Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 9 September 2024 – Wednesday, 25 September 2024
Monday, 7 October 2024

Virtual Hearing

Name of Registrant:	**Obichi Ugwumadu**
NMC PIN:	12I1351E
Part(s) of the register:	Nurses part of the register, Sub part 1 RNA: Adult nurse, level 1 (30 August 2013)
Relevant Location:	Antrim/Surrey
Type of case:	Misconduct
Panel members:	Richard Weydart-Jacquard (Chair, registrant member) Jonathan Coombes (Registrant member) (Monday, 9 September 2024 – Wednesday, 25 September 2024) Kiran Bali (Lay member) Allwin Mercer (Registrant member) (Monday, 7 October 2024)
Legal Assessor:	Nigel Pascoe KC (Monday, 9 September 2024 – Wednesday, 25 September 2024) Angus Macpherson (Monday, 7 October 2024)
Hearings Coordinator:	Catherine Blake (Monday, 9 September 2024 – Wednesday, 25 September 2024) Rim Zambour (Monday, 7 October 2024)

Nursing and Midwifery Council:	Represented by Ben Anson Jones, Case Presenter (Monday, 9 September 2024 – Wednesday, 25 September 2024) Leeann Mohamed, Case Presenter (Monday, 7 October 2024)
Ms Ugwumadu:	Not present and not represented at the hearing
Facts proved:	Charges 3, 4, 6 (in its entirety), 7, 8a), 8b i), 8d), 8e), 10 (in its entirety), 11, 12 (in its entirety), 13, 14 and 15
Facts not proved:	Charges 1, 2, 5, 8b ii), 8c), 9a), 9b) and 16
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to adjourn the first day of the hearing

At the outset of the hearing the panel was informed that Ms Ugwumadu was not in attendance. Ms Love, on Ms Ugwumadu's behalf, made an application that the matter be adjourned until the second scheduled day of the hearing so that the registrant may be contacted in order to find out whether she intends to attend.

Mr Jones, on behalf of the Nursing and Midwifery Council (NMC), indicated that he did not oppose the application.

The panel decided to adjourn the first day of the hearing so that Ms Ugwumadu's attendance may be confirmed.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Ugwumadu was not in attendance and that the Notice of Hearing letter had been sent to Ms Ugwumadu's registered email address by secure email on 5 August 2024.

Further, the panel noted that the Notice of Hearing was also sent to Ms Ugwumadu's representative at the Royal College of Nursing (RCN) on 5 August 2024. On day two of the hearing, the panel was informed that the RCN would no longer be representing Ms Ugwumadu.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Ms Ugwumadu

The panel next considered whether it should proceed in the absence of Ms Ugwumadu. It had regard to Rule 21 and heard the submissions of Mr Jones who invited the panel to continue in the absence of Ms Ugwumadu.

Mr Jones referred the panel to the correspondence received by the NMC from Ms Ugwumadu:

> *'I am no longer able to continue to purse[sic] these issues.'*

Mr Jones submitted that this was a clear indication from Ms Ugwumadu that she would not be attending these proceedings and as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Mr Jones submitted that Ms Ugwumadu had voluntarily absented herself.

The panel also noted that numerous attempts to contact Ms Ugwumadu had been made by the NMC following the withdrawal of her legal representative, and that none of them had been successful.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Ms Ugwumadu. In reaching this decision, the panel has considered the submissions of Mr Jones and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Ugwumadu;
- Ms Ugwumadu has received the Notice of Hearing and confirmed that she does not wish to attend the hearing;
- Ms Ugwumadu has not provided the NMC with details of how she may be contacted other than her registered email address and phone details;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness is attending today to give live evidence, and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the deciding this case as quickly as possible.

There is some disadvantage to Ms Ugwumadu in proceeding in her absence. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to

give evidence on her own behalf. However, in the panel's judgement, this can be mitigated to some extent. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination, and it can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Ugwumadu's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Jones to amend the wording of charge 1.

The proposed amendment was to correct a typographical error. It was submitted by Mr Jones that the proposed amendment would provide clarity and reflect the evidence.

> "That you, a registered nurse:
>
> Between 11-15 December 2019;
>
> 1) Did not know how to use **a manometer** to inflate Resident A's cuff.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

Ms Love submitted that she supported the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to the registrant and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment to ensure clarity and accuracy and reflect the evidence.

Details of charge

That you, a registered nurse, whilst working for Emergency Personnel;

Between 11- 15 December 2019;

1. Did not know how to use a manometer to inflate Resident A's cuff.

2. Did not know how to;
    a. Suction/use a suction machine;
    b. Use a nebuliser;
    c. Use a cough assist machine;

3. Did not know how to change Resident A's inner cannula.

On 15 December 2019;

4. Brought medication from your home to Resident A's residence/on shift.

5. Instructed Colleague Z to administer unprescribed medication, you had brought from home to Resident A.

6. Did not escalate/record a review of Resident A's medication to the;
    a. Clinical Lead;

b. General Practitioner.

Whilst working at Antrim Area Hospital;

7. On 27 October 2020 whilst on shift, wore an access pass/card which did not belong to you.

8. On the nightshift of 2/3 March 2021;
   a. Failed to undertake/record any observations overnight for Patient B;
   b. Failed to administer amoxicillin to Patient C at;
      i. 22:00 on 2 March 2021;
      ii. 06:00 on 3 March 2021.
   c. Failed to undertake/record a complete set of observations for Patient D;
   d. Failed to record accurate fluid balance levels in one or more patients' fluid balance charts;
   e. Administered Cotrimoxazole 480mg which was prescribed to Patient E on Monday/Wednesday/Friday on a Tuesday.

9. On 2 June 2021;
   a. Failed to undertake any observations after 23:00 for one or more patients.
   b. Failed to administer 6 a.m. medication to one or more patients.

10. Failed to adequately complete to a support/supervision plan which commenced on 28 April 2021, in that you did not complete;
    a. An online medicine round;
    b. 6 feedbacks from a Band 6 or above;
    c. On-line training.

That you a registered nurse, whilst working for Sunbury Nursing Home;

11. On 9 October 2021, did not administer 2 Matrifen patches to Resident X as prescribed.

12. On 15 October 2021;
    a. Asked Colleague Y to inaccurately alter the medication count for Resident X's Matrifen in the controlled drug book.
    b. Inaccurately altered the medication count for Resident X's Matrifen from '7' to '6', in the controlled drug book.
    c. Took/removed/placed in your pocket a Matrifen patch from the controlled drug cupboard.
    d. On one or more occasion asked Colleague Y to misrepresent/lie about the accurate number of Matrifen patches in the controlled drug cupboard, to the Home Manager.

13. Your actions in one or more of the above charges 12 a), 12 b), 12 c), & 12 d) were dishonest in that you, sought to conceal your failure to administer the correct number of Matrifen patches to Resident X.

14. Your actions in charge 12 b) were dishonest, in that you falsified records to misrepresent the number of Matrifen patches in the controlled drug cupboard.

15. Your actions in charge 12 c) were dishonest, in that you without permission, took medication belonging to your employer.

16. You did not appropriately destroy/dispose of a Matrifen patch.

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

Background

Charges 1-6 arose whilst Ms Ugwumadu was employed as a registered nurse by Emergency Personnel (the Agency). She was contracted to provide nursing care to

Resident A at home, who suffered from motor-neurone disease and had complex care needs as a result.

