

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

**Substantive Hearing
Monday 2 March 2026 – Friday 13 March 2026
Monday 21 September 2026 – Thursday 24 September 2026**

Virtual Hearing

Name of Registrant:	Elizabeth Carolyne Mwambingu
NMC PIN:	90D01200
Part(s) of the register:	Nurses part of the register, sub part1 Registered Nurse – Adult RN1 (10 April 1990)
Relevant Location:	Wales
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, registrant member) Vanessa Bailey (Registrant member) Margaret Stoddart (Lay member)
Legal Assessor:	Megan Ashworth (Monday 2 March 2026 – Friday 13 March 2026) Nigel Ingram (Monday 21 September 2026 – Thursday 24 September 2026)
Hearings Coordinator:	Hazel Ahmet
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Mwambingu:	Not present and not represented at the hearing
Facts proved:	Charges 1d, 2a, 2b, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 4a, 4b, 5a, 5b, 7, 8a, 8b, 9, 10a, 10b
Facts not proved:	Charges 1a, 1b, 1c, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 2c, 6a, 6b, 6c, 6d, 6e, 10c, 10d, 10e
Fitness to practise:	Impaired

Sanction:

Strike-off Order

Interim order:

Interim Suspension Order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Mwambingu was not in attendance and that the Notice of Hearing letter had been sent to Mrs Mwambingu's registered email address by secure email on 29 January 2026.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Mwambingu

The panel next considered whether it should proceed in the absence of Mrs Mwambingu. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in the absence of Mrs Mwambingu. He submitted that Mrs Mwambingu had voluntarily absented herself.

Mr Radley referred the panel to the email from Mrs Mwambingu's representative, sent to the NMC on 3 February 2026 at 21:14pm, stating the following:

'I confirm that Mrs Mwambingu has not changed her position, and will not be attending the hearing.'

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Mrs Mwambingu. In reaching this decision, the panel considered the submissions of Mr Radley, the representations made on Mrs Mwambingu's behalf, and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Mwambingu, and she has voluntarily absented herself;
- Mrs Mwambingu has informed the NMC through her representative that she is not due to attend this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- There are a number of witnesses due to attend throughout the duration of this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred many years ago;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged that there may be some disadvantage to Mrs Mwambingu in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Mwambingu's decisions to absent herself from the hearing, waive her rights to attend, give live evidence to the panel, and/or be represented at the hearing. The panel had also been provided with written representations and documentation provided on behalf of Mrs Mwambingu.

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

Details of charge

"That you, a registered nurse, whilst employed as a nurse at the Bromfield Medical Practice ("the Practice"):

1. On one or more occasions provided (either directly or indirectly) a prescription to a patient following a consultation including, but not limited to:

- a. Patient A on 3 July 2017;
- b. Patient B on 8 August 2017;
- c. Patient C on 23 August 2017;
- d. Patient D on 25 August 2017;
- e. Patient E on 25 August 2017;
- f. Patient F on 14 July 2017;
- g. Patient G on 14 July 2017;
- h. Patient H on 18 July 2017;
- i. Patient I on 21 July 2017;

- j. Patient J on 3 July 2017 and/or 21 July 2017 and/or 4 August 2017;
- k. Patient K on 13 June 2017.

2. Your conduct in charge 1 arose in circumstances where:

- a. you acted outside the scope of your practice in that you did not hold any nurse prescriber qualifications;
- b. the prescription was not authorised by a doctor;
- c. you used prescription forms that had been 'pre-signed' by a doctor.

3. On one or more occasions you edited and/or added information to a patient's record including, but not limited to, the following patients:

- a. Patient L on 27 February 2019 and/or 4 March 2019;
- b. Patient M on 1 March 2019;
- c. Patient N on 7 March 2019;
- d. Patient O on 22 February 2019'
- e. Patient P on 1 February 2018'
- f. Patient Q on 4 March 2019'
- g. Patient R on 7 March 2019'
- h. Patient S on 8 March 2019 and/or 19 March 2019;
- i. Patient K on 17 May 2018.

4. Your conduct in charge 3 above arose in circumstances where:

- a. you edited and/or added information to the patient's record without recording why you were editing and/or adding information to the original patient record;
- b. you had no interaction with the patient prior to editing and/or adding information to the patient's record to justify amending the record or alternatively you did not record the patient interaction that led to you editing and/or adding information to the patient's record.

5. Your conduct in charge 3 and/or 4 was dishonest in that:

- a. you edited and/or added information to the patient record despite having had no interaction with the patient that would justify you editing the original patient record;
- b. you edited and/or added information to patient records to assist the Practice in receiving financial reward for achieving 'QOF' targets.

6. On one or more occasions prior to May 2019 as the practice nurse did not ensure that the nursing/treatment room was adequately maintained in that:

- a. the room was not kept clean;
- b. equipment was not sterilised;
- c. a scalpel with blood present was not disposed of in the appropriate manner;
- d. soiled dressings were not disposed of in the appropriate manner;
- e. a needle was not disposed of in the appropriate manner.

7. On one or more unknown dates prior to 8 May 2019 did not ensure that medication was stored appropriately at the Practice.

8. On or around 6 March 2019:

- a. told staff at the practice not to record information about missed patient referrals on the Practice computer system.
- b. told practice staff to tell patients that their referral had been sent but that there was a problem with the system which meant that the hospital had not received the referral when you knew that was not correct.

9. Your conduct at charge 8 was dishonest in that you were trying to conceal the fact that the Practice was not processing patient referrals in a timely manner.

10. On one or more occasions behaved in bullying and/or unprofessional manner towards your colleagues in that you:

- a. shouted at staff;
- b. spoke to staff in a rude and or sharp manner;
- c. made sarcastic comments towards Glenys Davies;
- d. on unknown dates were verbally abusive to Glenys Davies;
- e. on an unknown date accused Glenys Davies of having an affair with a member of staff.

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

Submissions on the abuse of process application

At the outset of this hearing, the panel noted the abuse of process application made by Mrs Mwambingu's representative, within their written submissions:

'Given: the excessive unreasonable time delay, the absence of any restriction or sanction on practice, the registrant's unblemished ongoing employment, the questionable reliability of group witness statements and anecdotal material, and the clear [PRIVATE] - we submit that there is no longer a fair and reasonable case to answer in the public interest. The continuation of these proceedings risks amounting to an abuse of process. It is a well-established principle that justice delayed is not justice

served, and the cumulative delay in this matter has, in our view, rendered the prospect of a fair hearing increasingly untenable.

In these circumstances, we respectfully urge the NMC to give serious consideration to the humane, proportionate, and lawful course of action, namely the dismissal of this case.'

Mr Radley submitted that in this particular case, there are no exceptional circumstances that have been identified by Mrs Mwambingu's representative to justify a stay of proceedings, on the basis of delay. Mr Radley submitted that it is an exception to find a stay to be appropriate in any case, unless it is exceptional, as panels should make all efforts to hear cases, whenever possible to do so.

Mr Radley submitted it is 'unattractive' that there was *some* delay brought before this panel, but noted that this particular case has not faced extremely excessive delays in comparisons to other cases. Mr Radley submitted that Mrs Mwambingu's unblemished character or ongoing employment are not relevant. Mr Radley submitted that the panel are in the primary position to be able to decide on the quality of the evidence it hears, and whether that evidence is reliable; the panel can deal with this without there being a need to stay these hearings.

Mr Radley submitted that it is a very unfortunate circumstance that any individual may [PRIVATE], as a result of the accusations raised against them; however, this, he submitted, does not result in prejudice.

Mr Radley submitted that there is no abuse of process that should trouble this panel in moving forward with this hearing today.

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

Panel's decision and reasons on the abuse of process application

The panel were of the view that the delays in hearing this case have not been exceptional in regard to the length of time of the delays. The panel acknowledged

that, though these delays are not ideal, they are not sufficiently exceptional to constitute an abuse of process to the extent that Mrs Mwambingu cannot receive a fair hearing, or that it would be unfair to hear her case.

The panel determined that the unblemished previous record of Mrs Mwambingu is irrelevant to the considerations of whether or not there has been an abuse of process due to excessive delay.

The panel further considered that although Mrs Mwambingu's is [PRIVATE] due to the continuation of this case, this does not constitute a reason to stay this case. The panel also noted that [PRIVATE] before it from Mrs Mwambingu.

The panel therefore find that there are no grounds on which to consider that there has been an abuse of process in Mrs Mwambingu's case.

The panel therefore rejected this application.

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

During the live questioning of an NMC witness, Mr Radley made a request that this case be held partly in private on the basis that proper exploration of this witness' evidence may involve [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined that it would go into private session as and when any [PRIVATE] private matters arose during the live evidence of this NMC witness.

Background

Mrs Mwambingu was entered onto the NMC register in 1990. On 12 July 2019 the NMC received a referral from Jane Roberts, who is the lead nurse for the Betsi Cadwaladr University Community Health Board (“the Health Board”) regarding Mrs Mwambingu’s fitness to practise. The events that gave rise to the NMC referral in July 2019 arose within the context of a General Practice called ‘the Bromfield Medical Practice’. This practice was owned by Mrs Mwambingu’s husband and was located in Flintshire. In the Spring of 2019, the Practice experienced [PRIVATE]. The Practice was closed, and the Health Board oversaw the transfer of patients to other Health Care Providers. Following the closure of the Practice, there were extensive reviews and investigations as to how this happened. They identified issues in relation to Mrs Mwambingu’s conduct between 2017 and 2019, which formed the basis for the regulatory concerns that were considered by the NMC’s Case Examiners on 10 February 2023.

