Table of Contents

Impairment 2
Consensual panel determination 9
Essential criteria 10
The process 11
Offering no evidence 15
Abuse of process 18
Directing further investigation during a hearing 22
Evidence 24
Making decisions on sexual misconduct 31
Making decisions on dishonesty charges and the professional duty of candour 32
Agreed removal at hearings 35

Impairment

Reference: DMA-1 Last Updated: 28/01/2026

In this guide

- What do we mean by ‘impaired’ fitness to practise?

What do we mean by ‘impaired’ fitness to practise?

A key focus of our fitness to practise process is deciding whether or not a professional’s fitness to practise is currently impaired. We do this by assessing whether the professional would pose a risk to public safety, the public’s confidence in their profession or professional standards if they were permitted to practise without restrictions. Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.

Our legislation sets out the six types of concerns that can impair the fitness to practise of professionals on our register. These are set out in our guidance ‘allegations we consider’.

Determining whether someone is fit to practise means that we have to consider whether the charges about the professional’s practice which have been found proved:

- engage one of these types of concerns and
- indicate a continuing risk to:
  - public safety,
  - public confidence in their profession
  - professional standards

How do we decide if the charges found proved indicate a risk to public safety, public confidence or professional standards?

Our Fitness to Practise Committees take a staged approach to considering impairment.

Once panels have found the facts of a charge against the professional proved, they will go on to determine whether the facts found proved amount to conduct that falls within one of the allegations we consider. In lack of competence cases for example, this means determining whether the facts found proved amount to a lack of competence. Similarly in misconduct cases this means considering whether the facts found proved amount to serious professional misconduct.

If the facts proved amount to conduct that falls within one of the six types of concern that could impair a professional’s fitness to practise, they will go on to consider whether those facts mean that there would be a current or ongoing risk of harm to:

- people in their care or the public
- to the public’s confidence in the professions and/or
- professional standards

if they were permitted to practise without restrictions.

If there is no risk to public safety, public confidence or professional standards, there will be no impairment.

It is a matter for the panel to decide whether a professional is currently impaired i.e. whether they are capable of practising safely and effectively and without restriction. If the charges found proved indicate a continuing risk to public safety, public confidence in the professions or professional standards, then an impairment finding will be required.

However, just because a panel has found some or all of the charges proved, it doesn't follow that this will always result in a finding that the professional's fitness to practise is currently impaired.

To help determine if a professional's fitness to practise is currently impaired, panels should always ask themselves the following questions[1]:

1. has the professional in the past acted and/or is liable in the future to act as so to put those receiving care at unwarranted risk of harm; and/or
2. has the professional in the past brought and/or is liable in the future to bring the profession into disrepute; and/or
3. has the professional in the past committed a breach of one of the fundamental tenets of the [nursing/midwifery] profession and/or is liable to do so in the future and/or
4. has the professional in the past acted dishonestly and/or is liable to act dishonestly in the future.

They should also consider[2]:

- whether the concern can be addressed by taking steps to strengthen practice
- whether the concern has been addressed
- whether it is highly unlikely that the conduct will be repeated

Considering all the above questions will ensure that the panel considers:

- Public safety (any risk of harm to people in the professional's care or to their colleagues)
- Any risk to the public's confidence in the professions and/or to professional standards.

Further information can be found in our guidance on Insight and strengthened practice.

Basis of Impairment

It's important that our panels consider both the risk to public safety and to the public's confidence in the professions and/or professional standards.

In some cases, a professional will be impaired because of the risk they pose to public safety. In other cases, impairment will be based on the risk they pose to public confidence or professional standards. In some cases, impairment will be based on a risk to public safety, public confidence and professional standards. The panel should always consider all three elements (public safety, public confidence and professional standards) before making their decision.

It is important that panels are clear on what basis they have decided that a professional's fitness to practise is impaired because this will help to inform what sanction is most appropriate.

Public safety

A professional's fitness to practise will only be impaired on public safety grounds if they pose an ongoing risk of harm to those receiving care from the professional (and/or their families) and/or to colleagues. When deciding whether or not there is an ongoing risk of harm, the panel will need to consider:

- the seriousness of the conduct that gave rise to the concern
- how the professional responded to what happened. However, professionals, and all those engaging with the FtP process, come from a wide range of cultures and backgrounds, with different cultural norms and communication styles. These differences do not change the professional's obligations, but the panel should consider how they might affect the professional's presentation of personal factors, such as apologies and insight.
- the likelihood of the professional repeating this behaviour in the future,
- any relevant contextual factors

Concerns about lack of competence or clinical skill can more easily be addressed and remediated than those relating to deep seated attitudinal concerns.

Further information about this can be found in our guidance on insight and strengthened practice.

It is important that we're aware of any relevant information as early as possible, so we're able to make the right decision on a case at the earliest opportunity. Where a professional has taken steps to address their behaviour, it's important that they engage with the regulatory process so that the Fitness to Practise Committee is aware of these steps.

Further guidance for professionals on how to do this is available in our guidance on engaging with your case.

Public confidence in the professions and/or professional standards

Our objectives of upholding public confidence in the professions and professional standards are often referred to more broadly as our public interest objectives.

A finding of impairment on the grounds that the professional's practice needs to be restricted or marked to maintain public confidence in the professions generally, or to uphold professional standards, requires panels to consider whether the substance of the charges found proved, (whether or not the conduct occurred within the professional's clinical practice), means that there would be a risk to the public's confidence in the professions or to professional standards if the professional was permitted to practise without restrictions.

This means that in some cases, a professional's fitness to practise may be impaired even though there is no ongoing risk to the safety of people receiving care from that individual. This is because the proven concerns about their conduct or professional practice by and of themselves, were so serious that a finding of impairment is necessary to maintain the public's confidence in the profession generally and to declare and maintain professional standards.

This will also include (but is not limited to), situations where the professional's conduct, whether inside or outside their professional practice demonstrates a deep-seated attitudinal issue that could put people receiving care at risk of harm or require action to uphold public confidence and professional standards.

Decision makers will therefore need to consider whether:

- The conduct or behaviour was by and of itself so serious that a finding of impairment is necessary to maintain the public's confidence and trust in the professions and to uphold, declare and maintain professional standards.
- The conduct or behaviour arose because of a deep seated attitudinal issue that places those receiving care at risk of harm or that undermines public confidence and professional standards.

Whether these questions are considered separately or together will depend on the particular circumstances of the case, but if either of the above points is met, that will be sufficient to require a finding of impairment.

A finding of impairment based on public confidence or maintaining professional standards is more likely to occur in cases where the conduct breaches a fundamental tenet of the profession as set out in the Code. The following list gives examples of conduct that would breach the fundamental tenets of the profession (whether or not it occurs within professional practice). It is an exhaustive list but gives some examples of the types of conduct where a finding of impairment is likely to be required:

- Sexual misconduct
- Sexual behaviour towards someone in the professional's care or their close family
- Deliberately causing harm to vulnerable adults, children or to people receiving care or knowingly taking risks with their safety
- Committing specified criminal offences and other criminal offences that create risks to public confidence and professional standards
- Discriminatory behaviour
- Serious and sustained dishonesty
- Breach of the duty of candour
- Violent or coercive or predatory behaviour

These types of behaviour may be indicative of harmful attitudinal issues that are more difficult to address and put right, whether or not they occur within the individual's professional practice.

This does not mean that an impairment finding is automatic in every case.[3] Each case will turn on its own facts. Dishonest conduct, for example, can span a wide spectrum of behaviours[4] and a finding of impairment will not necessarily follow upon a finding of dishonesty.[5] Our Sanctions Guidance contains more information about the range of dishonest conduct.

Similarly, panels should consider very carefully whether the professional has fully addressed the issues and whether an impairment finding is required in order to maintain public confidence and professional standards. In some cases the misconduct may be so serious that a finding of impairment will be required to maintain public confidence and uphold professional standards, notwithstanding evidence of substantial insight and remediation.

Conduct, such as for example, sexual misconduct, that represents a serious departure from professional standards is likely to pose an ongoing risk to public confidence and professional standards, even where the prospect of the conduct being repeated is low.[6]

It should also be noted that many of the types of conduct listed above are likely to create public safety risks risks to public confidence and professional standards. This underlines the importance of panels considering all three different forms of risk.

What do we mean by a 'deep seated attitudinal issue'?

Professionals on our register provide care and support to individuals who are often at their most vulnerable due to their health conditions or personal circumstances. It is therefore essential that these professionals consistently demonstrate behaviours that maintain public trust and ensure the safety and wellbeing of those receiving care.

Our Code outlines the values and behaviours expected of all registered professionals. These are not merely aspirational ideals, they form the fundamental tenets of the professions. They represent the core principles that underpin safe, effective, and compassionate care. Adherence to these principles also serves to maintain public confidence in the professions we regulate. These values and behaviours include, but are not limited to:

- Respect for others
- Treating others fairly
- Inclusion
- Openness
- Integrity
- Honesty
- Compassion
- Putting the needs of people receiving care first

A *deep-seated attitudinal issue* refers to an ingrained mindset or belief system that is contrary to these values and behaviours, Deep-seated attitudinal issues are resistant to change and pose risks to the safety and wellbeing of people receiving care and to the public's confidence in the professions generally and to professional standards.

When a professional demonstrates behaviours contrary to the values and behaviours set out in the Code, this may reflect more than a single lapse in judgement. It may indicate an underlying attitude fundamentally incompatible with professional practice. Such conduct (whether it occurs within or outside professional practice) is not only a breach of the Code but may also constitute a serious risk to public safety, the public's confidence in the professions and professional standards.

