Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Tuesday, 8 September 2026

Virtual Hearing

Name of Registrant:	Nadine Wilson
NMC PIN:	97Y0127O
Part(s) of the register:	Midwives Part of the Register: RM: Midwife (19 March 2001) Nurses Part of the Register Sub Part 1: RN1: Adult nurse, level 1 (14 August 1997)
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Rachel Carter (Chair, Registrant member) Claire Braithwaite (Registrant member) Nicola Strother Smith (Lay member)
Legal Assessor:	Robin Leach
Hearings Coordinator:	Catherine Blake
Nursing and Midwifery Council:	Represented by Andrew Mason, Case Presenter
Ms Wilson:	Present and represented by Dr Abbey Akinoshun of ERRAS Legal Services
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (6 months) to come into effect at the end of 17 October 2026 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to confirm the current suspension order.

This order will come into effect at the end of 17 October 2026 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the third review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel effective from 18 October 2024. This was reviewed on 15 September 2025 where the panel decided to extend the substantive suspension order for six months. This was reviewed again on the 29 January 2026 where the panel decided to extend the order for six months from April 2026.

The current order is due to expire at the end of 17 October 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved by way of admission which resulted in the imposition of the substantive order were as follows:

'First set of charges (2019)

That you a registered nurse and/or registered midwife:

1) On 5 March 2019 in relation to the preparation of an intra venous (I/V) Syntocinon, infusion for Patient A:
   a) Failed to read the prescription chart;
   b) Failed to prepare 10 international unts (iu) per 500 ml of sodium chloride;
   c) Prepared 40 iu per 500 ml of sodium chloride;
   d) Prepared a label with 40 iu per 500 ml of sodium chloride.

2) *On 5 March 2019 in relation to Patient A failed to demonstrate knowledge of the correct dosage of Syntocinon to be administered to a patient who was in labour.*

3) *On 5 March 2019 in relation to Patient A failed to carry out the required:*
   a) *Observations every hour;*
   b) *Blood sugar/glucose tests;*
   c) *Vital signs;*
   d) *Amniotic fluid checks;*
   e) *Foetal Heart monitoring.*

…

5) *Having been subject to undertakings as varied on 13 October 2022 failed to complete the undertakings within 6 months*

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

<u>Second set of charges (2023)</u>

That you, a registered nurse and/or registered midwife, between 18 December 2022 and 19 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in the following:

1) *On or around 19 December 2022, in relation to patient 2:*
   a) *Administered intravenous medication.*

   b) *In relation to charge 1(a) was acting outside her level of competency.*

2) *On 3 January 2023 failed to escalate Patient 3's condition, namely that they were hypothermic.*

3) *On 9 January 2023 in relation to Patient 4:*

   a) *Failed to support the patient's perineum effectively;*

b) Failed to ensure the CTG was correctly; recording during the third stage of labour;

c) Did not recognise the correct order of the labour procedure, namely:

i. The administration of Syntocinon:

ii. Delivery of the placenta;

iii. Suturing.

4) On 18 January 2023 in relation to Patient 5:

a) Did not make a record in a timely manner; namely within 30 minutes;

b) Did not recognise a Post-Partum Haemorrhage ("PPH").

5) On 19 January 2023, in relation to Patient 6:

a) The management and administration of medication, namely:

i. Oramorph;

ii. Syntocinon.

b) Incorrect labelling of a blood sample;

c) Delayed Patient 6 receiving an epidural.

6) On 25 January 2023 in relation to Patient X:

a) In regard to the timings of listening to the foetal heart rate in the first stage of labour, namely every 15 minutes;

b) In regard to Cardiotocography (CTG) physiology.

7) On 3 February 2023 in relation to patient 7:

a) Administered intravenous antibiotics on the incorrect occasion;

b) Did not make a proper record in regard to the administration of the intravenous antibiotics.