The regulatory concerns in this case are as follows:

1. Working outside your scope of practice by issuing prescriptions as a non-prescriber without evidence of GP [General Practitioner] discussions
2. Editing of patient notes after initial consultations
3. Utilising pre-signed prescriptions
4. Poor infection control and adherence to health and safety rules
5. Dishonesty
6. Bullying of staff

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Radley on behalf of the NMC, alongside the written submissions provided by Mrs Mwambingu.

The panel considered that there is some ambiguity in the evidence before it, as to when Doctor Tom had retired from being a Partner at the Practice. However, the panel determined that Mrs Mwambingu's own evidence, which is contained within her defence bundle, is the most reliable account, given her position at the Practice, and her familial relation to Doctor Tom. Mrs Mwambingu stated that Doctor Tom had retired in 2014. Consequently, at the time of these charges arising, the panel was of the view that it was Doctor Sekela, Mrs Mwambingu's daughter, who was the sole Partner in the Practice, and that Doctor Tom was employed as a locum, on an ad hoc basis. Doctor Yusaf was also employed as a locum doctor and had no financial interest in the practice.

The panel also considered that this Practice was a small practice, and at the time in which these charges arose, the practice was experiencing significant, increasing financial pressures, which eventually led to the closure of the Practice and the Health Board stepping in to take control of the management of patients.

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

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:

- Jane Roberts: Lead Nurse for Primary Care in the East Area at the Health Board.
- Steve Coleman: Investigating Officer at the Health Board.
- Karen Goodwin: Pharmacist at the Health Board.
- Glenys Davies: Receptionist at the Practice.
- Joanne Lewis: Practice manager at the Practice (August 2017 – May 2019)
- Lisa Walls: Primary Care Contracts Manager at the Health Board.
- Ayesha Begum: Case Officer at the NMC.

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 the NMC and Mrs Mwambingu.

In deliberating on Charge 1 in its entirety, the panel considered for each patient in turn, whether or not there was a prescription for the patient concerned. Next, for those prescriptions that had been issued, the panel considered the Egton Medical Information Systems ('EMIS') Practice diary page for the relevant day to ascertain whether a doctor was present on site at the time or shortly after their consultation who could have authorised and signed the prescription, before the prescription was given to the patient. The panel also had regard to Karen Goodwin's evidence as a pharmacist, who stated that at the time of these alleged incidents occurred, it was a common practice for prescriptions to be issued under one prescriber's name, but being signed, by another prescriber.

Furthermore, the panel in considering any of the charges before it, did not have the benefit of a handwriting expert witness who may have been able to confirm which signature belonged to which clinician on the prescriptions provided to the panel.

Furthermore, in relation to the charges to be decided on, the panel had regard to Mrs Mwambingu's defence bundle, in which she had indicated that she had asked Doctor Sekela to review the clinical findings, and authorise the prescriptions, as she was to be found in a flat above the general practice at the time. The panel then took into account the evidence from Lisa Walls, that Doctor Sekela had gone [PRIVATE] leave from 7 June 2017 and had not returned to the practice until November 2017.

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

Charge 1)

On one or more occasions provided (either directly or indirectly) a prescription to a patient following a consultation including, but not limited to:

Charge 1a)

Patient A on 3 July 2017;

This charge is found NOT proved.

Patient A was recorded in the EMIS diary as having an appointment with Mrs Mwambingu at 09:45 on 3 July 2017. The copy of the prescription showed Doctor Sekela as the printed issuing doctor as well as having a doctor's signature.

In reaching its decision, the panel took into account the evidence before it that showed Doctor Tom was present at the Practice on 3 July 2017, when Patient A was provided with a prescription. The panel were therefore of the view that the NMC had

not produced evidence to negate the possibility that a doctor could have authorised and signed this prescription to Patient A on 3 July 2017. The panel noted that there was no evidence of Doctor Tom having made note of a review on Patient A's EMIS record but determined that this did not impact the panel's finding this charge is found not proved. This lack of information on Patient A's record does not preclude the possibility that Mrs Mwambingu consulted with a doctor to request that they authorise a prescription, after which, a doctor reviewed the patients notes, before authorising it.

Consequently, the panel found this charge not proved.

Charge 1b)

Patient B on 8 August 2017;

This charge is found NOT proved.

Patient B was recorded in the EMIS diary as having an appointment with Mrs Mwambingu at 10:15am on 8 August 2017. The copy of the prescription showed Doctor Sekela as the printed issuing doctor, as well as having a doctor's signature.

The panel considered that there was in fact a prescribing GP present at the time of this charge. The panel, in considering any of the charges before it, did not have the benefit of a handwriting expert witness who may have been able to confirm that the signature provided to authorise the prescription for Patient B on 8 August 2017, was not that of Doctor Yusaf.

Consequently, the panel determined that this charge is found not proved, for the same reasons provided above in Charge 1a.

Charge 1c)

Patient C on 23 August 2017;

This charge is found NOT proved.

Patient C was recorded in the EMIS diary with Mrs Mwambingu at 10:15am on 23 August 2017. The copy of the prescription showed Doctor Tom as the printed issuing doctor as well as having a doctor's signature.

In reaching its decision, the panel noted the fact that there was no doctor present at the Practice until 12:45pm. The panel noted that although Patient C was seen at 10:15am on 23 August 2017. Mrs Mwambingu may have consulted with a doctor after 12:45pm to request authorisation for Patient C's prescription. Therefore, the panel was of the view that the NMC had not negated the possibility that Mrs Mwambingu had provided a prescription to Patient C without the authorisation and signature of a doctor.

Consequently, the panel found this charge NOT proved.

Charge 1d)

Patient D on 25 August 2017;

This charge is found proved.

Patient D was recorded in the EMIS diary as having an appointment with Mrs Mwambingu at 16:10pm on 25 August 2017. The copy of the prescription showed Doctor Sekela as the printed issuing doctor as well as having a doctor's signature.

In reaching its decision on Charge 1d, the panel took into account the fact that on 25 August 2017, Doctor Sekela was [PRIVATE].

The panel however considered the EMIS record, which showed that no other doctors were present on 25 August 2017. Patient D was the last patient to be seen at 16:10pm. The NHS number on the prescription matches that provided in the identification key, and the suggested medicine on the clinical notes matches that on the prescription.

The panel noted that the EMIS record corroborates the documentary evidence of Jane Roberts, who produced a spreadsheet that shows no other practitioners were present on this day. The EMIS record is also further corroborated by the investigation team's conclusion, which took into consideration the prescription script for Patient D having a handwritten note stating, '*no other doctors in*'.

On the balance of probabilities, the panel determined that no doctor was present at the Practice on 25 August 2017. The panel concluded that Mrs Mwambingu did not discuss authorising Patient D's prescription with any doctors, and that the prescription was therefore, not authorised.

Consequently, the panel found this charge proved.

Charge 1e)

Patient E on 25 August 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account the fact that the NHS number on the prescription provided by the NMC in support of this charge does not match that presented by the NMC under Patient E's name, nor does it match any other of the patients' NHS numbers presented in this case. Consequently, the panel determined that, as it cannot identify which patient this actually is, it would be procedurally unfair to pursue this charge.

Consequently, the panel found this charge not proved.

Charge 1f)

Patient F on 14 July 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account the fact that it does not have before it a prescription matching Patient F's details, neither is there an EMIS diary printout to demonstrate if a doctor was present or not at the practice, for that day.

Consequently, given the lack of evidence before it, the panel found this charge not proved.

Charge 1g)

Patient G on 14 July 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account the fact that the NHS number on the prescription provided by the NMC in support of this charge, does not match the NHS number presented by the NMC under the Patient G's name, nor does it match any other of the patients' NHS numbers. Furthermore, the panel considered that the dates alleged in this charge did not correspond to any prescription for this patient. In addition, the panel did not have the benefit of an EMIS diary before it in order to establish whether or not a doctor was present on 14 July 2017 at the practice.

Consequently, the panel determined that, as it cannot identify which patient, if any, Charge 1g is relating to, it would be procedurally unfair to pursue this charge.

Consequently, the panel found this charge not proved.

Charge 1h)

Patient H on 18 July 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account the fact that the NHS number on the patients' prescription produced by the NMC in support of this charge, does not match the NHS number presented by the NMC under the Patient H's name, nor does it match any other of the patients' NHS numbers. Furthermore, the panel considered that the dates alleged in this charge did not correspond to any prescription for this patient. In addition, the panel did not have the benefit of an EMIS diary before it in order to establish whether or not a doctor was present on 18 July 2017 at the practice.

Consequently, the panel determined that, as it cannot identify which patient, if any, Charge 1h is relating to, it would be procedurally unfair to pursue this charge.

Consequently, the panel found this charge not proved.

Charge 1i)

Patient I on 21 July 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account the fact that the NHS number on the patients' prescription produced by the NMC in support of this charge, does not match the NHS number presented by the NMC under the Patient I's name, nor does it match any other of the patients' NHS numbers. Furthermore, the panel considered that the dates alleged in this charge did not correspond to any prescription for this patient. In addition, the panel did not have the benefit of an EMIS diary before it in order to establish which doctor was present on 21 July 2017 at the practice.

Consequently, the panel determined that, as it cannot identify which patient, if any, Charge 1i is relating to, it would be procedurally unfair to pursue this charge.

Consequently, the panel found this charge not proved.

Charge 1j)

Patient J on 3 July 2017 and/or 21 July 2017 and/or 4 August 2017;

This charge is found NOT proved.

In reaching its decision, the panel took into account that there is no evidence before it of a prescription, which relates to Patient J.

Consequently, due to the lack of evidence before it, the panel found this charge not proved.

Charge 1k)

Patient K on 13 June 2017.

This charge is found NOT proved.

Patient K was recorded in the EMIS diary as having an appointment with Mrs Mwambingu at 11:15am on 13 June 2017.

