Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 26 September 2025 – Monday, 29 September 2025

Virtual Meeting

Name of Registrant:	**Stephen Hodgson**	
NMC PIN:	07I0498E	
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – 10 December 2007	
Relevant Location:	Liverpool	
Type of case:	Misconduct	
Panel members:	Robert Pragnell Melanie Lumbers Anjana Varshani	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Charles Conway	
Hearings Coordinator:	Abigail Addai	
Facts proved:	Charges 1, 2, 3 and 4	
Facts not proved:	N/A	
Fitness to practise:	Impaired	
Sanction:	Striking-off Order	
Interim order:	**Interim suspension order (18 months)**	

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Hodgson's registered email address on 30 July 2025 and to his registered address by recorded delivery and by first-class-post on 4 August 2025.

The panel had regard to the Royal Mail '*Track and Trace'* printout which showed the Notice of Hearing was delivered to Mr Hodgon's registered address on 5 August 2025. It was signed for against the printed name of 'Hodgson'.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

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

Details of charge

That you, a registered nurse, whilst working at [PRIVATE] ("the Home")

1) Took alcohol from the home stock, without authorisation, on a number of occasions as set out in Schedule 1.

2) On 29 December 2023, in relation to Resident A, failed to record administration of insulin at 06.35 on the electronic medication administration system (eMar).

3) On the nightshift commencing on 29 December 2023, slept whilst on duty for over 45 minutes.

4) Your actions at charge 1 were dishonest in that you took alcohol from the home's stock, knowing it did not belong to you, and that you had no authorisation to do so.

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

Schedule 1:

a) 30 December 2023 at approximately 00:58.
b) 12 January 2024 at approximately 02:52.
c) 15 January 2024 at approximately 23:01.
d) 16 January 2024 at approximately 01:08.
e) 16 January 2024 at approximately 05:42.

Background

The charges arose whilst Mr Hodgson was employed as a registered nurse by [PRIVATE] ("the Home"). Mr Hodgson was employed as a Night Nurse at the Home between 23 October 2023 and 5 February 2024.

The referral made by Witness 1, on 12 February 2024, raised the following concerns:

- During the night shift of 28 – 29 December 2023, Mr Hodgson administered Insulin to Resident A at 06:35, advised it had been given at handover, but failed to record it on the medication system (eMar) necessitating a follow up call to confirm the administration of the insulin.

- During the night shift of 29 – 30 December 2023, at around 02:30, Mr Hodgson was found by Witness 3 sleeping in the nurse's office during his shift, having not answered his phone for approximately 30 minutes and having not attended to the residents' needs at 01:30 as prearranged. There was a local investigation.

- On 2 February 2024, Colleague A noticed a discrepancy in stock from the Home's

licensed bar, since the last stock take on 27 December 2023. The motion activated close-circuit television (CCTV) covering the bar for the period in question was requested by Colleague A and reviewed by Colleague A and Witness 1, who identified Mr Hodgson entering the bar on five occasions during three-night shifts, and removing alcohol from the bar. The alcohol taken was Vodka, Whiskey, Gin and Tequila. The CCTV identified the following instances of alcohol being taken by Mr Hodgson:

- 30 December 2023 at 00:58;
- 12 January 2024 at 02:52;
- 15 January 2024 at 23:01;
- 16 January 2024 at 01:08; and
- 16 January 2024 at 05:42.

On 4 January 2024, Mr Hodgson's probation was extended by three months due to outstanding training, not attending induction sessions, sleeping on duty (believed to be only one occasion, as above) and not accurately recording medication administration (believed to be only one occasion, as above).

Following the concerns about alcohol being taken from the Home's bar coming to light, Mr Hodgson was suspended from the Home on 2 February 2024. Mr Hodgson was invited to an investigatory meeting with the General Manager on 5 February 2024 but did not attend. Mr Hodgson instead submitted his resignation with immediate effect and denied all allegations. The disciplinary procedure therefore could not continue.

A referral was raised to the Care Quality Commission ("CQC") on 9 February 2024 to which the only response has been a notification of acknowledgement. No reports were made to the police.

