Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 14 August 2023 – Tuesday, 22 August 2023

Virtual Hearing

Name of Registrant:	**Emmanuel Xavier Udo**
NMC PIN	03G0252O
Part(s) of the register:	Sub Part 1 RN1: Adult Nurse, Level 1 (4 July 2003)
Relevant Location:	Kent and Medway Maidstone and Tunbridge Wells
Type of case:	Misconduct
Panel members:	John Vellacott (Chair, lay member) Terry Shipperley (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Nandita Khan Nitol
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mr Udo:	Not present and unrepresented
Facts proved by admission:	Charges 1, 2, 4, 5a), 6a), 6b), 7), 8a), 8bi), 8biii), 8b)iv), 8c)ii), 8c)iii), 8dii), 8d)iii), 8e), 9a) and 9b)
Facts not proved:	Charges 3, 8bii), 8b)v), 8b)vi), 8c)i) and 8d)i)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Udo was not in attendance and that the Notice of Hearing letter had been sent to Mr Udo's registered email address by secure email on 17 July 2023.

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

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Mr Udo 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 Mr Udo

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

Mr Radley referred the panel to the email from Mr Udo, dated 7 August 2023 which stated:

> *'I write to confirm that I will not like to attend the hearing due to take place from the 14th of August because of my ill health and also I am not in the UK presently.*'

Mr Radley submitted that Mr Udo had voluntarily absented himself and has not applied for an adjournment. He submitted that adjourning the hearing today would be unlikely to secure his attendance at a future date.

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 Mr Udo. In reaching this decision, the panel has considered the submissions of Mr Radley, 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 Mr Udo;
- Mr Udo has informed the NMC that he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Five witnesses are due to attend;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 -2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Udo in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address. He has responded to the allegations in the Case Management Form (CMF). However, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. In the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Udo's decisions to absent himself, from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to amend the charge

The panel of its own volition invited submissions from Mr Radley to amend the wording of charge 5. As the charges were being read it noted a typographical error within this charge. The proposed amendment was to correct a typographical error and delete the year '2022' and to add the year '2020'.

The panel heard an application made by Mr Radley, on behalf of the NMC, to amend the wording of charge 5. In addition, Mr Radley proposed to amend the wording of the charges 5 and 6. The proposed amendment was to delete part b as this appears to be the wrong date and substitute it in charge 6 as a new b.

<u>Original charges:</u>

5. On 22 October 2022 you:

a) failed to administer insulin to a patient at the prescribed time;
b) administered 14 units of insulin instead of the prescribed 18 units;

6. Between 24 October 2020 and 25 October 2020, you administered incorrect dose/s of insulin to a patient in your care;

Proposed charges:

5) On 22 October ~~2022~~ **2020** you:

    a) failed to administer insulin to a patient at the prescribed time;
    ~~b) administered 14 units of insulin instead of the prescribed 18 units;~~

6) Between 24 October 2020 and 25 October 2020, you administered incorrect dose/s of insulin to a patient in your care;
    a) Administered incorrect doses of insulin to a patient;
    b) Administered 14 units of insulin instead of the prescribed 18 units

Mr Radley referred to the exhibits in the evidence bundle and submitted that the proposed changes to the charges would provide clarity and more accurately reflect the evidence. He submitted that this amendment does not affect the fairness or cause any injustice to Mr Udo or the proceedings.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel decided that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Udo and no injustice would be caused to either party by the proposed amendment being allowed. The panel further found that these amendments did not widen the scope and seriousness of the charges Mr Udo faced. The panel determined that it was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) On 18 January 2018, administered analgesia to the wrong patient;

2) On 27 November 2018, failed to undertake frequently or at all, observations on a post-operative patient;

3) On 10 August 2019. administered medication to a patient while the patient was asleep, causing a choking hazard;

4) On 19 April having administered Lorazepam to a patient, you failed to sign the drug chart to confirm this had been done;

5) On 22 October 2020 you:

   a) failed to administer insulin to a patient at the prescribed time;

6) Between 24 October 2020 and 25 October 2020, you administered incorrect dose/s of insulin to a patient in your care;
   a) Administered incorrect doses of insulin to a patient;
   b) Administered 14 units of insulin instead of the prescribed 18 units

7) During a night shift on 27 October 2021, you failed to conduct frequently or at all, clinical observations for Patient A;

