefore concluded that on one or more of the dates set out in the schedule, you administered the medication and signed the MAR Chart to show that you had administered morphine sulphate on one or more of the times set out in schedule 1.

Accordingly, the panel found Charge 1 proved.

Charge 2

That you, a registered nurse, when providing personal care to Patient A:

2. Produced a hand written MAR chart on which you recorded the said administration of Morphine Sulphate 30mg tablets to Patient A on one or more of the dates/times set out in Schedule 1, when on one or more of those occasions you had not administered or witnessed the administration of the medication.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Kirsty Evans which reads:

'The Registrant [you] told us that Patient A was self-medicating following his discharge from hospital on 28 August 2020. I understand that Patient A was deemed to have capacity, and was able to manage his own medication. This was confirmed in his assessment so there was no issue there. However, the Registrant told us that four days following discharge, Patient A was struggling to get to the kitchen to get his medication, so he asked the Registrant to help him by handing him his medication. This escalated on day five with asking the Registrant to put his medication in a pot for him. We asked the Registrant very specifically, in her own words, what she did to support Patient A with his medication. The Registrant said

that there was one occasion where she got the medicine from the kitchen, popped the tablet out of the packet and put it into a pot. She then handed it to Patient A. The Registrant said that on other occasions the Registrant had put the medication into the pot and left it for Patient A to take himself later.

The Registrant set up a MAR chart to document the medication she was supporting with. However, it seemed that the Registrant was signing to confirm that Patient A had taken medication, when she had only left it in a pot for him and not actually seen him take it…'

The panel found that Kirsty Evans witness evidence was consistent with her written evidence. She was found to be a credible witness and explained she had written her statement based on notes she made at the time of visiting you, which she had crosschecked with her colleague's notes, who was also present at that meeting.

The panel next had regard to Karen Holland's witness statement which reads:

'When I visited Patient A in the evening in September 2020, she had signed the MAR chart to say that she had administered morphine MST tablets at a certain time – 9pm- to say she had given it then but my shift was finishing at 8pm and I was there in his home before 8pm so how could she given the morphine tablet to him at 9pm that day?'

Although you said in oral evidence that you were using the timings on the MAR Chart as a *"rough guide"* for reminding Patient A to take his medication, the panel was of the view that good nursing practice would include administering the medication at the correct time and signing for it accordingly. It did not find it plausible that a nurse of some 26 years with experience in a theatre setting, would approach the completion of MAR Charts in a community setting differently to the practice you described you undertook in a hospital setting. Karen Holland's evidence in her initial report of a Safeguarding referral was that Patient A's stepson told her that you had left the home at 19:00, and therefore could not

have administered at 21:00 as required. You were not in the home when Karen Holland arrived, and you said that you attended early on that occasion.

The panel took into account Patient A's MAR Chart. As with Charge 1, the panel considered that you viewed the MAR Chart as an important document, given that you amended the legend. The panel also noted from the MAR Chart that you had administered the MST on day seven at 21:00 as required. Therefore, it did not accept that you were treating this document as a *'reminder'* to Patient A to take his dexamethasone.

Accordingly, the panel found charge 2 proved.

Charge 3

That you, a registered nurse, when providing personal care to Patient A:

3. On one or more of the dates and times set out in Schedule 2, administered to Patient A or helped Patient A self-administer Ramipril medication, which had been discontinued.

This charge is found proved.

In reaching this decision, the panel took into account that Patient A's Discharge Summary from Whiston Hospital confirmed that Ramipril and MST had been discontinued on 28 August 2020. However, it appears that Ramipril was still in Patient A's possession. The MAR chart created by you was administered to Patient A and was signed for every single day from day four after discharge.

The panel noted that the Safeguarding Report included a conversation between yourself and Joanne McIver. When asked why the oral MST and Ramipril medication was listed on the MAR sheet, you said that you provided Patient A with the medication that was in his bag. However, the Discharge Summary was clear that the Ramipril was '*held'* and

‘currently normotensive for GP to review’. In light of this information, the panel was satisfied that Ramipril should not have been administered.

You agreed the initials which appeared alongside the administration of Ramipril on the MAR chart were your own. The panel therefore determined that you had administered Ramipril.

In these circumstances, the panel determined that it was more likely than not that on one or more of the dates and times set out in Schedule 2, you administered Patient A Ramipril medication which had been discontinued.

Accordingly, the panel found charge 3 proved.

Charge 4

That you, a registered nurse, when providing personal care to Patient A:

4. Produced a hand written MAR chart on which you recorded the said administration of Ramipril to Patient A on one or more of the dates/times set out in Schedule 2, when on one or more of those occasions you had not administered or witnessed the administration of the medication.

This charge is found proved.

The panel noted that, unlike charge 2 there was no direct evidence, from other witnesses of there being an entry in the MAR chart of you recording the administered drug at a later time.

However, the panel had regard to an explanation provided by you in the undated *‘Statement for information’.*

In that letter you said that Patient A had an Alexa device which would remind him to take his medicine and:

> *'…while attending to Patient A in the morning at 9am, he would say that he had already taken his medication prior to the arrival of the carer and I often recorded on MAR charts as taken...'*

Although this admission is generic to all medication, the panel considered it to be sufficient for the panel to find that on one or more times you had recorded Ramipril as having been taken, despite not witnessing it.

During oral evidence, you said that Patient A had generally taken his insulin injection prior to your arrival at his home. Insulin was not written on the MAR chart, it is therefore likely that by you saying he had taken his medication, this was his oral medication including Ramipril. The panel found it was more likely than not that you had signed for the administration of the Ramipril when you had not witnessed it being administered.

Accordingly, the panel found Charge 4 proved.

Charge 5

That you, a registered nurse, when providing personal care to Patient A:

5. Your action(s) at charges 1 and/or 2 and/or 3 and/or 4 were beyond the scope of your authority in providing personal care to Patient A in accordance with his care plan.

This charge is found proved.

The panel first had regard to the *'summary of care needs and care plan'* from Knowsley's CCG, which commissioned the tasks agreed for the Company and for any carers to

conduct for Patient A on behalf of the Company. This was limited to personal hygiene matters and generic care. It did not extend to medication administration or management.

