Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 17 July 2024 – Monday, 22 July 2024

10 George Street, Edinburgh, EH2 2PF

Name of Registrant:	**Boodeo Nawah**
NMC PIN:	05D0132O
Part(s) of the register:	Registered Nurse - Sub Part 1 Adult Nursing (Level 1) – 6 April 2005
Relevant Location:	London
Type of case:	Misconduct and Lack of competence
Panel members:	Michelle McBreeze (Chair, Lay member) Margaret Marshall (Registrant member) Barry Greene (Lay member)
Legal Assessor:	Graeme Henderson
Hearings Coordinator:	John Kennedy
Facts proved:	Charges 1, 2, 3, 4, 5
Facts not proved:	Charge 6
Fitness to practise:	Impaired
Sanction:	**Suspension order (With Review) (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel considered the issue, at start of this meeting, of whether there had been good service. It had regard to the Notice of Meeting that had been sent to Mr Nawah's registered email address by secure email on 10 June 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, fact that this meeting was heard virtually on or after 15 July 2024, and invited him to provide written submissions or any other material by 9 July 2024.

In the light of all of the information available, the panel was satisfied that Mr Nawah has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The Panel also considered that, having read all of the papers this case remained suitable to be determined at a meeting.

Details of charge as amended

That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

1) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of medication management and administration (but not restricted to) one or more occasions set out within Schedule 1.
2) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of documentation and record keeping (but not restricted to) one or more occasions set out within Schedule 2.

3) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of communication with patients and staff (but not restricted to) one or more occasions set out within Schedule 3.
4) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of safe handover of patients (but not restricted to) one or more occasions set out within Schedule 4.
5) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of recognition and escalation of deteriorating patients (but not restricted to) one or more occasions set out within Schedule 5.

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

That you, whilst employed by London Northwest University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 1 June 2020 to 7 November 2021:

6) Failed to inform the Trust of [PRIVATE], which impacted your ability to carry out your duties as a registered nurse.

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

SCHEDULE 1

1) On an unknown date in 2020, you administered Phenobarbital to an unknown patient and did not know this was a controlled drug.
2) On 15 December 2020, in relation to an unknown patient:
    a) did not administer medication to said patient and/or
    b) signed to record that you had administered medication when you had not and/or
    c) left the medication unattended in a drawer.
3) On 16 February 2021, administered un-fractured heparin to an unknown patient when it was not prescribed.

4) On 17 February 2021, in relation to an unknown patient who was due to be transferred to another ward:
    a) failed to sign the drug chart following the administration of the IV antibiotic and/or
    b) failed to have a second checker present for the administration of the IV antibiotic
5) On 16 April 2021, did not know how to check whether a medication was in stock.
6) On 16 April 2021, did not administer medication to an unknown patient in a prompt manner and/or left the medication at the patient's bedside table.
7) On 16 April 2021, did not check an unknown patient's observations before administering medication.
8) On 7 May 2021, wished to undertake urinary catheterisation of an unknown patient without having the relevant training to do so.
9) On 7 May 2021, took 3 tablets of 2.5mg of Bisoprolol for a patient when the correct dosage was one tablet of 3,75mg of Bisoprolol.
10) On 19 May 2021, administered Co-Amoxiclav to an unknown patient who was allergic to penicillin.
11) On 19 May 2021, did not know that Co-Amoxiclav contained penicillin.
12) On 17 June 2021, prepared to administer Dalteparin, to an unknown patient who had been admitted with bleeding
13) On 7 June 2021, did not undertake observations of patients prior to administering medications without being prompted to so by a colleague.

SCHEDULE 2

1) On an unknown date in December 2020, did not complete a new admission booklet and/or make contemporaneous notes for a new patient.
2) Following the imposition of an informal action plan on 18 December 2020, did not:
    a) complete the medication assessment tool within the 4-week time frame and/or within the extension of two weeks.
    b) complete the documentation training in respect of record keeping within the 4-week time frame and/or within the extension granted for a further two weeks.

c) complete the communication training for ELMS system within the 4-week time and/or within the extension granted for a further two weeks.
d) Did not produce a reflective account on the administration of Heparin by 22 March 2021.

3) Did not complete the mandatory training on ELMS within the 4-week time frame.
4) On 17th May 2021, did not complete a referral for an unknown patient on the internal referral system promptly.
5) On 20 May 2021, incorrectly recorded an unknown patient's observations in another patient's observation chart.
6) On 20 May, incorrectly recorded a patient's observation in another patient's file.
7) On 7 June 2021, incorrectly recorded the vital signs scores of an unknown patient in another patient's NEWS charts.

SCHEDULE 3

1) On 17 February 2021, when an unknown patient under your care was unwell and suffered a cardiac arrest, did not escalate to a senior colleague that the patient was unwell.
2) On 23 March 2021, did not undertake the following tasks during your shift without being prompted to do so by a colleague.
    a) making patients beds and/or
    b) undertaking personal care for patients and/or
    c) assisting patients with feeding.
3) On 10 April 2021, did not display a courteous manner towards patients.
4) On 7 May 2021, acted in a rude manner towards a patient's family and by telling them to "go go go" or words to that effect and gesturing with your hands.
5) On 10 May 2021, did not respond to an unknown patient who had requested assistance with pain relief.
6) On 13 May 2021, in relation to a patient who had specific food instructions, you failed to
    a) record those instructions in the patient's notes and/or
    b) handover those instructions to another colleague.
7) On 19 May 2021, did not help an unknown patient with their breakfast despite instructions from a colleague to do so.