Examples of such behaviours might include (but are not limited to):

- Serious or sustained dishonesty
- Discrimination
- Abusive or degrading treatment of others
- Violence, particularly where it is premeditated
- Sexual misconduct (including sexual relationships with those receiving care or those close to them)
- Wilful neglect (whether this is towards those receiving care or occurs outside professional practice).
- Deliberate breaches of an interim or substantive order

As set out previously, a single incident involving such conduct may be serious enough, by and of itself to require a finding of impairment because of the risks to either public safety or to public confidence and professional standards. Although the existence of a deep-seated attitudinal issue may be an aggravating factor at sanctions

stage, it should not be treated as a 'threshold' test for a finding of impairment. In some cases an impairment finding will be required even in the absence of evidence of a deep-seated attitudinal issue.

We also recognise that, while deep-seated attitudinal issues can be difficult to address, meaningful change is not impossible. There may be circumstances in which there is compelling evidence that a professional has genuinely reflected on their behaviour and attitudes, recognised the impact on those affected by it and the wider profession, and taken steps to effect genuine change. Where a professional can demonstrate insight, learning and development they may no longer pose a risk to public safety, public confidence in the professions and to professional standards.

Examples of conduct that might lead to a finding of impairment

As explained above there are a number of factors that panels must consider in order to reach a finding of impairment such as context, how the professional responded to the concern, and the risk of any ongoing harm to public safety, public confidence or professional standards and seriousness of the conduct.

The examples below are indicative only, because each case will need to be considered on its own facts and merits and the panel may need to consider other factors that are relevant to the case they are considering. When assessing cases decision-makers should also take steps to ensure that bias (whether conscious or unconscious) doesn't impact their decision making, and that they consider all the facts of a case without preconceived ideas.

We've included some examples below of conduct, which might lead to impairment findings. In some instances, even when there's no evidence of an ongoing risk to public safety, an impairment finding may be required in order to maintain public confidence and professional standards.

Example 1

A nurse is claiming wages for shifts that they didn't work over a sustained period of time including claiming for full shifts when they either attended very late or left very early. They have also falsified time sheets for a number of shifts they've claimed for but not worked by forging the signature of their authorising manager on time sheets. While there were no clinical issues with the nurse's conduct her employers dismissed her. The nurse is now working for an agency elsewhere and again there are no clinical concerns about her practice and she's provided positive testimonials from her colleagues relating to her clinical practice and demonstrated remorse. Deliberately and persistently forging colleagues' signatures could amount to evidence of dishonest conduct and could amount to a sustained, deliberate fraud against the nurse's previous employer over a lengthy period of time. Honesty and integrity are important cornerstones of the profession. If dishonesty of this kind is proved this would be a significant departure from expected standards. A finding of impairment will be necessary to maintain confidence in the profession and to maintain and uphold professional standards, even though there are no concerns with the nurse's professional practice.

Example 2

A nursing associate is convicted of causing death by dangerous driving. This offence was unrelated to the nursing associate's professional practice, in that they weren't driving as part of their role as a nursing associate, nor were they driving to or from work. The nursing associate receives a custodial sentence. Such conduct will not necessarily raise risks to public safety in their role as a nursing associate for the panel to consider but will raise questions of whether there is a risk to public confidence in the profession and to professional standards.

In this case, the fact that the nursing associate has been convicted of causing death by dangerous driving and been given a custodial sentence is an indication of the seriousness of the matter which will need to be carefully assessed as to whether it is likely to undermine the public's confidence in the profession and professional standards. A finding of impairment is likely to be appropriate in this case in order to uphold public confidence and professional standards.

Example 3

A nurse is providing 1:1 overnight care to a patient who is completely reliant on this care for all of their needs. The patient is considered highly vulnerable and at risk of aspirating, requiring almost constant attention. The nurse is found asleep, having rolled up blankets into pillows and positioned chairs into a makeshift bed. They're also found to have deliberately placed the patient's bed at a 45 degree angle so that their head is below their feet, heightening the risk of aspiration. On being discovered the nurse denies having been asleep and the patient is found to be hypoxic, although they are eventually stabilised. The actions of the nurse placed the patient at risk of harm. By rolling up blankets to use as pillows and positioning chairs to make up a bed, the nurse has acted

deliberately and placed their needs above those of the patient. In these circumstances, where it would be clear to a reasonable and competent professional that the conduct could result in harm to the person receiving care, this could not only lead to a finding of impairment on public safety grounds but it could also undermine the public's trust and confidence in the professions and amount to a departure from professional standards. Such conduct is likely to result in a finding of impairment on these grounds.

Example 4

A referral comes from coroner who was not only critical of care provided by a nurse but who also found that she had lied on oath to the coroner's court. The nurse, an advanced nurse prescriber with an unblemished 25 year career, is found by a panel to have falsified medical records to show that they had prescribed antibiotics to an elderly patient when they hadn't. The patient was also diagnosed as suffering from sepsis which lead to their death. When asked questions about the incident, whilst under oath at the subsequent coroner's inquest, the nurse persisted in this falsehood and her account was discredited by the coroner. The panel determined that the nurse had missed clear warning signs of infection and also the fact that the nurse had deliberately misled the coroner's court was found proved.

The nurse's conduct amounts to a serious breach of the code. Where professionals have deliberately breached the professional duty of candour by covering up when things have gone wrong, especially where it could cause harm to people receiving care a finding of impairment is likely to be made.

The actions of the nurse in failing to identify clear warning signs may be remediable, and may have been remediated through strengthened practice, but falsifying medical records and persisting with this falsehood by lying to the coroner's court increases the seriousness of the matter and could also amount to a breach of the duty of candour. The actions of the nurse undermine the public's trust and confidence in the profession and mean that a finding of impairment is likely to be required to uphold public confidence and professional standards.

Example 5

We receive a referral about an incident that occurred 8 years previously. The nurse was working in a prison when they were told a prisoner had ingested an unknown substance. The documentation from the incident is unclear, due to poor record keeping by the nurse. There is no evidence of her examining the prisoner, who was subsequently returned to his cell because of staffing pressures in prison. The documentation appears to indicate that the nurse stopped observations on this prisoner. However, she maintains she did examine the prisoner and told the prison officers to 'keep an eye' on him. Prisoner was found unconscious the next morning and required hospitalisation to stabilise his condition.

The matter is investigated by the NMC and progresses to a FtPC hearing.

At the FtPC the charges are found proved and to amount to serious professional misconduct. The nurse demonstrates insight into her past practice and recognises the gravity of what she did by failing to ensure further observations were carried out and by failing to keep clear accurate notes, as well as the harm it caused to the prisoner. She also acknowledges the risk of harm that would occur to prisoners generally through poor record keeping and clinical practices because of their vulnerability as prisoners and their dependence on clinicians to safeguard them and tells the panel that this now shapes her practice as a nurse. She provides testimonials from colleagues who know about the incident and have discussed it with her. She provides evidence of how she's strengthened her practice by taking courses directly relevant to the conduct. She provides evidence demonstrating what she's learned on these by providing examples of how she's incorporated what she's learned into her everyday practice.

The nurse provides insightful evidence and does not deflect responsibility for her actions, having engaged openly and honestly with the prison ombudsman enquiries and with the NMC. Evidence is also provided from witnesses who corroborate that they have discussed the incident with the nurse. Witnesses also attest to the fact that there were significant staffing shortages and systemic issues at the prison at the time of the incident that affected clinical practices. Her employer confirms that since the incident occurred, she's worked without any clinical concerns and is a valued and effective member of their team. They have no concerns about her record keeping or clinical practice.

Taking all the above factors into account, while the nature of the misconduct was serious the evidence of strengthened practice since the incident occurred, and contextual factors, suggests that the risk of the conduct being repeated in future is low and a finding of impairment to ensure the public's confidence in the professions may not be required in this instance.

Example 6

A community nurse is caring for a vulnerable patient at home. The patient lacks capacity. The nurse steals money from the patient and is subsequently arrested and charged by the police and is later convicted of theft although avoids a custodial sentence.

The conduct amounts to a serious breach of the code. Financial abuse of those receiving care, not only poses a risk of harm to them but it is also capable of significantly undermining the public's trust and confidence in the professions as well as professional standards. The professional's conduct brings the nursing profession into disrepute and amounts to a breach of the fundamental tenets of the profession. Conduct such as financial abuse of those receiving care by a professional will lead to a finding of impairment.

Example 7

Over the course of several months a nurse repeatedly makes sexualised comments to two health care assistants whom they line manage as well as often touching them on the legs and arms. The nurse often waits until the female staff members are alone and continues the conduct despite the staff members making it clear that this makes them feel uncomfortable.

The conduct of the professional amounts to a serious breach of the code. It not only poses a risk of serious harm to more junior and vulnerable colleagues due to the power imbalance in their relationships, but appears to be premeditated and related to a harmful deep seated attitudinal issue. While the conduct wasn't directed at people receiving care, it has placed colleagues at unwarranted risk of harm and may amount to a deep seated attitudinal issue that could pose a risk to the public in their professional practice. Not only may their conduct pose a risk of sexual misconduct towards those receiving care, sexual misconduct can also undermine relationships between professionals, which can impact on the standard of care they deliver. Such conduct is capable of undermining the public's trust and confidence in the professions and professional standards.[7]

Example 8

A midwife is investigated by their employer after being reported for having posted discriminatory comments on an open social media account. These comments are anti Muslim and openly label all Muslims as criminals and terrorists and call for all Muslims to be "kicked out of the country".

Whilst there may not be any direct evidence that the midwife has ever behaved in a discriminatory way towards those receiving care, and there may be no evidence of deficient clinical practice, the comments demonstrate a deep-seated attitudinal issue given the language used. In this example more weight will be given to the risk of harm to the public's confidence in the professions and the need to uphold professional standards.

Providing reasons for a decision on impairment

Where the Fitness to Practise Committee reaches a decision on impairment, they should clearly articulate their reasons for coming to their decision. The reasons should include a comprehensive explanation of the factors they have considered and their conclusions in relation to those factors.