The commissioned work detailed the following responsibilities you were to undertake, including:

1. One staff to assist with all aspects of washing and dressing each morning as required, and give Patient A time and maintain his privacy and dignity at all times.
2. One care staff to assist if required with maintaining continence hygiene and all hygiene needs as required to maintain skin integrity, comfort and dignity
3. Care staff to monitor pressure areas at each intervention and report any changes.
4. Patient A feels at present he is able to prepare his own meals and drinks. Care staff to monitor when attending and provide assistance if required.

The panel was of the view that as the Director, Manager and nominated person of the Company, you should have had an intimate knowledge of the commission. In oral evidence, you were asked if you knew what your role and obligations were and you told the panel that you were given a summary of Patient A's care needs and care plan. However, in producing the MAR Charts and administering medicine, the panel determined that you had deviated from your responsibilities and as such, had gone beyond the scope of your authority.

The panel also noted from your response to the concerns that you accepted your shortcomings. You stated the following:

> *'While my intentions were to provide compassionate care, the outcome highlighted significant areas for improvement'*

Accordingly, the panel found Charge 5 proved.

Charge 6

That you, a registered nurse, when providing personal care to Patient A:

6. Your actions at charges 2 and/or 4 was dishonest in that you sought to create the misleading impression that medication had been administered at particular times when it had not been.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, paragraph 74:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.'*

The panel first considered your state of mind at the time of the incident and had regard to the MAR Chart and your oral evidence.

The MAR Chart showed that you administered the medication at 21:00. Karen Holland's evidence in her initial report of a Safeguarding referral was that Patient A's stepson told her that you had left the home at 19:00, and therefore could not have administered at

21:00 as required. You were not in the home when Karen Holland arrived, and you said that you attended early on that occasion.

The panel noted that whilst administering medication for Patient A, you were operating under CQC guidelines. Your *'handling medication'* competency had expired on 23 August 2020, and you were required to resit the course.

In oral evidence, you told the panel that you administered the medication and you used the times as a *"rough guide"*. You also explained that Patient A contacted you on 5 September 2020, informing you that he was in pain and wanted to have an early night. You subsequently went to his home at 18:30, where Patient A informed you that he was in pain, and you made the entry to show that Patient A had been administered the MST as required.

The panel considered that this misstatement in the MAR chart occurred in highly unusual circumstances. The only person who saw the MAR chart, until it was discovered on 5 September 2020 was you. You and you alone had administered the medication and would have known that you did not attempt to record the correct time. The panel also took into account that you were out of date with CQC training and may not have been aware of what would have been expected of you in a hospital or domestic setting. The panel formed the view that you believed you were doing the right thing, even though that belief was mistaken.

In these circumstances, the panel determined that you did not aim to deceive anyone in making the entries that you did. You genuinely held a belief that it was acceptable to complete a MAR chart in the manner that you did.

The panel determined that you had administered the medication or been told it had been self-administered by Patient A, and you created and completed the MAR chart according to the way you chose to do it. This had been in place for five days when the incident occurred, and no one had taken up any issue with either the MAR chart or you

administering the medication before. The panel therefore considered that knowing this and these being the circumstances, you were not seeking to mislead anyone at this stage.

The panel considered whether your act, in light of that state of mind, was dishonest by the standards of ordinary decent people. It came to the conclusion that although what you did was not commensurate with good nursing practise, it could not be described as dishonest.

Therefore, the panel found Charge 6 not proved.

Charge 7

That you, a registered nurse, when providing personal care to Patient A:

7. Were dishonest in that you stated that Patient A had self-administered medication when you had administered it.

This charge is found proved.

The panel had regard to the test set out in *Ivey* when making its decision.

The panel first considered your initial accounts to Holly Barton and Kirsty Evans. You told them you put Patient A's medication in a pot and handed the pot to Patient A. However, after the incidents, in your undated Statement of Information (during the safeguarding investigation), you maintained that Patient A self-administered his own medication. You repeated this position in a *'reflection summary'* which accompanied a letter by the RCN to the NMC dated 5 June 2024.

In your Statement of Information, you explained that Patient A's mobility was deteriorating and requested that you pass him the medication. To the panel, this was a vehement denial of the concerns outlined in the Safeguarding Report and the accounts given by other witnesses. The panel also noted that in the same statement, you said the following:

'When I was about to leave at 7pm, Patient A informed me that he will take his medication given that he had taken his medication before 9am that morning and felt that there was enough and safe time interval between'

However, the panel was of the view that this clearly contradicted your initial oral accounts where you told Holly Barton and Kirsty Evans that you used a pot to give Patient A his medication. Further, you signed the MAR Chart to state that you had administered the medication at 21:00 as required, which contradicts the accounts you gave to the panel and the witnesses.

In these circumstances, the panel concluded that it is more likely than not that you were acting dishonestly in providing the Statement of Information. The panel considered that in providing that statement, you were well aware that you were providing a false account in which you denied the administration of medicine. Your motive for doing so was to avoid the consequences of your unauthorised administration of medicine to Patient A.

The panel considered whether your act, in light of that state of mind, was dishonest by the standards of ordinary decent people. It came to the conclusion that ordinary decent people would consider your actions, involving an attempted cover up, to be dishonest by their standards.

Therefore, the panel found Charge 7 proved.

Charge 8

That you, a registered nurse, when providing personal care to Patient A:

8. Failed to inform Knowsley Clinical Commissioning Group ('CCG') and/or the District Nursing team that Patient A's needs as set out in his care plan had changed in that he now needed support with his oral medication.

This charge is found proved.

The panel heard that Patient A had capacity (and was able to use Alexa to assist with medication reminders) on discharge from hospital on 28 August 2020. However, Patient A's partner spoke of a change in Patient A's capacity to take his medication soon after his discharge. This is further corroborated by your undated statement where you state that Patient A's mobility had deteriorated and requested that you pass him his medication. You also reiterated this in oral evidence, where you said you considered this to be a natural consequence of his poor health. Although you claim that Patient A only deteriorated on 5 September 2020, the panel found the fact you prepared a MAR chart on day four of his discharge from the hospital as evidence that he had deteriorated much sooner. The panel considered his inability to remember to take his drugs or to handle them himself was a change in his condition, and a change in care needs and that you should have notified the relevant authorities on that date.

The panel also considered that Joanne McIver was clear that this change should have been flagged to both the district nurses and the CCG to prompt further review. You further state the following in your undated statement:

> *'If a client were to ask Mossdel healthcare for activities that were not in his care plan, the policy is for the carer to report to management depending on what it is.'*

Accordingly, the panel determined that you were aware of your responsibilities and knew that you should have informed the CCG and district nurses that Patient A required support with his medication.