8) On 1 June 2021, failed to tell colleague 1 that you were restricted from administering medications.
9) On 8 June 2021, disclosed the diagnosis and prognosis of an unknown patient to a family member despite the patient's instructions not to do so.
10) On 8 June 2021, did not attend call bells from patients without being prompted to do so by a colleague.
11) On 17 June 2021, did not offer assistance to a colleague when she was struggling to care for an unwell patient.
12) On 17 June 2021, did not introduce himself to patients and/or explain his role when administering medications to patient's

SCHEDULE 4

1) On 17 February 2021, in relation to an unknown patient under your care who was then transferred to a different ward, failed to:
    a) provide a handover detailing the care you had provided to the department and/or
    b) whether you had administered IV antibiotics to said patient.
2) On 6 April 2021, failed to handover to staff that:
    a) a doctor was attending to an unknown patient in his bay to undertake a chest drain on said patient.
    b) an unknown patient was experiencing severe headaches during the day.
3) On 7 May 2021, did not know why a patient had been admitted and/or their past medical history when handing over to a colleague.

SCHEDULE 5

1) On 17 February 2021, when an patient suffered a cardiac arrest, did not assist with and/or undertake CPR on the patient.
2) On 6 April 2021, failed to prioritise unwell patients according to their needs when carrying out observations
3) On 14 April 2021. Did not attend promptly to a patient who was ringing for assistance as they had low oxygen levels.
4) On 14 April 2021, did not know how to respond if a patient's MUST score was 1 or 2

5) On 17th May 2021, in relation to a patient on a catheter, failed to:
    a. notice that the patient's urine had turned pink and/or
    b. observe the patient hourly to check for signs of deterioration.
6) On 1 June 2021, did not prioritise the treatment of a patient with deranged electrolytes when instructed to do so by a colleague during handover.
7) On an unknown date in relation to a patient who was at risk of choking, did not sit a patient up before feeding them.

Decision and reasons on application to amend the charge

The panel on its own violation decided to amend Charge 1 Schedule 1 sections 10 and 11.

It heard and accepted the advice of the legal assessor who referred to Rule 28 of the Rules. The panel had to consider whether or not having regard to the merits of the case and fairness to Mr Nawah the required amendment could not be made without injustice.

The panel was of the view that if it were to make a radical amendment fairness required that the proposed amendment should be presented to Mr Nawah for his comment.

The panel had regard to the allegations set out in Schedule 1 and noted there was a small inconsistency in the witness statements and the timeline of the events provided. The majority of the evidence stated the event in Sections 10 and 11 of Schedule 1 happened on 19 May 2021; however, in Witness 1's statement the date was typed as 19 May 2022. This was then repeated in the charge.

The panel noted that Mr Nawah had left his employment at the Trust on 7 November 2021 and therefore would not have been on a shift on 19 May 2022. Therefore, the panel concluded that considering the totality of the evidence it is most likely that the date of 19 May 2022 had been a typographical error and that there would be no disadvantage to Mr Nawah for the panel to amend the charge to reflect the correct date of the incident.

The Panel did not consider the amendment would prejudice Mr Nawah. He would have been provided with all of the documentation that was before the panel and should have been aware of this discrepancy.

The proposed amendment was to resolve a typographical error in the charge to accurately reflect the majority of the evidence. The charge was accordingly amended as follows.

10) ‘On 19 May ~~2022~~ **2021**, administered Co-Amoxiclav to an unknown patient who was allergic to penicillin.
11) On 19 May ~~2022~~ **2021**, did not know that Co-Amoxiclav contained penicillin.’

Background

The charges arose whilst Mr Nawah was employed as a registered nurse by London North West University Healthcare NHS Trust (the Trust) where he had been working as a Staff Nurse from June 2016 until November 2021.

The Trust made the referral on 2 November 2021 to the Nursing and Midwifery Council (NMC) following concerns about Mr Nawah’s performance and competence from December 2020 to November 2021. In particular the Trust had concerns about his record keeping, medication management and administration, communication with patients, their families and colleagues, and poor clinical care and judgement. The Trust also alleged that Mr Nawah failed to inform them [PRIVATE] that impacted his ability to practice safely. The Trust placed Mr Nawah on a Capability plan in January 2021 which progressed through the informal stage, formal stage one, and stage two. Although a hearing was booked, for a stage three capability meeting with the head of nursing, no such hearing took place. The hearing was set for 8 November 2021 but he resigned from the Trust on 7 November 2021.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Mr Nawah.

The Panel heard and accepted the advice of the legal assessor. He advised the panel to have regard to all of the evidence and to consider whether or not the witness statements or local statements contained evidence of what happened or evidence of what the witness had been told had happened. There was also evidence of conclusions reached. The panel had to be satisfied that any conclusion reached was based on valid reasoning and accurate facts. The panel also had to have regard to whether or not there was contemporaneous MAR (Medicine Administration Record) charts Datix Reports or other documentation, such as patient records to confirm these accounts. Whilst corroboration was not required the burden of proving each charge was with the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Practice Development Nurse at the Trust, with responsibility for training of nurses
- Witness 2: Clinical Nurse Manager on the Ward with line management responsibilities
- Witness 3: Sister Nurse at the Trust, was supervisor during the stage 1 capability
- Witness 4: Clinical Site Practitioner at the Trust, was supervisor during the stage 2 capability stage

- Witness 5: Staff Nurse in A&E, supervised during stage 1 formal plan

The panel also had regard to written representations Mr Nawah had submitted to the Trust's reports. The panel had particular regard to the direct supervision reports submitted by various registered nurses to the trust. These nurses were tasked with assessing Mr Nawah's abilities during particular shifts and were contemporaneous records of what they saw.

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

Charge 1 as Amended

"That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

1) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of medication management and administration (but not restricted to) one or more occasions set out within Schedule 1.