8) On 17 November 2021:

   a) during handover you provided colleagues with inadequate information relating to patients you had cared for;
   b) in relation to Patient B you:
      i. failed to ensure that both dextrose and insulin were attached to the syringe pump as prescribed;
      ii. failed to sign out controlled drugs in the presence of a second nurse;
      iii. failed to sign Patient B's drug chart to confirm intravenous phosphate polyfuser had been administered;
      iv. administered medication to Patient B via an incorrect route and/or without checking the prescribed route for administration;
      v. failed to follow the correct procedure when setting up a syringe driver by not having a second nurse present;

vi. having administered medication, failed to obtain a second nurse's signature on Patient B's drug chart;

c) In relation to Patient C, you failed to follow the correct procedure for controlled drugs in that you:
    i. did not have a second nurse present when signing out morphine;
    ii. did not have a second nurse present when administering morphine;
    iii. administered morphine to Patient C via an incorrect route and/or without checking the prescribed route for administration;

d) In relation to Patient D, you failed to follow the correct procedure for controlled drugs in that you:
    i. did not have a second nurse present when signing out oxycodone and midazolam;
    ii. did not obtain a second nurses signature on Patient D's drug chart;
    iii. administered medication to Patient D via an incorrect route and/or without checking the prescribed route for administration;

e) did not complete visual infusion phlebitis scores for one or more patients;

9) During a night shift on 31 October 2019 in relation to Patient E you failed to:
    a) check if Patient E's syringe pump was on and/or working;
    b) conduct and/or note frequently or at all, clinical observations for Patient E;

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

Background

On 10 January 2022, the NMC received a referral from TFS Healthcare (the Agency) raising concerns about Mr Udo's fitness to practise. At the time of the concerns raised in the referral, he was working as an agency nurse with Maidstone and Tunbridge Wells NHS Trust (the Trust).

Mr Udo was allegedly involved in a number of incidents relating to errors in his administration of medication which included failure to carry out appropriate patient assessments and issues with his record- keeping on placements provided by the agency.

On 18 January 2018, while working a shift at the Trust Mr Udo allegedly administered analgesia to the wrong patient. He admitted the error and confirmed that he had administered a painkiller to the wrong patient.

On 27 November 2018, while working a shift at the Trust, Mr Udo took observations from a post-operative patient allegedly only twice during his 12 hour shift, at night and in the morning, when he was supposed to check the patient every one– two hours. Issues were also raised with Mr Udo's handover, as he allegedly handed over the wrong information for the wrong patients to colleagues who were taking over from Mr Udo. In explaining his actions, Mr Udo said the patient wanted to be left alone to sleep and had refused to have their observations taken on two occasions.

On 10 August 2019, the Trust alleged that Mr Udo had administered medication to a patient while they were sleeping, creating a choking hazard. Mr Udo said that he administered the patient their regular medication as normal, and they took the tablet themselves and swallowed it down with water. Before taking the tablet, the patient asked him what the medication was for, and Mr Udo said it was for pain relief. Around two hours later, the patient called to ask Mr Udo what the medication was for and how they had taken it. Mr Udo said he had explained it was pain relief and the patient had taken it with water. The patient became upset and anxious. Mr Udo then called the nurse in charge and the on-call doctor to settle the patient. Mr Udo's account differs to the allegation that the patient was given medication while sleeping, causing a choking hazard. Witness 1 said it is difficult to reach a conclusive outcome on what happened during this incident as it is one person's word against another's. She also confirms that she is not a direct witness as per her written evidence as she was not there at the time.

On 19 April 2020, while working a shift at the Trust, Mr Udo allegedly administered a patient Lorazepam but forgot to sign the drug chart to confirm the administration. Mr Udo admitted the error and he said that he had forgotten to do so as the shift was hectic and short- staffed. Mr udo said that he had written the dose and time the medication was administered on his nursing evaluation and informed the day staff during the handover.

While working shifts at the Trust between 22– 25 October 2020, Mr Udo was responsible for caring for a patient prescribed insulin. Mr Udo missed one dose of insulin on 22 October 2020. The patient's dosage of insulin had also been increased from 14 units to 18 units but on 24 and 25 October 2020, Mr Udo administered the incorrect (reduced) dosage of 14 units to the patient. Mr Udo admitted to the error. Mr Udo agreed that he had administered the patient the wrong dose of 14 units of insulin instead of their prescribed 18 units. He said the ward was busy and there were a lot of distractions which caused him to lose his concentration. As a result of the incident, he said he had learned to double check medications.

On 27 – 28 October 2021, Mr Udo was working a night shift at the Trust, and he was responsible for caring for Patient A. On administration, Patient A's target oxygen saturation was adjusted by the clerking doctor, so it was lower in light of the patient's chronic lung disease. The adjusted target saturation was detailed on Patient A's paper drug chart, but not their digital records (known as NEWS2). As the adjusted measurement was not recorded on Patient A's digital record, Mr Udo and other nurses responsible for Patient A's care between 27 – 28 October 2021 did not make sure Patient A's target oxygen saturation was lower, in order to take account of her chronic lung disease. Patient A collapsed and died on 28 October 2021. Concerns were raised, in relation to Mr Udo's failure to undertake any clinical observations on Patient A for a period of 8 hours. Mr Udo said he completed all observations that he was required to do for the patient while he was caring for her. However, witness 3 who was on shift with Mr Udo, was concerned that she did not see him taking any handover notes during his shift.