Concerns were raised about Ms Ugwumadu's practice after she allegedly did not know how to use a manometer to inflate Resident A's cuff, how to change Resident A's cannula, nor how to operate a variety of medical equipment vital to his care. There was also an incident in which Ms Ugwumadu attended Resident A's home and produced a tablet from her pocket that was said to be antihistamine or anti-sickness medication. Ms Ugwumadu then allegedly asked a carer to administer that medication which had not been prescribed for the patient.

Charges 7-10 arose whilst Ms Ugwumadu was employed as a registered nurse by Antrim Area Hospital (the Trust) via an agency, JustNurses. Complaints were received over a number of shifts and while working on various wards. These concerns were in relation to Ms Ugwumadu's clinical practice whilst on shifts. The agency was informed of these concerns and the agency conducted investigations with Ms Ugwumadu. Ms Ugwumadu was placed onto a support plan but failed to fully engage with it. Ms Ugwumadu was then suspended from the agency.

Charges 11-16 arose while Ms Ugwumadu was employed as a registered nurse by Sunbury Nursing Home (the Home). Ms Ugwumadu administered one patch of Matrifen to a patient instead of two as had been prescribed. She told Colleague Y this when checking the prescription of the same medication with a registered nurse some days later. She then, at the advice of a second nurse, informed the manager of the Home (Witness 9) of her mistake. However, she then allegedly asked Colleague Y to alter the count of medication in the controlled drug (CD) book to cover up her mistake. Later in the day she asked Colleague Y to go with her to the medicine cupboard. She then allegedly asked Colleague Y to change the number of remaining patches in the CD book, but he refused. He then witnessed her alter the number in the CD book and take a patch and put it in her pocket.

Ms Ugwumadu was asked about the matter but denied knowing anything about the alteration in the CD book or the missing patch. The patch was never found and was allegedly not destroyed/disposed of correctly.

Decision and reasons on facts

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

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

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

- Witness 1: Clinical Manager at Emergency Personnel.
- Witness 2: Registered Nurse Manager at JustNurses at the time of the charges.
- Witness 3: Person W, Resident A's wife.
- Witness 4: Registered Manager at Emergency Personnel at the time of the charges.
- Witness 5: Colleague Z, Support Worker at Emergency Personnel at the time of the charges.

- Witness 6: Health Care Assistant at Emergency Personnel at the time of the charges.
- Witness 7: Deputy Manager at JustNurses at the time of the charges.
- Witness 8: Registered Nurse at Antrim Area Hospital at the time of the charges.
- Witness 9: Home Manager at Sunbury Nursing Home at the time of the charges.
- Witness 10: Colleague, Staff Nurse at Sunbury Nursing Home at the time of the charges.

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

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

Charges 1 and 2

'That you, a registered nurse, whilst working for Emergency Personnel;

Between 11- 15 December 2019;

1. *Did not know how to use a manometer to inflate Resident A's cuff.*
2. *Did not know how to;*
    a. *Suction/use a suction machine;*
    b. *Use a nebuliser;*
    c. *Use a cough assist machine'*

These charges are found NOT proved.

The panel noted that the evidence relating to charges 1 and 2 (including all sub-charges) is the same and so it has considered each charge separately and will present its findings collectively.

In reaching its decision, the panel took into account the written and oral evidence of Witness 1, Witness 3 and Witness 4.

The panel took into account the following from Witness 3's statement as the primary evidence for these charges:

> *'I was concerned with her lack of knowledge. The nurses that come to care for my husband are supposed to be ITU trained. They need to know about the trachy, the cough assist machine and nebuliser. She didn't seem to know how to do all these things on one of her previous visits. I observed this myself. I also mentioned this in my email.'*

The panel had regard to the contents of the email from Witness 3:

> *'I had already raised my concerns regarding Obichi's mentoring ability and her lack of competence as an ITU nurse working with a tracky[sic] patient on Saturday morning. As she was not able to use anonnmeter[sic] to inflate [Resident A's] cuff or suction him or know how to change his inner cannula. If you want further evidence on her competence you can ask [a colleague] or the carers.'*

The panel also noted the following from Witness 1's statement:

> *'Resident A had a live in homecare package. This meant that all the care we provided was in his own home 24 hours a day. Resident A had a diagnosis of Motor neurone Disease (MND). He had several medical needs. He had a tracheostomy in his airway to help breathing. He had a ventilator and also had suctioning and nebuliser – to manage his respiratory system. As the nurse attending the home, Obichi would have been responsible for these things. Resident A also needed*

assistance with medication. He had a peg to administer his medication and nutrition. He also had a catheter. The catheter bag requires maintenance by way of flushing and emptying the bag. This was also Obichi's responsibility.

…

'This matter occurred on 15 December 2019. I believe that Emergency personnel were first made aware by the wife of Resident A. She sent an email in the very early hours of 16 December 2019 which has been exhibited…'

The panel also noted Witness 4's statement:

'The concerns were brought to our attention by the wife of the patient. She emailed in with her complaint. I am aware that this has been exhibited ... We were also notified also by an employee namely [Witness 5]. She was a carer working on the same package. She emailed in and I am aware that the email has been exhibited ... Also witness to the matter was the live in carer called [Witness 6]. She no longer works with us. I exhibit the current job description for our carers ... We do not have a copy available from the time of this incident but it is very unlikely to be much different.'

The panel noted that these charges go to Ms Ugwumadu's clinical competence in the use and operation of medical equipment. The panel was of the view that the evidence in support of these charges was not sufficient to meet the burden of proof for this charge. In particular, the panel was of the view that the corroborating evidence did not adequately support Witness 3's statement.

The panel appreciated that Witness 3 gave her perspective on Ms Ugwumadu's apparent competence to undertake these clinical tasks. However, the panel also paid close attention to the statements and testimony of Witness 1 and Witness 4, which attested to Ms Ugwumadu having been deemed competent to carry out these clinical tasks following her hiring interview by another registered nurse. In particular, the panel noted Witness 4's

evidence that Ms Ugwumadu would not have been given the role were she not deemed competent in all the skills required to care for Resident A.

The panel considered that the observation made by Witness 3 of Ms Ugwumadu's clinical skills being insufficient to undertake the tasks listed in these charges had not been made by a healthcare professional. As such, the panel could not be confident given her previous professional competence sign off, that Ms Ugwumadu 'did not know' how to carry out these tasks.

Accordingly, the panel found charges 1 and 2 not proved.

Charge 3

'That you, a registered nurse, whilst working for Emergency Personnel;

Between 11 - 15 December 2019;

3. Did not know how to change Resident A's inner cannula.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, Witness 3 and Witness 4 above, as well as the written and oral evidence of Witness 5.

Bearing in mind their decision at charges 1 and 2 above, the panel carefully considered whether there was sufficient evidence that Ms Ugwumadu did not know how to change Resident A's inner cannula.

The panel paid close attention to Witness 5's written and oral testimony which were consistent and supportive of Witness 3's testimony that Ms Ugwumadu did not know how

to change Resident A’s inner cannula and required Witness 5, a care assistant, to demonstrate this skill:

> *‘Regarding the comments I made about the inner cannula in my email, all I can remember is that Obichi did not know how to do it. She asked me to do it and she watched me. I am not able to remember anything else about the incident.’*

The panel considered the direct witness evidence of Witness 5 as a member of the care team, to be supportive of and consistent with Witness 3’s account. Consequently, the panel determined that Ms Ugwumadu did not know how to change Resident A’s inner cannula.