It is essential that the Fitness to Practise Committee demonstrates that they have considered the future risk that the professional poses to people receiving care and any risks to public confidence and professional standards. Where there is a finding of impairment, the reasons for that finding should be clear.

Likewise, where the Committee finds the allegations proven, but reaches a decision of no impairment, they will clearly need to explain why no finding of impairment is required, taking into account considerations of public safety, public confidence and professional standards.

1 CHRE v NMC and Grant - Paragraph 76 Mrs Justice Cox referring to Dame Janet Smith in her Fifth Report from The Shipman Enquiry
2 Cohen v GMC [2008] EWHC 581 (Admin) para 63
3 Professional Standards Authority for Health and Social Care v Health Care Professions Council (Roberts) [2020] EWHC 1906 (Admin)
4 Lusinga v NMC [2017] EWHC 1458 (Admin)
5 PSA v (1) GMC (2) Uppal [2015] 1304 (Admin)
6 Yeong v GMC [2009] EWHC 1923 (Admin)
7 PSA v Yong and HCPC [2021] EWHC 52 (Admin)

Consensual panel determination

Reference: DMA-2 Last Updated: 23/06/2021

A consensual panel determination takes place when we agree with the nurse, midwife, or nursing associate that their fitness to practise is impaired and what the appropriate sanction is for their case. The nurse, midwife or nursing associate must admit the factual allegations against them. We'll also agree on any interim order that might be required.

This agreement is put in writing, and we then ask a panel to approve the provisional agreement we've reached.

The provisional agreement will usually be considered by a panel at a meeting but could be considered at a hearing if the nurse, midwife or nursing associate asks for one.[1] (See dealing with cases at meetings or hearings.)

We use consensual panel determinations to help to resolve cases more quickly and easily.

The panel will make its own decision about whether the nurse, midwife or nursing associate's fitness to practise is impaired, what sanction, if any, to impose, and whether an interim order[2] is required.

1 The provisional agreement may also be considered at a hearing if one is considered 'desirable'. This is unlikely to be the case given the nurse, midwife or nursing associate will have accepted the factual allegations against them, that their fitness to practise is impaired and agreed with us the appropriate sanction to be imposed and any interim order.
2 See our guidance on 'Interim orders after a sanction is imposed'

Essential criteria

Reference: DMA-2a Last Updated: 27/02/2024

In this guide

- Overview
- Admission of the facts
- Admission of impairment

Overview

We'll only consider a consensual panel determination agreement where:

1. we are satisfied that there is enough evidence to enable the Fitness to Practise Committee to make a finding of impairment;
2. the nurse, midwife or nursing associate accepts the facts of the allegation and that their fitness to practise is impaired.

Usually it will be appropriate to wait until we have completed our investigation before considering whether a consensual panel determination will be appropriate. If the professional agrees with the outcome of our investigation and our proposed sanction it will often be appropriate to refer the matter directly to a panel for a consensual panel determination, rather than referring the matter to the case examiners for a case to answer decision.

Admission of the facts

A nurse, midwife or nursing associate must accept the facts of the allegation in full. We won't drop serious parts of the factual allegation in exchange for admissions to other parts.

If parts of the factual allegation don't increase the overall seriousness of the case, or it's highly unlikely parts of the factual allegation can be proved, we'll consider no longer proceeding with that part of the allegation.

Admission of impairment

As well as admitting the factual allegations, the nurse, midwife or nursing associate must also accept that their fitness to practise is impaired. This includes accepting the grounds on which their fitness to practise is impaired, for example, in a misconduct case accepting that the factual allegations amount to misconduct.

This shows a level of insight that's essential for a sanction to be agreed and for the case to be resolved by a consensual panel determination agreement.

The process

Reference: DMA-2b Last Updated: 27/02/2024

In this guide

- Agreeing a consensual panel determination
- Comments from the referrer
- What happens at the meeting or hearing?

Agreeing a consensual panel determination

We first consider if the nurse, midwife or nursing associate has met the essential criteria. If they meet the criteria, we consider if the nurse, midwife or nursing associate has legal advice or representation.

If there are concerns about the nurse, midwife or nursing associate's ability to understand the effects of seeking a consensual panel determination, we'll try to resolve them, and may recommend that they seek legal advice. If it's not possible to resolve those concerns, it might not be possible to pursue a consensual panel determination.

If the case is suitable to be resolved by a consensual panel determination agreement, we'll reach a provisional view on the appropriate sanction level.

We do this by assessing all the circumstances of the case with reference to our sanctions guidance. We'll share our view on the sanction with the nurse, midwife or nursing associate, including if we think an interim order is necessary.

If, after discussing the sanction with the nurse, midwife or nursing associate we can't agree on the appropriate level of sanction, the case will proceed to a meeting or hearing without any consensual panel determination agreement.

If we're able to agree on the appropriate level of sanction, we'll then prepare a provisional agreement. This will include a statement of the facts, why we consider that their fitness to practise is impaired, the proposed sanction and any interim order that may be required. The nurse, midwife or nursing associate must confirm that they agree the contents of the provisional agreement.

Either party can decide they no longer want to resolve the case with a consensual panel determination agreement at any time before it's taken to a meeting or hearing.

If this happens, the case will proceed to a meeting or hearing, which will take place without any consensual panel determination agreement in place. The panel won't have sight of the draft agreement.

Comments from the referrer

We'll always let the person who referred the case and any interested parties (such as family members) know what we've provisionally agreed with the nurse, midwife or nursing associate. We'll usually share the entire agreement unless there's any private or confidential information that would be considered by the panel in private, in which case, we'd redact that information in line with our Information Handling guidance.

We'll ask the person who referred the case to send us any comments they might have about the proposed agreement so that we can consider their views. We might also ask the person who's been affected by the case to send any comments they have about the proposed agreement so that we can consider their views too.

We don't ask for comments where the referrer is the police force referring a conviction or caution unless the force

or its personnel have had significant and ongoing involvement in the case.

We will always carefully consider any comments provided by a referrer. This can sometimes lead us to reconsider our view of the case. If that happens, we'll try to reach a new agreement with the nurse, midwife or nursing associate. If we can't reach a new agreement, the case will go to a meeting or hearing without any consensual panel determination agreement.

If we can reach an agreement, then the case, including the revised proposed agreement, will be considered by the panel. This will usually be at a meeting but can be at a hearing if the nurse, midwife or nursing associate asks for a hearing.

At the meeting or hearing, we'll usually provide the panel with any comments from the referrer so the panel can take those comments into account in reaching its decision.

If there are comments from the referrer we don't think are fair or relevant for the panel to see, we may not provide them to the panel. For example, if the referrer makes new allegations that weren't part of the allegations which form the basis of the proposed agreement, we wouldn't share that information with the panel. Instead, we'd consider treating the new allegations as a new referral.

We'll let the referrer know if we don't think we can share some or all of their comments with the panel, and we'll explain why.

If we're sharing the referrer's comments with the panel, we'll always share them with the nurse, midwife, or nursing associate first so they can raise any concerns or objections.

If a referrer insists that their comments aren't shared with the nurse, midwife or nursing associate, we won't be able to share those comments with the panel or the nurse, midwife or nursing associate.

What happens at the meeting or hearing?

The provisional agreement will usually be considered by a panel at a meeting, but can be considered at a hearing if the nurse, midwife or nursing associate asks for one.

At a meeting, the nurse, midwife or nursing associate won't be in attendance, and there won't be a case presenter.

Where a panel considers the agreement at a hearing, the nurse, midwife or nursing associate will be able to attend, and our case presenter will be in attendance.

At the meeting (or hearing), the panel will be provided with the consensual panel determination agreement and should consider all aspects of it.

When the panel considers the agreed statement of facts, it will need to be satisfied that it has a clear picture of the factual background. The panel might request more information if it thinks our agreed statement of facts hasn't made clear, or covered sufficiently, the substance and details of what went wrong.[1]

The panel should exercise its own independent judgement to decide whether the nurse, midwife or nursing associate's fitness to practise is impaired (including the reason for impairment, for example, whether their behaviour amounted to misconduct), what sanction, if any, to impose using our sanctions guidance, and whether it's necessary to impose an interim order. The panel isn't bound by the agreement, but it must consider the agreement carefully when reaching its decision.

We'll only put forward a provisional agreement for consideration where we consider that it sets out a reasonable, proportionate and fair outcome.

The panel can decide to:

- accept the provisional agreement, or
- reject the provisional agreement.

Accepting the provisional agreement

Before the panel accepts the provisional agreement it should be satisfied that:

- the facts are found proved by admission, (or at a hearing, announce that the allegation is proved by admission) and,
- the nurse, midwife or nursing associate's fitness to practise is impaired by reason of the relevant ground of impairment.

The panel should also impose the sanction and any interim order as set out in the provisional agreement

Rejecting the provisional agreement

The panel may make a different decision about whether the nurse, midwife or nursing associate is impaired, what sanction to impose, and what interim order to impose. However, the provisional agreement should always form the starting point for the panel's decision-making. Where the panel reaches a different conclusion, it must provide clear reasons for doing so.

Where the panel disagrees with the conclusions set out in the provisional agreement, the outcome will depend on the nature of the disagreement and if the matter is being considered at a meeting or a hearing.

Based on the admitted facts, if the panel decides that the nurse, midwife or nursing associate's fitness to practise isn't impaired, it should make that finding and close the case. The panel is free to decide to impose a less restrictive sanction than proposed in the provisional agreement. They can do this without any adjournment being necessary (this applies to both meetings and hearings).

If the panel is considering the matter at a meeting and wishes to impose a more restrictive sanction than the one proposed, it should adjourn the matter. The case will then be considered by another panel at a hearing. The nurse, midwife or nursing associate should then be advised of the reasons given by the first panel about why they consider a more restrictive sanction might be required.