Decision and reasons on facts

In reaching its decisions on the alleged facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and Mr Hodgson's response to the allegations.

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

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

- Witness 1: General Manager at the Home at the time of the concerns
- Witness 2: Lead Registered Nurse at the Home at the time of the concerns.
- Witness 3: Team Leader at the Home at the time of the concerns.

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

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

Charge 1

'That you, a registered nurse, Took alcohol from the home stock, without authorisation, on a number of occasions as set out in Schedule 1.'

This charge is found proved.

In reaching this decision, the panel took into account that the Home had discovered there was a loss of alcohol after the stock take. Subsequently, the Home reviewed the CCTV evidence and identified an individual taking alcohol from the dates outlined in Schedule 1. The panel also reviewed the CCTV which depicted an individual entering a bar on five different occasions on three-night shifts. The panel noted that it could not identify Mr Hodgson and relied on Witness 1's witness statement when making its decision. Witness 1's witness statement reads:

> *'Later on 2 February 2024, after I had been forwarded the CCTV footage from Colleague C and reviewed it, I spoke with Mr Hodgson by telephone about the concern that he had taken alcohol from the bar area at the Home'*

> *'Had Mr Hodgson attended the investigatory meeting on 5 February 2024, I would have shown him the CCTV footage we had from the nights he was seen taking alcohol from the bar and given him the opportunity to explain himself.'*

The panel was mindful that the CCTV was served on Mr Hodgson as part of the NMC's evidence. The panel accepted Witness 1 statement which confirmed the individual in the CCTV was Mr Hodgson. Further, it noted that Mr Hodgson was given the opportunity to challenge the evidence, but he did not.

The panel also took into account that when the allegations were put to Mr Hodgson, he initially denied any involvement. Therefore, the panel accepted that this was Mr Hodgson's initial response. However, the panel was mindful that Mr Hodgson subsequently made admissions to the NMC on 3 September 2025. It noted that Mr Hodgson admitted that he was the individual who took alcohol, consumed it, and provided reasons as to his motivations behind it. Therefore, the panel was satisfied that Mr Hodgson was the same individual in the dates set out in Schedule 1.

Therefore, the panel found charge 1 proved in its entirety.

Charge 2

‘That you, a registered nurse, on 29 December 2023, in relation to Resident A, failed to record administration of insulin at 06:35 on the electronic medication administration system (eMar).’

This charge is found proved.

In reaching this decision, the panel took into account Witness 2’s witness statement which states the following:

‘In this probationary review meeting, I addressed Mr Hodgson’s failure to record the insulin he had given to Resident A. Mr Hodgson apologised and said that he “had forgotten at the time”. Mr Hodgson suggested that he used the laptop which had access to eMar when doing medication rounds going forward, instead of using the handheld device which had access to eMar. Mr Hodgson explained he had experienced difficulties with eMar on the handheld device so was going back to the office to sign for medications, and on this occasion, by the time he got back something else had happened so he forgot to sign for Resident A’s insulin administration.’

The panel was of the view that Mr Hodgson accepted his failings in not recording the administration of insulin. It found that the eMar record had not been completed either on the handheld device or on the laptop to show the administration of the insulin. The panel accepted the explanation given at the time that he had intended to complete it on the laptop on the return to the office but that he became distracted and failed to do so. It noted the Home accepted the response at the time and at his probation review later agreed an alternative method for the information to be recorded.

The panel then had regard to the eMar record for Resident A, dated 29 December 2023, which confirmed Mr Hodgson’s conduct. The panel found this to be consistent with other contemporaneous documents, including the minutes from the probationary review with Witness 2 dated 4 January 2024, which shows Mr Hodgson apologising for not signing the

insulin and Witness 2's witness evidence which highlight Mr Hodgson's admissions for failing to sign at the time.

> *'In terms of the record keeping , I did document it in hand over and hand over to the day nurse that it has been administered. The reason for not recording it on the laptop was that I had been logged out of the laptop and was unable to log back in.'*

In light of all the evidence, the panel found charge 2 proved in its entirety.