SCHEDULE 1

1) On an unknown date in 2020, you administered Phenobarbital to an unknown patient and did not know this was a controlled drug. **[NOT PROVED]**
2) On 15 December 2020, in relation to an unknown patient:
    a) did not administer medication to said patient and/or **[PROVED]**
    b) signed to record that you had administered medication when you had not and/or **[NOT PROVED]**
    c) left the medication unattended in a drawer. **[PROVED]**
3) On 16 February 2021, administered un-fractured heparin to an unknown patient when it was not prescribed. **[NOT PROVED]**

4) On 17 February 2021, in relation to an unknown patient who was due to be transferred to another ward:
    a) failed to sign the drug chart following the administration of the IV antibiotic and/or **[NOT PROVED]**
    b) failed to have a second checker present for the administration of the IV antibiotic **[NOT PROVED]**
5) On 16 April 2021, did not know how to check whether a medication was in stock. **[PROVED]**
6) On 16 April 2021, did not administer medication to an unknown patient in a prompt manner and/or left the medication at the patient's bedside table. **[PROVED]**
7) On 16 April 2021, did not check an unknown patient's observations before administering medication. **[PROVED]**
8) On 7 May 2021, wished to undertake urinary catheterisation of an unknown patient without having the relevant training to do so. **[PROVED]**
9) On 7 May 2021, took 3 tablets of 2.5mg of Bisoprolol for a patient when the correct dosage was one tablet of 3,75mg of Bisoprolol. **[PROVED]**
10) On 19 May 2021, administered Co-Amoxiclav to an unknown patient who was allergic to penicillin. **[PROVED]**
11) On 19 May 2021, did not know that Co-Amoxiclav contained penicillin. **[PROVED]**
12) On 17 June 2021, prepared to administer Dalteparin, to an unknown patient who had been admitted with bleeding. **[PROVED]**
13) On 7 June 2021, did not undertake observations of patients prior to administering medications without being prompted to so by a colleague. **[PROVED]**

This charge is found proved.

In reaching its decision the panel considered each section of the schedule in order to determine if the charge can be found proved. The panel then concluded that having found at least one section of the schedule to be proved charge 1 is found proved.

Schedule 1 section 1 – Not Proved

The panel were unable to find any evidence to support this charge. The panel had sight of a DATIX report which had been generated as part of the Trust's Capability Assessments. It noted that within this report there is a record of Mr Nawah administering phenobarbital incorrectly on 28 December 2019. The panel noted that this date does not match the date given in this section as "*an unknown date in 2020"* therefore this section is found not proved.

Schedule 1 section 2 – a) and c) Proved b) Not Proved

The panel considered that in the witness statement of Witness 2 and Witness 4 this incident was reported and had sight of a contemporaneous account of the incident. The panel also had sight of the photograph of the medication drawer that was mentioned in the witness statement. In this drawer was a pot containing a number of different medicines. The panel was therefore satisfied that sub-sections a) and c) are found proved.

However, when considering sub-section b) this was an allegation that Mr Nawah signed a record of administering the medication. The panel noted that it did not have any MAR Charts or other records demonstrating that he had signed that he had administered the medication. Therefore, this sub-section was found not proved.

Schedule 1 section 3 – Not Proved

The panel noted that this allegation was described in detail within the formal stage one capability action plan. The Trust's position was that he should have known not to administer un-fractured heparin as it had not been prescribed. However, the panel considered that within Mr Nawah's written statement to the Trust he stated that he was under the impression that the medication was prescribed.

The NMC did not present the panel with patient notes, MAR charts and other documents and the panel was unable to resolve this factual conflict, on the papers that it did have, in favour of the NMC. It noted that the initial complaint was that he administered the drug to a patient who was due for a procedure. This raised the possibility that what was originally

alleged was that he ought not to have administered the drug even although it was prescribed.

Therefore, this section is found not proved.

Schedule 1 section 4 – Not Proved in Entirety

The NMC did not obtain a witness statement from the member of staff who witnessed this event nor did it provide documentation in the form of patient records (including a MAR chart). The panel noted that it had been provided a statement produced by the Trust as part of their investigation made by a nurse who was present at the time of the incident; however, this nurse was not a witness before the NMC and has not provided a statement to this hearing about the incident. The witness had received a complaint from another ward regarding a patient who had been transferred out of Mr Nawah's ward. The complaint was that there was no record of IV being administered. It was the evidence of this witness that Mr Nawah had no recollection of the event but went off to investigate. The witness did not follow him. The panel noted that it did not have records to show that it was Mr Nawah's responsibility to administer the drug; a MAR Chart to show that Mr Nawah failed to sign for the IV antibiotic and that there was no second checker. Therefore, the panel found this section not proved.

Schedule 1 section 5 – Proved

The panel noted that it had sight of the direct supervision notes which were produced as part of the Trust Capability Plan detailing the incident. These supervision notes were contemporaneous and produced by a registered nurse who was assigned to supervise Mr Nawah on the relevant date. The panel noted that the supervision notes reported that Mr Nawah was unaware of what medications the hospital had in stock, or where to look for medications that were in stock. In light of this the panel considered it unlikely on the balance of probabilities that Mr Nawah knew how to check if a medication was in stock. Therefore, this section is found proved.

Schedule 1 section 6 and 7 – Proved

The panel considered these two sections together given that they relate to an incident on the same date and were observed as part of the same direct supervision.

The panel had sight of the Trust drug administration policy which states:

> *'The Registered Nurse administering the medication is responsible for ensuring that the patient has had the medicine provided administered, and that the medicine administration has been recorded. Exceptions to this would be when the patient has been successfully assessed and entered into the Trust Self Administration Scheme (see section 34 of this policy). These medicines must always be locked in the patient's bedside locker.'*

The panel noted that Witness 5 records in the supervision notes that when they checked the patient after Mr Nawah had done a medications round that the medications were still on the patient's bedside table and therefore could not have been properly administered. The panel considered that this is in breach of the above Trust policy of which Mr Nawah should have been aware.

The panel considered that since the medication was not administered it would have been impossible for Mr Nawah to complete observations before administering medication.

Therefore sections 6 and 7 are found proved.

Schedule 1 section 8 – Proved

The panel noted that it had sight of Mr Nawah's training records which was produced on 9 April 2021 as part of the Trust investigation and male catheterisation was not listed as one of the modules *'passed'* and therefore it concluded that it is reasonable to believe that Mr Nawah did not have the competence to perform a male catheterisation procedure.