8) On 4 February 2023 in relation to patient 8:

a) Did not provide the correct information during labour, namely the direction in which to push;

b) In regard to the battery on the Cardiotocography equipment:

i. Allowed the battery to cease to function;

ii. Failed to have a backup battery.

c) *Did not stimulate Patient 8's baby without prompting;*

d) *Did not provide third stage labour medication without prompting.*

9) *On 5 February 2023 in relation to an unknown patient:*

a) *Did not complete records in a timely manner;*

b) *Failed to stimulate the baby of the patient.*

10) *On 10 February 2023 in relation to an unknown patient required prompting to:*

a) *Check the patient's blood pressure;*

b) *Escalate the patient's condition;*

c) *Administer fluids.*

11) *On 11 February 2023 in relation to Patient 9:*

a) *Did not escalate Patient 9's condition to:*

i. *A midwife in charge*

ii. *An anaesthetist*

b) *Provided incorrect information to:*

i. *Colleague Y regarding Patient 9's heart rate;*

ii. *To Patient 9, namely the reasons for the administration of Terbutaline.*

12) *On 12 February 2023 in relation to Patient 10 in labour:*

a) *Delayed the care of Patient 10;*

b) *Did not or did not adequately, communicate with Patient 9 during delivery of Patient 10's baby;*

c) *Delayed the stimulating and/or covering of Patient 10's baby.*

13) *On or around 13 February 2023 failed to store a placenta correctly.*

14) *On 16 February 2023 in relation to Patient 11, failed to:*

a) *Recognise low sodium levels;*

b) *Carry out one or more tests/checks on sodium levels;*

…

d) Escalate Patient 11's condition regarding sodium levels to:

i. A senior colleague;

ii. A doctor.

15) On 17 February 2023 in relation to Patient 11, failed to:

a) Recognise or take appropriate action when Patient 11 suffered a post-partum haemorrhage;

b) Record Patient's 11 blood loss in a timely manner.

c) To keep proper and/or accurate records.

16) Did not effectively communicate with colleagues during handovers on:

a) 9 January 2023

b) 18 January 2023

c) 19 January 2023

d) 25 January 2023

e) 4 February 2023

f) 11 February 2023

g) 12 February 2023

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

The second reviewing panel determined the following with regard to impairment:

'The panel determined your insight has deepened since the last review; however, it was not satisfied that you have demonstrated how you would apply your increased insight and learning to your practice in the future as a midwife. The panel acknowledged that you admitted the charges at the original hearing. However, the panel was of the view that your insight is not yet sufficient to indicate that you are able to practise safely and effectively as a midwife. The panel noted that you have shown a significant level of remorse. It noted in your reflection dated 4 December 2025 you wrote:

> '…My actions had the ability to cause serious harm to the women and babies in my care; its effect could be felt long after the actual events have transpired. apologise to the women who were in my care, their families, my colleagues, the members of my profession other members of the wider healthcare profession, as well as the public as a whole. In doing so I recognise that I did not uphold the standards of the professional code of practice of the Nursing and Midwifery Council. I understand the level of risk that I posed to the safety of the women and babies in my care, because of my poor competencies and decision making as a professional…'

With regards to the second point, the panel noted that while you outline in your reflection that you would escalate concerns to a midwife, you do not provide any detail on how you would do so, i.e. by explaining the techniques in your training. The panel was of the view that given the extent of the competency concerns in this case, your reflections do not sufficiently illustrate the learning from the training you have completed and how you would utilise those skills in practice.

The panel noted that you provided two testimonials from a registered midwife who has worked with you for over a decade and was also the course instructor for one of the training courses you completed. It noted that while these testimonials were positive, they are limited in providing an overall picture of your competency as a midwife. The panel noted that these testimonials referred to one course which is also annual mandatory training for midwives. The panel had no other information regarding your participation, engagement and ability to implement the learning into practice with the numerous other areas of practice relevant in this case.

The panel was of the view that at this time, it had insufficient evidence before it to demonstrate that you have been able to implement your further learning into practice. It noted that you are currently working as a HCA and thus are not able to carry out midwifery duties, however, it had no

evidence before it of how you have transferred your training to your current role nor how you would do so if you were to return to midwifery practice.

The panel bore in mind the tests in Grant Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin), *and* Cohen v General Medical Council [2008] EWHC 581 (Admin) *as well as the NMC Guidance (REV-2a).*

The panel determined that the first three limbs of the Shipman test remain engaged when looking at the position today and going forward, namely that you are liable in the future to put patients at risk of harm, you are liable in the future to bring the profession into disrepute and are liable in the future to breach one of the fundamental tenets of the midwifery profession.