In considering this charge, the panel had site of an EMIS diary entry which indicated that on 13 June 2017, Doctor Yusaf was present for the entirety of the day. As such, the panel determined that on the balance of probabilities, it is more likely than not that Mrs Mwambingu did consult Doctor Yusaf about the authorisation of Patient K's prescription.

Consequently, this charge is found NOT proved.

Charge 2)

Your conduct in charge 1 arose in circumstances where:

Charge 2a)

you acted outside the scope of your practice in that you did not hold any nurse prescriber qualifications;

This charge is found proved.

In reaching its decision, the panel took into account the written and oral evidence of Jane Roberts, Karen Goodwin, Ayesha Begum, alongside the written response of Mrs Mwambingu.

The panel considered the following from Karen Goodwin's written statement:

'I do not know whether any medication within the Practice was prescribed by Liz. In any case, Liz should not have been issuing prescriptions because she was not an independent prescriber. I know Liz was not an independent prescriber because if she were it would have needed to be listed on the Practice's website and she would have had a J number. A J number is a unique number given to each independent prescriber. This number is printed on the bottom of a prescription in the address box and identifies who prescribed the medication. J numbers were held by a health professional within BCUHB that was qualified to issue prescriptions. In order to gain a J number from BCUHB you had to be a registered prescriber with your regulatory body, in Liz's case this would have been the NMC.'

The panel also noted that, when questioned by Steve Coleman on 4 February 2021 as to whether Mrs Mwambingu had ever been a qualified prescriber, as far as her clinical practice is concerned, she answered as follows:

'No'.

The panel also considered the documentary evidence given by Ayesha Begum, which confirmed what the standards were for Nurse Prescribers, and confirmed that there was no independent prescribing qualification listed against Mrs Mwambingu's name on the NMC register.

The panel determined that it is more likely than not, given the evidence before it, that Mrs Mwambingu did act outside the scope of her practice, in that she did not hold any nurse prescriber qualifications.

Consequently, this charge is found proved.

Charge 2b)

the prescription was not authorised by a doctor;

This charge is found proved.

The panel determined that, having found Charge 1d proved, this charge is found proved also. The panel reiterated its finding that there was no doctor at the Practice to have signed or authorised the prescription which was given to Patient D. The panel also bore in mind Mrs Mwambingu's documentary evidence in which she denied that she had given a prescription to Patient D, which was not authorised by a doctor, and that she stated she may have omitted to make a record of a discussion with a doctor. In any event, the panel noted that there was no record of such an alleged discussion.

Consequently, the panel found Charge 2b proved.

Charge 2c)

you used prescription forms that had been 'pre-signed' by a doctor.

This charge is found NOT proved.

The panel determined that the NMC has not discharged its burden of proving the provenance of the signature on the prescription. Therefore, the panel was unable to say how the signature on the prescription came to be. The panel also noted Mrs Mwambingu's defence bundle, in which she stated that three doctors at the practice all refuted the suggestion that they would make available pre-signed prescriptions.

The panel in considering this charge, did not have the benefit of a handwriting expert who may have been able to confirm which signature belonged to which doctor on the prescription.

Furthermore, the panel noted the oral evidence of Glenys Davies and Joanne Lewis, both of whom had stated that whilst they had seen prescriptions in Mrs Mwambingu's room, they could not now be confident that they had seen any 'pre-signing' of prescriptions with signatures on.

In conclusion, the panel determined that it does not have sufficient evidence before it to prove that Mrs Mwambingu had used prescription forms that had been 'pre-signed' by a doctor.

Therefore, this charge is found not proved.

Charge 3)

On one or more occasions you edited and/or added information to a patient's record including, but not limited to, the following patients:

Charge 3a)

Patient L on 27 February 2019 and/or 4 March 2019;

This charge is found proved.

In reaching its decision, the panel considered the following section from Jane Roberts's written statement:

'The second patient, [Patient L] records show she had a consultation with [Doctor Sekela] on 16 October 2018. The records then show on 27 February 2019, Ms Mwambingu edited her records by adding her body mass index, blood pressure and smoker status. However, the records

show this patient did not have a consultation with Ms Mwambingu or [Doctor Sekela] on 27 February 2019.’ [sic]

The panel also had reference to Jane Roberts’s documentary evidence in which Patient L’s original consultation date and time is listed, as well as a large list of added patient data and assessments, approximately five months later on 27 February 2019, and 4 March 2019.

The panel therefore concluded that, on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, that on the balance of probabilities this charge is found proved.

Charge 3b)

Patient M on 1 March 2019;

This charge is found proved.

In reaching its decision, the panel considered the following section from Jane Roberts’s written statement:

‘The eleventh patient, [Patient M] had an appointment with [Doctor Sekela] on 20 June 2018. The records then show Ms Mwambingu added information relating to the patients foot, such as whether there was a pulse or sensation, on 01 March 2019. However, the records do not show that this patient had a consultation with [Doctor Sekela] or Ms Mwambingu on 01 March 2019.’ [sic]

The panel also considered the documentary evidence of Jane Roberts, in which she had shown which patients had had their patient notes edited. Through this documentary evidence, it is clear that Mrs Mwambingu had inputted additional information and data into the record of Patient M.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 3c)

Patient N on 7 March 2019;

This charge is found proved.

In reaching its decision on Charge 3c, the panel considered the following from Jane Roberts's written statement:

'The first patient, [Patient N] records show she had an appointment with [Doctor Sekela] on 10 December 2018. The records then show on 07 March 2019, Ms Mwambingu edited 10 records, this included adding that the patient had never smoked, their weight and blood pressure. Despite this there is no record to show this patient had a consultation on 07 March 2019. Further, there is no record to show this information was taken by [Doctor Sekela] on 10 December 2018.'

The panel further considered the documentary evidence provided by Jane Roberts, in which she exhibits the edits in the form of additional information and data, made to the records of Patient N on 7 March 2019.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, that this charge is found proved.

Charge 3d)

Patient O on 22 February 2019;

This charge is found proved.

In reaching its decision on Charge 3d, the panel took into account the following section of Jane Roberts's written statement:

'The second patient, [Patient O] , records show she had a consultation with [Doctor Sekela] on 23 October 2018. The records then show Ms Mwambingu amended her records on 22 February 2019, this included adding the patient's height and weight. Despite this there is no record to show this patient had a consultation on 22 February 2019.'

The panel also took into account the documentary evidence of Jane Roberts, in which she presents the EMIS patient records for Patient O, showing the additional data and information which was added by Mrs Mwambingu on 22 February 2019.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, that this charge is found proved.

Charge 3e)

Patient P on 1 February 2018;

This charge is found proved.

In considering this charge, the panel determined that the EMIS record in relation to Patient P, is the true source of where Mrs Mwambingu's editing lies. The panel considered that there was a typographical error in Jane Roberts's witness statement, in matching the date which discusses Patient P.

However, the panel considered that the date did match what was present on the EMIS record at the Practice, which the panel then relied upon as its primary source of evidence for Charge 3e.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 3f)

Patient Q on 4 March 2019;

This charge is found proved.

In reaching its decision, the panel took into account the following section of Jane Roberts's written statement:

'The sixth patient, Pnt. Q had a consultation with Ms Mwambingu on 11 September 2018. On 04 March 2019, Ms Mwambingu edited this patients notes to add their body mass index and information about their asthma review. This record does not show any consultation occurring with this patient on 04 March 2019.'

The panel also took into account the documentary evidence of Jane Roberts, in which she presents the EMIS patient records for Patient Q, showing the additional data and information which was added by Mrs Mwambingu on 04 March 2019.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 3g)

Patient R on 7 March 2019;

This charge is found proved.

In reaching its decision, the panel took into account the following section of Jane Roberts's written statement:

'The first patient, Pnt. R had a consultation with Ms Mwambingu on 22 May 2018. Nearly a year later on 07 March 2019, Ms Mwambingu has edited the patient's records to add a mental health review, blood pressure, alcohol consumption, height and weight. Despite this there are no records showing Ms Mwambingu had a consultation with this patient on 07 March 2019.'

The panel also took into account the documentary evidence of Jane Roberts, in which she presents the EMIS patient records for Patient R, showing the additional data and information which was added by Mrs Mwambingu on 07 March 2019.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 3h)

Patient S on 8 March 2019 and/or 19 March 2019;

This charge is found proved.

In reaching its decision, the panel took into account the following section of Jane Roberts's written statement:

'The third patient, Pnt. S had a consultation with on 11 October 2018 with [Doctor Yusaf]. On 19 March 2019, Ms Mwambingu edited the records to add information relating to the patient's blood pressure, mental health review, weight and body mass index. There is no evidence in the records that this patient had a consultation with Ms Mwambingu on 19 March 2019.'

The panel also took into account the documentary evidence of Jane Roberts, in which she presents the EMIS patient records for Patient S, showing the additional data and information which was added by Mrs Mwambingu on 8 March 2019 and/or 19 March 2019.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 3i)

Patient K on 17 May 2018;

This charge is found proved.

In reaching its decision, the panel took into account the following section of Jane Roberts's written statement:

'I exhibit a further example of Ms Mwambingu editing patient notes as Exhibit JR/08. I am unable to say why some of the records in this exhibit have been crossed out. In this instance, the patient (" Pnt. K had seen Ms Mwambingu on 04 March 2017. Over a year later, on 17 May 2018, Ms Mwambingu edited records to say they were having recurrent UTIs, a history of eating disorders and that Pnt. K had attended an examination with a support worker. Having looked through Pnt. K records I cannot see any evidence that Ms Mwambingu had a consultation with on 17 May 2018. The page with the work "appointments" written at the top provides a record of all the appointments attended by does not show Pnt. K this having an appointment on 17 May 2018. As every appointment Pnt. K has to be booked on EMIS there should have been a record of it. Ms Mwambingu edited records over a year later, this could not have been an imputing error. The way EMIS works is it time stamps all entries onto the records and it does not allow you to edit the date or time of the entry.' [sic]

The panel further considered the documentary evidence from Jane Roberts, in the form of an evidence bundle for patient K:

'This patient's case record was looked into by the investigator following a statement made by the former admin team. They alleged that the lady had blamed [Doctor Sekela] and [Mrs Mwambingu] for a delayed cancer diagnosis. As part of the review, it was noted that the patient had seen [Mrs Mwambingu] on 4th March 2017 and the record was altered on 17th May 2018.' [sic]

The panel also took into account the documentary evidence of Jane Roberts, in which she presents the EMIS patient records for Patient K, showing the additional data and information which was added by Mrs Mwambingu on 17 May 2018. The panel noted that there was no appointment for Patient K on 17 May 2018, when the alterations to their record had taken place.