On 17 November 2021, Mr Udo was responsible for the care of Patient B while working a shift at the Trust. Patient B was found to have a syringe pump with the insulin infusion running without intravenous dextrose. Intravenous dextrose is required to run alongside insulin to ensure a patient's blood sugar does not decrease. Patient B was supposed to be on a variable rate insulin infusion and was prescribed insulin and dextrose. Allegedly Mr Udo had not run the dextrose alongside the insulin. Patient B was also prescribed intravenous phosphate polyfuser, which Mr Udo had administered correctly, but allegedly

failed to sign Patient B's medication chart, so it was unknown how long the intravenous phosphate polyfuser was running.

Mr Udo said he kept Patient B's prescribed infusions running throughout his shift and there had been two running at the same time. He said that at around handover, one of these fluids had run out and he therefore went to get a replacement bag but became distracted. Mr Udo said that he could not remember whether he had handed over this information when he finished his shift. Mr Udo said that he had learned to be more careful in his practice to avoid incidents like this happening. He said that he had learned to check and double check with colleagues to avoid such errors from happening.

On 17 November 2021, Mr Udo was responsible for the care of Patient C while working a shift at the Trust. Mr Udo had signed for the administration of subcutaneous medication for analgesia for Patient C. However, Mr Udo did not obtain an additional signature, which is required for syringe drivers. Mr Udo had also attached Patient C's syringe driver to an intravenous cannula, instead of a subcutaneous cannula, which is the incorrect route. Mr Udo said that the controlled drug, morphine, was counter-signed in the controlled drug register by him and the nurse in charge, but Patient C's drug chart was only signed by him because it had become practice that only one nurse signed the drug chart. Mr Udo admitted that he went to Patient C's bedside alone to set up the driver and that he did not check the intravenous cannula was working before attaching the syringe and did not check Patient C's prescribed route. He admitted that he set up Patient C's syringe pump to an intravenous cannula instead of a subcutaneous line and that he cannot explain how and why he did this. Mr Udo admitted that he did not check the intravenous site frequently. Mr Udo said that he had learned that he should be more careful in his practice to avoid such incidents.

On 17 November 2021, Mr Udo was responsible for Patient D's care at the Trust. Patient D was prescribed the controlled drugs Oxycodone and Midazolam. After administering these medications, Mr Udo signed Patient D's medication chart but did not get these counter-signed by a second nurse. Patient D's syringe driver was attached to an intravenous cannula, rather than the subcutaneous cannula, so again Mr Udo

administered these via the wrong route. Once again, Mr Udo said that he would take more care in his practice to avoid such incidents.

As a result of these concerns the agency stopped providing Mr Udo with shifts. This is because, due to the nature of agency work, they were unable to provide him with further support, management or supervision.

Mr Udo is currently registered to work with another agency, but he has not yet worked any shifts for them.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Radley, who informed the panel that Mr Udo, in his completed CMF made full admissions to all the charges except charge 3.

The panel considered the Case Management Form (CMF) prior to the hearing. The panel noted that Mr Udo had fully completed the form. It considered that this was properly admitted in evidence and would further consider its reliability in its deliberations. The panel noted that Mr Udo has admitted to all charges except charge 3. However, the panel have concluded that there is not sufficient evidence supported for the charges he had admitted namely 8bii), 8b)v), 8b)vi), 8c)i) and 8d)i) . The NMC do not suggest otherwise but it has not sought to withdraw the charges. In these circumstances, the panel will ignore the admissions of charges 8bii), 8b)v), 8b)vi), 8c)i) and 8d)i) and had drawn no adverse inference from it .The panel will continue to consider the allegations on the strength of the evidence.

The panel therefore finds charges 1, 2, 4, 5a), 6a), 6b), 7), 8a), 8bi), 8biii), 8b)iv), 8c)ii), 8c)iii), 8dii), 8d)iii), 8e), 9a) and 9b) proved in their entirety, by way of Mr Udo’s admissions.

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 from five witnesses. Witness 1, on receipt of complaints, exercised management responsibility and undertook fact finding in October 2022 which uncovered previously archived complaints concerning Mr Udo. These matters have been included in the referral and Witness 1 gave evidence in respect of all the charges. However, her evidence was largely hearsay and relied upon documentary exhibits. Witness 2, Witness 3 and Witness 5 were able to give relevant evidence in respect of the admitted charges. Witness 4 was able to give relevant evidence in respect of the admitted charges and also gave direct evidence in relation to charges 8bii), 8b)v), 8b)vi), 8c)i) and 8d)i).

