

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Thursday, 9 April 2026 – Monday, 13 April 2026**

Virtual Meeting

Name of Registrant: **Caroline Seabrook**

NMC PIN: 14I2282E

Part(s) of the register: Registered Nurse – Mental Health
RNMH – 8 September 2017

Relevant Location: Essex

Type of case: Health/Misconduct/Conviction

Panel members: Tracy Stephenson (Chair, lay member)
Genevieve Nwanze (Registrant member)
Tracy Jane Jones (Lay member)

Legal Assessor: Graeme Henderson

Hearings Coordinator: Ekaette Uwa

Facts proved: Charges 1(in respect of [PRIVATE]), 2a),
2b),2c),2d), 2e)(in respect of cocaine), 2f),3, 4, 5,
6 and 7

Facts not proved: Charge 1 (in respect of [PRIVATE])

Fitness to practise: Impaired on grounds of misconduct and
conviction

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 that the Notice of Meeting had been sent to Ms Seabrook's registered email address by secure email on 11 February 2026.

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, and dates and the fact that the meeting would take place on or after 11 March 2026.

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

The panel was provided with a '*Proof of Service*' bundle. Within that bundle was a screenshot which disclosed Ms Seabrook's registered email address. The panel noted that, whilst this element was relevant to service, the screenshot also contained information indicating that Ms Seabrook was subject to an interim suspension order. The panel recognised that such information should is not ordinarily disclosed to the panel prior to making findings of fact.

The panel determined that, as an experienced professional panel, it would disregard this information and not allow it to influence its decision making.

Details of charge

"That you, a registered nurse:

- 1) [PRIVATE].

- 2) Whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:
 - a) Engaged in communication with Child Service User A.
 - b) Met in person with Child Service User A.
 - c) Provided a lift in your car to Child Service User A.
 - d) Invited Child Service User A to your home.
 - e) Provided to Child Service User A and/or permitted Child Service User A to take in your presence, alcohol and/or drugs, namely Cocaine.
 - f) Drove under the influence of alcohol and/or drugs with Child Service User A in the car.
- 3) Continued to have contact with Child Service User A after being told not to by your employer on 27 July 2021.
- 4) Failed to maintain records of your communication and interactions with Child Service User A in respect of the contact that you had with him as referenced in charge 2a.
- 5) Were convicted on 30 September 2021 for driving whilst intoxicated on 6 August 2021.
- 6) Were convicted on 21 September 2021 for driving whilst under the influence of drugs namely Cocaine on 8 August 2021.
- 7) Your actions at charge 2 demonstrated that you had formed an inappropriate relationship with Child Service User A and/or breached professional boundaries.

AND in light of the above, your fitness to practise is impaired [PRIVATE].

Schedule 1

[PRIVATE]

The panel was informed that the decision by the NMC to include the conviction charges (Charges 5 & 6) was contrary to the Rules. Rule 29 (2) states:

'The Fitness to Practise Committee may consider one or more categories of allegation against a registrant provided always that an allegation relating to a conviction or caution is heard after any allegation of misconduct has been heard and determined.'

The panel was informed that [PRIVATE] conviction charges should be heard at impairment stage. It would have been normal practise for the misconduct charges to be raised at a later point in the hearing.

The panel determined that it should only consider the conviction charges at a later stage in the hearing and place the material, relating to these convictions, out of its mind.

Background

The charges arose whilst Ms Seabrook was employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service by North East London Foundation Trust (“NELFT”).

The alleged concerns relate to Ms Seabrook’s conduct in relation to Child Service User A, who was 16 years old at the time and is said to have occurred between the period of 20 July 2021 to 2 August 2021. The concerns relate to:

- Breaches of professional boundaries with Child Service User A by forming an inappropriate relationship with the child;
- Failure to safeguard a child service user placing them at risk of harm, including allegedly providing and/or permitting the child to take alcohol and/or drugs namely cocaine in your presence; and
- [PRIVATE].

Decision and reasons on facts

Before making any findings of fact, the panel heard and accepted the advice of the legal assessor.