The panel therefore concluded that on the basis of the evidence before it in the form of patient data records, alongside the statement of Jane Roberts, and on the balance of probabilities, this charge is found proved.

Charge 4)

Your conduct in charge 3 above arose in circumstances where:

Charge 4a)

you edited and/or added information to the patient's record without recording why you were editing and/or adding information to the original patient record;

This charge is found proved.

In considering this charge, the panel were of the view that, having reviewed each of the patient records above in Charge 3, there is no evidence of Mrs Mwambingu having recorded a rationale for adding late information to the records of patients.

Consequently, given the absence of recording that it was a retrospective entry, or the rationale for making a retrospective entry, this charge is found proved.

Charge 4b)

you had no interaction with the patient prior to editing and/or adding information to the patient's record to justify amending the record or alternatively you did not record the patient interaction that led to you editing and/or adding information to the patient's record.

This charge is found proved.

When considering Charge 4b, the panel noted that none of the patient records in Charge 3 recorded any interaction with each patient prior to the editing and adding of information into their patient records. In light of the length of time after the initial consultation, when the additional information and data was added, the panel drew the inference that there had been no further interaction with the respective patient, to justify Mrs Mwambingu to have amended their record.

The panel was satisfied that there had been no further interaction with the patient to justify amending this record, as opposed to this having been an oversight, and omitting to make a record of the interaction.

The panel noted Mrs Mwambingu's explanation that she had added data retrospectively for read coding, but having had regard to the notes, the panel did not consider that Mrs Mwambingu was adding data for this purpose. Furthermore, the panel rejected Mrs Mwambingu's explanation that she was entering 'health data' from mental health consultations, for these patients, given the fact that the data appeared to be largely for asthma or diabetes review purposes.

Consequently, this charge is found proved.

Charge 5)

Your conduct in charge 3 and/or 4 was dishonest in that:

Charge 5a)

you edited and/or added information to the patient record despite having had no interaction with the patient that would justify you editing the original patient record;

This charge is found proved.

In considering the charge of dishonesty, the panel first considered the evidence relating to Mrs Mwambingu's state of knowledge or belief as to the facts. Having ascertained her state of knowledge or belief as to the facts, the panel went on to consider whether her actions were honest or dishonest by the standards of ordinary decent people.

The panel first considered Mrs Mwambingu's state of knowledge relating to editing or adding information to a patients' record, without recording a rationale, as to why this was being done retrospectively. The panel was of the view that any nurse would understand that entering such information, without recording a rationale, would compromise basic nursing standards. A registered nurse would also understand that these patient records are considered as important documents, that future clinicians would rely on for their accuracy, which could lead to serious patient harm. Therefore, Mrs Mwambingu's actions could have compromised patient safety, and led to a real clinical risk.

The panel bore in mind Mrs Mwambingu's response, in which she claimed herself to be a '*very experienced*' practice nurse; the panel considered that this was all the more reason as to why Mrs Mwambingu should have been aware as to how inappropriate her actions were.

The panel concluded that Mrs Mwambingu's actions would be regarded as dishonest.

Consequently, this charge is found proved.

Charge 5b)

you edited and/or added information to patient records to assist the Practice in receiving financial reward for achieving 'QOF' targets.

This charge is found proved.

The panel, in considering Mrs Mwambingu's state of mind and knowledge/belief regarding whether 'QOF' targets were suspended, had regard to her defence bundle provided to the NMC. In this document, Mrs Mwambingu provided news articles which evidenced the dates over which 'QOF' targets were 'relaxed' or 'suspended', and GP practices did not have to provide information on those targets to the Health Board. The panel determined however, that all but one of the patients identified in Charge 3, fell outside of the evidenced duration in which 'QOF' targets were suspended.

Furthermore, the panel bore in mind the evidence from Lisa Walls who informed the panel in her live evidence, that she could not recollect any period over 2019 in which 'QOF' targets were suspended; this witness was of the view that these were still being required to be reported to the Health Board.

Consequently, the panel determined that Mrs Mwambingu would have been aware that 'QOF' targets would garner a financial reward when reported to the Health Board, during the relevant dates, for all but one of the patients mentioned in Charge 3.

Additionally, the panel considered that at the relevant time, the Practice was experiencing significant financial difficulties, and that Mrs Mwambingu would have

been aware of this, particularly as she had adopted significant parts of the Practice Manager role, alongside her nursing role. Furthermore, Mrs Mwambingu was the person in the practice who read coded the patient data which the Health Boards' computer systems used to extract the data needed to calculate the payments related to the 'QOF' targets.

The panel determined that, having established Mrs Mwambingu's knowledge at the relevant time, and her actions carried out with this knowledge, that by the standards of ordinary decent people, her actions would be considered to be dishonest.

Consequently, this charge is found proved.

Charge 6)

On one or more occasions prior to May 2019 as the practice nurse did not ensure that the nursing/treatment room was adequately maintained in that:

Charge 6a)

the room was not kept clean;

This charge is found NOT proved.

The panel considered the photographic evidence before it, provided by Karen Goodwin which demonstrated that the room was not clean, regarding infection control at the practice. However, the panel considered that there was no date or time stamp on these photographs. Furthermore, the panel took into account the evidence provided by Mrs Mwambingu in her defence bundle to the NMC; that she was not working on the day in which the photographs before the panel were taken.

The panel considered that the NMC had not advanced any evidence that Mrs Mwambingu was working in the practice on the day the photographs were taken. Furthermore, it considered from Mrs Mwambingu's evidence, that bailiffs had entered the practice and that their presence may have interrupted clinical procedures and prevented appropriate cleaning of the premises.

Finally, the panel took account of Mrs Mwambingu's evidence that at the relevant time, a range of other clinicians were utilising practice rooms on behalf of the Health Board. In light of this, the panel determined that the NMC had not met its burden of proof that Mrs Mwambingu was the individual who was responsible for the negative state of the treatment room contained within the photographs.

Accordingly, the panel did not find Charge 6a proved.

Charge 6b)

equipment was not sterilised;

This charge is found NOT proved.

The panel found this charge not proved for the same reasons as mentioned above in Charge 6a.

The panel considered the evidence of Glenys Davies, that the Practice steriliser was broken and used to store items other than equipment. However, the panel also took into account Mrs Mwambingu's evidence who did not deny that the steriliser was broken, but said that the Practice used disposable equipment for minor procedures that were already sterile, and single use.

The panel preferred the evidence of Mrs Mwambingu as she is a qualified nurse, over the evidence of Glenys Davies, who was not qualified, nor would she herself be utilising such equipment in her role as a Practice receptionist.

Consequently, the panel found this charge not proved.

Charge 6c)

a scalpel with blood present was not disposed of in the appropriate manner

This charge is found NOT proved.

The panel found this charge not proved for the same reasons as mentioned above in Charge 6a.

Charge 6d)

soiled dressings were not disposed of in the appropriate manner;

This charge is found NOT proved.

The panel found this charge not proved for the same reasons as mentioned above in Charge 6a.

Charge 6e)

a needle was not disposed of in the appropriate manner.

This charge is found NOT proved.

The panel bore in mind the evidence of Glenys Davies in her documentary evidence, whereby she had stated that she had found a used needle within a waste bin of the treatment room, however, she could not recall precisely when this occurred. The panel considered that there was an inconsistency between the documentary evidence of Glenys Davies, and her live evidence before the panel, in that during her live evidence, she referred to having found the needle in a waste bin of a doctor's room, as opposed to the treatment room in question.

The panel determined that the evidence of Glenys Davies was both vague and inconsistent, and therefore, considered the NMC had not discharged its burden of proof.

Consequently, this charge is found not proved.

Charge 7)

On one or more unknown dates prior to 8 May 2019 did not ensure that medication was stored appropriately at the Practice.

This charge is found proved.

In considering this charge, the panel took into account the documentary and live evidence of Karen Goodwin, who outlined to the panel that doctors and nurses both have responsibility in appropriate storage of medicine at the Practice. The panel also noted that Karen Goodwin could attest to accuracy of the photographic evidence presented to the panel as she had witnessed this herself. The witness told the panel she had seen medication including controlled drugs that had been returned to the practice being stored inappropriately.

The panel also considered Karen Goodwin's evidence that patient medication should not have been returned to the practice, but rather taken directly to a pharmacy for destruction. Under panel questions, Karen Goodwin stated that in the unlikely event that a practice agreed to take possession of such returned medication, that it must be stored in a locked away fashion, so as to prevent theft, or patient access and be disposed of appropriately as soon as possible. The panel considered the evidence of Karen Goodwin to be clear and consistent throughout.

The panel also had regard to Mrs Mwambingu's response in which she adduced evidence from Doctor Tom and Doctor Sekela, alongside an employee of a pharmacy, to suggest that the Practice did regularly return such medications to a pharmacy for destruction. However, the panel considered the evidence of Karen Goodwin that when they were sorting out the returned medications after the practice had closed they filled seven doop boxes, and as such, considered this to be an excessive amount of medication which was not stored appropriately and far in excess of a couple of days' worth of returned medication.