The panel found all five of the NMC's witness to be credible and determined that their evidence was inherently plausible. Oral evidence was consistent with witness statements and in respect of Witness 4, materially consistent with contemporaneous statements made at the time of the allegations.

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

The panel has drawn no adverse inference from the non-attendance of Mr Udo.

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 Lead employed by the agency
- Witness 2: Clinical support worker at the time employed by the Trust
- Witness 3: Registered staff nurse at the time employed by the Trust
- Witness 4: Ward manager, employed by the Trust
- Witness 5: Director of Quality Governance, employed by the Trust

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

The panel then considered the disputed charge and made the following findings.

Charge 3

That you, a registered nurse:

3) On 10 August 2019, administered medication to a patient while the patient was asleep, causing a choking hazard;

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and written statement of Witness 1 along with the reflective statement provided by Mr Udo.

The panel noted the oral evidence of Witness 1, who said that she was unsure of what exactly happened as she did not witness the incident herself. The panel further noted the written evidence of Witness 1 where she stated that:

'It is possible that the patient may have become confused and did not remember taking the medication. I am unsure if the patient had any cognitive issues as TFS Healthcare was provided with limited information from the Maidstone.

From the statement produced by Mr Udo, it seems as if he raised the issue appropriately by notifying the nurse in charge and the doctor on call. This incident is difficult one to reach a conclusive outcome for as it is one person's word against another.'

The panel carefully considered the above evidence of Witness 1 and found that it does not support the contention of the allegation in charge 3. On the contrary, Witness 1 appeared to have the impression that Mr Udo did raise the issue to the appropriate authority.

The panel also noted Mr Udo's reflective statement and found it to be reasonable and credible. In his statement he clearly described the incident in question and the steps he had taken.

'…I am writing to respond to a complaint raised by one of the patients in SSSU on the 10th of August 2019 night shift I looked after this patient and during drug rounds she was given her medications as prescribed She took the tablet by herself and swallowed it down with water Before she took the tablet she asked what the medication were meant for and I told her it was for pain relief This was about 21.30 At about 23.30 about two hours after she took the tablet she called and asked what the medications were and how she took it I told her again it was her painkiller and that she took it down with water She said she was not in pain and did not need any painkiller I explained to her that it was written on the regular side but if she didn't need it I would not have given her She was upset and became anxious I called the nurse in charge to speak to her to allay her

anxiety I also called the SHO on call who came and spoke to her She settle and slept well for the rest of the shift I also handed over the medication issue to the day staff.'

The panel did not hear from any direct witnesses in relation to the 2019 incident who contradicted the evidence of Mr Udo. It did not receive any evidence that Mr Udo did not report or escalate the medication issue to his colleagues, neither had it received any investigation documents in relation to the incident.

In considering all of the above evidence the panel determined that the NMC has not discharged its burden of proof in respect of charge 3.

In light of the above, the panel determined that the NMC has not discharged its burden of proof on the balance of probabilities.

Accordingly, this charge is found not proved.

Charge 6)

That you, a registered nurse:

6)Between 24 October 2020 and 25 October 2020, you administered incorrect dose/s of insulin to a patient in your care;

a) Administered incorrect doses of insulin to a patient;
b) Administered 14 units of insulin instead of the prescribed 18 units

While the panel accepted Mr Udo's admissions to these matters, it was of the view these were in effect the same incident rather than two separate matters.

Charge 8bii)

That you, a registered nurse:

8) On 17 November 2021:

b)in relation to Patient B you:

ii) failed to sign out controlled drugs in the presence of a second nurse;

This charge is found NOT proved.

The panel noted the wording of the charge 8b)ii), which is drafted as a failure. For the NMC to prove a failure, it must prove that Mr Udo did not sign out controlled drugs in the presence of a second nurse; and that there was a duty to do so.

The panel first determined whether Patient B was prescribed any controlled drugs.

The panel carefully considered the Datix report regarding Patient B which was completed by Witness 4. In answer to the panel's question, Witness 4 could not recall whether Patient B was prescribed any controlled drugs. Therefore, the panel found no evidence that Patient B was receiving controlled medication.

In light of the above evidence, the panel next considered whether Mr Udo would have been under a duty to sign the drugs if the medications were not controlled drugs. Witness 4 confirmed in his oral evidence that there is only a requirement for a second signature when the medication taken out of the cupboard is a controlled drug.

The panel concluded that in relation to Patient B, Mr Udo did not have any positive duty to sign out the drugs in the presence of a second nurse as the drugs were not controlled.

Therefore, the panel determined that the NMC has not discharged its burden of proof in respect of charge 8b)ii).

Accordingly, this charge is found not proved.