Therefore, the panel found Charge 8 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 in light of the fact there was limited time available on the last day allocated for this hearing, it did not go on to consider whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

Submissions on misconduct

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

Ms Amaning invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Amaning submitted that your conduct fell seriously short of what is expected and required of a registered nurse. She submitted that while the Company was a relatively new venture at the time, you had been a registered nurse for a substantial period of time. As such, a nurse with your level of experience ought to have a firm grasp of the importance of administering medication safely, correctly and the importance of accurate record keeping.

Ms Amaning submitted that the misconduct is serious because you exposed Patient A to a risk of harm by administering the discontinued Ramipril, despite his AKI. Moreover, your conduct resulted in actual harm by virtue of the morphine overdose.

Ms Amaning submitted by leaving Patient A to take his own medication and not observing Patient A ingest the medication is also serious. She submitted that morphine MST is a controlled drug, and as such, the practice was dangerous and created an unacceptable risk of harm to the patient.

With regards to charges 2 and 4, Ms Amaning told the panel the misconduct is serious and placed a vulnerable patient at risk of receiving inaccurate and potentially harmful doses of medication. Further, it created an environment whereby other professionals would have been denied an opportunity to accurately assess the needs of Patient A. In respect of charge 7, Ms Amaning said that it is conduct that fellow practitioners would consider deplorable.

Ms Amaning referred the panel to the NMC Guidance: Misconduct (reference: FTP-2a). She submitted that your case falls within the remit of the guidance. Ms Amaning also invited the panel to consider that while you were not working as a registered nurse, the matters are closely related to your practice as a registered nurse.

Ms Amaning submitted that your conduct at charges 1 to 4 constitutes a breach of the basic values of the nursing profession. She submitted that morphine is a controlled drug and improper administration carries a serious risk of harm. Similarly, the Ramipril had been discontinued due to Patient A's AKI and the continued administration further exposed the patient to harm. In these circumstances, the NMC submits that you were acting without any consideration of the correct clinical picture.

Ms Amaning also invited the panel to find serious misconduct in relation to charge 7. She submitted that the dishonesty constitutes a stark departure from the standards expected of a registered nurse, and honesty and integrity are fundamental tenets of the profession.

Ms Amaning invited the panel to consider that a number of parts of the Code had been significantly departed from namely, 3, 3.1, 8, 8.2, 8.3, 8.5, 8.6, 10, 10.2, 10.3, 13, 14, 18, 18.2, 18.3, 20, 20.2.

Mr Nwokedi invited the panel to consider that the panel's findings at their highest do not cross the threshold into serious professional misconduct. He submitted that this is not a case of repeated misconduct or sustained dishonesty. Rather, this is a case of a single episode of misconduct in a palliative setting in exceptional circumstances, including a deteriorating patient with unclear boundaries and systemic communication gaps.

With regards to charges 1 and 3, Mr Nwokedi submitted that you did not know that the medication had been discontinued. He submitted that this is not a case where you knew you were breaching instructions. Instead, this is a case where a carer stepped beyond her role.

With regards to charges 2 and 4, Mr Nwokedi submitted that you believed you were doing the right thing and did not intend to mislead. He submitted this is not a case of falsification, rather a case of poor documentation, misunderstanding and informal practice. In these circumstances, these are remediable failings not misconduct.

With regards to charge 5, Mr Nwokedi submitted that context is important because this was not a setting within your normal practice as a nurse. Further, this was not a deliberate disregard for professional boundaries. In respect of charge 8, Mr Nwokedi submitted that this is a situation where there was a judgment error in a complex setting. With regards to charge 7, Mr Nwokedi submitted that you do not seek to minimise the seriousness. However, this is not a case of clinical dishonesty, and this incident should be viewed as an isolated incident.

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

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to significant breaches 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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it .

8 Work cooperatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required.

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 complete the necessary training before carrying out a new role

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

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

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

To achieve this, you must:

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

20 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In determining whether your actions amounted to misconduct, the panel decided to take the charges in turn.

Charge 1

The panel took into account the following:

- You were not commissioned to administer any medication to Patient A. Therefore, you were working beyond the scope of your responsibilities.
- There was no valid prescription in place, given that the MST had been discontinued after Patient A was discharged from hospital.
- As the appointed director, manager and 'nominated person' of the Company, you could be expected to be more assiduous with Patient A's care.
- You did not alert the other care providers that you were administering MST.
- Having decided to administer medication to Patient A, you failed to check his hospital discharge summary, which would have properly informed you of his prescribed medication.
- MST is a controlled drug and therefore dangerous if administered contrary to prescription;
- Patient A was an extremely vulnerable patient in the last days of his life.

In light of these findings, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 2

The panel determined that the MAR chart was not necessary because medication administration was outside of the commission. It was also of the view that MAR charts are

a legal and well-established document, and in failing to complete to the standards expected of the nursing profession, there was a potential for a risk of harm. You signed that Patient A had taken the medication when you did not see him ingest this. As a consequence, the records were inaccurate and could have impacted other professionals ability to provide Patient A's safe and effective care. Further, the inaccurate records had the potential to mislead other healthcare professionals.

In these circumstances, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 3

The panel took into account the following:

- You were not commissioned to administer any medication to Patient A. Therefore, you were working beyond the scope of your responsibilities.
- There was no valid prescription in place, given that the Ramipril had been discontinued after Patient A was discharged from hospital.
- As the appointed director, manager and 'nominated person' of the Company, you could be expected to be more assiduous with Patient A's care.
- You did not alert the other care providers that you were administering Ramipril.
- Having decided to administer medication to Patient A, you failed to check his hospital discharge summary, which would have properly informed you of his prescribed medication.
- Ramipril was discontinued due to the patient's AKI and if administered contrary to prescription, it could be harmful;
- Patient A was an extremely vulnerable patient in the last days of his life.

The panel noted that Patient A's Ramipril had been discontinued due to his AKI and was documented in his discharge summary. By failing to check the documentation and continuing to administer the Ramipril, Patient A was exposed to a potential risk of harm.