The panel noted the fact that while Mrs Mwambingu did not have an exclusive responsibility to ensure that medication was stored appropriately at the Practice, she was *one of* the clinicians with an individual and collective responsibility to ensure appropriate storage.

Consequently, this charge is found proved.

Charge 8)

On or around 6 March 2019:

Charge 8a)

told staff at the practice not to record information about missed patient referrals on the Practice computer system.

This charge is found proved.

In considering this charge, the panel considered the statements and live evidence of Glenys Davies and Joanne Lewis.

The panel heard the live evidence of Glenys Davies, where she explained that Mrs Mwambingu often undertook patient referrals on behalf of the doctors. Some referral requests were put in the administration tray which was located in reception. Glenys Davies noted that Doctor Sekela also had a tray in her own room, however, Glenys Davies and Joanne Lewis became increasingly concerned about the referrals that were building up in the administration tray, in reception.

The panel noted Glenys Davies's evidence that reception staff received between 3-6 calls per week, by phone, from patients, concerned around the lack of action relating to their referrals to other health providers. Glenys Davies also explained that by comparison, when Doctor Tom was in charge of the Practice, he requested that this type of patient contact be noted on EMIS. However, on 6 March 2019, Mrs Mwambingu told reception staff to no longer document when patients called the practice to ask about their referrals.

The panel noted the following from the statement of Glenys Davies:

'On 06 March 2019, Liz came into reception and told all the staff that we were no longer allowed to document on the patients' notes that a patient

had called the practice to ask about their referral. Liz said we should not do this because it would leave an audit trail if the patient left the practice. [...] Liz said we should make a note of the missed referral in the Practice's message book. [...] Liz also told me that I was not to give the patient any information about the referral not being done, instead I should just tell the patient that I would pass a message onto Liz. I was not happy about this and felt it was unprofessional...' [sic]

The panel also noted the following from the witness statement of Joanne Lewis:

'...Liz instructed all staff at the Practice to stop making notes of any missed referrals or late referrals. Liz said we should not do this because if the patient left the Practice we would need to send their notes to another practice and it would reflect badly on the Practice and look unprofessional to have records of missed referrals in the notes.'

The panel determined that, given the evidence before it, it is more likely than not that Mrs Mwambingu told staff at the practice not to record information about missed patient referrals on the Practice computer system.

Consequently, this charge is found proved.

Charge 8b)

told practice staff to tell patients that their referral had been sent but that there was a problem with the system which meant that the hospital had not received the referral when you knew that was not correct.

This charge is found proved.

In considering this charge, the panel took into account the documentary and live evidence of Joanne Lewis, which it considered to be clear and consistent.

The panel noted the following paragraph from the witness statement of Joanne Lewis:

'Liz also instructed staff that we should not tell patients that their referral was late, instead we should say the referral was sent but a problem with the system meant the hospital had not received it. At one point the patients started ringing the hospitals directly before calling us. Then we told them the referral had been done they would say they spoke to the hospital so they knew it had not been done.'

The panel determined that, given the evidence before it, it is more likely than not that Mrs Mwambingu told practice staff to tell patients that their referral had been sent but that there was a problem with the system which meant that the hospital had not received the referral when you knew that was not correct.

Consequently, this charge is found proved.

Charge 9)

Your conduct at charge 8 was dishonest in that you were trying to conceal the fact that the Practice was not processing patient referrals in a timely manner.

This charge is found proved.

In making its decision, the panel considered firstly what Mrs Mwambingu's knowledge, state of mind, and belief was at the relevant time of this charge. The panel considered that, in light of what it had found proved in Charge 8 above (in telling practice staff not to record information about missed patient referrals, and also telling practice staff to provide an inaccurate reasoning to patients as to why the hospital had not received their referral), Mrs Mwambingu would have known that this was a form of concealment.

Furthermore, the panel considered that by the standards of ordinary, decent people, this deliberate concealment, would be considered dishonest.

Consequently, this charge is found proved.

Charge 10)

On one or more occasions behaved in bullying and/or unprofessional manner towards your colleagues in that you:

In considering Charge 10, the panel had regard to the live and documentary evidence of Glenys Davies and Mrs Mwambingu and considered that the two of these individuals were consistent in that there was a difficult relationship between the two of them.

The panel also had regard to Joanne Lewis's evidence.

Charge 10a)

shouted at staff;

This charge is found proved.

In considering this charge, the panel took into account the interview between Steve Coleman and Joanne Lewis, whereby Joanne Lewis said:

'Liz Mwambingu would get annoyed with us and tell us off and I feel that she was bullying us by shouting at us quite often but she never did this in front of the patients. However, on some occasions she would apologise.'

The panel, therefore, given the evidence before it directly in relation to Ms Mwambingu having shouted at her staff members, found this charge is found proved. The panel considered that Mrs Mwambingu's actions were unprofessional.

Charge 10b)

spoke to staff in a rude and or sharp manner;

This charge is found proved.

In considering this charge, the panel took into account the written and oral evidence of Joanne Lewis. The panel determined that the evidence of Joanne Lewis was clear and consistent between both her contemporaneous documentary evidence, and her live evidence before the panel. The panel took particular regard to the following sections of Joanne Lewis's written statement:

'Whilst working at the Practice several members of the reception staff raised concerns to me that Liz was bullying them. For example, Liz would be rude to them in front of patients and belittle them. Personally, I did not feel bullied or threatened by Liz. However, the reception staff felt it was Liz's way or no way.'

And

'At one point around the end of 2018 and beginning of 2019, [Glenys Davies] raised a verbal complaint to me about Liz. [Glenys Davies] said that she generally felt like Liz was sharp [...] she found Liz to be generally unapproachable. When this was discussed with Liz she apologise for being sharp. Nevertheless, not much changed and the reception staff continued to feel bullied, like they were often walking on egg shells.' [sic]

The panel also considered Glenys Davies's live evidence before the panel, where she said she felt bullied as a result of how she was spoken to in a rude manner by Mrs Mwambingu; she experienced Mrs Mwambingu as *'intimidating'*.

The panel, therefore, given the evidence before it directly in relation to Ms Mwambingu having spoken to staff in a 'rude' and 'sharp' manner, found this charge is found proved. The panel considered that Mrs Mwambingu's actions were unprofessional and amounted to the bullying of Glenys Davies.

Charge 10c)

made sarcastic comments towards Glenys Davies;

This charge is found NOT proved.

In considering this charge, the panel bore in mind the evidence provided by Glenys Davies, however, determined that this evidence was vague and nonspecific as to the date, time, and nature of Mrs Mwambingu's alleged sarcastic comments. When questioned by the panel, Glenys Davies was unable to recall any specific comments which had been made by Mrs Mwambingu. The panel did consider however that there was an inconsistency between Glenys Davies's witness statement and her oral evidence. In her written statement, Glenys Davies had indicated that it was both an osteopath and Mrs Mwambingu that made sarcastic comments as they walked past her. However, under panel questioning, her evidence was limited to only the osteopath who had made sarcastic comments towards her.

Consequently, given the vagueness of the evidence before it, this charge is found not proved.

Charge 10d)

on unknown dates were verbally abusive to Glenys Davies;

This charge is found NOT proved.

The panel in considering this charge noted the Merriam-Webster Dictionary definition of verbally abusive, which is as follows:

'harsh and insulting language directed at a person'

The panel considered that in any event, the accusation of having an affair, on its own, without more, such as the use of profanity, would itself not amount to verbal abuse.

The panel considered that this charge was inherently non-specific as to the alleged verbal abuse suffered by Glenys Davies. The panel noted that the only evidence that was put before it to support Charge 10d was a single line in Glenys Davies's written statement that suggested an example of this verbal abuse, as follows:

'Liz's actions put a strain on the Practice. I recall at one point Liz teamed up with the Practice Manger [...] and they started to be verbally abusive towards me.'

Consequently, the panel found this charge not proved.

Charge 10e)

on an unknown date accused Glenys Davies of having an affair with a member of staff.

This charge is found NOT proved.

In considering this charge, the panel considered the written evidence of Glenys Davies:

'Liz once accused me of having an affair with Doctor Tom'

The panel however considered the fact that this evidence as provided by Glenys Davies is second-hand hearsay, as, upon live panel questioning, Glenys Davies had admitted that she had merely '*heard*' this accusation from someone else in the practice, and that she had not directly been accused by Mrs Mwambingu.

Consequently, given that the evidence before it was not sufficient to reach the burden of proof, the panel found this charge not proved.

Interim order

Mr Radley submitted that the NMC are seeking an interim suspension order for a period of 18 months.

Mr Radley submitted that there are serious findings of fact that have taken place by the panel, and that there is a necessity for an order due to the risk to patients being relatively high. Mr Radley submitted that there are particular concerns with reference to the impact on patients, the record keeping in relation to patients and the findings of dishonesty.

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, the finding of dishonesty in this case, alongside all other reasons set out in its decision on the facts stage.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case as there are no workable conditions for this case at this stage, nor would this order mark the public interest. However, the panel determined that an interim suspension order for a period of 18 months would be appropriate.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Mwambingu's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

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.*'

Mr Radley submitted the following in written form to the panel, in relation to misconduct:

'Introduction

The Panel have considered the facts of the case and have found the following;

- a. The facts proven are – 1d, 2ab, 3a,b,c,d,e,f,g,h,i, 4ab, 5ab, 7, 8ab, 9, 10ab.*
- b. Facts not proven are - 1a,b,c,e,f,g,h,i,j,k, 2c, 6a,b,c,d,e, 10c,d,e.*

The following representations are made to the Panel regarding the question of misconduct in the case of Mrs Mwambingu ('ECM').