Charge 8b)v)

That you, a registered nurse:

8) On 17 November 2021:

b) In relation to Patient B you:
v) failed to follow the correct procedure when setting up a syringe driver by not having a second nurse present;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

The panel noted the wording of the charge 8b)v), which is drafted as a failure. For the NMC to prove a failure, it must prove that Mr Udo did not set up a syringe driver in the presence of a second nurse; and that there was a duty to do so.

The panel first determined whether there was a need or policy to set up a syringe driver in the presence of a second nurse for all drugs.

The panel considered the evidence of Witness 4 who confirmed in his oral evidence that if the drug was a controlled one, there should always be two nurses and if it was not, any Registered Nurse can set up the syringe driver without the presence of a second nurse.

The panel next determined whether Patient B was prescribed with any controlled drugs.

Referencing the panel's decision on charge 8bii), where it was proved that Patient B was not prescribed controlled drug, which was also confirmed by Witness 4, the panel was satisfied that Mr Udo followed the correct procedure by setting up the syringe without the presence of a second nurse and that there was no failure in his duty.

Therefore, the panel determined that the NMC has not discharged its burden of proof in respect of charge 8b)v).

Accordingly, this charge is found not proved.

Charge 8b)vi)

That you, a registered nurse:

8) On 17 November 2021:

b)In relation to Patient B you:
vi) having administered medication, failed to obtain a second nurse's signature on Patient B's drug chart;

This charge is found NOT proved.

In reaching this decision the panel referenced its decision on charge 8b)ii) where it was confirmed that Patient B was not prescribed any controlled drug as such there was no requirement for a second nurse as per the evidence of Witness 4.

Therefore, the panel determined that the NMC has not discharged its burden of proof in respect of charge 8b)vi).

Accordingly, this charge is found not proved.

Charge 8c)i)

That you, a registered nurse:

8) On 17 November 2021:

c) In relation to Patient C, you failed to follow the correct procedure for controlled drugs in that you:
    i. did not have a second nurse present when signing out morphine;

This charge is found NOT proved.

In reaching this decision the panel took account of the evidence of witness 4.

Witness 4 said in his oral evidence said that the morphine for Patient C was signed out by two people when taking it out from the cupboard, and during his evidence Witness 4 also named the second nurse whose signature was on the drug chart.

The panel could find no evidence which contradicted the evidence of Witness 4.

In light of the above, the panel determined that there is positive evidence that there were two people signing out the controlled drug which contradicted the contention of the charge.

Accordingly, this charge is found not proved.

Charge 8d)i)

That you, a registered nurse:

8)On 17 November 2021:

d) In relation to Patient D, you failed to follow the correct procedure for controlled drugs in that you:
i) did not have a second nurse present when signing out oxycodone and midazolam;

This charge is found NOT proved.

In reaching this decision the panel took account of the evidence of Witness 4.

In response to panel questions, Witness 4 confirmed that the controlled drugs oxycodone and midazolam, for Patient D, was signed out in the presence of another nurse.

The panel could find no evidence which contradicted the evidence of Witness 4.

In light of the above evidence, the panel determined that there is positive evidence that there were two people signing out the controlled drugs which contradicted the contention of the charge 8d)i).

Accordingly, 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 Mr Udo'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 suitability to remain on the register unrestricted.

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, Mr Udo's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Radley provided the panel with written and oral submissions with regard to misconduct, which stated:

1. *The Registrant Emmanuel Udo (EU) has admitted all the Regulatory Charges with the exception of charge 3. The Panel have reviewed the evidence and have confirmed the admissions with the exception of charges 3, 8bii, v, vi, 8ci, 8di, .*

2. *The panel will now be considering Misconduct.*

3. *In this case the Registrant has, to his credit and the NMC say quite properly, accepted that his actions amount to misconduct.*

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

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

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

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

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

   And

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

7. *The NMC assert that here, E U's, acts or omissions, falls short of the standards set out in The Code: Professional standards of practice and behaviour for nurses and Midwives (2015) ("The Code")*

8. *Due to Mr Udo falling short of "the Code" and what he did or failed to do, for the reasons below The NMC assert that E U's actions amounts to serious professional misconduct and this has resulted in him currently being impaired.*

9. *The actions reported and either accepted or found proven are failings directly related to clinical practice, medication management resulting in several SI investigations and impacting on vulnerable patients.*

10. *These acts or omissions are not simply breaches of a local disciplinary policy or minor concerns, they are matters at the heart of and fundamental to the professional's practice. It is a serious concern at the heart of a caring profession specialising in the vulnerable patients.*

11. *This can be serious professional misconduct because these issues relate to the nurses, role as a registered professional and the potential impact on his area of practice, such as, medications management concerns, poor record keeping, inappropriate participation in hand overs (lack of attention and note taking) at the handovers.*