The panel noted in Witness 4's direct supervision notes dated 7 May 2021 stated that Mr Nawah wanted to do a male catheterisation when he knew he had not completed the training. This was prepared by a registered nurse who had been tasked with supervising Mr Nawah. There was no reason to question its accuracy.

Therefore, this section is found proved.

Schedule 1 section 9 – Proved

The panel considered that in the direct supervision notes from Witness 5 dated 7 May 2021 it states that Mr Nawah was about to give a patient three tablets of 2.5mg Bisoprolol instead of the prescribed dose of one 3.75mg tablet - but for the intervention of the supervising nurse. Therefore, the panel found this charge proved.

Schedule 1 sections 10 and 11 – Proved

The panel considered these sections together as they relate to the same incident on the same date. The panel had regard to the statement provided to the NMC and the local statement provided by the same witness. The witness told Mr Nawah not to commence his drug round before it was counter checked. Although the drug had been prescribed there was a clear indication, on the MAR chart that the patient was allergic to penicillin. The patient was also wearing a red wrist band. Mr Nawah administered the drug and, as a result the patient came out in a rash. He knew or ought to have known that the drug should not have been given to a patient who was allergic to penicillin.

The panel noted that within the Trust drug policy it states that a registered nurse is expected to know what the active ingredients are in any medication they administer. It further noted that it had sight of a photograph of the electronic MAR chart where it is highlighted that the patient was allergic to penicillin.

The panel found that during the capability meeting on 1 June 2021 when asked about administering the medication to the patient who was allergic Mr Nawah stated: *'I didn't know co-amoxiclav contained penicillin'.* Therefore, the panel found both sections proved.

Schedule 1 section 12 – Proved

The panel noted that in the direct supervision notes of Witness 4 it is recorded that Mr Nawah was observed dispensing Dalteparin to administer to a patient who had been admitted with bleeding.

The panel therefore found this section proved.

Schedule 1 section 13 – Proved

The panel noted that in the direct supervision records of Witness 4 it is recorded that Mr Nawah needed prompting to do observations of patients on 7 June 2021.

The panel therefore found this section proved.

Charge 2

That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

2) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of documentation and record keeping (but not restricted to) one or more occasions set out within Schedule 2.

SCHEDULE 2

1) On an unknown date in December 2020, did not complete a new admission booklet and/or make contemporaneous notes for a new patient. **[NOT PROVED]**
2) Following the imposition of an informal action plan on 18 December 2020, did not:
    a) complete the medication assessment tool within the 4-week time frame and/or within the extension of two weeks. **[NOT PROVED]**

b) complete the documentation training in respect of record keeping within the 4-week time frame and/or within the extension granted for a further two weeks. **[PROVED]**
c) complete the communication training for ELMS system within the 4-week time and/or within the extension granted for a further two weeks. **[NOT PROVED]**
d) Did not produce a reflective account on the administration of Heparin by 22 March 2021. **[PROVED]**

3) Did not complete the mandatory training on ELMS within the 4-week time frame. **[NOT PROVED]**
4) On 17th May 2021, did not complete a referral for an unknown patient on the internal referral system promptly. **[NOT PROVED]**
5) On 20 May 2021, incorrectly recorded an unknown patient's observations in another patient's observation chart. **[PROVED]**
6) On 20 May, incorrectly recorded a patient's observation in another patient's file. **[PROVED]**
7) On 7 June 2021, incorrectly recorded the vital signs scores of an unknown patient in another patient's NEWS charts. **[PROVED]**

This charge is found proved.

In reaching its decision the panel considered each section of the schedule in order to determine if the charge can be found proved. The panel then concluded that having found at least one section of the schedule to be proved charge 2 is found proved.

Schedule 2 section 1 – Not Proved

The panel noted that in the Capability Performance Management Action plan dated 18 December 2020 it is recorded that Mr Nawah used a completed admission booklet for another patient. However, the panel considered that this incident is not dated and that it is not included in the Capability Timeline that the Trust produced detailing all the incidents involving Mr Nawah. There is no direct witness or documentary evidence to support this allegation. Therefore, the panel concluded that due to the lack of information around the date of this incident and no direct report of the event this section is found not proved.

Schedule 2 section 2 a) – Not Proved

The panel noted that while Mr Nawah had been asked to complete a drug administration assessment, for which it has records of him completing within the timescale outlined. The panel was not satisfied that this drug administration assessment is the same as the charges *'medication assessment tool'* and that they may be two separate assessments. Therefore, the panel found this sub section not proved.

Schedule 2 section 2 b) – Proved

The panel noted the Capability Informal Meeting letter sent to Mr Nawah on 9 February 2021 which stated:

> *'Documentation e-learning (accountability and record keeping) has not been completed. You stated you could not find it on ELMS and have not asked for help to find it in the six weeks of your action plan.'*

The panel therefore found this sub section proved.

Schedule 2 section 2 c) – Not Proved

The panel noted the Capability Informal Meeting letter sent to Mr Nawah on 9 February 2021 which stated:

> *'The communication training is currently unavailable on ELMS hence you have not been able to complete.'*

The panel considered that given this it would be manifestly unfair to charge Mr Nawah with not completing a task which could not be completed within the timescale due to issues outwith his control. Therefore, this sub section is found not proved. It could not be said that he failed to demonstrate the required knowledge skill or judgement expected of him.

Schedule 2 section 2 d) – Proved

The panel noted that within the detailed timeline produced as part of the Trust Capability Report it is stated that Mr Nawah did not provide the requested reflective account by the 25 March 2021. Therefore, it was not produced by the required date of 22 March 2021. However, the panel did note that Mr Nawah [PRIVATE] submitted the reflective piece on 6 April 2021. The panel did not find this to be a satisfactory reason for not submitting the report on time nor [PRIVATE].

Therefore, this sub section was found proved.