In light of these findings, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 4

The panel took into account that you had signed the MAR chart to indicate that Patient A had taken his medication at the allocated times. However, you did not see Patient A ingest the medication. The panel also adopted its findings in charges 1 and 2 in determining whether your actions amount to misconduct. In failing to oversee Patient A ingesting the medication, there was a potential risk of harm. Because of this, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 5

The panel took into account that you were the *'nominated person'*, manager and director of the Company and as such, should have ensured compliance with the care package. It also noted that you went beyond your contracted obligation by administering medication when you were only commissioned to provide personal care.

The panel determined that while you may have been acting compassionately, your actions were a deliberate disregard of your responsibilities outlined in the commission. As a result, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 7

The panel had found that you were initially open and candid at the time but later changed your position. As such, it was of the view that your actions were serious because you were not acting honestly and attempted to conceal the fact that you administered the

medication. Therefore, your dishonesty is directly linked to your clinical practice as a nurse.

Accordingly, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 8

The panel determined you were or should have been aware of the steps required to inform the CCG and district nurses of any changes in the patient's condition. You were also aware that Patient A deteriorated within days after he left hospital. In failing to inform the relevant parties of Patient A's deterioration, you deliberately went against the care plan and the care you were commissioned to provide.

The panel took the view that as a registered nurse, you cannot derogate from your code of conduct and responsibilities when working as a carer. You retain a registered nurse's skills, knowledge and registration.

The panel therefore determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Interim order

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.

Submissions on interim order

Ms Amaning invited the panel to impose an interim suspension order on the grounds of public protection and the wider public interest for a period of 12 months. This application was made in accordance of Article 31 of the Nursing and Midwifery Order 2001.

Ms Amaning submitted that the charges found proved give rise to both clinical and attitudinal concerns. She submitted Patient A suffered actual harm as a direct result of your actions at charges 1 and 3 and is directly linked to your clinical practice.

Ms Amaning submitted that an interim order is necessary in the wider public interest. She submitted that a reasonable, well-informed member of the public, fully informed of the facts of this case, would be concerned if you were permitted to practice unrestricted.

Ms Amaning submitted that an interim suspension order for a period of 12 months will cover any relisting dates and takes into account the current backlog the NMC faces.

Mr Nwokedi opposed the interim order application. He submitted that you have been working unrestricted for six years and no further issues have been raised with your practice. You have also provided the panel a number of positive testimonials and training to address your failings, including record keeping and medicines administration. Further, he submitted that the concerns related to your practice in a community setting and you no longer work in community, and now work in a hospital within a structured clinical environment. Therefore, this materially reduces any risk.

In respect of proportionality, Mr Nwokedi submitted that the hearing will not resume until October. As such, the impact of an interim suspension order would be severe and immediate. [PRIVATE].

Mr Nwokedi submitted that should the panel choose to impose an interim order, then a conditions of practice order could manage any risks. He invited the panel to impose the following conditions:

- Restrictions on medicines administration
- Requirements of supervision
- Limitation to your current hospital and;
- Prohibition on community work

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

The panel took into account that you have been practising unrestricted for six years with no further concerns raised on your practice. You have also provided the panel with six positive testimonials that speak to your current practice, and training on record keeping and medicines administration. For the avoidance of doubt, the panel did not make findings of actual harm being caused to Patient A at the facts stage. Nonetheless, the panel have identified risks in the following areas:

1. Medicines administration.
2. Record keeping.
3. Practising as a nurse in the community or indeed outside the theatre setting;
4. Your lack of candour when things go wrong.

In these circumstances, the panel determined that an interim order is required in your case on the basis that one is necessary for the protection of the public. The panel considered that there would be a real risk to patients if an order was not made.

The panel next considered whether to impose an interim conditions of practice order.
It considered that imposing an interim suspension order would be highly disproportionate at this stage. In the light of this, the panel decided that there were workable conditions that

could be formulated that would protect the public and the wider public interest. As such it has determined that the following conditions are proportionate and appropriate:

'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 practice to your role as Theatre Practitioner performing scrub duties with your current substantive employer Stepping Hill Hospital Stockport NHS Foundation Trust.

2. You must not administer medication until signed off as competent to do so by a registered nurse.

3. You must not complete record keeping until signed off as competent to do so by a registered nurse.

4. 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.

5. 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).
6. 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.

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

The panel decided to make this interim order for a period of 12 months on the basis that it is possible that the hearing set down for 27 October 2026 may be relisted.

Submissions on impairment

The panel resumed on 27 October 2026.

Ms Amaning first invited the panel to consider the NMC Guidance at DMA-1 and submitted that when looking at impairment and the facts found proven, you do present an ongoing risk of harm to people receiving care, to the public confidence in the profession and also when considering your professional standards. As such, Ms Amaning submitted that your fitness to practice is currently impaired on both the grounds of public protection and also in the wider public interest.

Ms Amaning referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Amaning submitted that at charges 1-4 as found proven, the repeated clinical concerns over a period of time, albeit short, demonstrate an ongoing risk of repetition.

With regard to charge 5, Ms Amaning submitted that you demonstrated attitudinal concerns by acting outside of the scope of your authority. At charge 7, the panel found that you had been dishonest in an attempt to conceal the fact you had given the medication to Patient A by stating they had self-administered. Ms Amaning submitted that there are public interest considerations when looking at impairment at charge 8. She submitted that your actions in deliberately choosing to go against the care plan and failing to notify the clinical commissioning group and district nurses of the change of the patient's condition, are matters the public would rightly be concerned about.

Ms Amaning submitted that this conduct demonstrates serious failings and that there is a need here to uphold proper professional standards and to maintain public confidence. She submitted that your conduct in the charges found proved calls into question your suitability to remain on the register and practice without restriction.

Ms Amaning submitted that when looking at the *Grant* test, in light of the charges found proved, all four limbs are engaged in this case. With regard to limb a, Ms Amaning submitted that your conduct exposed Patient A to risk of harm, arising from you continuing to administer morphine sulphate which had been discontinued by the hospital. Ms Amaning submitted that your actions in the past in respect of Patient A, created a real risk of harm to a vulnerable patient during the last days of his life.

Ms Amaning submitted that similar considerations apply to charge 3 in that there was a risk of harm posed to Patient A by you continuing to administer Ramipril, which had been discontinued by the hospital.