Charge 3

> *"That you, a registered nurse, on the nightshift commencing on 29 December 2023, slept whilst on duty for over 45 minutes."*

This charge is found proved.

In reaching this decision, the panel took into account the contemporaneous evidence before it, including Witness 3's witness statement. Witness 3 explained that Mr Hodgson was required to assist with a resident who required personal care. However, Mr Hodgson did not show up. Witness 3 then made attempts to find Mr Hodgson, including multiple unanswered telephone calls. Mr Hodgson remained uncontactable via telephone so Witness 3 went to look for him and found him sleeping in the Nurses office. Witness 3 knocked on the door to the Nurses office and shouted his name to wake him up.

> *'I knocked the door to the Nurse's office as I could see Mr Hodgson asleep in his chair at his desk through the window in the door. Mr Hodgson did not wake up from me knocking the door. I then went into the Nurse's office and loudly raised my voice to wake up Mr Hodgson by saying his name. Mr Hodgson then woke up to me shouting his name and I said to him that the staff had been trying to get in touch with him for over 45 minutes to help a resident. Mr Hodgson brushed off what I said and he just said "sorry I will go now." At this time, I did*

not say anything to him about him being asleep because the resident required his attention.'

The panel found that Witness 3's statement was further corroborated by Witness 2 who confirmed that Mr Hodgson made admissions to falling asleep in the office. Mr Hodgson also provided further submissions to the incident on 3 September 2024.

'It was warm in the office and I had just closed my eyes and must have nodded off'

The panel found that it had nothing before it to undermine the facts within charge 3. Therefore, it found charge 3 proved in its entirety.

Charge 4

"Your actions at charge 1 were dishonest in that you took alcohol from the home's stock, knowing it did not belong to you, and that you had no authorisation to do so."

This charge is found proved.

In line with the panel's findings in charge 1, the panel was satisfied that the evidence of Witness 1 determined that Mr Hodgson was not authorised to take the stock. The panel also had regard to *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, paragraph 74:

'*When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as*

to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.'

It also took into account Witness 1's witness statement which details that Mr Hodgson took the following:

'I understand, having reviewed the CCTV footage that the alcohol taken was Vodka, Whiskey, Gin and Tequila'

The panel determined that Mr Hodgson knew that the alcohol did not belong to him and further knew as the only registered nurse on duty that he was not authorised to take it. It determined that a reasonable person would find this state of mind to be dishonest.

Therefore, the panel found charge 4 proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Hodgson's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

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

Representations on misconduct and impairment

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

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

The NMC identified the specific, relevant standards where Mr Hodgson actions amounted to misconduct including section 10, 10.1, 10.5, 20 and 20.1 of the Code.

The NMC submitted that the breaches of the Code amount to misconduct and are serious. The NMC submitted that by not making a record of insulin that had been administered, other professionals and third parties looking at the records would be led to believe that it had not been given. Further, Mr Hodgson knew that by sleeping on duty, he was placing vulnerable residents under his care at risk of harm. Such conduct in the NMC's submission falls short of the standard required of a registered nurse.

The NMC submitted that honesty and integrity are the cornerstone of the nursing profession and Mr Hodgson's conduct is a significant departure from the standards of a registered nurse. Therefore, Mr Hodgson's conduct and behaviour is such that it amounts to misconduct

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council [2008] EWHC 581* (Admin).

The NMC invited the panel to find Mr Hodgson's actions in taking the alcohol amounted to misconduct and his fitness to practise as a result was impaired. The NMC submitted that limbs a, b, c and d of *Grant* is engaged. Mr Hodgson had taken alcohol from the stock of the Home bar whilst in the course of his employment and he knew that this would amount to theft and was dishonest by taking the alcohol on more than one occasion. The NMC submitted that Mr Hodgson brought the profession into disrepute and disregarded the standards expected from a nurse in his position.

The NMC submitted that Mr Hodgson slept on duty whilst he had vulnerable residents in his care. Therefore, the residents were put at risk of harm. The NMC submitted that Mr Hodgson was employed as a night nurse and was nowhere to be found for approximately 45 minutes and was found sleeping in the nurses' office. It is the NMC's submission that a nurse sleeping on duty is not expected of someone in the nursing profession.