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

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: Sharon Hall, Assistant Director,
Northeast London Foundation Trust;
- Witness 2: John Styman, Managing Director,
Creative Support Solutions Ltd
- Witness 3: Katherine Showell, Social Worker at
the Essex County Council
- Witness 4: Melanie Munday, Care Coordinator
and Senior Occupational Therapist,
North Essex Partnership University
NHS Foundation Trust

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor and considered the documentary evidence before it.

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

Charge 1

[PRIVATE].

Schedule 1

[PRIVATE]

This charge is found proved in respect of [PRIVATE] .

[PRIVATE]

Charge 2a)

That you, a registered nurse, whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:
Engaged in communication with Child Service User A.

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it, including documentary evidence, witness statements and Ms Seabrook's own admissions.

The panel reviewed the evidence before it and considered whether Ms Seabrook engaged in communication with Child Service User A on one or more occasions between 14 July and 2 August 2021 whilst not on shift. It had regard to consistent witness statements from colleagues and professionals involved in Child Service User A's care. These included evidence from colleagues who observed Child User A receiving calls and text messages from Ms Seabrook.

Further, the panel placed significant weight on the documentary evidence, including screenshots and telecommunication data demonstrating a pattern of calls and text message exchanges between Ms Seabrook and Child Service User A during the relevant period. This evidence included records of missed calls and message activity which corroborated the witness accounts.

The panel also noted that a download of phone data had been undertaken, which further supported the existence and frequency of communications between Ms Seabrook and Child Service User A. The panel considered that the evidence was mutually corroborating and compelling. Ms Seabrook's own admission at the local level, provided clear and cogent evidence of her communication with Child Service User A during the relevant period and whilst she was not on shift.

Accordingly, the panel found charge 2a) proved.

Charge 2b) and c)

That you, a registered nurse, whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:

Met in person with Child Service User A.

Provided a lift in your car to Child Service User A.

This charge is found proved.

Given the overlap in the evidential basis for the allegations in charges 2b) and 2c), the panel decided to consider these charges together.

In reaching this decision, the panel considered all the evidence before it. It had regard to the following:

- Witness statement of Mr Styman, where he stated as follows:

'...By this point, staff were aware that Caroline was meeting Service user A and so they followed to check who he was meeting. When at Morrisons, staff directly observed Service user A get into Caroline's car, so they alerted police...'

- Notes of investigation meeting with Mr Leontin Ochea dated 16 August 2021, where he stated:

'... I saw her turning back with SUA. they were joking and pushing and giving each other the finger...'

- Notes of investigation meeting with Jamie Strong held on 26 August 2021, where he stated:

'...He said the police were on to her and she dropped him off at Doncaster...'

'...The following morning, he was driving with CS listening to music, smoking in the car and drinking again...'

- Notes of investigation meeting with Ms Seabrook held on 4 November 2021, where she stated:

'... I did pick him up as he wanted to go to friend's, I didn't leave him at the service station, he walked away from the car and didn't come back as I had said to him that I wasn't happy with what was going on and wanted to take him back to the home...'

When asked 'where had he asked you to take him' Ms Seabrook responded: 'To a friend that lived in Scotland.'

The panel also had evidence of an incident where Ms Seabrook took Child Service User A to Romford by car from his placement. The panel considered the witness evidence. It noted consistent accounts from professionals who supported Child Service User A describing occasions on which Ms Seabrook was observed in the company of Child Service user A outside of her professional duties. In particular, the panel placed weight on evidence that Child Service User A was followed by staff and subsequently seen entering Ms Seabrook's vehicle.

The panel further considered documentary and investigative material from the local investigation, which described an incident in which Child Service User A was observed with Ms Seabrook in a Morrison car park. This evidence was consistent with the witness statements and supported the finding that they met in person.

In addition, the panel had regard to evidence that Ms Seabrook transported Child Service User A over a significant distance, including an occasion where she drove him with the intention of taking him to visit a friend in Scotland. This was supported both by witness evidence, Child Service User A's accounts and Ms Seabrook's own admission.

Accordingly, the panel was satisfied, on the balance of probabilities, that Ms Seabrook did meet in person with Child Service User A and did provide him with a lift in her car, on one or more occasions during the relevant period and whilst she was not on shift.