Ms Amaning submitted that limb a can also be said to have been clearly engaged by you in the past, by virtue of your actions at charges 2 and 4. Your actions by creating the MAR charts, which were legal documents which you had signed to say that Patient A had taken medication, when in fact you did not see him take the medication. This in turn created inaccurate records for other care providers, namely the district nurses, who could have

been misled as to the accurate clinical picture for Patient A, which clearly would have posed a risk of harm to Patient A.

Ms Amaning further submitted when considering limb a that it has also been engaged by your actions at charge 5. In that, you were commissioned to provide personal care and that was set out in the care plan. By acting beyond the scope of the personal care plan and by exceeding that authority and administering medication, there was a risk of harm created by you in failing to recognise that clinical oversight was required for the administration of medication.

Ms Amaning finally submitted in respect of limb a, that the failings to inform the care commissioning group and or the district nurses as to Patient A's condition as seen at charge 8, also created a further risk of harm as the relevant teams were not in possession of essential information about Patient A and they therefore could not appropriately assess the clinical needs of the patient, thereby placing Patient A at a risk of harm.
In relation to limb b, Ms Amaning submitted that it is also engaged in this case as members of the public are entitled to expect that nurses involved in caring for vulnerable patients will do so safely, that they will maintain accurate records and act within established parameters of their authority. Ms Amaning submitted that members of the public are entitled to expect that you will act honestly and inform other health care professionals of a patient's deterioration and or changes to a patient's condition. Ms Amaning submitted that these expectations are fundamental and that they are key to the unique position of trust which is held by nurses. She submitted your conduct brought the profession into disrepute.

With regard to limb c, Ms Amaning submitted that the fundamental tenets of the nursing profession have been breached in this case. She submitted that nurses are required to act with honesty, practise safely, maintain clear and accurate records, work within the limits of their competence and reduce any harm, or the potential for harm associated by their practise. Ms Amaning submitted that in the findings of this case, each of these

fundamental tenets of the profession have been breached and therefore limb c is engaged.

With regard to limb d, Ms Amaning submitted that this question can be answered in the affirmative as found at charge 7 as you had dishonestly stated that Patient A had self-administered medication when you in fact had administered it. Ms Amaning submitted that you deliberately provided an alternative version of events in a bid to minimise what you had done and to conceal the fact that you had administered the medication.

Ms Amaning referred to the case of *Cohen v The General Medical Council* and addressed the panel on the three questions in this case to be considered here.

Ms Amaning submitted that when considering whether these concerns can be addressed, whilst the panel may find that conduct relating to medication administration concerns are easily remediable and could be remediated through supervision and assessments, the deep-seated attitudinal concerns which this case has shown, provide ongoing concerns regarding your honesty and openness, which are more difficult concerns to address.

Ms Amaning submitted that when looking at whether the concern has been addressed, there is some evidence of remediation in the bundle provided by you. However, Ms Amaning submitted that the insight that has been provided is developing and that you have yet to show how you would deal with similar situations in a community setting, where you may have sole responsibility for medication administration.

With regard to whether the behaviour is highly likely to be repeated, Ms Amaning submitted that there is a real risk of repetition as the underlying attitudinal concerns demonstrated by you in this case, do give rise to that risk. Ms Amaning submitted that you deliberately went against the care plan that you had been commissioned to provide and deliberately sought to conceal that you had administered medication. This was dishonest and done in a bid to cover up your mistakes.

Ms Amaning submitted that you have engaged with the NMC throughout the fitness to practice process and you are someone who can be said to have had an otherwise positive professional record. Ms Amaning submitted however, that your insight is developing. Ms Amaning submitted that the reflective pieces which you provided in April and again in October do demonstrate this and do also show within your bundle that you have also undertaken some up-to-date training in a bid to address some of the issues of concern. There are certificates in the bundle pertaining to medication administration and Ms Amaning submitted that in view of this, you have not yet fully shown that you understand the risks associated with your conduct and it is only once a full understanding and appreciation of the seriousness of the risks that were associated with your actions have been fully addressed, that the risk of repetition will be reduced.

Ms Amaning therefore submitted that in this instance, should the panel not make a finding of impairment on both grounds of public protection and also on the wider public interest grounds, it would severely undermine the professional standards and also the confidence in which the public places in the nursing profession as a whole.

Mr Nwokedi invited the panel to find that your practice is not currently impaired on both grounds.

Mr Nwokedi submitted that your failings date back to 2020 and it is now six years on and you have since produced documents and evidence which demonstrates insight, understanding of your position and what you would do differently now.

Mr Nwokedi referred to your most recent reflection dated October 2026, which is also supported by relevant training, including medication administration, communication and teamwork, clinical record keeping and promoting patient safety through effective communication and teamwork. Mr Nwokedi submitted that your training addresses the knowledge required to recognise and manage the risks identified. Mr Nwokedi submitted that he does not suggest that completion of a course by itself proves that a practitioner

has changed, however when combined with your reflection, it explains all that you have taken from this learning.

Mr Nwokedi referred the panel to a number of testimonials from current employers. Mr Nwokedi referred to the testimonial of Ms Hadfield, senior sister who describes accurate contemporaneous record-keeping and escalation in your current theatre practise. Another testimonial by Mr Nudds refers to your competency and consistently high standards of written and electronic records. Mr Nwokedi submitted that the work they describe is within your current theatre role, and you are applying your learning in this role.

Mr Nwokedi submitted that following the adjournment in April, there were interim conditions imposed and since then, you have practised under these conditions, and no issues have been raised. Mr Nwokedi submitted that the accounts from senior colleagues who know you, work with you and describe the areas the panel was concerned about, is evidence of observed practise, competency, and application of safeguards over time.

Mr Nwokedi addressed charge 7 specifically and told the panel that it is recognised that this is a serious finding. Mr Nwokedi submitted that you were initially open and candid before later changing your position on this and being dishonest. He submitted that while remaining serious, the initial candour is a relevant part of the picture which the panel must assess when considering whether the incident demonstrates a continuing risk.

Mr Nwokedi referred to your reflective statement whereby you reflect on the candour and recognise that avoiding responsibility, minimising an incident, or failing to communicate can further undermine trust. Mr Nwokedi submitted that in your reflections, you also address the importance of a truthful explanation, reporting, investigation and learning.

Mr Nwokedi referred to the case of *Professional Standards Authority and NMC 2017 CSIH 29* and submitted that in your case, there is full insight. Although the facts in that case were not identical the panel should follow the approach of the Court in that case.