The Law

Article 22 of the Nursing and Midwifery Order 2001 provides;

22.— (1) This article applies where any allegation is made against a registrant to the effect that—

- (a) her fitness to practise is impaired by reason of —*
 - (i) misconduct,*

Law regarding Misconduct -

The panel will be familiar with the leading case of Roylance v GMC [1999] UKPC 16 where Lord Clyde provided guidance when considering what could amount to misconduct.

‘[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [Nurse] practitioner in the particular circumstances’

Further assistance may be found in the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v GMC [2004] EWHC2317 (Admin);

‘[Misconduct] connotes a serious breach which indicates that the [Nurse’s] fitness to practice is impaired.

And

‘The adjective ‘serious’ must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.

Other NMC Guidance documents

FTP – 2a (06/05/25) With particular reference to when a charge become serious misconduct.

The Panel are also referred to the NMC guidance, “how to determine seriousness” at PRE – 2 (last updated 01/10/24).

FTP – 2a – iii Making decisions on Dishonesty charges and the Professional duty of candour

The Panel will be aware that the professional standards of practice and behaviour for nurses, midwives and nursing associates sets the standards that patients and public tell the NMC that they expect.

This case can be described as serious professional misconduct because the issues relate to the nurses role as a registered professional (a nurse in general practice), the impact on their area of practice which may affect the role in providing a lack of credible evidence for safeguarding which in turn, could affect patient confidence, relationships with staff and patients alike.

The Code for professional conduct

The professional standards of practice and behaviour for Nurses, Midwives and Nursing Associates (2015) (The Code) -

The Panel will be aware that the CODE sets out the professional standards of practice and behaviour for Nurses, Midwives and Nursing Associates

The NMC say, what she did, amounts here to serious professional misconduct.

The Code – Application to this case

The NMC suggest the following areas are engaged and may assist the Panel to identify failures by the nurse;

Prioritise people

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

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

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

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

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

Preserve safety: You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your

professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

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

20 Uphold the reputation of your profession at all times

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, treating people fairly and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

22 Fulfil all registration requirements

To achieve this, you must:

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Other considerations

Considering Seriousness: - the panel will be aware that seriousness is an important concept which informs various stages of our regulatory processes. The public's trust and confidence in all nurses, demonstrating the behaviour found by the Panel here must, we submit, amount to serious professional misconduct.

Contextual factors: - When considering seriousness of the misconduct, you will take into account evidence of any relevant contextual factors. However, we have limited evidence from the Registrant to support this.

The Factual findings: - Panel have already carried out a review of the evidence and it is not necessary to recite all the facts found proven here.

The NMC recognise that nurses, midwives and nursing associates sometimes make mistakes or errors of judgement. However, the concerns here are far reaching and very serious.

A panel will consider 'ECM's' practising history and not just at the period of time when the concerns arose. This will help the Panel understand if this is a particular area of practice where there are serious concerns.

If the Panel agree that the Nurse has fallen short of "the Code", the NMC say, what she did or failed to do amounts here to Serious Misconduct which has resulted in the Nurses practice currently being impaired.

The actions reported and found proven are failings directly related to, safety of patients, nursing care and behaviour towards support staff welfare.

The actions proven against the Registrants are not simply breaches of a local disciplinary policy or minor concerns, they are matters at the heart of

and fundamental to the professional's practice such as honesty and integrity.

The NMC say these are serious concerns at the heart of a caring profession, for example;

- a. Failure to safeguard patients*
- b. Acting outside practice*
- c. Dishonesty*
- d. Medication errors*

The actions found proven are failings directly related to professional responsibility where her behaviour, could have impacted seriously on Patients. For example, if an urgent Nursing emergency arose and the records relied upon were inaccurate.' [Sic]

Submissions on impairment

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

Mr Radley submitted the following in written form:

'NMC representations on Impairment

The Panel are now considering whether 'ECM's fitness to practise 'is impaired'.

Law on impairment

The relevant section to be considered is, (Art 22(1) of the Nursing and Midwifery Order 2001).

Impairment is not defined in the legislation.

NMC Library consider the question at DMA – 1.

There have been many legal cases which have developed the concept of impairment and the factors that should be considered when deciding whether a professional's fitness to practise is impaired.

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

“a can professional on our register practise as a nurse midwife or nursing associate safely and effectively without restriction”.

Consideration has been given to the nature of the concern by looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;

“Do our findings of fact in respect of the [nurse'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 professions 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 professions; and/or*
- d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

The panel have made the decisions on the 'Facts' and Misconduct. The next step for the Panel will now be to decide whether the professional's fitness to practise is currently impaired.

The NMC represent that this question is answered positively. The NMC represent that the professional's fitness to practise is currently impaired and that all four limbs of the Cox Judgement are engaged.

A decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. It is dependent on the individual circumstances surrounding each concern found by the panel.

The panel will no doubt review any part of the CODE found to have been breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors.

The NMC say that the breach's of the Code here involves breaching a fundamental tenet of the profession and the Panel would be entitled to conclude that a finding of impairment is required in the case of 'ECM'.

The finding of impairment, the NMC say, is required for Public Protection and Public Interest.

Context - The Fitness to Practise Panel will consider the context in which things have happened. Here the panel will be asked to consider, amongst other aspects.

- Any factors relating to the professional existing at the time of the charges (based on the evidence).*
- ECM's husband had retired and her daughter stepped in but was on maternity. A number of locums covered*
- The environment of the practice*

- *Financial difficulties in the practice*
- *Telling staff to lie – i.e missing patient appointments*

The NMC say that these features, and any others within the case, do substantially adversely affected the professional's ability to practice professionally unrestricted, and as a consequence the professional will not be able to demonstrate that they are currently able to practise in accordance with your test.

Learning, Insight and strengthened practice - The learning, insight and steps the professional has taken to strengthen their practice.

Here, the professional has not engaged in the hearing process.

Evidence of direct training that a panel could find to be relevant to her practice failings may appear limited. The Panel will be considering matters such as:

- a. Does any reflective piece address the concerns effectively?*
- b. Any learning to address the charges? Or evidence of risks being addressed*
- c. Portfolio / certificate evidence of training/ references etc*

The NMC submit it is likely that the conduct will be repeated and this is a very real concern for the NMC. This is especially the case when the Registrant is not engaging.

The NMC are concerned that the impact will be truly accepted by the Registrant. This will affect the professional's ability to practise in the manner expected, resulting in the NMC, suggest a finding of impairment. The consequences of the professional's conduct ranged from, risk to patients due to inaccurate records, lack of co-workers trust and confidence and dishonesty in her practice.

For these reasons the NMC say that the Registrant's fitness to practice is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

1) Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1) treat people with kindness, respect and compassion
- 1.2) make sure you deliver the fundamentals of care effectively

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
- 8.4)** work with colleagues to evaluate the quality of your work and that of the team
- 8.5)** work with colleagues to preserve the safety of those receiving care

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

To achieve this, you must:

9.1) provide honest, accurate and constructive feedback to colleagues

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

10) Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

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

10.3) 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, as appropriate:

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

14) Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1) act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3) document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

16) Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.4) acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5) not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

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

18.4) take all steps to keep medicines stored securely

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) Uphold the reputation of your profession at all times

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, treating people fairly and without [...] bullying or harassment

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

21) Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3) act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

24) Respond to any complaints made against you professionally

To achieve this, you must:

24.2) use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25) Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1) identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, and therefore, the panel considered each charge found proved and whether or not each of these amounted to serious professional misconduct.

Charges 1d, 2a and 2b)

The panel initially grouped together and considered whether or not Charges 1d, 2a and 2b amounted to serious professional misconduct.

The panel took into consideration the fact that Mrs Mwambingu was not a practitioner who had independent nurse prescribing qualification which would have allowed her to prescribe medication. The panel highlighted that the prescription issued by Mrs Mwambingu for Patient D was not authorised by a doctor, which is substantiated by the fact that there was no doctor present at the Practice during the Friday afternoon in question. The panel determined that, in issuing this prescription, Mrs Mwambingu exposed Patient D to a risk of harm. Specifically, the panel considered the fact that Mrs Mwambingu did not have the appropriate knowledge, skills, or formal qualification to issue such a prescription. The panel determined that Mrs Mwambingu acted entirely outside of the scope of her practice as a registered nurse.

The panel determined therefore that Mrs Mwambingu's actions in Charges 1d, 2a and 2b fall well below the standards expected of any registered nurse and amount to serious professional misconduct.

Charges 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 4a and 4b)

In considering whether or not Charge 3 in its entirety, alongside Charges 4a and 4b amounted to serious professional misconduct, the panel noted the fact that these charges involved nine separate patients, and that Mrs Mwambingu's editing and/or adding information to these patients' records occurred over a nine-month period. The panel highlighted that Mrs Mwambingu's actions were not isolated incidents, but rather a pattern of behaviour repeated on multiple occasions.

The panel noted that there was no rationale given, in any form, as to why Mrs Mwambingu had entered such information onto these patient records, and crucially, how she had come to obtain such information; the information inputted was not related to any patient consultations.

The panel considered these charges to be particularly serious, given the fact that the information which was inputted into these patient records would have been accessed by and formed a false evidence base upon which other clinicians potentially could have acted upon. The panel determined therefore that Mrs Mwambingu's actions led to a serious risk of harm to all nine of these patients.

The panel determined therefore that Mrs Mwambingu's actions in Charges 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 4a and 4b, fall well below the standards expected of any registered nurse and amount to serious professional misconduct.

Charges 5a, 5b)

In considering whether or not Charges 5a and 5b amounted to serious professional misconduct, the panel highlighted again that Mrs Mwambingu's dishonesty in entering erroneous data into nine separate patient records, was particularly serious as it presented a real risk of harm to those patients.