12. *The panel will be aware that seriousness is an important concept which informs various stages of our regulatory processes. The public's trust and confidence in all nurses, demonstrating the behaviour found by Mr Udo here must, we assert, amount to a misconduct.*

13. *When considering the seriousness of misconduct, you will consider evidence of any relevant contextual factors. Mr Udo was working in a busy unit at what was a very stressful time. He was working as a bank staff member and possibly was nervous of the escalation process* (Witness 5). *However, as a professional nurse, the interests of the patient are paramount, and Mr Udo did not priorities these needs sufficiently. This is, of course, a matter for the Panel.*

14. *The panel have already carried out a full review of the evidence and it is not necessary to recite all the facts proven here.*

15. *I turn to "the Code"*

"The Code" (2015)

16. *The NMC say that "The Code" has been breached. The following particular areas of the code being engaged are;*

17. *Section 1 - Treat people with dignity and uphold their dignity: 1.2, 1.3, 1.4,*

18. *Section 3 – Make sure people's physical, social and psychological needs are assessed and responded to: 3.2 (Patient A), 3.4*

19. *Section 6 – Use best practice 6.1*

20. *Section 8 - Working cooperatively: 8.1, 8.2, 8.3, 8.4, 8.5, 8.6,*

21. *Section 9 – Sharing skill knowledge and experience for the benefit of people receiving care and your colleagues: 9.2*

22. *Section 10 – Keep clear and accurate records relevant to your practice 10.1, 10.2, 10.3, 10.4, 10.5,*

23. *Section 11 – Be accountable for your decision to delegate tasks and duties to other people. 11.2, 11.3.*

24. *Section 14 Be open and candid – Admissions are made here but the panel may consider that is there a full acceptance required by the code?*

25. *Section 16 – Act without delay if you believe there is a risk to public safety or protection. 16.1, 16.2, 16.3,*

26. *Section 18 – Administer medications – The panel may be concerned about the number of issues with medication and the serious implications. 18.2*

27. *Section 19 - Be aware of and reduce as far as possible any potential for harm associated with your practice: 19.1*

28. *Section 20 - Uphold the reputation of the profession – 20.1, 20.3, 20.5, 20.6, 20.8*

29. *The Panel may, be particularly concerned about;*

    i. *Medicine management issues*

    ii. *Poor note taking, cooperation in handovers*

    iii. *Record keeping*

These factors can have a serious effect on workplace culture, and therefore patient safety if it is not dealt with effectively. This, we say, underpins the need to identify this behaviour as serious misconduct in the case of Mr Udo.'

Submissions on impairment

Mr Radley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest by written and oral submissions, which stated:

'…

1. *The Panel are now considering whether Mr Emmanuel Udo's fitness to practise 'is impaired' (Art 22(1)(a) of the Nursing and Midwifery Order 2001).*
2. *Impairment is not defined in the legislation.*
3. *There have been many legal cases which have developed the concept of impairment and the factors that should be considered when deciding whether a professional's fitness to practise is impaired. The question that will help decide whether a professional's fitness to practise is impaired is:*

"Can the nurse, midwife or nursing associate practise
Kindly, safely and professionally?"

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

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

   a. *Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
   b. *Has in the past brought and/or is liable in the future to bring the professions into disrepute; and/or*
   c. *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the professions; and/or*
   d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

5. *The NMC represent that this question is answered positively. The NMC represent that the professional's fitness to practise is impaired.*
6. *The Panel will be aware that a decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. It is dependent on the individual circumstances surrounding each concern.*
7. *The panel will no doubt ask themselves if any part of the CODE has been breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors the panel feel is important. The NMC refer the panel to the earlier concerns on the breaches of the CODE.*

8. *The NMC say that the breaches of the Code involves breaching a fundamental tenet of the profession, the Panel would be entitled to conclude that a finding of impairment is required in Mr Udo's case. The finding of impairment, the NMC assert, is required to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour (Yeong v GMC [2009] EWHC 1923 (Admin) Hamer para 36.07).*
9. *The Fitness to Practise Panel will consider the context in which things have happened. Here the panel will be asked to consider;*

    - *The professional's working environment and culture*
    - *It is relevant that this was a busy time*
    - *That so many had raised concerns through Datix about the Registrants practice*
    - *The potential risk of harm to the Patients of medicines errors*

10. *The NMC say this does adversely affect the professional's ability to practice professionally and as a consequence the professional will not be able to demonstrate that they are currently able to practise kindly, safely and professionally.*

11. *The third area of context is the learning, insight and steps the professional has taken to strengthen their practice. Here the professional has engaged in the process, to a degree. He has not attended to explain his case. There is limited evidence that he has taken steps to address concerns or risks identified in the case.* Witness 5 *stated, that the reflective piece is not to the standard expected.*