With regard to public interest, maintaining public confidence in the nursing profession and upholding professional standards, Mr Nwokedi told the panel that even if it is satisfied that you can practise safely, it must consider whether the seriousness of the conduct requires a finding of impairment to maintain confidence in the profession. Mr Nwokedi submitted that a properly informed member of the public would know the seriousness of the panel's findings, and they would also know the full context and the evidence it now has before it. They would take note of the fact that the panel initially found you to be open and candid before later changing your accounts and they would note that the initial candour is relevant to the assessment of the whole episode. Mr Nwokedi also submitted that a well-informed member of the public would also note that there is no finding that you caused Patient A's death and this does not mean that your conduct was safe, but the distinction is that the assessments must proceed on the findings that have been made. A well-informed member of the public would also note your years of practise without incident.

Mr Nwokedi submitted that with regard to this incident, it was in a specific role which you no longer practise in or engage in and your reflection has addressed the concerns that have been raised in these findings.

Mr Nwokedi submitted that the clinical failings have been addressed through the relevant learning and training, your reflection and observed practise and therefore you are not currently a risk to the public. Mr Nwokedi also submitted that there is no risk to public confidence if it is found that you are not impaired, and that is because of the learning, the work, the rehabilitation, and your own record as a registrant for the NMC.

Since you had not given evidence at this stage of the hearing, the panel asked a number of questions in respect of which Mr Nwokedi would provide answers. One of these involved an enquiry about a CV that you had submitted in advance of the earlier hearing. It was resubmitted with a separate bundle that was produced on the morning of 27 October 2026. The contents of the CV appear to be identical.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Grant*, *Cohen* and *PSA v NMC*.

Decision and reasons on impairment

The panel next 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 NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

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

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

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

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

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

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

The panel first considered whether any of the limbs of the Grant test were engaged as a result of your past conduct and whether these limbs are still currently engaged.

The panel determined that your past actions did put a patient at an unwarranted risk of harm to an extremely vulnerable patient towards the end of their life, suffering with a terminal illness. The panel determined that you had acted outside the scope of your commission as you had not been commissioned to administer any medication whatsoever in this role. With regard to whether you are liable in the future to put a patient at unwarranted risk of harm, the panel first accepted that in your current role you are clinically competent and the panel does not consider you pose a risk to patients in this area/your current role. The panel had regard to the quality and extent of the testimonials

provided by those working alongside you in your current role. The panel considered that you are working in a controlled environment as part of a larger clinical team, where there are checks and balances through process and procedures. Your current role is not one of lone working and is in an environment where you have practised for over 20 years; whilst in this role you manage and handle medications, you do not routinely administer them in your role as a scrub practitioner.

The panel had already conducted a risk assessment at the conclusion of the earlier part of the hearing and determined that you presented a risk to patients in the following areas:

1. Medicines administration
2. Record keeping
3. Practising as a nurse in the community or indeed outside the theatre setting
4. Your lack of candour when things go wrong

The panel imposed an interim conditions of practice order. The panel noted that you have not addressed how you operated under these conditions in your reflective statement. Although the conditions envisaged that you could administer medicines and be involved in record keeping this would only be permitted once you have been signed off as competent to do so. You have produced positive and up to date testimonials from a number of colleagues, one of whom has reported you as being signed off as being competent in the administration of medication and record keeping.

The panel considered the nature and context of your dishonesty, including that found proved in charge 7 when considering whether your dishonesty would likely pose a risk to patients in future. Albeit this could be said to be a fleeting moment of dishonesty in a stressful and developing situation, the panel determined it was a clear attempt to avoid blame once you came to appreciate the gravity of your actions. The panel do not accept that your initial honest account, followed by a change of account and dishonesty, is to your credit.

The panel went on to consider your actions at charge 7, alongside the document you provided today, which included your CV and your current employment status. The panel questioned you on a section of your CV which states:

> '*I have never been the subject of any NMC referrals, local disciplinary actions, or criminal cautions/convictions.'*

Having taken your instructions, Mr Nwokedi informed the panel that this CV had been prepared prior to the start of the hearing and that it was confirmed that you were not the subject of interim orders. It was your position that there was nothing inaccurate about the CV as the interim order was only imposed at the end of that part of the hearing.

It was pointed out to Mr Nwokedi that this part of the CV was not a declaration that you had not been the subject of interim orders. You had declared that you had not been the subject of an NMC referral. Mr Nwokedi then sought time to seek further instruction. When the hearing reconvened, Mr Nwokedi informed the panel that you were in the habit of regularly updating your CV and that this was just an error that you forgot to change.

These proceedings commenced in December 2020. Your explanation would require the panel to accept that many parts of your CV had been updated across the past six years, but you had unwittingly missed the paragraph aforementioned.

The panel was not satisfied with your explanation and found that it demonstrated a lack of probity. With these aspects of dishonesty, the panel considered whether this was evidence of a deep-seated attitudinal issue and whether that meant you may pose a risk to patients in the future, should anything go wrong in your clinical practice. The panel determined that these aspects of your character do pose a risk in the future as it could not be satisfied that if an error were to occur, you would not be prepared to deceive. The panel considered that the dishonesty relating to your CV is a live example of a document which is dishonest, as you have been referred to the NMC for the past six years, which leads the panel to be concerned about when and how this document has been used while you have been under

investigation. The panel noted that reference was made to your CV having been used in a successful job application in 2025, in the testimonial of Ms Hadfield.

With regard to limb b and limb c, the panel determined that your misconduct in the past had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel considered that your actions relate directly to patient care, specifically to a vulnerable patient, accurate record keeping, prevention of harm and it also considered your dishonest actions. The panel determined that your integrity could not be relied upon and it was therefore satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered limb d of the test and considered that you had acted dishonestly in the past, as it found proved in charge 7, you sought to deceive when you stated the patient had self-administered, when they had not and this was in an attempt to minimise the impact on yourself. The panel considered the various aspects of dishonesty as mentioned when considering limb a. The panel considered that your actions at today's hearing still lacked candour and integrity as it was not satisfied that it was an error on your part by leaving in the fact you were not subject to NMC investigations, despite being referred since 23 December 2020. The panel considered that you had an opportunity to be honest when asked by the panel, but it did not find your response to be truthful. The panel was not satisfied that you would be honest in the future.