In light of the above, the panel determined that your fitness to practise remains impaired on the ground of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required given the serious public protection concerns that you are not yet competent to practise safely as a midwife.

For these reasons, the panel finds that your fitness to practise remains impaired.'

The second reviewing panel determined the following with regard to sanction:

'Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has

also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risks identified and the wide-ranging nature of the concerns. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the public protection issues identified, in particular the concerns around your ability to practise safely and effectively, an order that does not restrict your practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the extent of the concerns regarding your competency and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest at this time. The panel was not satisfied that you have demonstrated a sufficient level of insight and remediation to be permitted to return to practice. The panel was not able to formulate conditions of practice that would adequately address the concerns without being overly onerous to the point where conditions would not be workable.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on your previous lack of competence. It considered that you need to gain a full understanding of the competencies of a midwife and demonstrate how you would implement your training to strengthen your practice. The panel concluded that a further suspension order would be

the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. It would also give you an opportunity to approach health professionals to attest to your strengthened practice and ability to demonstrate putting your learning and training in practice.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined that imposing a suspension order for a period of 6 months would provide you with an opportunity to demonstrate developed insight and strengthened practice, undertake continued training and reflect fully on how you can implement the training in practice to avoid repetition of the failings in this case. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 17 April 2026 in accordance with Article 30(1).

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

Any future panel reviewing this case would be assisted by:

- *Evidence of continued training in relevant areas of midwifery and fundamental midwifery competencies*
- *A detailed reflection including an understanding of how you would implement your learning and training in practice with examples to include the detailed steps you would now take to address the deficiencies which have been proved in the charges that you admitted.*

- *Testimonials from colleagues/ managers/ supervisor/ course instructors that detail your participation and engagement with training and learning and how you have demonstrated this in practice.*

A future panel may be assisted, if you wish to do so or are so advised, to give evidence under oath or affirmation so a panel can directly question you in respect of your learning over the six months this order has been in place.'

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle, and your written reflections, training certificates and testimonials. It has taken account of the submissions made by Mr Mason on behalf of the NMC, and by Dr Akinoshun, on your behalf.

Mr Mason briefly summarised the background to the case.

Mr Mason referred to the decision of the previous panel, and the recommendations listed at the end of its decision. He submitted that it was a matter for the panel to determine whether your current fitness to practise remains impaired. He referred the panel to the NMC Guidance at Rev-2a and FtP-16b and noted that the persuasive burden is on you to establish that your fitness to practise is no longer impaired.

The panel also had regard to Dr Akinoshun's submissions. He submitted that you have demonstrated a significant and sustained process of remediation, reflection and professional development. He referred the panel to your extensive reflections.

Dr Akinoshun invited the panel to find that the risks previously identified which justified suspension have been sufficiently reduced. He submitted you are now capable of safe and effective practice.

Dr Akinoshun submitted that you have been subject to a substantive suspension order for two years. He submitted that you remain committed to the Fitness to Practice process. He noted that you have not been able to practise as a midwife during that time, but have still taken steps to remediate.

Dr Akinoshun referred the panel to your bundle, and submitted that you have undertaken extensive remediation in the past two years. In particular, he submitted you have completed substantial training in midwifery and competencies. Dr Akinoshun submitted this demonstrates an active attempt by you to identify relevant areas of deficiency and retrain in order to return to safe practice.

Dr Akinoshun further submitted that you have undertaken extensive reading and reflection, and that this is evident in the written reflections the panel has seen. He submitted you have sought to identify what went wrong, why it went wrong and what ought to have been done differently.

Dr Akinoshun submitted that you have been working as a healthcare assistant. He informed the panel that you have voluntarily shadowed experienced midwives in order to further strengthen your practice.

Dr Akinoshun referred the panel to the positive testimonials submitted on your behalf. He noted that you have received testimonials from two trainers as well as from senior colleagues.

Dr Akinoshun submitted that you are now extremely unlikely to repeat the behaviours that led to your suspension. He invited the panel to revoke the current suspension order.