When the second panel considers the matter following an adjournment at a meeting, the nurse, midwife or nursing associate will have the opportunity to make any further submissions in writing or in person. The second panel must consider the terms of the provisional agreement afresh and shouldn't be influenced by any views expressed by the first panel. The panel should consider any further views expressed by us, the nurse, midwife or nursing associate and/or their representative.

If the panel is considering the matter at a hearing and wants to impose a sanction that is more restrictive than the one proposed in the provisional agreement, it must:

- first indicate that it is considering a more restrictive sanction, and
- give both our case presenter and the nurse, midwife, nursing associate and/or their representative the opportunity to comment.

If the nurse, midwife, nursing associate or their representative agrees to the more restrictive sanction, the panel can continue to impose the sanction. The CPD will count as being rejected, and the matter adjourned to a full hearing if the nurse, midwife, nursing associate, or representative don't agree to a more restrictive sanction. This includes if they aren't in attendance and can't be contacted to ask for their consent.

We would encourage the nurse, midwife or nursing associate or their representative to attend any CPD hearing. If they don't attend the hearing, they should be contactable by phone or video link to address anything that may arise on the day of the hearing. These arrangements should be made ahead of the hearing.

The panel's reasoning

The panel should provide clear reasoning for its decisions on why the nurse, midwife or nursing associate is impaired (including the reason for impairment, for example, why their behaviour amounted to misconduct), the appropriate sanction, and whether an interim order is necessary. This should include how the outcome protects the public and satisfies any public interest.

The panel may adopt the agreement's reasoning, and should explain which parts of the agreement it accepts and why. If it disagrees with any part of the agreement, the panel should explain which parts it disagrees with and identify clear reasoning and justification for doing so.

If the panel has had sight of comments from the referrer, then it should explain in its reasoning how the panel has considered these comments as part of its decision making process.

The panel should include the full consensual panel determination agreement in its decision document, even in cases where it disagrees with the conclusions reached. As that agreement reflects what's been agreed between the parties, it's better practice for the panel to express its decision and views separately after the text of the agreement, rather than altering the original agreement. The panel may correct typographical or spelling errors within the agreement.

Where the panel decides that the nurse, midwife or nursing associate's fitness to practise is impaired and imposes a sanction, we'll publish the panel's reasons, including the consensual panel determination agreement, in line with our Fitness to Practise Publication Guidance.

Requests for further information

Consensual panel determinations will usually be considered at meetings unless the registrant has specifically requested a hearing. If the panel decides it needs clarification or further information on an issue, it should consider postponing or adjourning the meeting with directions. This is so that the matter can be looked into, and if necessary further submissions, documents or evidence can be sent to the panel.

Taking such a step is more proportionate than referring the case to a hearing when it might not be needed to resolve the issue.[2]

At a hearing, if the panel decides that it needs clarification or further information on an issue, it should raise this with the parties before deciding to accept or reject the provisional agreement. Our case presenter and the nurse, midwife or nursing associate can then address the panel on the points raised.

1 Professional Standards Authority v (1) Nursing and Midwifery Council (2) Jozi [2015] EWHC 764 (Admin) at [22] and [33].

2 At a meeting, the panel has the power to determine its own procedure under Rule 10(4) Fitness to Practise Rules 2004

Offering no evidence

Reference: DMA-3 Last Updated: 01/09/2025

In this guide

- What is offering no evidence?
- Where part of the charge doesn't make the case more serious
- No realistic prospect of proving the facts of the case
- No realistic prospect of fitness to practise being impaired
- Informing the referrer about a decision to offer no evidence
- Offering no evidence: the panel's decision making process
- What happens after the panel's decision?

What is offering no evidence?

We keep all cases under review while we prepare them for the Fitness to Practise Committee. Sometimes, as part of that review, it becomes clear to us that it wouldn't be in the public interest to carry on with all or part of the case. In limited circumstances it may be appropriate for us to use our power to 'offer no evidence'.[1] This means that we'll ask a full panel of the Fitness to Practise Committee to approve our decision not to continue with all or part of the case against a nurse, midwife or nursing associate. We will only offer no evidence in a particular case if it fits with our overarching objective.

We'll only apply to offer no evidence against a nurse, midwife or nursing associate in the following circumstances:

- When a particular part of the charge adds nothing to the overall seriousness of the case.
- When there is no longer a realistic prospect of some or all of the factual allegation being proved.
- When there is no longer a realistic prospect of a panel finding that the nurse, midwife or nursing associate's fitness to practise is currently impaired.

It will be up to the panel to decide whether it agrees that it's appropriate for us to offer no evidence, and not continue with all or part of the case against the nurse, midwife or nursing associate. When we ask a panel to do this and the case is at a hearing, we will open our case and fully explain the background, and our reasons for offering no evidence. If the case is being considered at a meeting we will set this out clearly in our statement of case.

In some circumstances we may apply to offer no evidence on part of the charge in a case where we've agreed a consensual panel determination with the nurse or midwife. If we are doing this we'll make it clear that we want to offer no evidence, and fully explain our reasons, in the text of the draft agreement between us and the nurse, midwife or nursing associate.

Where part of the charge doesn't make the case more serious

If we're satisfied that one or more of the alleged facts against the nurse, midwife or nursing associate doesn't add anything to how serious the case against them is, we may decide to offer no evidence on those parts of the charge. We won't do this unless we're satisfied that the remaining parts of the charge properly reflect the extent of our concerns about the nurse, midwife or nursing associate's fitness to practise, and the evidence about them. We'll need to consider the risk of harm to patients, or the public's trust in nurses, midwives and nursing associates that could arise from what the nurse, midwife or nursing associate is alleged to have done.

No realistic prospect of proving the facts of the case

It's not in the public interest for us to pursue factual charges against a nurse, midwife or nursing associate if there isn't enough evidence to prove them. Offering no evidence because there isn't enough evidence to prove the facts, so that there's no longer a realistic prospect, will only be appropriate if:

- the state of the evidence has changed since case examiners made a finding of case to answer[2]
- it has become apparent that the case examiners' decision was made on an incorrect basis
- the charge relies on the evidence of a witness who cannot attend a hearing, and an application to rely on their statement as hearsay evidence has been rejected
- the case was referred directly to the Fitness to Practise Committee, and since then, our investigation has shown that it is no longer in the public interest to continue with the allegation or part of the allegation.

No realistic prospect of fitness to practise being impaired

We'll only consider offering no evidence because there's no realistic prospect of the panel deciding that the nurse, midwife or nursing associate's fitness to practise is currently impaired if:

- it's become clear that the case examiners' decision was made on an incorrect basis, or
- new evidence about the nurse, midwife or nursing associate's current fitness to practise has emerged, for example evidence about the context in which the incident occurred or evidence of their insight and any steps they've taken to strengthen their practice.

The passage of time may be a relevant change in circumstances. However, the nurse, midwife or nursing associate would need to show that they have worked in a professional capacity, using their registration. The application will often be supported by evidence from the professional showing that they have addressed the concerns raised about their practice. However, this is not a requirement in every case. Sometimes the evidence that the nurse, midwife or nursing associate has continued in unrestricted practice with no further concerns raised, will be sufficiently compelling to support a decision to offer no evidence. We will always 'offer no evidence' where we consider that there is no longer any realistic prospect of the professional's fitness to practise being found to be impaired.

Informing the referrer about a decision to offer no evidence

If we've decided to offer no evidence, we'll tell the person who first referred the nurse, midwife or nursing associate to us about this, if we can do so without risking any unfairness or prejudice at a future hearing (which could happen, for example, if that person was a witness in the case).

If that person is a witness in the case, we will decide what information we can give them. Our general approach is that we should give them as much information as we possibly can, while making sure the future hearing is fair. Ideally, we'll be able to explain our reasons for offering no evidence fully. We'll always tell them that the panel might decide to reject our application, and proceed with the charge of its own accord.

If the person who first referred the nurse, midwife or nursing associate to us provides us with any comments about our decision we will place these before the panel if they are relevant, and if it would be fair to do so.

There will be cases where it won't be possible for us to fully explain our decision to offer no evidence before the meeting or hearing. If this happens, we will let the person who referred the concerns to us know, before the meeting or hearing, that we have decided to offer no evidence. We will then give them a full explanation for our decision after the meeting or hearing.

Offering no evidence: the panel's decision making process

If we're offering no evidence at a hearing, before the charges are read out, we will tell the panel that we intend to offer no evidence to all or part of the charges. This means that when the charges are read out, the panel won't ask the nurse, midwife or nursing associate for a response to the charge(s) we're offering no evidence on, until it has heard and decided our application.

When we offer no evidence, we'll invite the panel to consider the steps we've taken to obtain the evidence relevant to the facts, the nature of the evidence, and what evidence was considered by the case examiners. If the case is being considered at a hearing our case presenter will give the panel a full opening statement so the panel clearly understands the case, and why we are offering no evidence on all or part of the charges. Often, the case presenter will provide a written opening of the case which fully and fairly summarises the evidence to the panel. In

some situations the case presenter may decide it is more helpful for the panel to be provided with copies of some or all of the evidence to help it reach its decision. If the case is being considered at a meeting, we'll set out our reasoning in our statement of case.

We will always make the panel fully aware of the steps we took during the investigation, including any problems we encountered, and what we did about them. When we do this, we consider that we have a duty of good faith to fairly explain how serious the allegations were, and why we no longer intend to pursue them.

In very rare cases, the charges we want to offer no evidence on might be so serious that they would make it unfair for the same panel to go on and hear the rest of the case. If that happens, we will arrange for a separate panel to deal with the full hearing or meeting.