Accordingly, the panel determined that this charge is found proved.

Charge 4

‘That you, a registered nurse, whilst working for Emergency Personnel;

> *On 15 December 2019;*
>
> 4. *Brought medication from your home to Resident A’s residence/on shift.’*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, Witness 3, Witness 4, Witness 5 and Witness 6, as well as the written evidence of Ms Ugwumadu.

The panel had regard to Witness 5’s statement:

> *‘When she produced this medication it was from her uniform pocket. She said I have this medication that can cure Resident A. I recall asking her if it was prescribed and she said no… I can’t remember what the medication was. She didn’t say more or what it would do. She was going to use the medication but I disagreed.*

I said, no, it's illegal to use unprescribed medication on a patient. She then put the medication back in her pocket.

…

'It was not a medication I had seen before and I do not believe that it was one of his prescribed medications. It was not on his MAR chart, it was not from the stock and she said it was not his.'

The panel had regard to Witness 3's statement:

'I believe that Obichi attended my home on Friday 13 December 2019 for a day shift. [A nurse specialist] was also conducting a visit on this day, she had come to change the trachy. Obichi asked [her] why my husband wasn't on antihistamine medication. [She] informed her that he didn't need it. Obichi also asked me about this medication. I told her that he didn't have allergies and these tablets hadn't been prescribed by a doctor. She said they can help the patients to feel relaxed and sleep.'

The panel also took into account the following from Witness 6's statement:

'[Witness 5] was arguing with Obichi because Resident A had run out of a medication. I do not know what medication it was. Obichi said she had some at home and brought it out of her pocket... I did not see the bottle but I know she took something out. Obichi said she had the same dose and type of medication. It was a Saturday or Sunday, Resident A's medication was finished and he was having diarrhoea and vomiting that day, so Obichi said maybe he medication can help.

'[Witness 5] responded immediately that that's not allowed. [Witness 5] told her that she can't bring medication from home and you cant give it to Resident A, so Obichi put it back into her pocket.

…

‘[Witness 5] was telling Resident A’s wife and the night staff what happened during the day. [Witness 5] was handing over to them about the other medication and that Obichi had brought out her own medication.’

The panel also noted Ms Ugwumadu’s email dated 30 December 2019:

‘I did not arrive at the clients house with an unprescribed medication

…

‘On no occasion did I bring any medication to be administered to Resident A from home’

The panel preferred the evidence of Witness 5 as their evidence was consistent and they were a direct witness to Ms Ugwumadu bringing an unknown medication into Resident A’s home. Accordingly, the panel found this charge proved.

Charge 5

‘That you, a registered nurse, whilst working for Emergency Personnel;

On 15 December 2019;

5. *Instructed Colleague Z to administer unprescribed medication, you had brought from home to Resident A.’*

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 3, Witness 5 and Witness 6 as well as written evidence of Ms Ugwumadu.

In particular, the panel had regard to Witness 5’s statement:

'…Obichi produced an unprescribed medication from her pocket and asked me to give it to Resident A.

…

'She was going to use the medication but I disagreed. I said, no, it's illegal to use unprescribed medication on a patient. She then put the medication back in her pocket.'

The panel also took into account the following from Witness 6's statement:

'[Witness 5] was arguing with Obichi because Resident A had run out of a medication. I do not know what medication it was. Obichi said she had some at home and brought it out of her pocket… I did not see the bottle but I know she took something out. Obichi said she had the same dose and type of medication. It was a Saturday or Sunday, Resident A's medication was finished and he was having diarrhoea and vomiting that day, so Obichi said maybe her medication can help.

'[Witness 5] responded immediately that that's not allowed. [Witness 5] told her that she can't bring medication from home and you cant give it to Resident A, so Obichi put it back into her pocket.

…
'[Witness 5] was telling Resident A's wife and the night staff what happened during the day. [Witness 5] was handing over to them about the other medication and that Obichi had brought out her own medication.'

The panel had regard to Witness 3's statement:
'[A registered nurse] told me that Obichi had brought some tablets and showed both [Witness 6] and [Witness 5] and asked [Witness 5] to administer the tablet to my husband. I do not know what kind of medication this was. This happened while I

was out. I had no reason to doubt what [the nurse] said as he was always very professional. He went on to explain that both of the carers refused and [Witness 6], the live in carer, told Obichi that she should not give him anything not prescribed.'

The panel noted this evidence from Witness 3 in relation to this charge was indirect evidence relayed to her by another nurse.

The panel also noted Ms Ugwumadu's email dated 30 December 2019:

> *'On no occasion did I asked [Colleague Z] to administer any drug aside from what was prescribed on the drug chart.'*

As above, the panel considered that the evidence from both witnesses is clear that Ms Ugwumadu did indeed bring the medication from her home into Resident A's home. The panel considered that, on the evidence before it, it was likely that Ms Ugwumadu had suggested the administration of the unprescribed medication might help Resident A. However, noting that the charge pertains to an instruction to Colleague Z, the panel considered that an instruction requires a more overt statement of direction than is contained in the evidence.

The panel noted the direct eyewitness evidence of Witness 5 and Witness 6, disagree in their evidence that Ms Ugwumadu asked Colleague Z to administer the medication.

The panel was of the view that the witness testimony from both Witness 5 and Witness 6 were consistent in that Ms Ugwumadu made a suggestion to administer the medication to Resident A. The panel noted that this conflicted with Ms Ugwumadu's own account in her local interview in which she denied bringing any medication to Resident A's home.

The panel preferred the evidence of Witness 5 and Witness 6. It was of the view that there was no reliable evidence to suggest that Colleague Z had been instructed by Ms Ugwumadu to administer the medication, and accordingly found this charge not proved.

Charge 6

'That you, a registered nurse, whilst working for Emergency Personnel;

On 15 December 2019;

6. Did not escalate/record a review of Resident A's medication to the;

a. Clinical Lead;

b. General Practitioner.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, Witness 2 and Witness 5.

In particular, the panel noted the following from Witness 1's statement:

'If Obichi felt that needed a review of his medication then she should have informed the Clinical Lead. There is no record of her doing so.'

The panel also noted Witness 5's statement:

'If we felt he needed different medication then the nurse would speak to GP.'

The panel was aware that Witness 3 stated in an email dated 16 December 2019 that Ms Ugwumadu had requested that Witness 3 speak to Resident A's General Practitioner (GP) to prescribe antihistamine tablets. However, the panel was of the view, given Witness 1's description of Emergency Personnel's policy, that the responsibility to escalate for medication review was in fact still with Ms Ugwumadu and thus this did not constitute effective escalation.

Having found that Ms Ugwumadu suggested to administer the unprescribed medication to Resident A, the panel determined that it would have been necessary for her to have followed this up with the Clinical Lead or GP to request a change of medication for

Resident A. The panel has seen evidence that Ms Ugwumadu did not escalate this to the Clinical Lead for clearance as per the testimony of Witness 1. Furthermore, Witness 1 informed the panel that there was no evidence Ms Ugwumadu escalated this to Resident A's GP either in the form of communication with the Clinical Lead or in Resident A's care notes.

The panel took note of Witness 1's live evidence in which she confirms a GP would be required to sign off on any new medication if the Clinical Lead was not involved. Additionally, the panel paid particularly close attention to Witness 5's evidence, which was corroborative of this and stated that if a new medication was required the nurse would speak to the GP.

Accordingly, the panel determined that Ms Ugwumadu did not escalate a review of Resident A's medication to the Clinical Lead of GP.