The panel ultimately was of the view that Mrs Mwambingu's dishonesty in entering erroneous data was driven by a desire to obtain funding from the North Wales Health Board ('NWHB') Practice funding followed defined clinical tasks being undertaken and recorded for patients with certain health conditions. The panel highlighted that due to Mrs Mwambingu's dishonest actions, the NWHB would have been impacted in that it would have had less funding to allocate to patients who required clinical care based on robust, evidence-based health data.

The panel determined therefore that Mrs Mwambingu's dishonest actions in Charges 5a and 5b fall well below the standards expected of any registered nurse; these actions amount to serious professional misconduct.

Charge 7)

In considering whether or not Charge 7 amounted to serious professional misconduct, the panel determined that as a registered nurse who was also the *de facto* Practice Manager at the time of these events, Mrs Mwambingu held a

responsibility to ensure that medication was stored appropriately at the Practice.

The panel were concerned that there was a large quantity of medication that was stored incorrectly. There was far more that could be accounted for than a few patient medicines returns to the practice being held before being returned to a pharmacy, as per local policy. Rather, the panel highlighted that Mrs Mwambingu stored these medications at the Practice.

The panel considered that this was not merely poor practice, but actually presented a risk of harm, as the drugs which were not securely kept, may have been readily to people whom they were not prescribed for, and therefore, presented a potential safety risk.

The panel considered Mrs Mwambingu's failure to ensure that medication was stored appropriately at the Practice to be all the more serious, as some of the drugs were not securely stored at the practice, were controlled drugs. These drugs, in and of themselves, by law, were required to have been subject to the strictest controls and safeguards.

The panel was of the view that whilst other members of staff within the Practice also held a responsibility to ensure that controlled drugs are monitored and stored appropriately and safely; this included Mrs Mwambingu as a registered nurse.

The panel determined therefore that Mrs Mwambingu's actions in Charge 7 fall well below the standards expected of any registered nurse; these actions amount to serious professional misconduct.

Charges 8a, 8b and 9)

In considering whether or not Charges 8a, 8b and 9 amounted to serious professional misconduct, the panel determined that, in telling Practice staff not to record information in relation to missed patient referrals, Mrs Mwambingu

deliberately intended to prevent other clinicians or practices from being aware that patients had called to '*chase*' their referrals. The panel considered Mrs Mwambingu's actions to be deliberate and intended to protect the reputation of the Practice.

The panel further considered that, in instructing practice staff to lie to patients, and inform them that their referrals had been sent, Mrs Mwambingu's actions were dishonest, and also exposed patients to a serious and unwarranted risk of harm. Mrs Mwambingu's actions resulted in a delay in patients accessing specialist care which they required.

The panel determined that Mrs Mwambingu's actions were a breach of the duty of candour, a breach of the NMC Code of Conduct, and caused an unwarranted risk of harm to patients who required specialist care.

The panel determined therefore that Mrs Mwambingu's actions in Charges 8a, 8b and 9 fall well below the standards expected of any registered nurse; these actions amount to serious professional misconduct.

Charges 10a and 10b)

In considering whether or not Charges 10a and 10b amounted to serious professional misconduct, the panel considered the context surrounding these two charges and determined that within the Practice, Mrs Mwambingu was in a position of power as the Practice Manager. The panel noted that the colleagues in which Mrs Mwambingu bullied and/or acted unprofessionally towards were dependent on the Practice for their employment. The panel noted that Mrs Mwambingu's actions would have resulted in an unprofessional and potentially intimidating environment in which her colleagues would have been unable to raise concerns to their senior. The panel was of the view that Mrs Mwambingu's actions within Charges 10a and 10b presented a pattern of behaviour over a protracted period of time which did not resolve, despite it having been brought to her attention by her colleagues.

The panel specifically highlighted the following passages from Joanne Lewis's statement:

'Liz Mwambingu would get annoyed with us and tell us off and I feel that she was bullying us by shouting at us quite often but she never did this in front of the patients. However, on some occasions she would apologise.'

'Whilst working at the Practice several members of the reception staff raised concerns to me that Liz was bullying them. For example, Liz would be rude to them in front of patients and belittle them.'

'At one point around the end of 2018 and beginning of 2019, [Glenys Davies] raised a verbal complaint to me about Liz. [Glenys Davies] said that she generally felt like Liz was sharp [...] she found Liz to be generally unapproachable. When this was discussed with Liz she apologise for being sharp. Nevertheless, not much changed and the reception staff continued to feel bullied, like they were often walking on egg shells.' [sic]

The panel overall was of the view that based on the witness evidence before it, Mrs Mwambingu did create an unpleasant, intimidating, and bullying atmosphere amongst practice staff due to the manner in which she had communicated with those staff members.

The panel determined therefore that Mrs Mwambingu's actions in Charges 10a and 10b fall well below the standards expected of any registered nurse; these actions amount to serious professional misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 finds that both colleagues and patients were put at unwarranted risk of harm. Colleagues were caused actual emotional harm as a result of Mrs Mwambingu's misconduct. The panel determined that the falsification of records that other health care professionals might act on, not storing controlled drugs appropriately, the prescribing of drugs without the correct qualifications to do so, and the overall dishonesty as seen within Mrs Mwambingu's misconduct, led to unwarranted risks of harm to patients. The panel also considered Mrs Mwambingu's bullying and intimidating behaviour towards her colleagues caused them actual emotional harm and created a toxic working environment, which may have indirectly caused an unwarranted risk of harm also to the patients who who's referrals for specialist care may not have been undertaken in a timely manner.

The panel was of the view that Mrs Mwambingu's colleagues, alongside members of the public, would consider her behaviour as deplorable. The panel particularly highlighted Mrs Mwambingu's prescribing of medications without adequate qualifications, her dishonest alteration of patient records and lack of honesty about the progress of patient referrals. It determined that these actions would undermine the public's trust. The panel determined that, in taking Mrs Mwambingu's misconduct as a whole, it was clear that she had a disregard for systems and processes which are put in place to protect patients from harm and did so over a protracted period of time.

Consequently, the panel concluded that Mrs Mwambingu's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. The panel determined that honesty is the core of the nursing profession. The panel determined that Mrs Mwambingu's dishonesty was both long standing and in the panel's view, likely premeditated and systematic in nature. Mrs Mwambingu's dishonesty impacted numerous patients and was directly related to her clinical practice. The panel determined that Mrs Mwambingu's misconduct presents a deep-seated attitudinal issue, and that her dishonesty is extremely difficult to remediate.

The panel also considered Mrs Mwambingu's behaviour to be coercive as she would instruct her junior staff within the Practice to lie about the progress of patient referrals, would cause a hostile environment and once again, an unwarranted risk of harm to patients and colleagues. The panel was of the view that this such misconduct once again shows attitudinal concerns; Mrs Mwambingu's poor behaviour continued even after this was reported to her from her colleagues, and after she was given the chance to change.

The panel considered that Mrs Mwambingu had a further disregard for the safe dispensing and storage of medication, alongside the fact that she had a cavalier disregard for patient safety.

The panel was of the view that it would be extremely difficult for Mrs Mwambingu to remediate her misconduct, as her actions are seriously indicative of deep-seated attitudinal issues.

Regarding insight, the panel considered that Mrs Mwambingu has not acknowledged the harm she has caused, or any of the unwarranted risks of harm she put her patients in. The panel did bear in mind that there were several positive testimonials attesting to Mrs Mwambingu's good practice as a nurse, however, noted that the majority of these focused on the closure of the practice. Furthermore, the panel had

no evidence before it to indicate that the authors of these testimonials were aware of the allegations being raised against Mrs Mwambingu. Therefore, the panel could not assign much weight to these testimonials.

Mrs Mwambingu has exhibited a very little amount of remorse, and her reflections have centred entirely on projecting the blame of her actions onto others who worked at the Practice. The panel took into account the following passages from Mrs Mwambingu's response bundle:

'In the last 2 years, BMC had multiple meeting with BCUHB to discuss [PRIVATE] and stretched resources. The GP had a private conversation with a medical director and LMC doctor regarding [PRIVATE]. BCUHB were repeatedly told about the [PRIVATE] and had even labelled the surgery as unsustainable: but despite this little support was given and the practice subsequently became the 26th practice to close in Wales since October 2015.'

'During this distressing time for patients and staff and despite the fact that no patient had ever made any complaint about Dr Sekela and me or come to any harm DR Bowdler decided it was expedient to stat forensically examining our past consultations...'

Consequently, the panel was of the view that the misconduct is extremely serious, and that Mrs Mwambingu would be unable at this stage to practice safely, effectively and without restriction. The panel is of the view that there is a risk of repetition based on the fact that Mrs Mwambingu's actions did not occur as isolated incidents but rather continued over a protracted period of time. Mrs Mwambingu has not taken any realistic steps to strengthen her practice, including a reflective piece demonstrating insight into the impact of her actions on patients, colleagues and the public's confidence in the nursing profession. Given Mrs Mwambingu's lack of recognition of her failings, there is a lack of any safeguard to prevent reoccurrence and consequently, a real risk of repetition. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel was of the view that an informed member of the public fully aware of the details of this case would be shocked and appalled to know that a registered nurse had been so dishonest and acted in such a manner that Mrs Mwambingu has. Consequently, the panel determined that a finding of impairment on the public interest ground is also required, given Mrs Mwambingu's dishonesty, her long standing misconduct, her disregard for patient safety.

Having regard to all of the above, the panel was satisfied that Mrs Mwambingu's fitness to practise is currently impaired on both grounds of public protection and in the wider public interest.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley, in relation to sanction, submitted the following in written form:

'The NMC submit that the following matters should be considered by the Panel at the sanctions stage of Mrs. Mwambingu's case.

Proportionality

The Panel will be seeking to find a fair balance between Mrs. Mwambingu ("ECM"), the nurses rights and our overarching objectives

The NMC's case is that the 'Fitness To Practice Committee' can justifiably restrict the Nurses right to practice in this case.