Schedule 2 section 3 – Not proved

The panel first considered that this section did not make reference to the two-week extension on the completion of tasks that Mr Nawah had been granted, and that this differs from the other requirements of section 2. The panel noted that by 8 February 2021 Mr Nawah had completed all the mandatory training courses and that this date is within the two-week extension period granted to the four-week time frame in the other incidences.

The panel considered that it would be manifestly unfair to criticise Mr Nawah for this given that the Trust had clearly agreed to the extension on matters within the capability plan. Therefore, this section is found not proved.

Schedule 2 section 4 – Not proved

The panel noted that Witness 3 stated it took Mr Nawah around 30 minutes to complete an internal referral and that they would have expected an experienced nurse to complete this in around 5 or 10 minutes. However, the panel considered that the word '*promptly'* is subjective and there is no set standard provided against which the timescale Mr Nawah took could be measured.

Therefore, the panel found this section not proved.

Schedule 2 section 5 and 6 – Proved

The panel considered these two sections together as they are on the same date and relate to the same incident as recorded by Witness 3. The panel noted that while section 6 does not state a year but merely *'20 May'* given that the other dates in the section are listed chronologically, and that as noted above given the only month of May that Mr Nawah was under supervision was in 2021 it is reasonable to conclude that this incident occurred on 20 May 2021.

The panel noted the direct supervision notes of Witness 3 which state that Mr Nawah recorded the observations for one patient in another patient's file on 20 May 2021. Therefore, the panel found section 5 and 6 proved.

Schedule 2 section 7 – Proved

The panel noted that in the direct supervision of Witness 4 that Mr Nawah went to record the vital observations of a patient in the National Early Warning Score (NEWS) chart of another patient. Therefore, this section is found proved.

Charge 3

That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

3) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of communication with patients and staff (but not restricted to) one or more occasions set out within Schedule 3.

SCHEDULE 3

1) On 17 February 2021, when an unknown patient under your care was unwell and suffered a cardiac arrest, did not escalate to a senior colleague that the patient was unwell. **[NOT PROVED]**

2) On 23 March 2021, did not undertake the following tasks during your shift without being prompted to do so by a colleague. **[NOT PROVED]**
    a) making patients beds and/or
    b) undertaking personal care for patients and/or
    c) assisting patients with feeding.
3) On 10 April 2021, did not display a courteous manner towards patients. **[PROVED]**
4) On 7 May 2021, acted in a rude manner towards a patient's family and by telling them to "go go go" or words to that effect and gesturing with your hands. **[PROVED]**
5) On 10 May 2021, did not respond to an unknown patient who had requested assistance with pain relief. **[NOT PROVED]**
6) On 13 May 2021, in relation to a patient who had specific food instructions, you failed to **[PROVED]**
    a) record those instructions in the patient's notes and/or
    b) handover those instructions to another colleague.
7) On 19 May 2021, did not help an unknown patient with their breakfast despite instructions from a colleague to do so. **[PROVED]**
8) On 1 June 2021, failed to tell colleague 1 that you were restricted from administering medications. **[NOT PROVED]**
9) On 8 June 2021, disclosed the diagnosis and prognosis of an unknown patient to a family member despite the patient's instructions not to do so. **[PROVED]**
10) On 8 June 2021, did not attend call bells from patients without being prompted to do so by a colleague. **[PROVED]**
11) On 17 June 2021, did not offer assistance to a colleague when she was struggling to care for an unwell patient. **[NOT PROVED]**
12) On 17 June 2021, did not introduce himself to patients and/or explain his role when administering medications to patient's **[PROVED]**

This charge is found proved

In reaching its decision the panel considered each section of the schedule in order to determine if the charge can be found proved. The panel then concluded that having found at least one section of the schedule to be proved charge 3 is found proved.

Schedule 3 section 1 – Not Proved

The panel noted that it had multiple third hand accounts of this however none of the NMC witness statements were from parties who were present at the time of the incident. This allegation is based on the conclusions reached by some of the supervising staff of the Trust. The panel were unable to agree with that conclusion.

The panel had regard to the local statements made by those who were present. On 17 February 2021 a patient was about to be discharged from the hospital and was waiting on his bed and it was difficult to communicate with him. There was no requirement for Mr Nawah to supervise him. The patient suddenly became unwell and the first member of staff to notice this pressed the emergency button and summoned a cardiac arrest doctor. In the event CPR was performed by a nurse with the assistance of a doctor.

It further noted that there was some initial confusion over whether the patient was in a cardiac arrest or not.

The panel decided it is reasonable to conclude that the incident was appropriately escalated to a senior colleague, as the crash trolly was present during the incident and there are records of a doctor attending. The panel considered that if it was the case that, since another nurse had appropriately escalated the incident it would therefore have been wholly inappropriate for Mr Nawah to further escalate the incident.

The panel decided that this section is found not proved.

Schedule 3 section 2 – Not Proved

The panel considered this section as a whole. The criticism was that Mr Nawah failed to exhibit basic nursing care in relation to making beds, personal care and assisting patients with feeding. The gravamen of this charge is to do with Mr Nawah's competency in communication with patients and staff. None of these matters alleged relate to communication skills. Whilst there are general complaints in both the NMC witness statement and the supervision notes none of these specific complaints raise communication issues.

Therefore, the panel considered that this section does not properly match charge 3 and is found not proved.

Schedule 3 section 3 – Proved

The panel considered the direct supervision feedback from Witness 5 which stated that Mr Nawah told a patient there was no food and that it was not his role to provide a patient with food. In fact there was food and it was Mr Nawah's duty to see that he was provided with it whether by himself or arranging a care assistant to do so. The panel noted that this is recorded as being said in a dismissive manner towards the patient and did not demonstrate respect to the patient and holistic care expected from a registered nurse.

The panel therefore found this section proved.