Charge 7

'That you, a registered nurse, whilst working at Antrim Area Hospital;

7. *On 27 October 2020 whilst on shift, wore an access pass/card which did not belong to you.'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 2 and the documentary evidence of Ms Ugwumadu.

The panel considered Witness 2's statement in which she confirmed that Ms Ugwumadu had taken this pass, however noted the context that Ms Ugwumadu was new to the hospital, and it was her first shift:

‘We recognise Obichi should not have taken the pass but as it was one of her first shifts, she may not have known that these passes also operate as medicine keys. We discussed this with Obichi and she now understands the importance of returning the passes.’

The panel also considered Ms Ugwumadu’s documentary response to the complaint:

‘On the 27th of October 2020, I was on my way to work in ED when a car came towards me and stopped. This was my friend who lived outskirts of Antrim… She said she was running late and was hoping to catch one of her colleagues who worked on the same ward to help her return an access card which she had forgotten to hand in after her shift.
She then asked me to help her return the card and apologise on her behalf.

I accepted to do the favour. So I took the card which specified the ward it belonged to (C4).’

Accordingly, the panel found this charge proved.

Charge 8a

‘That you, a registered nurse, whilst working at Antrim Area Hospital;

8. *On the nightshift of 2/3 March 2021;*
    a. *Failed to undertake/record any observations overnight for Patient B’*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, who was clear that no observations had been recorded overnight for Patient B:

‘There were no observations recorded for by Obichi. I refer to National Early Warning Score (NEWS) chart. The last set of NEWS observations were completed

for at 1730 on 02 March by a day shift nurse. However there were no NEWS observations completed until the next morning at 0830 on 03 March 2021, and this was by a day shift nurse. Obichi had come onto shift as agency night nurse from 2000 on 02 March, she didn't carry out any observations for Patient B whilst she was on shift through to 0800 03 March 2021. NEWS observations were completed by a nurse on the day shift.

'The NEWS score for this patient was 1 at 1700 on 02 March, and they had a heart rate of 91. The day shift nurse had noted that observations for had to be carried out every 06 hours as per NEWS chart. The patient was stable with a NEWS score of 1, however the next set of observations should have been done at 2300. According to what I saw on the NEWS chart Obichi hadn't done any observations for during the night shift.'

Furthermore, the panel has sight of the NEWS charts, which records observations as incomplete for 3 March 2021. Additionally, the panel had sight of the Personnel Policy Document from the Trust, which stated that nurses must undertake observations at regular intervals for patients overnight. Consequently, the panel determined that Ms Ugwumadu had failed to undertake/record any observations overnight for Patient B. Accordingly this charge is found proved.

Charge 8b i)

'That you, a registered nurse, whilst working at Antrim Area Hospital;

> 8. *On the nightshift of 2/3 March 2021;*
>   b. *Failed to administer amoxicillin to Patient C at;*
>   i. *22:00 on 2 March 2021'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7 as well as the written evidence of Ms Ugwumadu

The panel considered both accounts in which Ms Ugwumadu explains she was unable to administer amoxicillin at 22:00 because of a problem with Patient C's cannula and that she was able to administer amoxicillin at 06:00 once the doctor had changed the medication to an oral route:

> *'After a lot of coxing[sic] and persuasion the Patient agreed to take all medication orally. I gave oral medication but called Nurse at night to inform the Doctor to come and change the prescribed IV antibiotics to oral before administering. This went on before midnight…Oral fluid was encouraged since [the patient] wouldn't allow a cannula to be inserted…*
>
> *The Dr eventually came to Change the IV antibiotic to oral at 8.00 when I was handling over to the day staff…I equally pointed this out to the staff who was taking over and asked the Dr to counter sign the missed antibiotic which had now been changed to oral for clarity.'*

The panel was aware of Witness 7's documentary and live evidence, however noted that it was indirect evidence that came from a report from another nurse on shift who the panel was unable to question.

The panel found this sub-charge proved. The panel regard this as a technical rather than substantial breach.

Charge 8b ii)

'That you, a registered nurse, whilst working at Antrim Area Hospital;

> 8. *On the nightshift of 2/3 March 2021;*
>   b. *Failed to administer amoxicillin to Patient C at;*

ii. 06:00 on 3 March 2021.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 7, as well as the documentary evidence of Patient C's MAR chart on the dates 2 and 3 March 2021.

Taking into account all the evidence before it, the panel preferred the evidence of Ms Ugwumadu that the medication was changed from intravenous to oral and has seen evidence via Patient C's MAR chart that the medication was given orally at that time.

Accordingly, the panel found this charge not proved.

Charge 8c

'That you, a registered nurse, whilst working at Antrim Area Hospital;

> *8. On the nightshift of 2/3 March 2021;*
> > *c. Failed to undertake/record a complete set of observations for Patient D'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7.

In particular, the panel noted the following from Witness 7's statement:

> *'As per my datix, the patient in side room 22 did have NEWS observations taken at 2200 on the 2nd March however were not completed again until the day shift arrived. I do not have access to any patient records regarding this.'*

The panel has seen no decisive evidence as to the identity of Patient D.

Furthermore, the panel has no documentary evidence to indicate what a complete set of observations for this undefined patient would have been. The panel was aware that, in Ms Ugwumadu's response to the charge, she indicated that she had carried out three complete observations for Patient D over that shift, however, Witness 7 did not have access to any Trust documentation to confirm or refute that assertion.

Accordingly, the panel found this charge was not proved.

Charge 8d

'That you, a registered nurse, whilst working at Antrim Area Hospital;

8. *On the nightshift of 2/3 March 2021;*
    d. *Failed to record accurate fluid balance levels in one or more patients' fluid balance charts'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, as well as the documentary evidence of Patient C's Fluid Balance Chart on the dates 2 and 3 March 2021.

The panel found this charge proved on the basis of Patient C's Fluid Balance Chart. In tandem with Witness 7's evidence, the panel noted that the chart was incomplete in that there were no figures recorded in the balance section and was therefore an inaccurate recording of Patient C's fluid balance on the relevant dates.

The panel has seen evidence that Patient C was in Ms Ugwumadu's care on 2 and 3 March 2021, and so she was responsible for accurately recording their fluid balance.

The panel accordingly found this charge proved.

Charge 8e

'That you, a registered nurse, whilst working at Antrim Area Hospital;

8. *On the nightshift of 2/3 March 2021;*
   e. *Administered Cotrimoxazole 480mg which was prescribed to Patient E on Monday/Wednesday/Friday on a Tuesday.'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, as well as the documentary evidence of Ms Ugwumadu and Patient E's drug chart on the dates 2 and 3 March 2021.

The panel had sight of Patient E's drug chart which indicates that the medication was indeed given on a Tuesday.

However, the panel was aware of Ms Ugwumadu's written response to this charge in which she stated that this dose had been given on Tuesday with authorisation from the doctor as it had been omitted earlier in the week:

> *'My patient had missed a dose on Monday night because she could not keep food down…*
>
> *'I pointed out that the Doctor had specified every other day and told her that I would make a note on the drug chart that would help indicate how many doses had been taken…*
>
> *'…the rule of antibiotics says if you forget to take a dose, take it as soon as you remember. The Patient had 24 hours to go before the next dose…I documented*

and went as far as hu lighting[sic] specific days on the drug chart, so that other colleagues would know the antibiotic is meant for every other day'

The panel relied upon the oral and written evidence of Witness 7. Accordingly, it found this charge proved as a technical rather than substantial breach.