The panel therefore concluded that limbs a, b and c and d of the *Grant* test were engaged in respect of your past conduct and potential future conduct.

The panel next considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) in which the Court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

The panel considered that on the face of it, the conduct can be remedied. It considered the dishonesty aspect of charge 7 and determined that as much as it is not acceptable, it might be understood that your actions were self-preservation. The panel then carefully considered the evidence before determining whether or not you have taken steps to strengthen your practice. The panel took into account of your reflection, relevant training and testimonials.

The panel considered that the conduct in relation to the clinical issues identified can be remediated, in terms of medication administration and record keeping and that you have demonstrated that in your reflective piece, the relevant training and the testimonials of those currently working with you. However, the panel were much less certain that the dishonesty it found was easily remediable.

The panel considered your reflective piece and found it to be well-written, however it also noted that it is academic, mechanical and lacks specificity, despite showing emotion and an extensive amount of remorse. However, the panel noted that it lacks insight and does not in any way explain the dishonesty aspects as found proved. The panel considered that you do not directly address these aspects, nor do you refer to the implications of your actions. The panel considered that you have not reflected on the actual incident itself, you have not given specific examples, and you have not identified or recognised that you had overstepped your scope of practice.

The panel then considered the testimonials from your colleagues with whom you work currently, which speak to your fitness to practice without restriction. However, the panel noted that these testimonials relate to a different environment to that of the environment in which the errors took place. The panel considered that you are currently not lone working

and determined that it could not rely upon these testimonials to show that your behaviour in the identified areas of concern, had been remedied.

The panel considered that you have undertaken relevant training addressing some of the concerns and referred to the certificates from the courses.

The panel considered your reflection, training, testimonials and that you have been subject to NMC proceedings for over six years. However, the panel returned to the issues of your inaccurate CV and could not reconcile the view that this indicated deep-seated attitudinal concerns. The panel was not satisfied that you have shown full insight into your actions and your dishonesty, and it could not be satisfied that should any issue occur in the future, you would not be dishonest when dealing with it.

The panel was therefore not satisfied that the concerns have been remediated and accordingly, determined that there is a risk of repetition. The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

The panel determined that a finding of impairment on public interest grounds is required to mark the seriousness of your misconduct and dishonesty and the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds 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 suspension order for the maximum period of one year with review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

The panel heard and accepted the advice of the Legal Assessor who referred to *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin).*Towuaghantse v GMC* [2021] EWHC 681 (Admin); and *Sawati v GMC* : [2022] EWHC 283 (Admin) in relation to issues regarding the 'rejected defence'.

Submissions on sanction

Ms Amaning informed the panel that in the Notice of Hearing, dated 13 March 2026 the NMC had advised you that it would seek the imposition of a six month suspension order, with review, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a striking off order is more appropriate in light of the panel's findings. Ms Amaning submitted that a striking-off order would adequately reflect the seriousness of the case, the risk that you pose and adequately satisfy the public protection and wider public interest.

Ms Amaning submitted the following aggravating and mitigating features in this case:

Aggravating:

- Deliberately and recklessly put a person receiving care at risk of suffering harm
- Repetition of behaviour over a period of five days
- Administered discontinued dangerous drugs
- Failure to work collaboratively with colleagues
- Dishonesty in giving evidence
- Repetition surrounding dishonesty
- Your actions exceeded the scope of your role
- Vulnerability of the person receiving care

Ms Amaning also invited the panel to consider your rejected defence and your dishonesty as serious aggravating features, in line with the case of *Nicholas-Pillai v General Medical Council.*

Mitigating:

- Events occurred over 6 years ago
- Your reflections
- Training has been undertaken
- Positive testimonials from your current employer

Ms Amaning went through the available sanctions and concluded that due to the seriousness of the findings, the need to uphold professional standards and maintenance of public protection, taking no action or imposing a caution order would be inappropriate in this case.

Ms Amaning submitted that a conditions of practice order would not be appropriate in this case due to the deep-seated attitudinal problems identified. She submitted that you have demonstrated deep seated attitudinal concerns which are of concern by your dishonesty and the serious findings surrounding medication administration. She submitted that a

conditions of practise order in this case would not adequately mark the overall seriousness, nor would they adequately reflect the public protection and public interest concerns. Ms Amaning submitted that there are no practical, workable conditions which could be appropriately formulated to address your dishonesty.

Ms Amaning went on to submit that a suspension order would not be suitable in this case as this is an extremely serious case and the misconduct and the underlying attitudinal concerns you have demonstrated are so serious that even a temporary removal would be inadequate and insufficient to maintain public confidence. She submitted that a suspension order would also be insufficient when considering the clear message that should be sent out about the standard and behaviours required of a registered nurse. Ms Amaning submitted that the conduct you have demonstrated is fundamentally incompatible with continued registration.

Ms Amaning submitted that the overarching objective of public protection can only be met by the imposition of a strike-off order and that a period of suspension would not be sufficient to protect people using services and to maintain both public confidence and professional standards. In these circumstances, Ms Amaning submitted that it is unrealistic that you would ever be able to return to unrestricted practise in the future, given that there are grave concerns surrounding your honesty and integrity. Ms Amaning submitted that you have completed some training and have demonstrated developing insight. However, you have up until April of this year sought to cover up what had gone wrong. Ms Amaning submitted that in line with the panel's findings that your conduct has brought the profession into disrepute, your conduct is so serious that public confidence in the profession and professional standards could not be maintained, even if you were permitted to continue practising following a period of suspension.

Ms Amaning submitted that when applying the guidance to this case, the concerns raise fundamental questions about your professionalism, as honesty is a core value which lies at the very heart of the nursing profession. Ms Amaning submitted that the misconduct in this case is deeply rooted and closely linked to attitudinal concerns that have been

repeated during these proceedings those attitudinal concerns led to the failure to adhere to the fundamental tenets of the profession in circumstances which makes your continued registration inappropriate.

Ms Amaning submitted that given a live example of dishonesty relating to the CV occurred only days ago, there is evidence here of a deep-seated attitudinal concern and as such there is no amount of insight and reflection which could be provided that would keep people receiving care and members of the public safe, or maintain public confidence in the profession and uphold professional standards. Ms Amaning submitted that you have repeatedly demonstrated that you are prepared to deceive to conceal your errors.