The NMC further submitted that Mr Hodgson not only failed to carry out his duties effectively but breached his duty under the NMC Code to keep clear and accurate records. The NMC invited the panel to consider that this conduct significantly undermines the trust members of the public place in professional nurses.

The NMC invited the panel to consider the approach of Silber J in the case of *Cohen* and asked it to consider the following:

- Whether the conduct that led to the charge(s) is easily remediable?
- Whether it has been remedied?
- Whether it is highly unlikely to be repeated

The NMC submitted that it does not have evidence to show that Mr Hodgson has shown insight into his actions. Further, at the initial investigation at local level, Mr Hodgson apologised for not recording Resident A's insulin. However, the NMC has not received a complete admission of the charges.

As a result, the NMC invited the panel to consider that there is a continued risk due to Mr Hodgson's lack of insight and failure to undertake relevant and sufficient training. The

NMC submitted that whilst reflection and training may not fully remediate the situation, it can provide remorse and a willingness to remedy the concerns. However, in the absence of these, the NMC submitted that the concerns remains. Mr Hodgson also has not worked since the concerns; therefore, a risk of repetition remains.

The NMC considers that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.

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

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

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

10 Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.5 take all steps to make sure that records are kept securely

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly….'

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel next considered whether the charges found proved in charges 1, 2, 3, and 4, amounted to misconduct.

Charge 1 and Charge 4 (taken together)

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel found that sections 20.1, 20.2 and 20.3 of the Code are engaged in respect of charges 1 and 4. It was satisfied that Mr Hodgson had taken the alcohol without permission on multiple occasions over numerous days when he knew should not have done so. Therefore, the panel determined that Mr Hodgson acted in a way that was not honest and did not show integrity.

The panel was of the view that Mr Hodgson was in a position of trust. The Home and the families of the vulnerable residents would expect Mr Hodgson to work in the best interests

of residents. However, Mr Hodgson's conduct fell seriously below the standards expected of a registered nurse.

The panel took into account that Mr Hodgson had taken alcohol from the Home's stock on multiple occasions and deprived the rightful owner of their property. Furthermore, the actions took place during the period that Mr Hodgson was the sole registered nurse in charge of sixty-seven residents with varying complex needs. It concluded that Mr Hodgson actions were not in the best interests of those in his charge. There was a potential for harm to occur to both residents and staff because of Mr Hodgson's actions.

The panel concluded that should any member of the public be made aware of Mr Hodgson's actions, they would consider it to be deplorable and it would damage confidence in the level of care nurses are able to deliver.

The panel found that Mr Hodgson's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Charge 2

The panel found that sections 8.3, 8.5, 10, 10.1 and 10.5 of the Code are engaged with in respect of the facts found proved in charge 2.

The panel concurred with the NMC submissions which reads:

> *'by not making a record of insulin that had been administered, other professionals and third parties looking at the records would be led to believe that it had not been given.'*

The panel was satisfied that Mr Hodgson admitted that the insulin was not correctly recorded as required. Whilst the administration of insulin needs to be recorded correctly, in this occasion there was no harm. The panel was satisfied that this had a potential to cause serious harm but this was a one-off event. While the medication was not recorded Mr Hodgson advised his colleagues orally at shift handover that it was given. In these circumstances, the panel determined that the only failing was failing to complete records

and therefore do not find this charge amounted to serious misconduct. Mr Hodgson apologised for his oversight on numerous occasions.

Charge 3

The panel determined that sections 1.1, 1.2, 1.4, 8.3, 8.5 and 20 of the Code are engaged in this charge. It noted that Mr Hodgson was employed to be awake and available to meet the needs of the resident throughout his shift as Night Nurse Manager. The panel further noted that it was Mr Hodgson's duty to discharge that function, and to ensure that he was adequately rested before commencing shifts to ensure he was able to stay awake. Whilst the panel accepted Mr Hodgson's circumstances at the time, his conduct resulted in residents needs not being met. It noted that this was not a momentary lapse, but it extended to approximately an hour. When Mr Hodgson was discovered, he had to be awoken by Witness 3 who described themselves as shouting his name. In these circumstances, both residents and staff were put at risk because Mr Hodgson could not deliver care, and the residents could not receive care from a registered nurse.