Where the case is being dealt with at a hearing, the panel will ask the nurse, midwife or nursing associate if they have anything they wish to say to the panel about our application. The panel will be given legal advice before they make a decision on our application.[3]

If the panel is not satisfied with the application to offer no evidence, it can still call evidence of its own motion.[4]

When it is considering whether to call evidence on its own, the panel may find that our guidance on directing further investigation during a hearing is helpful. If necessary, the panel would have to adjourn the hearing (or refer the case to hearing if it is at a meeting) to make sure witnesses can attend and give evidence. In some cases it may be appropriate for the panel to decide that this evidence will be heard by a different panel if this would be fairer to all parties.

What happens after the panel's decision?

If the panel does not approve of us offering no evidence, and either calls evidence on its own or directs us to carry out further investigation, the hearing will proceed (possibly after an adjournment to allow us time to investigate or arrange for witnesses to attend).

If we have offered no evidence on the whole of the charge against the nurse, midwife or nursing associate, and the panel agrees with our application, the panel will decide that the allegation is not well founded, and give its reasons. That will bring the case against the nurse, midwife or nursing associate to an end, and no findings will be made against them. The charge can only then be re-opened if there is a successful appeal to the courts against the panel's decision.

If we have offered no evidence only on parts of the overall charge against the nurse, midwife or nursing associate, and the panel agrees with us, the panel will provide reasons for its decision. It can then amend the charge[5] to remove those parts of the charge on which it has approved our application to offer no evidence. The nurse, midwife or nursing associate will not then have to answer those parts of the charge, and they will no longer form part of the allegation against them.

1 PSA v NMC & X [2018] EWHC 70 (Admin) para 55-57
2 For example, a witness may refuse to attend a hearing. We may have been aware that the witness was reluctant to engage at the case examiner stage and the case examiners may still have found a case to answer. Where this happens, it is still likely to amount to a change in the state of the evidence because we will have had the opportunity to consider any reasonable adjustments or measures to address the witness' concerns and to encourage them to attend.
3 Legal advice is likely to refer to the case of PSA v NMC & X [2018] EWHC 70 (Admin). This case also makes clear at paragraph 56 that R v Galbraith [1981] 1 WLR 1039 is not relevant to this type of application.
4 Rule 22(5) of the Rules
5 Under rule 28(1) of the Rules

Abuse of process

Reference: DMA-4 Last Updated: 21/02/2019

In this guide

- What is an abuse of process?
- How does the panel decide if there is an abuse of process?
- Abuse of process arguments
- Unreasonable delay
- Incomplete or non-disclosure of information
- Retracting a promise
- Bad faith or serious breach of professional duty

What is an abuse of process?

It's a claim that the case has been unfairly progressed and should be stopped. This can be made by a registrant or raised by a panel.

This guidance explains the circumstances in which it may be appropriate for a panel to use its power to stop a case as an abuse of process.

A nurse, midwife or nursing associate can make an abuse of process application at any stage of the panel's decision-making process. They can make the argument about the whole case against them, or about part of the case. Equally, a panel may decide on its own that there has been an abuse of process.

If the nurse, midwife or nursing associate makes the application, they will only succeed if they can show that it's more likely than not that the alleged abuse of process can't be properly rectified in any other way than to stop the case.

How does the panel decide if there is an abuse of process?

The panel can decide there is an abuse of process if:

- it will be impossible for the nurse, midwife or nursing associate to have a fair hearing, or
- continuing with the case would, in all the circumstances, offend the panel's sense of 'justice and propriety'.[1]

In deciding whether there has been an abuse of process which means the case should be stopped, the panel will consider whether the alleged abuse of process (such as delay, or a failure to disclose evidence) has caused serious prejudice or unfairness to the nurse, midwife or nursing associate.

In accordance with its overarching public protection objective, the panel will also consider whether there are ways of putting right the serious prejudice or unfairness, so that the nurse, midwife or nursing associate can have a fair hearing without stopping the case.

See some examples of the various types of abuse of process arguments that have been considered by the courts, below.

Abuse of process arguments

Unreasonable delay

The nurse, midwife or nursing associate's right to a fair hearing under human rights legislation includes a right to

having their case heard within a reasonable time, [2] so the length of any delay is a relevant consideration for the panel.

For our purposes, the relevant time runs from when we first notified the nurse, midwife or nursing associate that we were sending their case for an investigation.[3]

The panel will only use its power to stop all or part of a case due to delay, in exceptional circumstances. This could be where there is real prejudice to the nurse, midwife or nursing associate which means that a fair hearing would be impossible because of the delays.

In an argument about delay, the panel will hear submissions from the nurse, midwife or nursing associate, and from us, on the circumstances leading up the application.

These will include the chronology of events, any possible reasons for delays, the way the nurse or midwife engaged with our process, and what any external third parties did or failed to do.

Unreasonable delay will be a possible abuse, if the period of the delay gives grounds for 'real concern'.[4]

In considering this, it will be relevant to consider the effect of the delay on the proceedings and any unfairness it could cause to the nurse, midwife or nursing associate.[5]

If the delay affected the memory or availability of witnesses or documentary evidence, these may be factors the panel takes into account in deciding whether the delay means it's no longer possible for the nurse, midwife or nursing associate to have a fair hearing.

It will also be relevant to consider the stage the hearing has reached, and what steps we could take to lessen the effect of the delay and make sure a fair hearing is still possible.[6]

If the panel could make a direction, or the parties could take a particular course of action to put the unfairness right, it will be important to explore those options before the panel decides that the hearing should be stopped as an abuse of process.

The complexity of the case or delay caused by a nurse, midwife or nursing associate will not be a reason to stop all or part of the proceedings.[7]

Incomplete or non-disclosure of information

When we are investigating a nurse, midwife or nursing associate's fitness to practise, we need to provide them with enough information to understand the case against them, and to allow them to respond to our concerns.

One relevant factor to consider may be what level of disclosure is 'reasonable' in the circumstances.

Sometimes, where the nurse, midwife or nursing associate cannot reasonably be expected to gather relevant material themselves, we may need to help with this.

However there's no general duty on us, the regulator, to gather evidence on behalf of the nurse, midwife or nursing associate,[8] which would of course determine what evidence we'd have in our possession and what we'd therefore be able to disclose.

For more information about this, see our guidance on disclosure.

Increasingly, we ask the nurse, midwife or nursing associate to tell us about the context around what happened, and we do this early on in our investigation.

In deciding what disclosure is reasonable, it will be relevant to consider how the nurse, midwife or nursing associate initially responded when we asked them to tell us about relevant issues back when we started investigating.

If they refused to engage with our investigation at that stage, it is less likely to be reasonable to expect us to gather information on their behalf, about the same issues, if the case gets as far as a Fitness to Practise Committee panel.

This question will be relevant to whether the nurse, midwife or nursing associate has suffered prejudice or

unfairness.

The panel is responsible for regulating its own proceedings, and has various powers to require us and the nurse, midwife or nursing associate to exchange relevant information. The panel can consider whether to order adjournments, or give directions to obtain evidence, to see whether the issue that is alleged to cause an abuse of process, can be resolved without stopping the case altogether.

The panel can also ask for further information as to why the evidence is incomplete, to satisfy itself as to whether we have acted improperly, or whether the information has simply been lost.

In circumstances where there is evidence of impropriety in us not disclosing information to the nurse, midwife or nursing associate, potentially this could mean there is an abuse of process.

If the evidence before the panel remains incomplete, the panel can also consider its powers to decide what evidence is admissible, as a way of avoiding possible injustice.

It's possible that refusing to admit some of our evidence, because it would be unfair without also seeing or hearing the missing evidence, (which could provide important context), could avoid any injustice or unfairness.

Retracting a promise

Another possible ground for an abuse of process application is that we made a promise or gave the nurse, midwife or nursing associate an assurance, and later retracted it.

Some examples of this might be promising not to proceed with investigations about a particular concern, or promising that we would keep particular information private. There may be other kinds of promise or assurance that it would be an abuse of process to retract.

In some circumstances it wouldn't be an abuse of process for us to investigate and take action about a fitness to practise concern that we've previously told a nurse, midwife or nursing associate that we won't be proceeding with.

For example, there could be new information or evidence that we weren't aware of when we made the first decision that shows we need to take action to prevent the nurse, midwife or nursing associate putting patients or members of the public at risk of harm.

The panel should consider this when trying to assess whether there is unfairness or injustice to the nurse, midwife or nursing associate.

It is relevant that we have specific powers to revisit decisions under our rules[9] and in case law[10] which include decisions made at any stage of our fitness to practise.

When considering promises or assurances we gave to the nurse, midwife or nursing associate, the panel can, if it needs to, ask for information about:

- what assurances we gave
- the level of officer or decision maker
- when in our process we gave the assurance.

Equally, it may also be relevant to consider whether the nurse, midwife or nursing associate could reasonably have relied on the assurance.

For example, if we stated we would not take action about a particular incident we were investigating, but the nurse, midwife or nursing associate then disclosed another more serious concern, would it be reasonable for the nurse, midwife or nursing associate to assume that we would not investigate the new concern?

Possible unfairness or injustice after promises made to nurses, midwives or nursing associates might be able to be resolved by amending charges or some other action to cure the possible unfairness.

As always, the panel is able to consider any reasonable options to address any possible unfairness, before deciding that abuse of process is made out and that the case should be stopped.

Bad faith or serious breach of professional duty

Sometimes, if one of our officers or decision makers acts in bad faith, this could cause an abuse of process, if that bad faith causes prejudice or unfairness to the nurse, midwife or nursing associate meaning they can't have a fair hearing, or that to proceed would be an injustice.

An application based on bad faith will need to include specific examples and evidence of how the nurse, midwife or nursing associate says we've acted in bad faith, or one of our officers breached their professional duty. It will also need to explain how the nurse, midwife or nursing associate says the fairness of our process has been affected.