Charge 9a

'That you, a registered nurse, whilst working at Antrim Area Hospital;

9. *On 2 June 2021;*
    a. *Failed to undertake any observations after 23:00 for one or more patients.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 2 and Ms Ugwumadu.

The panel had sight of Ms Ugwumadu's written response to this charge in which she asserts that she did carry out observations for all patients in her care throughout the full course of her shift. The panel had no compelling evidence from the NMC witnesses to refute this assertion, merely a very indirect account from a nurse that was on shift at the time that Ms Ugwumadu had not undertaken observations after 23:00:

'She did her patients observations at 23:00, but never did any more overnight or in the morning'

The panel considered this indirect evidence was not sufficient. Accordingly, the charge is found not proved.

Charge 9b

'That you, a registered nurse, whilst working at Antrim Area Hospital;

> *9. On 2 June 2021;*
>
> *b. Failed to administer 6 a.m. medication to one or more patients.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2.

The panel determined that the charge itself was broad in nature with no specificity as to which medication was to be administered to which patients. The only evidence before the panel was an indirect and non-specific complaint made to JustNurses by the Trust regarding an alleged failure to administer medication to patients at 6am:

> *'She omitted to administer some 6am medications including IV'S'*

The panel did not consider this to be compelling due to the lack of any supporting evidence. Accordingly, this charge is found not proved.

Charge 10

'That you, a registered nurse, whilst working at Antrim Area Hospital;

> *10. Failed to adequately complete to a support/supervision plan which commenced on 28 April 2021, in that you did not complete;*
>
> *a. An online medicine round;*
>
> *b. 6 feedbacks from a Band 6 or above;*
>
> *c. On-line training.'*

This charge is found proved.

The panel noted that the evidence relating to these sub-charges is the same and so it has considered each sub-charge separately and will present its findings collectively.

In reaching this decision, the panel took into account the written and oral evidence of Witness 2 and Witness 7.

The panel considered Witness 2 and Witness 7 to be clear and consistent in their direct evidence to the panel that a support plan was put in place on 28 April 2021 for Ms Ugwumadu. The panel took account of Witness 2's statement that despite multiple attempts to get Ms Ugwumadu to engage with that plan, she did not complete an online medicine round, five out of the six feedbacks from Band 6 or above, or all of the online training:

> *'Despite us trying to engage with her and offering her support and further learning, it seems that her practice has not changed in order to adhere to the requirements of the role within the Northern Trust setting. She continued to practice as she saw fit.*
>
> *'She engaged with the action plan to a limited extent. She did attend the office as requested on 22/04/2023 and 28/04/2023. By this time we had received complaints on occasion. We discussed these but Obichi challenged much of what was put to her.*
>
> *'Obichi only completed 2 out of 6 feedback requirements, despite it being made clear that these were a supportive action to gather positive feedback on her practice to counter balance the concerns raised. Obichi was adamant that staff in the hospital rated her highly and asked for her to return to areas she is suspended from…In addition I do not believe she completed the on-line training which was recommended, although she said she did. This is because the reflection she completed in relation to this training did not correlate in any way with what was offered.'*

Accordingly, the panel found this charge proved.

Charge 11

‘That you a registered nurse, whilst working for Sunbury Nursing Home;

> *11. On 9 October 2021, did not administer 2 Matrifen patches to Resident X as prescribed.’*

This charge is found proved.

In reaching this decision, the panel considered the direct witness evidence of Witness 9 and Witness 10, as well as the documentary evidence of the MAR chart, which required two Matrifen patches to be administered to Resident X every 72 hours.

The panel noted that Matrifen patches are a controlled medicine and as such require the checking and signatures of two registered nurses prior to administration.

The panel determined that Witness 10’s evidence was credible and consistent between his witness statement and his testimony sustained under panel questions. The panel noted that Witness 10 stated that Ms Ugwumadu had admitted to him, upon discovery of her error, that she had only administered one Matrifen patch to Resident X not two on 9 October 2021:

> *‘A while later Obichi came to me and said she was worried about the mistake that she had made…’*

Furthermore, the panel took account of Witness 9’s direct evidence in which she stated Ms Ugwumadu had informed her of her error following its discovery on that shift:

> *‘On 15 October 2021 I was at work. At 5pm Staff Nurse Obichi came to me and told me that she had only put one patch on [Resident X] on Saturday 09 October 2021.’*

Consequently, the panel determined that this charge is found proved.

Charge 12a

'That you a registered nurse, whilst working for Sunbury Nursing Home;

12. *On 15 October 2021;*
    a. *Asked Colleague Y to inaccurately alter the medication count for Resident X's Matrifen in the controlled drug book.'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 9 and Witness 10.

In particular, the panel took note of the evidence of Witness 10 who informed the panel that Ms Ugwumadu had begged him to alter the medication count for Resident X's Matrifen in the CD book, stating that she was afraid she would lose her PIN for this error.

> *'Obichi then came back to me around 4 or 5pm. She was begging me to come with her and change the numbers in the book. She was a bit worried that she might lose her PIN.'*

The panel considered Witness 10's evidence to be credible and consistent between his written and oral evidence.

Furthermore, the panel determined that Witness 9's evidence, in which she informed the panel that Witness 10 had immediately come to her to disclose that Ms Ugwumadu had made this request of him, to be compelling and consistent.

Accordingly, the panel found this charge proved.

Charge 12b

‘That you a registered nurse, whilst working for Sunbury Nursing Home;

12. On 15 October 2021;

b. Inaccurately altered the medication count for Resident X’s Matrifen from ‘7’ to ‘6’, in the controlled drug book.’

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 9 and Witness 10.

The panel considered Witness 10’s statement in which he confirmed he was a direct witness to Ms Ugwumadu altering the medication count for Resident X’s Matrifen in the CD book:

> *‘We went to the room and I went with her inside but I didn’t do anything. No one else was in the room. She asked me to change the number and I said ‘no’. I then watched her change the number in the controlled drug book.*
>
> *…*
>
> *‘We checked the patches and there were six left. I told her there had been 7 earlier. She saw that the book had been changed and she was very angry…’*

The panel noted that this was supported by Witness 9’s account to the panel that she could see that the Matrifen count for Resident X had been altered accordingly:

> *‘I asked Staff Nurse Obichi for the drug keys at 5.10pm and looked at the book. The controlled drug book balance had been changed I saw 7 crossed out for 6. At 5:55 I went with… to the Dawney room and we checked [Resident X’s] box and there were only 6 patches.’*

The panel had sight of this excerpt from the CD book which displayed this alteration.

The panel also heard evidence from Witness 9 and Witness 10 that no other nurses were on duty in that unit on that shift. The panel considered that no one else would stand to gain from such an alteration to the medication record. Accordingly, the panel found this charge proved.

Charge 12c

'That you a registered nurse, whilst working for Sunbury Nursing Home;

> *12. On 15 October 2021;*
>
> > *c. Took/removed/placed in your pocket a Matrifen patch from the controlled drug cupboard. '*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 10 in which he describes seeing Ms Ugwumadu take a Matrifen patch:

> *'I also saw her take a patch. She put it in her pocket. She was wearing her light blue uniform with pockets on the side*.'

The panel determined that Witness 10's direct witness evidence, tested under panel questions, to be clear and consistent that Ms Ugwumadu placed a Matrifen patch from the CD cupboard in her pocket. Accordingly, this charge is found proved.