Therefore, the panel determined that Mr Hodgson's actions significantly fell short of the standards and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

Charge 1 and 4 (taken together)

The panel found limbs b, c and d were engaged in respect of charges 1 and 4. In considering limb a, the panel found that the taking of the alcohol occurred over a number of night shifts over a period of time. It noted that it was not an isolated incident and indicated a pattern of misconduct. The panel was satisfied that while the individual incidents only lasted a short period, they nevertheless occurred during a time where Mr Hodgson was supposed to be discharging his duty as a registered nurse.

However, whilst the panel accepts that Mr Hodgson was not where he was supposed to be, and it did not find evidence that he put the residents at unwarranted risk of harm, by taking alcohol without authorisation. Accordingly, the panel did not find limb a engaged.

In respect of limb b, the panel took into account that Mr Hodgson admitted and explained his rationale behind why he took the alcohol. The panel accepted his explanation:

'I would like to say that I am extremely regretful for my actions and although I accept the fact that I took the alcohol without permission , this action was not motivated by greed or monetary gain but more to do with [PRIVATE] *due to personal events in my life and how I regrettably found my myself dealing with this.'*

However, in doing so, the panel concluded that Mr Hodgson admitted the dishonesty. As a result, Mr Hodgson is liable to bring the nursing profession into disrepute.

The panel was also satisfied that Mr Hodgson, by taking the alcohol, had breached fundamental tenets of the nursing profession, which is to act with integrity and honesty at all times. Further, the panel found that Mr Hodgson acted dishonestly and acknowledged this within his submissions. However, the panel concluded that there remains a concern that he may act in a similar manner if faced with similar circumstances.

The panel then went onto consider the questions set out in *Cohen*. It found while there was some remorse shown by Mr Hodgson; there was no evidence of insight into the risk or implications of his conduct at the time. Further, the panel do not have evidence of the actions taken to remediate or change his behaviour insofar that it would not be repeated in the future. At no point has Mr Hodgson shown insight into how his actions affected the vulnerable residents, his colleagues or the wider nursing profession.

The panel further noted that the CCTV evidence showed Mr Hogdson removing alcohol from the Home's bar on multiple nights, although on one night shift, Mr Hodgson had attended the bar and taken alcohol on three separate occasions. It was persuaded that Mr Hodgson's conduct was attitudinal in that he was acting without any regard for the fact that the alcohol did not belong to him or that he had no right to take it.

Whilst there is some indication of remorse, in that Mr Hodgson said *'I am extremely regretful for my actions'*. The panel concluded that Mr Hodgson attributes his actions to personal circumstances which predate the incident, some by many years. Having considered all the matters in the round, the panel determined that Mr Hodgson's actions were wholly dishonest. Further, it was not persuaded that there was any evidence to indicate that this would not occur in similar circumstances in the future.

Charge 3

The panel took into consideration the submissions from Mr Hodgson and noted that he had chosen not to make any representations to address the allegation that he had fallen asleep during a night duty and he suggested that had been dealt with in the local investigation at the Home. The panel was mindful that determinations made by employers are separate matters and not relevant considerations for the panel to take into account and also when assessing misconduct or impairment. The panel was satisfied that sleeping on duty amounted to serious misconduct and went onto consider whether Mr Hodgson's conduct means his fitness to practise is impaired.

The panel considered the test in *Grant.* It found that although this was a single incident of misconduct, Mr Hodgson put residents at unwarranted risk of harm as he was not able to

discharge his duty as the sole registered nurse on duty. The panel determined that a nurse not being awake to provide care and failing to discharge their burden would put the profession into disrepute. As such, the panel therefore determined Mr Hodgson breached the fundamental professional tenets of safety, professionalism and integrity and neglected his fundamental responsibilities to patients.