Schedule 3 section 4 – Proved

The panel noted the direct supervision notes from Witness 4 that a patient's family member had submitted a verbal complaint to them about Mr Nawah's attitude and way of speaking and gesturing to them. The panel considered that it is more likely than not that the incident did happen.

Therefore, this section is found proved.

Schedule 3 section 5 – Not Proved

The panel considered the direct supervision notes of Witness 4 which describe this incident; however, there is not a first-hand account but rather a report by the patient to Witness 4. The panel noted that this incident is not related elsewhere in the evidence and that it is unable to test this further.

Therefore, the panel found this section not proved.

Schedule 3 section 6 – Proved

The panel considered this section in its entirety as the subsections delineate the manner a band 5 registered nurse would have been expected to act.

The panel noted Witness 3 stated:

> *'I supervised the registrant on 13 May 2021. He was not doing handovers properly about patients that were coming from nursing homes. He was expected to document the medical notes he had received from the nursing home. On that day, he had a patient with specific food instructions. He called the nursing home to obtain the information but failed to record it in the patient's medical notes and to handover the information to another nurse.'*

Therefore, this section is found proved.

Schedule 3 section 7 – Proved

The panel noted Witness 3 stated:

> *'I also supervised him on 19 May 2021. There were concerns that the registrant was not achieving expected standard in patient care. For example, on that day he did not help patients with their breakfasts. He wanted to do his medication round before helping for the breakfast. However, breakfasts had already been taken to the bay and they were standing by patients' bed. I saw him going to the medication room and coming back with medication for a patient. This patient had their breakfast next to them, and I asked him to give breakfast first and next medication.'*

Therefore, this section is found proved.

Schedule 3 section 8 – Not Proved

The panel noted that in the Stage Two Capability meeting of 1 June 2021 there is a reference to an incident happening but it is unclear whether that relates to the charge. The panel noted there is no other evidence.

Therefore, this section is found not proved.

Schedule 3 section 9 – Proved

The panel noted the direct supervision notes of Witness 4 which stated Mr Nawah informed a patient's family member, who was not next of kin, about the patient's diagnosis against the record that stated not to disclose any information thereby breaching patient confidentiality and their explicit instructions.

The panel therefore found this section proved.

Schedule 3 section 10 – Proved

The panel noted the direct supervision notes of Witness 4 and the Formal Stage Two letter Mr Nawah was sent by the Trust which stated that he needed to be prompted by colleagues to attend a call bell.

Therefore, this section is found proved.

Schedule 3 section 11 – Not Proved

The panel noted that while this incident is reported in the direct supervision notes of Witness 4 it is not referred to in the detailed chronology or the stage two letter. There is no statement from the colleague complaining of a lack of support or whether it was required.

In light of this and lacking any further context to the situation, such as if the colleague sought assistance, the panel on the balance of probabilities found this section not proved.

Schedule 3 section 12 – Proved

The panel noted that Witness 4 states:

> *'I confirm that one of the registrant's objectives during his stage 2 capability action plan was to improve his communication with patients. He lacked communication skills. He did not bother to explain to patients what he was doing, why he was doing it. When I was supervising him, I had to regularly prompt him in front of them so that he would introduce himself, explain why they needed to take that medication. I do not know if it was his way of talking in general, but most patients found him rude. Communication with patients is an essential skill as it is expected that a nurse will explain to their patients their actions. This enable a nurse to build trust and to facilitate treatment or care.'*

Therefore, this section is found proved.

Charge 4

That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

4) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of safe handover of patients (but not restricted to) one or more occasions set out within Schedule 4.

SCHEDULE 4

1) On 17 February 2021, in relation to an unknown patient under your care who was then transferred to a different ward, failed to: **[NOT PROVED]**
    a) provide a handover detailing the care you had provided to the department and/or
    b) whether you had administered IV antibiotics to said patient.
2) On 6 April 2021, failed to handover to staff that:
    a) a doctor was attending to an unknown patient in his bay to undertake a chest drain on said patient. **[PROVED]**
    b) an unknown patient was experiencing severe headaches during the day. **[PROVED]**
3) On 7 May 2021, did not know why a patient had been admitted and/or their past medical history when handing over to a colleague. **[PROVED]**

This charge is found proved

In reaching its decision the panel considered each section of the schedule in order to determine if the charge can be found proved. The panel then concluded that having found at least one section of the schedule to be proved charge 4 is found proved.

Schedule 4 section 1 – Not Proved

The panel considered both subsections together.

The panel noted that this section is closely linked to the incident referred to at Schedule 1 section 4, which the panel found not proved. There is an absence of witness and documentary evidence over who was to provide the handover and what was said or written during handover. The panel considered that following on from that decision to find it not proved earlier in relation to signing the drug chart it is logical to find this section not proved for the same reasons.

Therefore, this section is found not proved.

Schedule 4 section 2 – Proved

The panel noted the direct supervision notes of Witness 5 together with the Formal Stage One Capability Report both state that Mr Nawah had to be reminded about handover on 6 April 2021 and prompted to use the Situation Background Assessment and Recommendation (SBAR) tool during handover.

Therefore, this section is found proved in its entirety.

Schedule 4 section 3 – Proved

The panel noted that in the direct supervision notes of Witness 4 it is reported that Mr Nawah did not know why a patient was admitted and that there have been ongoing concerns around him not using SBAR consistently.

Therefore, this section is found proved.

Charge 5

That you, whilst employed by London North West University Healthcare NHS Trust ("the Trust") as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital ("the Hospital"), between 15 December 2020 to 7 November 2021, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a Registered Nurse in that you:

5) Did not demonstrate the required knowledge and/or skill and/or judgement in respect of recognition and escalation of deteriorating patients (but not restricted to) one or more occasions set out within Schedule 5.