Charge 12d

'That you a registered nurse, whilst working for Sunbury Nursing Home;

> *12. On 15 October 2021;*

d. On one or more occasion asked Colleague Y to misrepresent/lie about the accurate number of Matrifen patches in the controlled drug cupboard, to the Home Manager.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 10.

In particular, the panel took into account of the following from Witness 10's statement:

> *'After that Obichi then came to me and asked me to change my story. She wanted me to tell [Witness 9] that they were 6 patches in the cupboard when we checked in the morning. I told her that I wouldn't lie to [Witness 9]…*
>
> *I went and told [Witness 9] that Obichi had asked me to lie.'*

The panel determined that Witness 10's direct witness evidence, tested under panel questions, was clear and consistent that Ms Ugwumadu made this request. The panel also noted Witness 10's oral evidence that Ms Ugwumadu's demeanour changed from calm to panicked following the discovery of her mistake. Accordingly, this charge is found proved.

Charges 13, 14 and 15

13. 'Your actions in one or more of the above charges 12 a), 12 b), 12 c), & 12 d) were dishonest in that you, sought to conceal your failure to administer the correct number of Matrifen patches to Resident X.

14. Your actions in charge 12 b) were dishonest, in that you falsified records to misrepresent the number of Matrifen patches in the controlled drug cupboard.

15. Your actions in charge 12 c) were dishonest, in that you without permission, took medication belonging to your employer.'

These charges are found proved.

The panel noted that the evidence relating to charges 13, 14 and 15 is the same and so it has considered each charge separately and will present its findings collectively.

The panel bore in mind its previous decision at charge 12, including its assessment of the credibility of Witness 9 and Witness 10 in determining this charge.

The panel determined that Ms Ugwumadu's actions in charge 12 were deliberate and did not arise out of accidental or negligent behaviour. The panel considered that Ms Ugwumadu's actions at all of the sub-charges in charge 12 would be considered dishonest by the standards of ordinary decent people.

Additionally, the panel determined that, as an experienced registered nurse, Ms Ugwumadu must have known that her actions in charge 12 were dishonest and not the actions expected of a registered nurse.

The panel also bore in mind, regarding charges 12 b) and c), that Ms Ugwumadu's dishonesty occurred after she had already informed Witness 9 of her mistake.

Accordingly, the panel found charges 13, 14 and 15 proved.

Charge 16

'You did not appropriately destroy/dispose of a Matrifen patch.'

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 9's evidence, which suggested multiple ways in which the Matrifen patch could have been appropriately destroyed or disposed of:

> '*The process in relation to disposing of unused medications depends on the type of medicine. If as in this case, we had a patch unused at the end of the 28 day cycle, we would order one less for the following prescription. If the patch was wasted / unable to be used then we would 'denature' the medication. To use this method, two trained nurses take the medication and a controlled drug kit and add the medication to a powder. This is then taken away by a service provider. As we never found the patch it was not destroyed in this manner and I do not know where it went.'*

The panel heard live evidence from Witness 9 as to another method by which Matrifen patches could be disposed of, such as in a sharps bin or a clinical waste bin.

The panel also had sight of the Home's Medication Policy, which included instructions on the range of appropriate methods of disposing of medicines.

However, the panel was not presented with any compelling evidence that any of these disposal methods had not been carried out, merely that Witness 9 could not find the patch after searching for it. Consequently, the panel determined that the NMC has not discharged its burden of proof, and 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 the facts found proved amount to misconduct and, if so, whether Ms Ugwumadu's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

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

Mr Jones submitted that Ms Ugwumadu's actions across the three referrals indicated a pattern of poor patient care, poor clinical decision making, poor medication management and dishonesty. He submitted this has not been addressed by Ms Ugwumadu in any meaningful way. Mr Jones submitted that patients were put at risk of harm as a result of her actions.

Mr Jones identified the specific, relevant standards where Ms Ugwumadu's actions amounted to misconduct, in particular the following sections of the Code: 1.2, 2.1, 6.1, 6.2,

8.1, 8.2, 8.3, 8.4, 8.5, 9.2, 9.3, 10.1, 10.2, 10.3, 11.2, 13.2, 13.3, 14.1, 14.2, 14.3, 18.1, 18.2, 18.3, 19.1, 20.1, 20.2, 22.3, and 24.2.

Submissions on impairment

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

Mr Jones referred to the test as outlined in *Grant* and submitted that, by virtue of the charges found proved, Ms Ugwumadu's actions put patients at unwarranted risk of harm, that in so doing she brought the nursing profession into disrepute, that her actions breached fundamental tenets of nursing, and that her actions were dishonest.

Mr Jones submitted that Ms Ugwumadu's actions included wide-ranging clinical errors in patient care. He submitted that there is no evidence of remorse from Ms Ugwumadu concerning her actions. He submitted there is also no evidence before the panel of remediation by Ms Ugwumadu, nor accountability for her actions. Mr Jones submitted that there is nothing to suggest that Ms Ugwumadu has identified the problems and learnt from them such that the panel can be satisfied that she is capable of safe and effective practice. Accordingly, Mr Jones submitted that there is a real risk of repetition, and that public protection is engaged.

Mr Jones submitted that a finding of impairment is also needed in order to declare and uphold proper standards of conduct.

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

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> ***1.2*** *make sure you deliver the fundamentals of care effectively*
>
> ***6. Always practise in line with the best available evidence***
> ***6.2*** *maintain the knowledge and skills you need for safe and effective practice*
>
> ***8. Work cooperatively***
> **8.4** *work with colleagues to preserve the safety of those receiving care*
> **8.5** *share information to identify and reduce risk*
>
> ***9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***
> **9.2** *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*
>
> ***10. Keep clear and accurate records relevant to your practice***
> ***10.2*** *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> ***10.3*** *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

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

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

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

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

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

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

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

20. Uphold the reputation of your profession at all times

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

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

22. Fulfil all registration requirements

22.3 *keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance*

24 Respond to any complaints made against you professionally

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In relation to charge 3, the panel found Ms Ugwumadu's actions at this charge did not amount to serious misconduct. The panel took into account the context of this charge and considered that, while Ms Ugwumadu did not know how to change the inner cannula, she did seek advice from someone who was competent to do so. The panel determined that this behaviour did not contravene the Code, and that Ms Ugwumadu's behaviour at this charge did not amount to misconduct.

In relation to charge 4, the panel took the view that the act of bringing personal medication into a patient's home does not constitute serious misconduct.

In relation to charge 6, the panel found Ms Ugwumadu's actions at this charge did not amount to serious misconduct. The panel noted that there is evidence Ms Ugwumadu suggested there was a medication that might help Resident A's and that this was discussed with a visiting nurse specialist, and Resident A's wife. Whilst the panel was aware that the Agency's policy was not followed, and it deemed Ms Ugwumadu's behaviour to be below the standard expected, it determined that it did not constitute serious misconduct.

In relation to charge 7, the panel found Ms Ugwumadu's actions at this charge did not amount to serious misconduct. The panel was of the view that it was inappropriate for Ms

Ugwumadu to wear another colleague’s access passcard, however it was one of her first shifts working at the Trust and she did not appreciate this failing. Ms Ugwumadu returned the passcard immediately when confronted. Consequently, the panel determined this was not serious misconduct.