Further, nurses are required to be alert and wake throughout their shift as per Mr Hodgson's job description. Whilst the panel found Mr Hodgson's actions were in breach of limb a, b and c, it did not find limb d engaged in charge 3.

In respect of the questions set out in *Cohen,* the panel concluded that there is no evidence that it has been or is likely to be remediated. It took into account Mr Hodgson's submissions and determined that he did not address the facts within charge 3. Mr Hodgson seemed to rely on the fact that local investigation did not take the incident into a fully disciplinary meeting. However, the panel acknowledged that this was the case because Mr Hodgson had resigned before this could occur. In light of the above, the panel does not have anything before it to discharge the concerns raised. Therefore, it cannot be persuaded that there is no current impairment.

In light of the findings in the three charges, where serious misconduct was found, the panel determined that a finding of impairment on the grounds of public protection is necessary, given the identified risk of repetition.

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

Taking into consideration the findings above, the panel determined that a finding of impairment on public interest grounds is also required. It was satisfied that there is a need to uphold professional standards, and public confidence would be undermined if a finding of impairment were not made.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Hodgson off the register. The effect of this order is that the NMC register will show that Mr Hodgson has been struck off the register.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 4 August 2025, the NMC had advised Mr Hodgson that it would seek the imposition of a Striking-Off Order if it found Mr Hodgson's fitness to practise currently impaired.

The NMC identified the following aggravating factors in the case

- Lack of insight
- Dishonesty
- Place vulnerable residents at risk of harm

The NMC submitted that the mitigating factors in the case are contextual factors [PRIVATE].

The NMC invited the panel to impose a striking off order because Mr Hodgson placed vulnerable residents at a direct risk of harm. The NMC submitted the theft of alcohol was premeditated and his actions fell below the expected standards from a professional registered nurse. This in their submission is fundamentally incompatible with continued registration. Therefore, a striking off order is the appropriate sanction to protect patients, members of the public and to maintain professional standards.

Decision and reasons on sanction

Having found Mr Hodgson's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Sole registered nurse in charge of residents who had varying complex health needs
- Abuse of a position of trust
- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put vulnerable patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Mr Hodgson's admissions in the email sent to the NMC on 3 September 2025
- Contextual issues, [PRIVATE].

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

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Hodgson's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Hodgson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The

panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Hodgson's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel also noted that the type of misconduct did not relate to Mr Hodgson's clinical practice which made conditions in this case inappropriate.

The panel found attitudinal concerns within Mr Hodgson's misconduct. Further, in the absence of any remediation and insight, the panel determined it could not formulate conditions that would address the seriousness of this case and protect the public.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Regarding charges 1 and 4, the panel considered NMC Guidance: Sanctions for particularly serious cases (reference: SAN-2). The panel determined that Mr Hodgson's conduct was not a one-off incident and was

opportunist. Mr Hodgson stole alcohol from the Home he worked at whilst on duty and in doing so, he acted dishonestly.

The panel noted that all the serious misconduct were serious breaches of the fundamental tenets of the profession evidenced by Mr Hodgson's actions is fundamentally incompatible with Mr Hodgson remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. The panel had regard to NMC guidance: SAN-3d and determined that the facts found proven did not meet the requirements for a suspension order. The panel noted that this was not a single incident of misconduct, there was evidence of deep-seated attitudinal problems and there was a significant risk of repeated behaviour.

In light of all the panel's findings above, including that of dishonesty and sleeping whilst on duty, the panel went onto consider a striking-off order.

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

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

Mr Hodgson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Hodgson's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a

striking-off order. Having regard to the matters it identified, in particular the effect of Mr Hodgson's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mr Hodgson in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC. The NMC submitted that if a finding of public protection is made and a restrictive sanction is imposed, the NMC consider an interim be made in the same terms as the substantive order. The NMC submitted this should be imposed on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

The NMC further submitted that if Mr Hodgson is impaired on public interest alone and his conduct is fundamentally incompatible, then an interim suspension order should be imposed.

Decision and reasons on interim order

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

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

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

That concludes this determination.