For the reasons set out above, Ms Amaning respectfully invited the panel to impose a striking off order.

Mr Nwokedi invited the panel to impose a conditions of practice order.

Mr Nwokedi referred to the NMC guidance on sanctions, specifically the guidance on conditions of practice. He submitted that although the guidance states that the imposition of a conditions of practice should include the absence of deep-seated attitudinal problems as a factor favouring conditions. However, he submitted that what he would suggest is, this is guidance and that it does not say that the presence of such, legally excludes conditions being appropriate.

Mr Nwokedi submitted that the findings of the panel provide a concrete foundation for conditions as the panel have identified that you are clinically competent in your present theatre role and you do not pose a risk to patients in this area. Mr Nwokedi submitted that the panel's separate concern is that if something goes wrong, you may not respond candidly. And that concern must be addressed, but it does not follow that every aspect of your practise is unsafe or that the established safeguards in the present role have ceased to have value. Mr Nwokedi submitted that the appropriate response is to confine your

practise to that assessed environment and require evidence addressing the outstanding concerns.

Mr Nwokedi invited the panel to retain the essential structure of your current interim conditions of practice order. In addressing the dishonesty concerns, he proposed two focussed additions to the current conditions:

- You must have a nominated registered supervisor with whom you have scheduled meetings and written reports from, addressing professional conduct, escalation, accountability and any concerns arising in practise. These reports should draw on the employer's own observations and relevant governance information. The reports should not depend solely on your accounts.
- You must have a specific development plan addressing or enabling you to address in a focused manner the dishonest accounts found under charge 7, the CV and explanations rejected by the panel.

Mr Nwokedi submitted that the mitigating factors in this case are that you have attended these proceedings, you have provided materials on your training, your reflections and your positive testimonials. He submitted that you have also remained engaged throughout the proceedings and the panel itself has recognised your clinical competence and remorse.

[PRIVATE].

Mr Nwokedi submitted that a striking off order is not the inevitable consequence of attitudinal findings and that there is a realistic route to rehabilitation which requires consideration before concluding that removal from the register is necessary. Mr Nwokedi therefore submitted that should the panel decide that conditions are insufficient, he would invite it to impose a suspension order with review, as this would prevent practise and mark the seriousness of the findings. Mr Nwokedi submitted that a reviewing panel would be able to exercise its own judgements as to whether or not you have developed full insight in this period.

Mr Nwokedi concluded by inviting the panel to impose an 18 month conditions of practice order with review before expiry, based substantially on the existing interim conditions and those listed above and if the panel is not in agreement, a sanction of suspension order.

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 judgement.

The panel took into account the following aggravating features:

- Recklessly put person receiving care at risk of suffering harm over a period of five days
- Breaches of the Code
- Administered discontinued controlled drugs
- Failure to work collaboratively with colleagues
- Dishonesty in giving evidence
- Providing a dishonest explanation for the context of your CV
- Limited insight about the actual incident, specifically around your dishonest actions
- Vulnerability of the person receiving care

The panel also took into account the following mitigating features:

- Apologies to the family affected
- Passage of time since incidents, over 6 years
- Relevant training courses
- Reflective accounts

The panel considered the two aspects of dishonesty which it had identified and how much weight it would put on them when determining what sanction to impose.

The first aspect of dishonesty which the panel considered was the dishonesty as found proved in charge 7. The panel considered that when you realised the magnitude of the situation, you chose to be deceitful as an act of self-preservation. The panel considered that you have since been given the opportunity to be honest and change your mind without any jeopardy, but instead you remained deceitful. The panel considered this spoke to a deep-seated attitudinal issue.

The second aspect of dishonesty considered by the panel was that you presented your CV to the panel which includes false information. The panel considered that you had stated you updated your CV regularly and that this was simply an error. The panel did not find your explanation to be believable and found it to be dishonest. The panel found that both these episodes of dishonesty mirror each other in that when you were confronted with the seriousness of the situation, you were dishonest in an act of self-preservation. The panel considered both acts of dishonesty identified cumulatively and considered the dishonesty to be at the upper end of the scale of seriousness.

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

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

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

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

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *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 accepts that you currently practise within the confines of a conditions of practice order in your role at present, with no issues identified and several positive testimonials from colleagues which speak to your competence as a nurse in this role. Indeed, they speak to your ability now to manage and administer medication and complete accurate records. However, whilst the panel accepts your clinical competence in your current role, it

was unable to disregard the deep-seated attitudinal issues identified as referenced in the guidance. The panel is therefore of the view that there are no relevant, proportionate, workable or measurable conditions that could be formulated, given the nature of the charges in this case. The dishonesty identified in this case was not something that can be addressed through retraining.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, would not protect the public, uphold professional standards or address public confidence in the profession.

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

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*

- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel considered that to impose a suspension order on your registration, would allow time for you to fully reflect on your dishonesty. The panel considered that this period of suspension would give you a second chance to review your insight and reflect in detail on the incidents and your dishonesty. The panel was satisfied that in this case the misconduct was not fundamentally incompatible with you remaining on the register and that a suspension order would give you the opportunity to overcome the deep-seated attitudinal issues identified.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel considered that it would be disproportionate, as to impose a striking off order at this stage would suggest that you would never be able to overcome attitudinal issues such as dishonesty in this case. The panel also considered that you have demonstrated that you have overcome the clinical competency issues and that you are competent in your current role. Whilst the panel acknowledges that a suspension may have some punitive effect, it would be unduly punitive in your case to impose a striking-off order at this stage.

Balancing all of these factors, the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

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

In making this decision, the panel carefully considered the submissions of Ms Amaning in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking-off order would be disproportionate for the reasons given above.

The panel determined that a suspension order for the maximum period of one year with review, was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Attendance at any future hearing
- A reflective piece showing full insight into your actions and dishonesty and how you have overcome these – specifically an assurance on how you would act differently in future, should errors occur
- Evidence of steps taken by you to keep up to date with nursing, including courses and reading
- Testimonials from manager/supervisor from any paid/unpaid role

Interim order

As the suspension 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 suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Amaning that an interim suspension order for a period of 18 months would be necessary. Ms Amaning submitted that an interim suspension order is both necessary and proportionate on the grounds of public protection and public interest.

Mr Nwokedi made no submissions on this and left this matter for the panel to consider.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for the appeal period.

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

That concludes this determination.

This will be confirmed to you in writing