1 R v Maxwell [2011] 1 WLR 1837
2 Article 6(1) European Court of Human Rights
3 Deweer v Belgium (1980) 2 E H R R 439 - time begins - Attorney – General's Reference (No 2 of 2001) [2004] 2 AC 72 HL – "time runs from the earliest time when the defendant was officially alerted to the likelihood of criminal proceedings being taken against him or her, which would normally be when he or she was charged or served with a summons"
4 Dyer v Watson [2004] 1 AC 379
5 Okeke v Nursing and Midwifery Council [2013] EWHC 714
6 R (Gibson) v General Medical Council and another [2004] EWHC 2781 (Admin) 'mere unreasonable delay, absent prejudice'
7 Haikel v General Medical Council [2002] UKPC 37
8 R (Johnson) v Nursing and Midwifery Council [2008] EWHC 885 (Admin)
9 Under rule 7 of the Fitness to Practise Rules. To find out more, see our guidance on reconsidering closed cases
10 Which allows us to revisit a decision if there has been a fundamental mistake of fact: R (Jenkinson) v Nursing and Midwifery Council [2009] EWHC 1111; Fajemisin v General Dental Council [2013] EWHC 350; R (Chaudhuri) v General Medical Council [2015] EWHC 6621.

Directing further investigation during a hearing

Reference: DMA-5 Last Updated: 23/06/2021

In this guide

- Why should a panel order us to investigate further?
- When should a panel direct further investigation?

Why should a panel order us to investigate further?

In every case that goes to the Fitness to Practise Committee we need to make sure that we have given the panel all the relevant evidence. The panel needs to understand the background including the context in which the incident occurred, consider all the relevant facts and make a fair and fully informed decision that best protects the public.

If this hasn't happened, and there is important evidence available, that is missing, or that we haven't put before the panel, the panel can direct us to get that further evidence. The panel should not consider itself to be 'bound' by that lack of the evidence to find a charge not proved, it should take a more proactive role than a judge in a criminal trial, and where necessary intervene to make sure that cases are properly presented, and request the further evidence.

The panel can use its powers to require people to attend hearings or produce relevant documents[1], or its powers to adjourn the case, as it needs to.

When should a panel direct further investigation?

There are a number of reasons why a panel may direct us to carry out further investigations. These include:

- New information has come to light that neither we nor the nurse, midwife or nursing associate have seen, which could undermine our case, support our case, or support the case of the nurse, midwife or nursing associate.
- The information currently before a panel is obviously incomplete or does not cover all the areas of concern. One example of this could be missing pages from patient notes, or from some other important document.
- Further information is essential to clarify or expand on evidence already obtained
- The nurse, midwife or nursing associate has provided new information about the context in which the incident occurred which would have a material impact on the outcome of the case

If it's clear to the panel that evidence exists that it requires in order to make its decision, but we have not provided it with that evidence, it should consider whether to adjourn the hearing to allow us to gather that evidence. In making this decision the panel should consider the following:

- Whether the evidence is important to an issue it has to decide.
- Whether the evidence needs to be tested, perhaps through asking questions of witnesses.
- Whether the panel can consider its decisions and reach a satisfactory conclusion without this evidence.
- Our overarching duty to protect the public, and the panel's duty to make a decision that satisfies the overarching objective in a fair and proportionate way.
- The overall fairness of the proceedings. As well as the nurse, midwife or nursing associate's right to a fair hearing, this also includes fairness to the people involved in the events the case is about, and fairness to us in exercising our statutory function of protecting the public.
- The public interest in the expeditious disposal of the case and the potential inconvenience caused by any delay to the registrant and any witnesses.[2]

If after considering all of the above the panel considers that the further evidence is needed to help it decide an important issue in the case and will help it make a decision that best protects the public, it should order us to carry out the further investigation.

When further evidence is received during a hearing, panels may need to consider whether to amend the charge.[3] When considering whether to amend a charge, the panel will consider the fairness in doing so and the overarching objective to protect the public.

1 Rule 22 (5) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules')
2 Rule 32 (4) Nursing and Midwifery Council (Fitness to Practise) Rules Order of the Council 2004
3 Rule 28 Nursing and Midwifery Council (Fitness to Practise) Rules Order of the Council 2004

Evidence

Reference: DMA-6 Last Updated: 09/06/2025

In this guide

- Overview
- Admissibility of evidence
- Other investigations or proceedings
- Consistency of accounts
- How evidence is given to a panel
- Who decides what evidence is admissible
- Weight
- Credibility
- Burden of proof
- Hearsay
- No case to answer
- When should panels resolve disputes regarding context
- Further evidence

Overview

One of the Fitness to Practise Committee's (FtPC) most important functions is to resolve disputes between the NMC and the nurse, midwife or nursing associate. Unless the nurse, midwife or nursing associate admits the charges against them, or agrees with our evidence, the panel will need to decide what happened.

This will include resolving whether a contextual factor was present as a matter of fact if it is disputed, and if the contextual factor would have a material impact on the outcome of the case. Panels resolve disputes using the evidence that is put before them.

If we can't agree any part of our case, we will attempt to prove it by putting evidence before the panel. The nurse, midwife or nursing associate is also able to put evidence before the panel in support of their position.

Admissibility of evidence

The only evidence that may be provided to the panel is evidence which is relevant to one of the issues the panel needs to decide. It also needs to be fair to the people involved in the case, including patients, family members and loved ones, the nurse, midwife or nursing associate and us as a regulator, that the panel considers that evidence.

Evidence *may* be unfair where it cannot be challenged.

For example, this could be where the person who gives the evidence cannot be questioned, or where it relates to a subjective opinion as opposed to an objective (although possibly disputed) fact.

Other investigations or proceedings

Often another organisation or body[1] will have carried out some form of investigation into the matters being considered by the panel. It may even have reached a decision on the same or similar issues. For example, we sometimes need to investigate incidents that the police have investigated but have not resulted in a conviction, or conduct or circumstances that are closely related.

Both the material generated in the other investigations/proceedings and the decision itself could be admissible in

NMC proceedings.

Material gathered in the course of other investigations or proceedings

If it is relevant to the regulatory allegations or necessary to understand the wider background, evidence generated by or put before another organisation or body could be admissible in NMC proceedings. It can be presented to a panel and form part of the bundle[2]. Such material can include statements of fact and expressions of expert opinion.

It is for the FtP Committee to decide what weight to give to this evidence, using its expertise and experience as an independent panel.

One reason why we might put such evidence before a panel is that there are inconsistencies between accounts a witness or professional has given at different times and in different proceedings. Inconsistencies between accounts can be relevant to a panel's assessment of witness credibility.

Sometimes, where a witness has provided a detailed account of events in other proceedings and is happy to confirm its truth in a brief statement, their adoption of a previous account (with or without any further comment) can be more efficient and avoid unnecessary distress.

When we are investigating a concern and know or suspect that such material exists we will usually seek it out, unless we are sure there is no need to do so – for example, the professional is no longer on the register or the referral is manifestly unfounded. If that material is relevant we will consider putting it before the panel.

Findings of other organisations or bodies

If a professional has been convicted of a crime or another health or social care organisation has made adverse findings against them, the NMC can always rely on these decisions when seeking to prove the underlying facts they are based on[3].

In all other instances, it will be a matter for the panel whether to admit the findings of other organisations or bodies[4].

When considering whether to admit evidence of findings made by another body, the panel will need to address the following:

1.
2.
    This assessment should consider, among other things, how rigorous and fair were these other proceedings – for example, was there full argument, live evidence and cross-examination; was it a decision of a court or tribunal. Similarly, the panel might also consider the extent to which the professional was on notice that findings relevant to their practice may be made and what, if any, opportunity they had to respond.

The way such findings can be used, *if* admitted, is limited.

Decisions of third parties can be put before a panel for two reasons: to help explain or give necessary narrative in proceedings or, in rarer cases, such decisions might be given some (limited) value as evidence of facts alleged.

Conclusions reached by a court of law or judicial inquiry (such as Coroners proceedings) are more likely to be admitted as *prima facie* evidence of the facts they have established[5] than findings of other bodies. However, normally they will not be admissible, or raised only for their narrative value.

The fact that another body has found certain matters proved does not mean that the panel can simply adopt those findings. It must not use the findings of another body as a substitute for reaching its own decision on the issues before it. The panel must reach its own view and own conclusions having regarded all the relevant evidence. It must allow the nurse, midwife or nursing associate to argue their case and rely on their own evidence. It can be unfair for the judgments to significantly influence the tribunal's mind on the crucial issues before it for the same reasons[6].

Findings by non-judicial bodies, such as an employer's disciplinary process, on the issues the FTP panel would need to decide, or matters very closely related, cannot usually be fairly admitted. Where necessary they might instead be included to provide narrative background or establish related facts[7]. In some cases, for example, it

might be important for the panel to know that a professional was disciplined and sanctioned at a certain point, because it is relevant to what happens next.

Consistency of accounts

As well as consistency with known or accepted facts and consistency within the account itself, decision-makers can better judge an account's credibility by looking at its consistency with other accounts given by the same witness. This is one way in which evidence from other proceedings or investigations might be relevant to, and relied upon in, NMC proceedings.

A panel should closely consider any inconsistencies, assess evidence as a whole (including other factors going to credibility), and draw its own conclusions accordingly. Though it is entitled to find that since a witness is not reliable on one point of their evidence, they are not reliable on others[8], inconsistencies, unreliability or even evident fabrication in part of witness evidence does not automatically mean that everything they say is unreliable[9].

Inconsistencies between accounts could be attributed to numerous factors, including the passage of time, trauma of events[10] and neurodiversity.

Panels looking at concerns of sexual misconduct, or indeed any major trauma, should have in mind the CPS guidance on myths and stereotypes surrounding rape and other forms of sexual misconduct. In particular:

- Inconsistencies in accounts can happen where a person is telling the truth or not.
- Avoid an either/or argument that allows a complainant's evidence to be wholly dismissed because of a peripheral or small inconsistency. Don't present your argument as either you should believe the professional or the complainant for this reason.
- Rape can be very traumatic and memory can be affected in a number of ways. Understanding the effects of fear and the psychological mechanisms that may occur during a sexual assault is vital when considering recall and memory. Some, understandably, may try to avoid thinking about being raped or try to avoid recalling it all – this can impact upon recall.