In relation to charge 8a), the panel found Ms Ugwumadu’s actions at this charge did amount to serious misconduct. The panel considered that taking observations of patients is a fundamental aspect of nursing practice. Accordingly, the panel considered that Ms Ugwumadu did not carry out her duty to assess and record the Patient B observations overnight and as a result there was a significant risk to patient safety. The panel determined that this behaviour contravened the Code, and that Ms Ugwumadu’s behaviour at this charge amounted to serious misconduct.

In relation to charge 8b i), the panel did not find Ms Ugwumadu’s actions at this charge amounted to misconduct. In particular the panel accepted Ms Ugwumadu’s explanation that she had not been able to give the medication at the prescribed time as she did not have intravenous access. The panel was aware that Ms Ugwumadu had given the patient the medication at the next available time having discussed the difficulty with the doctor and suggesting that the medication be changed to an oral administration, and that this was recorded on the MAR chart. Accordingly, the panel determined this was not serious misconduct.

In relation to charge 8d), the panel did not find Ms Ugwumadu’s actions at this charge amounted to misconduct. The panel was of the view that this was a very broad charge in the sense that it concerns one or more patients, and the panel only had information pertaining to one patient. The panel found this charge proved technically on the basis that there was not a running balance on the chart. However, the panel had no evidence before it as to whether that patient or patients required intensive monitoring for their fluid balance, or their medical histories. On that basis, the panel determined that while this was an unfortunate omission on Ms Ugwumadu’s behalf, it did not meet the threshold of serious misconduct.

In relation to charge 8e), the panel found Ms Ugwumadu's actions at this charge did not amount to serious misconduct. The panel found this was a technical breach in that Ms Ugwumadu did not give the prescribed medication on the correct day. However, the panel considered that it has seen no evidence of harm to Patient E as a result of Ms Ugwumadu's actions at this charge, nor evidence that there would have been a risk of harm to Patient E. The panel was of the view that this was a medication error that should not have occurred. However, given the lack of evidence of any adverse risk or harm to Patient E, the panel determined that it did not meet the threshold of serious misconduct.

In relation to charges 10a) and 10c), the panel found Ms Ugwumadu's actions at these charges did amount to serious misconduct. The panel was of the view that Ms Ugwumadu was given ample opportunity to strengthen her practice, and that her reluctance to engage with the support and supervision plan despite numerous reminders demonstrates an underlying attitudinal issue. Regarding 10a) the panel heard evidence that Ms Ugwumadu demonstrated a poor attitude and a reluctance to uptake the training as requested by her manager, and that this pointed to a wider concern regarding Ms Ugwumadu's willingness to take steps to improve her practice. Regarding 10c), the panel heard evidence that Ms Ugwumadu's manager at JustNurses had provided extensive support for her to complete these online training sessions, but Ms Ugwumadu failed to complete them and complained that she thought they were 'stupid'.

In relation to charge 10b), the panel bore in mind that Ms Ugwumadu had undertaken up to two out of the six pieces of feedback and that the Trust terminated her employment, and thus her ability to gain additional feedback, partway through the supervision plan. The panel considered that Ms Ugwumadu should have given this feedback greater priority and while it deemed Ms Ugwumadu's behaviour to be below expected standards, it determined that it did not meet the threshold of serious misconduct.

In relation to charge 11, the panel found Ms Ugwumadu's actions at this charge did not amount to serious misconduct. The panel heard evidence that no harm was caused to Resident X as a result of Ms Ugwumadu's behaviour in this charge, and that Resident X

was capable of communicating if they were in pain which they did not. The panel noted that while this medication error was below expected standards, it was a one-off incident that Ms Ugwumadu admitted to immediately upon realising her error. Accordingly, the panel determined that this did not constitute serious misconduct.

In relation to charge 12 in its entirety, the panel found Ms Ugwumadu's actions did amount to serious misconduct. The panel considered that Ms Ugwumadu's behaviour at this charge was not an error, and it has seen no explanation for her behaviour other than her personal gain. The panel determined that in seeking to involve Colleague Y in her dishonesty, and falsifying the medication record, Ms Ugwumadu's behaviour contravened the expected standards of behaviour and performance set out in the Code, and that Ms Ugwumadu's behaviour at this charge was serious misconduct.

In relation to charges 13, 14, and 15, the panel found Ms Ugwumadu's actions at these charges did amount to serious misconduct. Having found dishonesty, the panel considered Ms Ugwumadu's behaviour to be serious misconduct in concealing a clinical mistake for her own benefit. Accordingly, the panel determined that this behaviour contravened the Code, and that Ms Ugwumadu's behaviour at this charge was serious misconduct.

The panel found that Ms Ugwumadu's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Ugwumadu'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.'

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

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

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

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

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

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that patients were put at risk of harm as a result of Ms Ugwumadu's misconduct. In particular, she failed to undertake clinical observations for a patient overnight, and the panel noted that there was a risk of missing the signs of that patient deteriorating. The panel also considered there was a significant risk of harm and patient safety was compromised in Ms Ugwumadu's attempts to alter a MAR chart.

The panel considered that the failings in some of the charges related to clinical performance and would be capable of being addressed through retraining. However, in respect of charges 10a), 10c) the panel considered the misconduct stemmed from Ms Ugwumadu's attitudinal issues and as such it would be very difficult to remedy. Specifically, Ms Ugwumadu's attitudinal issues at charges 10a) and 10c) pertain to an unwillingness to accept fault. In respect of charges 12, 13, 14 and 15, the attitudinal issues relate to underlying dishonesty. The panel determined that whilst Ms Ugwumadu's dishonesty was initially opportunistic and not longstanding/premeditated, in seeking to involve Colleague Y and falsifying the medication record immediately after having told the truth, Ms Ugwumadu's behaviour indicated a deep-seated attitudinal issue.

The panel has seen no evidence to suggest that Ms Ugwumadu has demonstrated any remorse for her failings or misconduct. There is also no evidence of developing insight, and subsequently no evidence of strengthened practice.

The panel determined that Ms Ugwumadu's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Keeping this in mind, the panel is of the view that there is a high risk of repetition, especially in light of the facts found proved depicting a pattern of behaviour over an extensive period of time. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

Additionally, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Ugwumadu's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to impose a striking-off order. It directs the registrar to strike Ms Ugwumadu off the register. The effect of this

order is that the NMC register will show that Ms Ugwumadu has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been provided in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Jones informed the panel that in the Notice of Hearing, dated 5 August 2024, the NMC had advised Ms Ugwumadu that it would seek the imposition of a striking-off order if it found Ms Ugwumadu's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Ugwumadu'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 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:

- That Ms Ugwumadu placed vulnerable patients at risk of harm.
- That Ms Ugwumadu placed a colleague at risk of harm and caused them distress.
- That Ms Ugwumadu has not provided any evidence of remorse, insight or remediation.
- That Ms Ugwumadu has not provided any evidence of strengthened practice.
- That Ms Ugwumadu's conduct was indicative of deep-seated behavioural and attitudinal problems, and that her dishonesty was calculated.

The panel found no mitigating features in this case.

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 not be proportionate or in the public interest to take no further action and would not protect the public.