12. *Whether it is likely that the conduct will be repeated is also a concern for the NMC. This will impact on the professional's ability to practise kindly, safely and professionally, resulting in the NMC suggesting a finding of impairment to be appropriate.*

13. *The consequences of the professional's conduct affected patient care and could have been very serious, which could result in distress. The behaviour found could impact the care being provided at the Hospital.*

14. *For these reasons the NMC say that Mr Emmanuel Udo's practice is impaired.'*

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

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 Mr Udo's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Udo's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

To achieve this, you must:

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

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

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:
11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

13 Recognise and work within the limits of your competence

To achieve this, you must:
13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment
13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence
13.5 complete the necessary training before carrying out a new role.

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

To achieve this, you must:
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other

healthcare setting and use the channels available to you in line with our guidance and your local working practices
16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:
18.2 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
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 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.'*

In the panel's judgement, Mr Udo's actions in each of the individual charges proved did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. It also noted Mr Udo's acceptance as set out in the CMF that his actions amounted to misconduct.

Mr Udo's failures had the potential to cause significant harm to patients and undermined public confidence. The panel determined that the numerous errors involving medication, record keeping, taking observations and communicating with colleagues were basic. Although, Mr Udo was made aware of these errors and had the opportunity to rectify them, he failed to do so. He repeatedly made similar errors over a significant period namely from 2018 until 2021.

The panel found that Mr Udo's actions in the charges found proved 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 considered whether by reason of his misconduct Mr Udo's fitness to practise is currently impaired.

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *...'*

The panel determined that limbs a, b and c, of the *Grant* test are engaged.

The panel determined that Mr Udo's failures potentially placed patients at an unwarranted risk of harm. The panel determined that Mr Udo's misconduct had breached the

fundamental tenets of the nursing profession and that his actions brought the reputation of the profession into disrepute.

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether Mr Udo's misconduct was remediable and whether it had been remedied. The panel then considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin). It determined that the misconduct in this case can be remediated.

The panel went on to consider whether Mr Udo remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

The panel carefully considered the documentation and found that there was some evidence that demonstrated limited insight when Mr Udo repeatedly accepted the errors and said that he would not act in the same way again. Additionally, the panel noted that there was evidence of difficult working environments due to shortage of staff which might have adversely affected Mr Udo's ability to practise safely and professionally. However, the panel considered that, Mr Udo, as a professional nurse could have escalated the matter to the appropriate authority.

In the panel's judgment, Mr Udo's reflective pieces, written at the time of each incident, were very limited with no details of how he would do things differently in the future or any material to indicate that he wished to remediate the concerns raised with his practice.

The panel has not been able to ascertain his current level of insight. The panel was therefore unable with confidence to accept that Mr Udo had demonstrated anything other than limited insight into his misconduct or that he had considered the impact on patients, colleagues and the reputation on the profession.

The panel next considered whether Mr Udo has taken any steps to strengthen his practice. The panel did not find any references, testimonials or evidence of Continuing Professional Development (CPD) to indicate strengthening of practice related to the regulatory concerns.

In the absence of any evidence of steps to strengthen his practice or provide evidence of remediation, the panel concluded that Mr Udo had not remediated his actions.

In all the circumstances, the panel considered that there remains a risk of repetition should Mr Udo return to unrestricted practice which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

Having regard to Mr Udo's conduct in this case, the panel considered that members of the public and patients would expect a nurse to provide safe and effective care to patients by ensuring all care is carried out safely. The panel therefore determined that a finding of impairment is also necessary on public interest grounds.

In light of all of the above, the panel concluded that Mr Udo's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mr Udo's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.
In reaching this decision, the panel has had regard to all the evidence that has been adduced 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 Radley provided the panel with written submissions with regard to sanction, which stated:

'*The panel are asked to consider the following matters relating to the sanction bid.*

Proportionality

1. *The panel will be seeking to find a fair balance between Mr UDO, the nurses rights and our overarching objective of public protection (Huang v Secretary of State for the Home Department [2007] UKHL 11)*

2. *The NMC's case is that The FTP committee can Justifiably restrict the Nurses right to practice in this case.*

3. *The panel will consider whether the sanction with the least impact on the nurses, practise would be enough to achieve "Public Protection and "In the wider Public Interest" looking at the reasons why the nurse, isn't currently fit to practise and any aggravating or mitigating features.*

4. *The sanction will of course be considered from the least serious to the most serious to achieve Public protection/Public interest.*

5. *The panel can conclude that the Nurse is not fit to practice without restriction currently because.*