How evidence is given to a panel

Evidence can be given to a panel in several different ways. What is important is that the panel can fairly consider the case before them.

At a meeting, evidence is in the form of written statements and documents. At a hearing, people might speak to the panel to give evidence and to answer any questions that we, the nurse, midwife, nursing associate or the panel may have. This will usually happen if there is a dispute over the facts in the case.

Our rules don't dictate how evidence should be given and people can give evidence to a panel in a number of ways. This includes attending a hearing centre, over video-link or by telephone.

A decision to hold a hearing at a hearings centre does not mean that a person needs to attend to give evidence 'in-person'. How a person gives evidence will be a separate decision.

In most circumstances, there is no disadvantage in someone giving evidence by video-link compared to appearing in the same room as the panel[11]. In some cases it may be better to give evidence by video-link rather than over the telephone, although telephone evidence may still be considered a fair way for the witness to give their evidence.

There is no requirement for witnesses located outside the UK who wish to give oral evidence remotely in hearings before our panels to seek prior permission from the authorities in the country from which they are giving their evidence.[12]

we'll consider what's fair and practical for the hearing in deciding how they will give their evidence. This includes if they have the right technology and any personal circumstances that might prevent their participation at the hearing centre or remotely. The Equal Treatment Bench Book may assist you when considering this. This resource provides guidance and advice on how to make hearings accessible and fair for every person involved.

We'll inform the nurse, midwife or nursing associate who is subject to the proceedings (and their representative)

in advance of the hearing how it is intended our witnesses will give evidence.

If the nurse, midwife, nursing associate or their representative object to how it is intended a witness will give evidence, we'll try to resolve any disagreements in advance of the hearing. We'll do this by arranging a preliminary meeting as soon as possible so a chair of the FtPC can decide how that witness should attend.[13]

The chair will hear from both sides. They'll also consider what benefit there might be in requiring a witness to attend our hearings centre, bearing in mind any concerns the witness may have about this. Ultimately, the decision for the Chair (or panel if an issue arises about how a witness is to give evidence at a hearing) will be whether a fair hearing can take place with the witness giving evidence in that way.

we'll ask them to give us some information about those witnesses which will include how they'd like to give their evidence.

If we think the way it's proposed that someone will give evidence would mean the hearing is unfair to us and the public interest which we represent, we'll arrange a preliminary meeting so that a Chair of the FtPC can give directions about how they should participate.

When the substantive hearing starts, we'll let the panel know how each witness will give their evidence. We won't make a formal application, so the panel won't need to make a decision about how people will give evidence at the hearing.

If, however, there is an objection about how someone gives evidence and we haven't been able to hold a preliminary meeting before the hearing, the panel may need to decide whether a fair hearing can take place with the witness giving evidence in the manner proposed.

If during the hearing, the panel or either side think that the way someone is giving evidence is causing a risk of unfairness, the panel can ask the individual to give evidence in a different way.

Who decides what evidence is admissible

The panel making decisions about the issues in the case will also decide what evidence is admissible.

This will usually mean that we provide that evidence to the panel. As professional adjudicators, we consider that if the panel members decide the evidence is actually inadmissible, they can put the information out of their minds when making a decision about what happened.[14]

Weight

When considering how disputes of fact are decided by the panel, a useful analogy is a set of weighing scales. Into one pan of the scales goes all the evidence that's supportive of a fact, and into the other goes all the evidence that's unsupportive. When we talk about the 'weight' of evidence, we mean how far a piece of evidence moves the scales.

Some evidence may be obviously reliable because of its nature and is therefore likely to carry substantial weight, for example documents created in the course of business, official records, audio/visual recordings.

The weight of other evidence may depend on what the panel decides about whether a witness or piece of evidence is credible.

Credibility

Credibility considers how much a witness account can be relied on. It involves more than whether the account is honest or not.

A person may have confidence in his or her recollection and be honest. However, that does not mean that their recollection provides any reliable guide to the truth on this basis alone. An account can be honest but objectively unreliable.

We believe memories to be more reliable than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.

Memories are fluid and malleable and can be subject to powerful biases. Events can come to be recalled as memories which did not happen at all or which happened to somebody else. The older the events, the more important it is to hold fast to these principles of reasoning.

The objective and reliable approach is to focus on the content of a person's evidence.

A panel will need to carefully consider issues such as:

- whether the evidence is consistent with contemporaneous evidence;
- whether it's consistent with admitted or incontrovertible facts;
- whether the evidence is internally consistent;
- whether it's consistent with previous accounts;
- whether it's supported by other evidence;
- how probable or plausible it is;
- the possible motive of the person giving evidence;
- the potential for mistake or unconscious bias.

Panels should consider whether evidence is plausible and consistent with objectively verifiable evidence (including evidence of what the witness has said on other occasions) and with known or probable facts. They should start with the objective facts as shown by authentic, contemporaneous documents, independent of the person giving evidence, and use oral evidence to test it[15].

Burden of proof

Where facts relating to an allegation are in dispute (including those relating to context), the burden of proving such facts rests on the NMC[16]. If a panel finds it more likely than not that something did take place, then it must treat it as having taken place.

It is a difficult but vital function of a panel to make findings of fact, particularly when accounts before it are diametrically opposed.

There are many considerations which help a panel to make a decision. Panels will assess the internal consistency of evidence, as well as its consistency against accepted facts and contemporaneous documents (where available). They will consider the passage of time, witness motivation, the potential for mistake, overall probabilities and the plausibility of evidence.

Generally speaking a panel should be able to make up its mind where the truth lies without needing to rely upon where the burden of proof lies[17]. This is because it is rare for a panel to conclude, after careful consideration of the evidence, that the case for and against the issue of fact is completely balanced and it cannot reasonably make a finding one way or another[18].

Hearsay

In general terms, hearsay is any evidence which is not given orally by a witness with direct experience of the matter they are giving evidence about, and which is being given to prove an issue in dispute.

Evidence given by telephone and video link is not hearsay evidence. To the extent that there are limitations on evidence given by remote means that is a matter of weight (see above).

Most commonly, hearsay evidence will involve a witness reporting what they were told about something in issue by another individual who is not themselves a witness, or a statement being placed before a panel without the maker of the statement giving oral evidence.

Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.[19]

Hearsay statements will usually carry less weight than oral evidence because it cannot be tested. Hearsay evidence may also be inadmissible where the weight which could be given to it in the circumstances of the case is zero, even where there is other evidence that could 'corroborate' (or support) it.[20] Although it's not possible to provide a complete list of situations where this could happen, one example is where the evidence of a crucial

witness is hearsay, and the fact that the nurse, midwife or nursing associate can't challenge it is so unfair that nothing else in the hearing process can avoid the unfairness.

No case to answer

There may be situations where, at the close of our case, the nurse, midwife or nursing associate feels that we just haven't put forward enough evidence to mean they still have a case to answer.

There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:

1. no evidence
2. some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.

The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken in to account.

Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.[21]

When should panels resolve disputes regarding context

As mentioned above there will be times when a FtPC will need to resolve whether a disputed contextual factor was present or not, and make a factual finding about that.

This will only be necessary if the contextual factor would have a material impact on the outcome of the case. For more information about our approach to context please see our guidance on taking account of context.

So at what stage of a hearing should a panel resolve whether a contextual factor is present? This is likely to be something that panels will need to decide on a case-by-case basis, and panels will need to be flexible in their approach.

Panels have a wide discretion under our rules to determine how a hearing is conducted, and they will need to use that discretion to decide when they think the dispute should be resolved.[22]

In some circumstances they might decide it is appropriate to determine the issue at the facts stage, or alternatively they may decide that it is more appropriate to decide the issue at the impairment stage. The decision on when to resolve a disputed contextual factor could depend on when the contextual factor is raised during a hearing.

Prior to the hearing, we'll have reviewed the case and tried to work with the nurse, midwife or nursing associate to clarify the important issues in the case. The case presenter should usually be able to assist the panel with whether a material contextual factor is in dispute and the most appropriate point to resolve it.

When the panel does resolve a dispute in relation to context they will need to make it clear in their reasons what the contextual factor was that they resolved, and how they reached their decision.

Further evidence

Our overarching objective is the protection of the public. Because of this, the panel has a responsibility to ask us to obtain further evidence if they are concerned that there are gaps in the evidence which will prevent them from properly performing their function.[23]

1 Possibilities include convictions, civil proceedings, family court proceedings, inquests, internal investigations by employers, and external investigations or inquiries such as those conducted by ombudsmen or commissioned by local authorities or other public bodies.

2 Enemuwe v NMC [2016] EWHC 1881 (Admin).

3 Criminal convictions are conclusive; findings of other health or social care regulators in the UK, or licencing bodies elsewhere provide prima facie evidence of the underlying facts; see rr.31(2)-(3) and r.31(4) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (SI 2004/1761) respectively.

4 r.31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (SI 2004/1761); Squier v General Medical Council [2016] EWHC 2793 (Admin); Enemuwe v Nursing and Midwifery Council [2015] EWHC 2081 and Towuaghanste v GMC [2021] EWHC 681 (Admin).