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 Ms Ugwumadu's 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 and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Ugwumadu's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Ms Ugwumadu's registration would be a sufficient and appropriate response. 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 and the attitudinal concerns identified. The panel was also not satisfied that Ms Ugwumadu would engage with conditions, given that she has historically not engaged with support and supervision plans. Furthermore, the panel concluded that the placing of conditions on Ms Ugwumadu'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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel decided that the conduct in this case was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Ugwumadu's actions are fundamentally incompatible with Ms Ugwumadu remaining on the register. As the panel has seen evidence of multiple instances of misconduct and deep-seated attitudinal issues, as well as no evidence of insight from Ms Ugwumadu, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel decided that Ms Ugwumadu's actions were significant departures from the standards expected of a registered nurse. The panel determined that the dishonesty in this case was at the higher end of the spectrum and as such, fundamentally incompatible with Ms Ugwumadu remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Ugwumadu's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Ms Ugwumadu in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Jones, who informed the panel that Ms Ugwumadu is currently subject to an interim suspension order due to expire on 21 January 2025. He did not invite the panel to impose an interim order on this basis.

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. It noted that Ms Ugwumadu is currently subject to an interim suspension order and that this will expire in four months.

The panel determined that this was adequate time to cover the 28-day appeal period, and that a further interim suspension order was not necessary. The panel noted that if an appeal was made the NMC could apply to extend the current interim suspension order. Accordingly, the panel determined to make no interim order.

Panel reconvened on 7 October 2024

After handing down its decision, the panel was informed that the original information provided by the NMC regarding the date that Ms Ugwumadu's interim suspension order would expire (21 January 2025) was incorrect, and that the interim order had in fact already expired on 22 September 2024. The panel noted that this means that no interim order is currently in place and Ms Ugwumadu's practise is not currently restricted.

Substitution of a panel member

Ms Mohamed first asked the panel to resume the hearing following the substitution of a panel member. She invited the panel to consider the NMC guidance in relation to the 'Constitution of panels' (ref: CMT-7) ('the Guidance').

Ms Mohamed submitted that Ms Ugwumadu has been put on notice in relation to the substitution of a panel member and the importance of the matter today, although this was

through an email late in the day on 6 October 2024. Pursuant to the guidance, the panel should consider whether proper procedures have been followed. Ms Mohamed submitted that this email should satisfy the panel that Ms Ugwumadu has been made aware of the panel member's substitution, and was advised to email or contact the NMC by 9:00 today if there were any issues with that. Ms Mohamed informed the panel that there has been no response from Ms Ugwumadu in relation to this.

Ms Mohamed submitted that the panel should also consider whether it is in the interests of justice for the substituted panel member to participate in the hearing. She stated that this is a narrow issue for the panel to consider as this hearing has been called to correct an error made on the last occasion, and there is no unfairness in the new panel member hearing the remainder of the matter.

Ms Mohamed submitted that the panel can be satisfied that the new panel member has been substituted for a fair purpose.

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

In making its decision, the panel considered the Guidance. It determined that the NMC understood that the previous panel member was not available for the hearing today; that the requirement for the panel to be made up of the same mix of members is met as the previous panel member was a registrant, as is the substituted panel member.

In its consideration of whether this substitution has been explained to Ms Ugwumadu, the panel had sight of the email sent by the NMC to her on 6 October 2024. Ms Ugwumadu was made aware of today's hearing and that one of the panel members would be substituted. Ms Ugwumadu was given the opportunity to respond by 9:00 on 7 October 2024 but had not made contact with the NMC by 11:16 (the time of this submission).

Accordingly, pursuant to the Guidance the panel determined that it is in the interests of justice for the substituted panel member to participate in this hearing in order to correct the error and protect the public.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Ugwumadu was not in attendance and that the Notice of Hearing letter had been sent to Ms Ugwumadu's registered email address by secure email on 4 October 2024.

Ms Mohamed submitted that this should be treated as a resuming hearing in relation to Rule 32(3) and that the notice confirms the hearing would take place on 7 October 2024. She explained to the panel that the NMC only managed to confirm the availability of the panel on 4 October 2024, and as a result the notice was sent as soon as reasonably practicable on the same day.

For these reasons, Ms Mohamed invited the panel to find that there has been good service of today's proceedings.

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

The panel also accepted that Ms Ugwumadu had been informed of today's proceedings as soon as was reasonably practicable, considering that there is no specific requirement of how many days in advance she should have been made aware of the hearing.

In the light of all of the information available, the panel was satisfied that Ms Ugwumadu has been served with the Notice of Hearing.

Decision and reasons on proceeding in the absence of Ms Ugwumadu

The panel next considered whether it should proceed in the absence of Ms Ugwumadu. It had regard to Rule 21 and heard the submissions of Ms Mohamed who invited the panel to continue in the absence of Ms Ugwumadu.

Ms Mohamed submitted that Ms Ugwumadu was not present at the substantive hearing and was only represented for the first day. Further, that she was put on notice of this hearing on 4 October 2024 and prior to that, was informed that there was an error within the proceedings. She was first informed of this during a telephone call on 27 September 2024 with the NMC Case Coordinator, and she did not indicate that she wanted to join the hearing in relation to this. Ms Mohamed submitted that as of today's date, there has been no further correspondence from Ms Ugwumadu in relation to this hearing.

Ms Mohamed submitted that it is in the interests of justice to expedite this matter as it should have concluded on 25 September 2024. In the absence of Ms Ugwumadu's participation, Ms Mohamed invited the panel to find that she has voluntarily absented herself from today's proceedings.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'.*

The panel has decided to proceed in the absence of Ms Ugwumadu. In reaching this decision, the panel has considered the submissions of Ms Mohamed and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Ugwumadu;
- The NMC has made multiple efforts to contact Ms Ugwumadu and she is aware that this hearing is taking place;
- Ms Ugwumadu has voluntarily absented herself;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- It is in the interests of justice, public protection and the public interest for the expeditious disposal of the case.

Submissions on interim order

Ms Mohamed made the following written submissions:

1. *'The panel has been requested to reconvene to correct an error in law.*

2. *This case concluded on Wednesday 25 September 2024. A striking off order was imposed. This will not take effect until 28 days after the decision has been communicated. The registrant was not present neither was she represented at the substantive hearing.*

3. *The NMC did not ask for an interim suspension order once sanction had been handed down due to the mistaken belief that the interim suspension order which had been in place prior to the substantive hearing starting would remain in place until 21 January 2025.*

4. *The panel therefore did not impose an interim suspension order as they believed that the public was suitable protected during any period of appeal by the interim suspension order. It is clear that the panel was of the view that an interim suspension order was necessary as they stated in their determination:*

…

5. The basis on which they formed their decision is incorrect.

…

11. The panel is asked to correct this error. It is submitted that the following case law applies:

R (Jenkinson) v Nursing and Midwifery Council [2009] EWHC 1111

…

12. It is submitted that the Panel handed down its decision in relation to an interim order ignorance [sic] of the correct legal framework. It is therefore submitted that the panel can on this occasion correct their decision.

Next steps:

13. It is submitted that legal advice is given as to whether an interim order should be imposed providing the correct legal framework and submissions sought from the parties.'

Ms Mohamed also made oral submissions in which she clarified that pursuant to Article 31(5)(iv) of the NMC Order 2001 (as amended), the interim order imposed on Ms Ugwumadu's registration will lapse on the making of the substantive order on 25 September 2024.

Ms Mohamed stated that given the panel's substantive decision on this case in that it imposed a striking off order, the panel is aware that the interim order will not come into effect until 28 days after the handing down of that substantive decision. An application for an interim order should have been made to cover this appeal period.

Ms Mohamed therefore invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and the public interest given the seriousness of the facts found proved and the substantive order made.

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 the appeal period in order to protect the public and meet the public interest considerations in this case.

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

That concludes this determination.