6. *The NMC say that the Statutory grounds of;*

"Public Protection and "In the wider Public Interest" are engaged

Aggravating features

The representations on aggravating factors are

1. *Multiple SI involving a number of patients.*
2. *Real risk of patient harm*
3. *Conduct continued after an initial warning and support.*
4. *This continued over a length period of time*
5. *lack of insight into failings – (HC comments on the reflective statement)*
6. *Impact on the profession – See "the Code" concerns in the Misconduct document.*
7. *Conduct putting patients at risk of real harm*

Mitigating features

The mitigating features are;

1. *No actual direct patient harm (potential)*
2. *Some insight demonstrated*
3. *Age experience and no previous findings against the Registrant*

Proposed sanction

1. *12 – 18 months conditions of practice order – This order would assist the nurses confidence and assist them getting back to practice*

- *This sanction that would protect patients, members of the public and maintain professional standards*
- *In terms of Public Interest the bar is set high – (Bawa-Gaba v GMC [1 WLR 942] para 13. 'The views of an informed and reasonable member of the public appraised of all the circumstances of the case'.*

2. *Based on the findings the NMC note that the Panel have found the limbs of Public Protection and Public Interest are engaged here.*

Interim orders

3. *The NMC make application for an interim order in this case.*
4. *NMC respectfully remind the panel of the line of cases leading to the case of Kamberova v NMC [2016]EWHC 2955 (Admin). A committee can consider the time spent on other orders if they are considering an interim order after sanction is imposed.'*

Decision and reasons on sanction

Having found Mr Udo'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:

- Multiple series of incidents involving a number of patients over a period almost four years.
- Real risk of patient harm.

- Conduct continued after warnings.
- Lack of insight into failings.

The panel also took into account the following mitigating features:

- Some insight demonstrated notably by Mr Udo's acceptance of responsibility of majority of charges and acceptance of his own impairment.
- Mr Udo worked as an agency nurse, and he did not have support.
- Busy working environment with a shortage of staff.

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 Udo'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 Mr Udo's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Udo's registration would be a sufficient and appropriate response. The panel is 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;*

- *Potential and willingness to respond positively to retraining;*
- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel was satisfied that the clinical failings found proved revealed identifiable areas of Mr Udo's practice which are in need of further assessment or training. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mr Udo should be able to return to practise as a nurse.

The panel took into account that Mr Udo is not currently working as a registered nurse in the UK and there is no information about whether he intends to return to nursing practice, or his willingness to comply with conditions of practice. However, the panel determined that it would be possible to formulate sufficient, appropriate and practical conditions which would address the failings highlighted in this case should he return to practice.

The panel was of the view that a conditions of practice order would allow Mr Udo to work on, and evidence insight and the impact of his failings as identified in this case on patients and colleagues.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate in the circumstances of Mr Udo's case. The panel determined that the concerns are related Mr Udo's practice and it considered that suspending Mr Udo from nursing practice would prevent him from addressing those concerns, developing his skills and demonstrating safe medication management along with record keeping, taking observations and communicating with colleagues. The panel was satisfied that Mr Udo's misconduct was not fundamentally incompatible with remaining on the register.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing… role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing…'

1. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from either:

    - Your line manager, mentor or supervisor detailing your progress including the plan, log and any training as set out in Condition 5 below.

2. You must not administer medication, whether orally, via injection or infusion unless directly supervised by another nurse until such time that you have been signed off as competent by your line manager, mentor, or supervisor (who must be a registered nurse).

3. You must ensure that you are supervised by a registered nurse any time you are working. Your supervision must consist of:

    - Working at all times on the same shift as, but not always directly observed by a registered nurse.

4. You must identify a personal development plan with you line manager, mentor or supervisor and keep a log of your progress towards addressing the following areas:
    - Medicine administration
    - Record keeping
    - Hand overs to colleagues, verbal and written
    - Patient Observations

5. You must provide a reflective piece for a reviewing panel covering the areas of concern identified.

6. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

The panel determined that this was the minimum time necessary for Mr Udo to find a nursing job that will afford him the necessary support, and demonstrate adherence to the conditions outlined above.

Before the order expires, a panel will hold a review hearing to see how well Mr Udo has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Mr Udo's attendance at any future hearing.
- An indication of Mr Udo's future intentions in relation to his nursing career.
- Testimonials and/or references from any work paid or otherwise.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel 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 Udo's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the written and oral submissions made by Mr Radley along with the submissions on sanction. He submitted that an interim order was required on public protection and public interest grounds for the same reasons given for the substantive conditions of practice order. Mr Radley invited the panel to make an interim conditions of practice order for a period of 12 months to cover any appeal period until the substantive conditions of practice order takes effect.

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 the only suitable interim order would be that of a conditions of practice order in identical terms to those imposed by the panel, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that Mr Udo cannot practise without restriction before the substantive conditions of practice order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.

This will be confirmed to Mr Udo in writing.