5 General Medical Council v Spackman [1943] A.C. 627; Constantinides v The Law Society [2006] EWHC 725 (Admin); Chaudhari v General Pharmaceutical Council [2011] EWHC 3433

6 Hoyle v Rogers [2014] EWCA Civ 257.

7 Enemuwe v Nursing and Midwifery Council [2015] EWHC 2081; Georgieva v Nursing and Midwifery Council [2017] 3 WLUK 479

8 Caldero Trading Ltd v Beppler & Jacobson Ltd and others [2013] EWHC 2191 (Ch)

9 Slocom Trading Ltd and another v Tatik Inc and others [2012] EWHC 3464 (Ch)

10 See for example Shabir v GMC [2023] EWHC 1772 (Admin)

11 YI v AAW [2020] CSOH 76 in which Lady Wise rejected the submission that it would be difficult to assess credibility of parties and witnesses giving evidence remotely on video screen and, whilst noting it was a little unsatisfactory that some witnesses gave evidence by mobile telephone, said that this did not have a bearing on her assessment of their credibility and reliability. See also: Polanski v Conde Nast [2005] UKHL 10; A Local Authority v Mother, Father, SX [2020] EWHC 1086 (Fam); National Bank of Kazakhstan v The Bank of New York Mellon [2020 unreported]; Re Smith Technologies (Insolvency and Companies Court) [2020 unreported]; Re One Blackfriars Ltd, Hyde v Nygate [2020] EWHC 845 (Ch); and Municipio de Mariana v BHP Group [2020] EWHC 928 (TCC).

12 The principle articulated in Home Department v Agbabiaka [2021] UKUT 00286 (IAC) in relation to evidence given in UK courts and tribunals does not apply to hearings of our Fitness to Practise Committee because our Fitness to Practise Committee is not part of the judicial system of the state (see General Medical Council v BBC [1998] EWCA Civ 949).

13 This is a different decision to what support a witness might need to give evidence for which we have separate guidance.

14 For an example of the Court of Appeal commenting on a panel's ability to do this, see R. (on the application of Chief Constable of Thames Valley) v Police Appeals Tribunal [2016] EWCA Civ 1315.

15 R (oao Dutta) v General Medical Council [2020] EWHC 1974 (Admin), para 39-40 and R (oao SS (Sri Lanka) v The Secretary of State for the Home Department [2018] EWCA Civ 1391, para 33-42.

16 Rule 30 The Nursing and Midwifery Council (Fitness to Practise) Rules 2004.

17 Re B (Children) [2008] UKHL 35, para 32

18 Stephens v Cannon [2005] EWCA Civ 222; Verlander v Devon Waste Management and another [2007] EWCA Civ 835; Constandas v Lysandrou (a protected party by her litigation friend and son Mr Michael Lysandrou) and others [2018] EWCA Civ 613

19 Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin).

20 The Professional Standards Authority v (1) The Nursing and Midwifery Council (2) Jozi [2015] EWHC 764 (Admin).

21 R v Galbraith [1981] 1 WLR 1039.

22 Rule 24(1) The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 allows Panels a discretion to determine the order of proceedings at a final hearing.

23 The Professional Standards Authority v (1) The Nursing and Midwifery Council (2) Jozi [2015] EWHC 764 (Admin).

Making decisions on sexual misconduct

Reference: DMA-7 Last Updated: 27/02/2024

When making decisions in cases about sexual misconduct, panels should be mindful of the myths and stereotypes surrounding rape and other forms of sexual misconduct. Panels should take account of the CPS guidance in this area and should ensure that their reasoning is not influenced by these common myths and stereotypes.

Making decisions on dishonesty charges and the professional duty of candour

Reference: DMA-8 Last Updated: 06/05/2025

In this guide

- Dishonesty and inferences
- How we approach evidence about a nurse, midwife or nursing associate's state of mind
- The professional duty of candour

Dishonesty and inferences

When making decisions on charges involving dishonesty, panels of the Fitness to Practise Committee must decide whether or not the conduct took place, and if so, what was the nurse, midwife or nursing associate's state of mind at the time.[1]

Any dispute over whether a nurse, midwife or nursing associate behaved dishonestly means that the panel's findings will depend on what conclusions they can draw about the nurse, midwife or nursing associate's state of mind from the basic facts.

To help the panel focus on the central issues and be able to express this in their reasoning, it needs to consider the following:

- what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time
- whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or
- whether there is evidence of alternative explanations, and which is more likely.

How we approach evidence about a nurse, midwife or nursing associate's state of mind

The panel will need to consider a number of factors when making decisions about a nurse, midwife or nursing associate's state of mind when they did or said something which we say is dishonest or kept silent about something which we say is dishonest[2].

What the panel must consider to reach its decision

As part of drawing conclusions about the nurse, midwife or nursing associate's state of mind, the panel must consider what the evidence says about the background facts or circumstances, and what the nurse, midwife or nursing associate knew or believed about what they were doing.[3]

There may be evidence about what was expected of the nurse, midwife or nursing associate in the particular circumstances.

This doesn't mean that the panel should hear evidence about the nurse, midwife or nursing associate's own standards of honesty or their own beliefs about what the prevailing standards of honesty in society are. This is not relevant to deciding whether or not the nurse or midwife behaved dishonestly.[4]

The question of what is honest or dishonest in a particular set of circumstances, is a question for the panel to determine by applying what it understands the standards of ordinary, decent people to be.

The law assumes that people from all walks of life can easily recognise dishonesty when they see it[5], and that in most situations it is not difficult to identify how an honest person would behave.[6]

It is important that the panel considers whether there is an alternative explanation for the nurse, midwife or nursing associate's conduct, which points away from them having behaved dishonestly.[7] It can be useful to ask whether their mind was engaged with what they were doing, or could they simply have made an innocent or careless mistake?

The panel must address this question by identifying evidence for any other explanations, not by speculating.

As a regulator, the burden and standard of proof mean that, for an allegation to be proved, we have to satisfy the panel that it is more likely than not, that it happened.

In a case about dishonesty, where there is evidence of different explanations for why the nurse, midwife or nursing associate might have done something, the question is which explanation is more likely?

The professional duty of candour

Breaches of the professional duty of candour are amongst the most serious category of concerns. Within our guidance on screening, we list breaches of the professional duty of candour as a concern which will require further investigation and in our sanctions guidance as cases we regard as particularly serious because it may be a concern which is more difficult for the profession to put right. This means that we will be keen to hear from the nurse, midwife or nursing associate about any reflections and opportunities to show insight because restrictive regulatory action is likely to be necessary when concerns of this nature aren't put right.

Although a breach of the duty of candour can amount to dishonesty, there are circumstances where there could be a breach which isn't dishonest. An example of this could be someone telling a colleague not to report an error that had occurred. We always regard breaches of the duty of candour as very serious, whether or not they are also dishonest.

To comply with the professional duty, nurses, midwives or nursing associates must:

- Be honest, open and truthful in all their dealings with patients and the public.
- Never allow organisational or personal interests to outweigh the duty to be honest, open and truthful.
- Act with integrity and give a constructive and honest response to anyone who complains about the care they have received.
- Act without delay and raise concerns if they experience problems that prevent them from working within the Code. Also act without delay and raise concerns if they or a colleague, or any other problems in the care environment, are putting patients at risk of harm. 'Doing nothing' and failing to report concerns is unacceptable.
- Apologise and explain fully and promptly what has happened and the likely effects if someone in their care has suffered harm for any reason. 'Near misses', where a nurse's, midwife's or nursing associate's act or omission puts a patient at risk of harm, must also be escalated as a point of concern.
- Cooperate with internal and external investigations.

We wouldn't usually refer specifically to breaches of the duty of candour as part of the misconduct charges. Instead we would expect the fact that the misconduct charged amounts to a breach of the duty of candour to be taken into account by a panel when considering misconduct, impairment and sanction when a case reaches those stages of a hearing.

1 Uddin v General Medical Council [2012] EWHC 2669 (Admin)
2 Under the professional duty of candour, nurses and midwives must be open and honest with patients when something that goes wrong with their treatment that could cause harm or distress. This means that nurses, midwives or nursing associates must tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong. Keeping silent when something has gone wrong is a breach of this professional duty.
3 Royal Brunei Airlines v Tan [1995] 2 AC 378, see 389C-E; Barlow Clowes International v Eurotrust International [2006] 1 WLR 1376, para 16; approved in Ivey v Genting Casinos (UK) Ltd [2017] UKSC

4 See Ivey at para 74, overruling the 'second leg' of R v Ghosh [1982] QB 1053.
5 Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67 para 53; further Ivey (para 48) restates that judges do not and must not attempt to define dishonesty, citing R v Feely [1973] QB 530.
6 See Royal Brunei Airlines as cited in footnote 2.
7 Uddin v General Medical Council, see footnote 1; R v Feely [1973] QB 530 as discussed in Ivey at para 67.

Agreed removal at hearings

Reference: DMA-9 Last Updated: 24/04/2023

Nurses, midwives or nursing associates can apply for agreed removal during a hearing before the Fitness to Practise Committee. In considering the application, the Assistant Registrar will take into account the panel's views.

When will we consider a removal application during a hearing?

Nurses, midwives or nursing associates who are subject to fitness to practise proceedings can apply for removal from the register at any stage of the process.

When a nurse, midwife, or nursing associate applies for agreed removal during a substantive hearing, the panel will decide when the application for agreed removal should be considered. The panel will consider how best to minimise the disruption caused to the hearing. This will usually mean waiting until the end of the finding of facts or impairment stage of the hearing, unless there is an urgent reason for the application to be considered earlier. In making this decision, panels should balance the need for the application to be considered against the public interest in the regulator being able to operate effective hearings. In particular, inconvenience to witnesses should be avoided where possible.

When the panel considers that it is appropriate for the application for agreed removal to be considered, they will be invited to make any recommendation on whether or not the application for removal should be agreed. The application will then be considered by the Assistant Registrar, who will take any recommendation given by the panel into consideration as one of the factors relevant to their decision. If the Assistant Registrar agrees the application for removal, there will be no need for the panel hearing to resume (unless there is an interim order in place) and the professional will be removed from the register. If the Assistant Registrar does not agree the application, the panel hearing will resume at the point where it was adjourned.