SCHEDULE 5

1) On 17 February 2021, when an patient suffered a cardiac arrest, did not assist with and/or undertake CPR on the patient. **[NOT PROVED]**

2) On 6 April 2021, failed to prioritise unwell patients according to their needs when carrying out observations **[PROVED]**
3) On 14 April 2021. Did not attend promptly to a patient who was ringing for assistance as they had low oxygen levels. **[PROVED]**
4) On 14 April 2021, did not know how to respond if a patient's MUST score was 1 or 2 **[PROVED]**
5) On 17th May 2021, in relation to a patient on a catheter, failed to: **[PROVED]**
    a) notice that the patient's urine had turned pink and/or
    b) observe the patient hourly to check for signs of deterioration.
6) On 1 June 2021, did not prioritise the treatment of a patient with deranged electrolytes when instructed to do so by a colleague during handover. **[PROVED]**
7) On an unknown date in relation to a patient who was at risk of choking, did not sit a patient up before feeding them. **[PROVED]**

This charge is found proved

In reaching its decision the panel considered each section of the schedule in order to determine if the charge can be found proved. The panel then concluded that having found at least one section of the schedule to be proved charge 5 is found proved.

Schedule 5 section 1 – Not Proved

The panel noted its findings in relation to Schedule 3 section 1, particularly about the circumstances of the incident and the lack of a firsthand account that matches what is alleged by the NMC. The panel noted that it was more probable than not that another person had already started to perform CPR on the patient before Mr Nawah came on the scene. If that were the case it would have been wholly inappropriate for Mr Nawah to also then assist and/or undertake CPR on the patient as this was being done by another registered nurse. There was also some evidence that Mr Nawah assisted in the sense that he was sent to fetch tubing.

The panel therefore found this section not proved.

Schedule 5 section 2 – Proved

The panel noted that Witness 5 stated:

> *'I supervised him on 6 April 2021 and wrote down that I had concerns regarding his lack of prioritisation of unwell patients. He was conducting observations in order of the patient number, observing patient 1, then patient 2 and then patient 3. He was not taking into account that some patients would need enhanced observations.'*

Therefore, this section is found proved.

Schedule 5 section 3 – Proved

The panel noted the direct supervision notes from Witness 5 that Mr Nawah did not respond promptly to a call bell from his patient who required oxygen. The panel considered that this was not a matter of misinterpretation of *'promptly*' and as a band 5 nurse Mr Nawah would have known the importance of responding immediately to a patient's oxygen alerts.

Therefore, this section is found proved.

Schedule 5 section 4 - Proved

The panel noted the direct supervision reports of Witness 5 which stated that Mr Nawah had difficulty doing a Malnutrition Universal Scoring Tool (MUST) Score for patients and did not know when to do it without prompting.

Therefore, this section is found proved.

Schedule 5 section 5 – Proved

The panel noted the statement of Witness 3 which stated:

‘On the same day, he was in charge of a patient who had a catheter and developed haematuria later that day. He failed to notice that the urine coming out was pinkish, which he should have easily noticed when he came to the bay. I asked him to keep an eye on it and to observe if it would worsen. He went to check the patient after I had asked him, but he did not come back to check them during the day. I had to ask an HCA to keep an eye on that patient. The correct process for a registered nurse would have been to check on the patient every hour. Fortunately, there was no harm to the patient because the HCA and I conducted regular observations.’

Therefore, this section is found proved.

Schedule 5 section 6 – Proved

The panel noted the Formal Stage Two Letter dated 4 June 2021 from Witness 1 which stated:

‘I witnessed you ignoring instruction when asked to provide treatment to a patient with deranged electrolytes.’

Therefore, this section proved.

Schedule 5 section 7 – Proved

The panel noted that in the Trust chronology it is stated that:

‘…concerns for patient safety as follows: not sitting a patient up before feeding them – choking hazard…’

Therefore, this section is found proved.

Charge 6

That you, whilst employed by London Northwest University Healthcare NHS Trust (“the Trust”) as a Band 5 Registered Nurse at Crick Ward, Northwick Park Hospital

("the Hospital"), between 1 June 2020 to 7 November 2021:

6) Failed to inform the Trust of [PRIVATE], which impacted your ability to carry out your duties as a registered nurse.

This charge is found not proved

In reaching its decision the panel had been provided with a copy of the Staff Nurse job description and the key policies the Trust had in place.

The panel noted that there was no stated policy document saying that it was a duty of a registered nurse to report [PRIVATE] to either the Trust or their line manager. The panel considered that it is also a commonly accepted standard that all workers are allowed privacy in relation to [PRIVATE] and as long as the individual assesses there is no detriment to performance there is no overarching requirement to [PRIVATE].

While working as a nurse may involve occasions where physical handling or physical care techniques are required this does not undermine the privacy of the individual nurse. Should a hospital or employer require disclosure it would be expected that this is clearly outlined in a set policy or as part of the terms of employment.

In this case the panel have seen no evidence that the Trust had in place a policy which required a registered nurse to disclose [PRIVATE]. Therefore, it would not be possible for Mr Nawah to fail in this duty since it did not exist.

This is another charge that arises from a belief that Mr Nawah should have performed CPR on a patient who suffered from a cardiac arrest on 17 February 2021. It was the belief of some involved in his management that he failed to do [PRIVATE]. The panel already found that there was no duty on Mr Nawah to perform CPR as others were doing so.

In any event there is no reliable evidence to the effect that Mr Nawah [PRIVATE]. There is evidence that shortly after 17 February 2021 there was a concern that he [PRIVATE]. In any event there is no compelling evidence that he withheld important information regarding something that may have impacted on his performance.

This charge is found not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Mr Nawah's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. The NMC define impairment as requiring the following question to be answered:

> *'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

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

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

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

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

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence as, at the time, he was below the standard expected of a band 5 registered nurse.

The NMC invited the panel to find Mr Nawah's fitness to practise impaired on the grounds that the facts found proved are a fair sample of Mr Nawah's professional performance and that it is unacceptably low for a band 5 nurse.

The panel accepted the advice of the legal assessor which included reference to *Calheam v GMC* [2007] EWHC 2606 (Admin)

The issue for the panel to decide was whether the facts found proved demonstrated a standard of performance that was unacceptably low which had been demonstrated by a representative sample of his work.