In response to panel questions, Dr Akinoshun confirmed that you had a substantive post on a surgical ward as a healthcare assistant for two years and that you resigned from it on 15 May 2026 to focus on meeting the requirements of this regulatory process, and therefore chose to work part-time on the bank. You did not undertake any shifts in midwifery. He confirmed that you have had some shadowing shifts of midwives in practice, and that you had received feedback from three or four.

Dr Akinoshun further confirmed that, in respect of your two on-tabled reflections both dated 15 April 2026 being very different, you had not used AI and not obtained any help from others in the drafting of your reflections.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that the last reviewing panel found that you had developing insight. At this hearing the panel considered that your recent reflections, dated 15 April 2026, demonstrate an acknowledgement of your responsibility, and some limited detail as to what you did wrong. Your reflections also show an understanding of how your actions could impact on the reputation of the profession. However, the panel determined that your reflection is limited especially in respect of the analysis and evaluation of what went wrong in each of the incidents, and how you would act differently in future. Your reflection mostly focuses on the principles of good midwifery practice but instead requires a more detailed analysis of how the mistakes occurred and how you would prevent them from recurring. Without this analysis and forward-thinking perspective the panel was concerned that your insight is limited.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the additional relevant training you have undertaken, which included

‘Effective fetal monitoring during labour’ completed 1 August 2026, ‘Raising awareness of reduced fetal movement (RFM)’ completed 18 March 2026, ‘Prediction, prevention and perinatal optimisation of preterm birth’ completed 6 August 2026, ‘Ultrasound: Saving Babies Lives’ completed 6 August 2026. However, the panel was concerned that this training was mostly e-learning, and there was some in-person training. In addition, the panel has seen little evidence of assessment results and scores from this training. The panel was therefore not satisfied that this training adequately addresses the concerns around your competence. The panel note that you have also not been able to specifically demonstrate how this training could be applied and how it would improve your clinical practice.

The panel had sight of several testimonials submitted on your behalf. The panel noted that it has not had the benefit of seeing any testimonials from your current or most recent manager or supervisor, nor any testimonials from the midwives who you shadowed. The panel did note that the midwives said they were too busy to write a testimonial for you. The panel was concerned by the quality of the testimonials that it has seen. It noted that one was from a friend of yours, and so could not be heavily weighted. The remaining three testimonials from colleagues and trainers were not dated, and one did not confirm the role or organisation of the author. Further, the panel was concerned that the testimonials do not provide evidence of, or refer to, your clinical competence. The panel could therefore not rely on these testimonials as it could not be satisfied of when some were written and in what capacity they were written, nor did they provide information as to your current practice.

The last reviewing panel determined that you were liable to repeat matters of the kind found proved. Today’s panel has considered that, as your insight remains limited, and it has very little evidence that your clinical practice has strengthened, it determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that your fitness to practise remains impaired.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'* The panel considered that your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing, and that they concern wide-ranging lack of competence across numerous practice areas. The panel has not seen sufficient evidence today to satisfy it that your practice has strengthened to the extent that conditions of practice would be appropriate, and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the all the concerns relating to your lack of competence.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on your previous lack of competence. The panel concluded that a further six-month suspension order would be the appropriate and proportionate response and would afford you time to further develop your insight and take steps to strengthen your practice. It would also give you an opportunity to

approach past and current health professionals to provide up to date testimonials attesting to your clinical practice.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of six months. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 17 October 2026 in accordance with Article 30(1).

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

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion and assessment of courses relating to the areas of lack of competence;
- Written competency assessments completed by the supervising midwives on shadowing shifts (scenario-based) and/or a contemporaneous reflective log;
- Detailed reflection from you as to why the clinical problems arose and what specifically you need to do to prevent the same situations recurring and also as to how you could incorporate your recent learning into your practice;
- Recent, dated testimonials on the organisation's headed paper from your most recent/current line manager or supervisor as to your current practice; and
- Your continued engagement with the Fitness to Practise process.

A future panel may be assisted, if you wish to do so or are so advised, to give evidence under oath or affirmation so a panel can directly question you in respect of your learning over the six months this order has been in place.

This will be confirmed to you in writing.

That concludes this determination.