The Panel will be looking at the reasons why the nurse, isn't currently fit to practise, any aggravating or mitigating features and the sanctions guidance contained on the NMC library (SAN – 2) and any other related sections.

The panel will consider whether the sanction with the least impact on the nurses practise would be enough to achieve Public Protection, be in the Public Interest and reflect the proper Nursing standards.

The sanction will of course be considered from the least serious to the most serious to achieve its objectives with the NMC addressing each in turn below.

The NMC submit that the Panel can conclude that the Nurse is not fit to practice currently, unsanctioned, based on the following representations;

Aggravating features

Registered nurses occupy a position of privilege and trust and must maintain professional standards at all times. In this case the NMC submit that "ECM" has failed to do so.

The representations on aggravating factors are:

The failings relate to a number of the fundamental tenets of the profession. The evidence of this is at (pages 16 -20), namely the code breaches found by the Panel.

Other professionals in the caring profession where mislead leading to an incomplete risk assessment document (records), trust and confidence issues. Referenced at page 21 Para 3.

The Registrants conduct includes blame/cover up.

Dishonesty – *reporting to the North Wales Health Board, Where the proven charges are serious matters for Nursing and the community at large. The panel have identified that other Health Service areas could have lost out financially.*

This demonstrates Prioritising financial gain over the care of others

Dishonesty – *Based on lies to patients about referrals being sent when they had not. Thus this Impacts on the profession and the reputation of Nurses has been bought into disrepute*

The registrant created an unpleasant, bullying environment for staff (page 25)

The Panel find the four limbs of the Grant test are engaged in this case.

The concerns are attitudinal in nature. These are recognised in the NMC library as being more difficult to put right

The Registrant worked outside the scope of her practice by providing prescriptions to patients that had been pre-signed. This meant that the appropriate ‘checks and balances’ of the prescribing system were not followed which put patients at a risk of harm. The Nurse acted outside of her scope of practice.

Public interest is engaged – How would a reasonable member of the public react to a nurse being found to be dishonest in circumstances such as these where patients and the board purse had been affected.

Mitigating features

The mitigating features are;

Limited engagement in the process

No previous clinical concerns

Proposed sanction

Honesty is at the heart of Nursing practice. The Panel have found two charges proven relating to Dishonesty one for financial gain and a second relating to patient records.

Clinical concerns or practice concerns are the most serious. This behaviour is at the heart of a caring profession, affecting patients, the public purse and colleagues alike.

The behaviour tends to suggest an attitudinal concern towards her responsibilities of honest/candid disclosure to patients and working effectively with other professionals. This emphasises the seriousness of the behaviour found proven.

As such, the concerns do raise fundamental questions about Mrs. Mwambingu's professionalism, honesty and integrity.

The NMC submit that the Public must be protected and that public confidence would be damaged where a nurse is permitted to continue to practice in cases such as this.

The NMC now address the options for sanction

No action – *This would not reflect the gravitas of the case*

Caution / warning – *As above.*

Conditions of practice - *This case involves dishonesty, attitudinal concerns and risk to Patients, which is very serious.*

The panel have identified limited insight (NMC say, even after a lengthy effort to engage the Registrant).

The key consideration when looking at whether a ‘Conditions of Practice’ order may be appropriate is whether conditions can be put in place that would address the public confidence in the profession and the NMC. Given the particular circumstances of this case, we submit that there are no conditions which could be drafted to address the issues relating to public protection and public confidence.

Given this and the gravity of our concerns, reflected by the rational of the Panels judgement, we submit that this is not a suitable order.

Suspension order – *This would not be a sufficient sanction for this case.*

The NMC’s guidance on suspension orders found at SAN-3d outlines that a suspension order may be appropriate in cases where the misconduct isn’t fundamentally incompatible with the nurse continuing to be a registered professional and the NMC’s overarching objective of public protection may be satisfied by a less severe outcome than permanent removal.

The NMC submit that the registrant’s actions were directly related to patient care, which demonstrates a departure from the conduct and behaviour expected of a registered professional in a caring profession. The seriousness of the registrant’s actions is reflected in the NMC guidance where it states;

Some behaviours are particularly serious as they suggest there may be a risk to people receiving care. Protecting people from harm, abuse and

neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right. Such behaviour also has the potential to seriously undermine the public's trust and confidence in the professions we regulate.

There are some serious concerns which are more difficult to put right and breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of the public who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care;

The Registrants behaviour represents serious conduct, which is difficult to put right, based on what we have been told and is incompatible with her remaining as a registered professional.

The conduct identified in the panel findings recognises aspects of the case where the Registrant would find it hard to rehabilitate, such as dishonesty.

Therefore, this cannot be a suitable option for disposal of the case.

Striking off Order

A striking off order is the only appropriate and proportionate sanction. For the reasons stated above, her Dishonesty raises fundamental, attitudinal concerns about her judgement and risked patients harm and the integrity of the profession.

Public confidence would be affected if she were not removed from the register.

The allegations, collectively, raise fundamental concerns about Mrs. Mwambingu's professionalism and her trustworthiness. There is a lack of

genuine remorse, insight and reflection. The overall impression of the evidence is that the Registrant was seeking to put the interests of her daughter's practice over those of patients and colleagues.

A lesser sanction than a striking off order is unlikely to be sufficient to protect the public or adequately maintain public confidence in the profession.

It is submitted that the public's trust could not be maintained if any lesser order were to be made than a striking-off order.

While the objective of any sanction imposed by the Fitness to Practice Committee is not to be punitive, it may sometimes have that effect.

*The guidance under SAN-2 and cases relating to offending by registrants, including **Bolton v Law Society [1994] 1 WLR 512**, illustrate the principle that the reputation of the professions is more important than the fortunes of any individual member and that while membership of a registered profession brings many benefits, this is part of the price.*

Sir Thomas Bingham MR said, that any solicitor who is shown to have discharged his professional duties with anything less than complete integrity, probity and trustworthiness must expect severe sanctions to be imposed upon him by the SDT¹. The most serious involves proven dishonesty, whether or not leading to criminal proceedings and criminal penalties. In such cases the tribunal has almost invariably, no matter how strong the mitigation advanced by the solicitor, ordered that such a solicitor be struck off the role of solicitors. The reason is the most fundamental of all, to maintain the reputation of the solicitor's profession and to sustain public confidence in the integrity of the profession.

Conclusion –

The NMC submit these are circumstances where the seriousness of the

registrant's findings means a striking-off order is the only appropriate order in the circumstances

The Panel are asked to consider imposing a striking off order in this case.'

Decision and reasons on sanction

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

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

The panel took into account the following aggravating features in relation to Mrs Mwambingu's misconduct:

- 1) There was an abuse of a position of trust;
- 2) There was conduct which deliberately or recklessly put people receiving care at a risk of suffering harm;
- 3) There were deliberate breaches of the Code;
- 4) There was a pattern of misconduct over a period of time;
- 5) There is an absence of insight;
- 6) There is evidence of premeditated behaviour;
- 7) There is a failure to work collaboratively with colleagues, in that Mrs Mwambingu created a toxic atmosphere;
- 8) There was an encouragement of other members of staff to lie to patients about the status of their referrals.

The panel also took into account the following mitigating feature:

- 1) [PRIVATE]

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

The panel next considered whether to place a conditions of practice on Mrs Mwambingu’s registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on ‘*Conditions of practice order*’ (Reference: SAN-2c Last Updated: 28/01/2026). Having found that Mrs Mwambingu’s dishonesty is so far ranging and having regard to the nature and seriousness of Mrs Mwambingu’s conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel also determined that it does not have confidence that if conditions were appropriate, that Mrs Mwambingu would abide by such conditions.

Consequently, the panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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

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

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

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

Whilst the panel acknowledged that the risks identified could be addressed for a period of time by Mrs Mwambingu being temporarily removed from the Register, it

considered that it would not be sufficient to protect the public in the long term, or to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the misconduct in this case. Given Mrs Mwambingu's lack of engagement, limited insight, lack of remorse, together with no evidence of training and development, the panel considered that there is no realistic possibility that she could address the concerns to such a level where she could return to practise safely. The panel determined that Mrs Mwambingu's deep-seated attitudinal issues would not be addressed with a temporary removal from the NMC register. The panel overall concluded that the misconduct in this case is so fundamental and relates to basic nursing practice, that it is unrealistic that Mrs Mwambingu could safely return to practice in the future.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to protect the public and the wider public interest.

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

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

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

The panel determined that Mrs Mwambingu's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Mrs Mwambingu's actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel in particular highlighted Mrs Mwambingu's dishonesty, the actual emotional harm that was caused to her colleagues as a result of her actions, alongside the unwarranted risk of harm that was caused to patients under her care. Mrs Mwambingu has failed to present evidence to the panel that she has taken steps to remediate any of her misconduct which was deep-seated, attitudinal, and protracted over a period of time. The panel took into account the following points from the NMC's Sanctions Guidance, SAN-4:

- 1) Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care;
- 2) misuse of power;
- 3) personal or financial gain from a breach of trust;
- 4) direct risk to people receiving care;
- 5) premeditated, systematic or longstanding deception.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse. The panel highlighted that Mrs Mwambingu has breached multiple areas of the code, and a fully informed member of the public, equipped with all of the facts of this case, would have their confidence in the profession undermined if Mrs Mwambingu was not removed from the NMC register.

This will be confirmed to Mrs Mwambingu in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Radley, who submitted that an interim order is necessary in this case in order to ensure that Mrs Mwambingu does not practice unsupervised during the 28-day appeal period. He submitted that the only proportionate interim order given the circumstances would be one of an 18-month interim suspension order, to be imposed on both grounds of public protection and in the wider public interest.

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 determined that to not impose an interim order at this stage would be inconsistent with the panel's finding. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover any appeal period.

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

That concludes this determination.