The panel also noted that the NMC submitted that a lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Mr Nawah were/was made aware of the issues around your/their competence?
- Is there evidence that you/they were given the opportunity to improve?
- Is there evidence of further assessment?

Decision and reasons on lack of competence

With regard to the three-stage test submitted by the NMC the panel was satisfied that there was evidence, in the various notes of meetings and action plans that Mr Nawah was aware of his competence issues. The Trust had provided Mr Nawah with opportunities to improve but there was little or no improvement. His work was monitored and assessed from 15 December 2020 until 7 November 2021.

The panel bore in mind that Mr Nawah was expected to operate in accordance with the Code of Professional Standards of Practice for Nurses Midwives and Nursing Associates (The Code).

Although other parts of the Code could be engaged the most relevant section of the Code is 22.3:

'*Keep your knowledge and skills up to date..*'

The panel determined that although he attained sufficient skills to qualify as a registered nurse he no longer exhibited up to date skills and knowledge at the material times.

The panel bore in mind, when reaching its decision, that Mr Nawah should be judged by the standards of the reasonably average band 5 registered nurse and not by any higher or more demanding standard. The panel considered that the facts found proved are a fair sample of Mr Nawah's work across a prolonged period of time, during which he was offered multiple opportunities to improve, and covered a wide breadth of issues.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Nawah's practice was below the standard that one would expect of the average registered nurse acting in Mr Nawah's role.

The panel noted that over a period of 17 months Mr Nawah was provided with supervision, given clear objectives for improvement, and opportunities to discuss his progress relating to those objectives. It noted that Mr Nawah disputed the need for him to be directly supervised during this time and took no responsibility for his lack of competence in medication administration, patient handover, and communication with patients and families. Additionally, the panel noted that, Mr Nawah has shown no insight into his duty to respect patient confidentiality in regards to patient care and diagnosis.

In light of all the above, the panel determined that Mr Nawah's performance demonstrated a lack of competence which would be expected of a band 5 registered nurse.

Decision and reasons on impairment

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

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

It also had regard to the test approved of in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin):

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

The panel finds that patients were put at risk and patients and their families were caused physical and emotional harm as a result of Mr Nawah's lack of competence. Mr Nawah's lack of competence had brought the profession into disrepute and breached the fundamental tenets of the nursing profession.

Regarding insight, the panel considered that Mr Nawah has shown no insight into his lack of competence. His communication with the NMC has been sporadic. In an email dated 22 April 2024 from [PRIVATE] that he had been suspended from both work and by the NMC. [PRIVATE], but the panel have had no sight of this. The issue of whether or not he was the subject of an interim suspension order was relevant to the issue of whether or not it would have been possible for him to return to safe and effective practice.

The panel was made aware that Mr Nawah had been the subject of an interim suspension order as of December 2021. As such it would not have been possible for him to remediate.

The panel is of the view that there is a risk of repetition as the lack of competence had been repeated over a prolonged period of time even while Mr Nawah was subject to a formal capability improvement plan. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required. The panel considered that a reasonable member of the public would expect to be treated by a nurse with the full competence required of a professional at their skill level and would be concerned if they thought a nurse found to be lacking this competency was permitted to practice without restriction.

Having regard to all of the above, the panel was satisfied that Mr Nawah's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with review. The effect of this order is that the NMC register will show that Mr Nawah's registration has been suspended.

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Mr Nawah that it would seek the imposition of a 12 month suspension order if it found Mr Nawah's fitness to practise currently impaired.

The panel also bore in mind Mr Nawah had made no submission on sanction.

Decision and reasons on sanction

Having found Mr Nawah's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. 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 panel had careful regard to the Sanction Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated errors despite appropriate additional support
- Potential for patient harm and actual harm
- Lack of insight
- Attempts to shift blame for his failures onto other professionals
- Potential deep seated attidutinal concerns
- Lack of remorse

The panel also took into account the following mitigating features:

- [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 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 Mr Nawah's practice would not be appropriate in the circumstances. It determined 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 placing conditions of practice on Mr Nawah's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Mr Nahwah was operating under conditions of practice throughout the period charged and there was no improvement in his work. These conditions involved him being directly supervised yet further errors occurred.

Furthermore, the panel concluded that the placing of conditions on Mr Nawah's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

Since Mr Nawah was found impaired due to lack of competence a striking-off order cannot be imposed until he has been subject to a substantive order for two years. Notwithstanding the aggravating factors identified above the panel considered that this sanction was the only sanction available to it to mark the gravity of the lack of competence found proved.

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

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

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

The panel determined that a suspension order for a period 12 months, with a review, was appropriate in this case to mark the seriousness of the lack of competence. The panel took into account the fact that, since Mr Nawah had been the subject of an interim suspension order since December 2021, it should take into account the time spent by Mr Nahwah under an interim order as per SG (in the light of *Kamberova v NMC* [2016] EWHC 2955 (Admin).

The panel took the period of suspension into account but determined that the public safety issues that it identified warranted the imposition of a suspension order for the maximum period of one year. The panel considered that to impose a lesser period of suspension on Mr Nawah would be unfair on him. He would be afforded the maximum period of time to consider his position and take steps towards safe and effective practise.

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

Any future panel reviewing this case would be assisted by:

- Mr Nawah's attendance at the review.
- A reflective piece using an established method commenting on how his lack of competence impacted on patients, the public confidence, and colleagues, and any causes and triggers of his lack of competence.
- Completed training on the internet or otherwise on medication administration, documentation and record keeping, communication and handover, and escalation of a deteriorating patient.
- His efforts to keep his knowledge of the profession up to date and his future intentions.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that an interim suspension order of 18 months is appropriate to adequately protect the public during any appeal made against the substantive order.

Decision and reasons on interim order

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

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

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

This will be confirmed in writing.

That concludes this determination.