Therefore, charge 2b) and 2c) are therefore found proved.

Charge 2d)

That you, a registered nurse, whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:
Invited Child Service User A to your home.

This charge is found proved.

The panel considered the evidence in relation to this charge including the text exchanges between Ms Seabrook and Child Service User A. It noted that there was compelling evidence indicating that Ms Seabrook extended an invitation to Child Service User A in a WhatsApp message to attend her home address.

'...can I not just get away with getting you in an uber to my house. Sticking you in front of the Tv with my bank card and unlimited takeaways...'

The panel was satisfied that Ms Seabrook did invite Child Service User A to her home on one or more occasions during the relevant period and whilst she was not on shift. Accordingly, charge 2d) is found proved.

Charge 2e)

That you, a registered nurse, whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:
Provided to Child Service User A and/or permitted Child Service User A to take in your presence, alcohol and/or drugs, namely Cocaine.

This charge is found proved in respect of cocaine and not proved in respect of alcohol.

The panel considered the NMC evidence including the assertions of Witness 3 during the local investigation. The panel also carefully considered the interviews conducted at the local investigation.

Ms Seabrook's stated as follows:

'I didn't offer them any spirits, I had none to offer. I had been drinking but not all day. I didn't offer them cocaine and later realised that someone else that I had been with earlier did leave cocaine in my car. SUA found it and kept messing around trying to get it and eventually he did take it and I didn't stop him...'

Ms Showell stated as follows:

'... SUA had been around and had said that a worker high up in his care had taken him out in their car, had offered him cocaine and had taken it in front of him. SUA didn't name CS- he was bragging. He couldn't believe it. One of the staff from SUA's home asked if this worker was CS by name There was then lots of matching up of incident reports'

Ms Melanie Lee stated as follows at the local investigation:

'yes, it was in a phone call. It is in the case records. On 21 July 2021 I took a phone call from SUA at 12:20 p.m. He stated he was under the influence of cocaine, he was giggling. SUA had gone missing from his placement. He said CS had picked him up and taken him to his friend's FOS placement in Romford. He said that she had been drinking Jack Daniels all day and was driving erratically. She sped off from FOS 's placement and gave SUA and FOS cocaine, which they took...'

'I met SUA later that day (21 July 2021) at the placement. He was still quite high. He wanted to talk about the events. I advised we would have to pass on anything he told us. SUA said again he was sorry he had caused trouble for CS. I advised him not to worry- it was not his fault. SUA said that CS had supplied cocaine that her brother had left in the car.'

Ms Showell in an email to Ms Hall dated 9 August 2021 stated as follows:

'...Whilst on the visit, SUA showed us some of the messages that they have been exchanging and it was mostly revolving around her picking him up for a drive. The ones that were sent today were discussing her either picking him up or ordering him an Uber from his placement to her house. Whilst there she offered him snacks, movie, drugs and alcohol.'

In relation to cocaine, the panel considered that there was no material before it to undermine the reliability of this evidence, and it was consistent with the wider evidential picture concerning the nature of Ms Seabrook's interaction with Child Service User A during the relevant period.

The panel was satisfied that Ms Seabrook provided and permitted Child Service User A to take cocaine in her presence. Ms Seabrook accepted that there was cocaine in her car but denied providing it to Child Service User A and that he in fact found it and she did not stop him taking it. The panel did not find this account credible when considering her overall behaviour with Child Service User A.

In relation to alcohol, the panel carefully considered whether there was sufficient evidence to establish that Ms Seabrook either provided alcohol to Child Service User A or permitted him to consume alcohol in her presence. The panel found that there was no clear evidence to support this allegation. In the absence of reliable evidence, the panel could not be satisfied, on the balance of probabilities, that this aspect of the charge was made out.

Therefore, the panel found charge 2e) proved in respect of cocaine and not proved in respect of alcohol.

Charge 2f)

That you, a registered nurse, whilst employed as a Band 7 Team Manager in the Emotional Wellbeing and Mental Health Intensive Support Service and not on shift, on one or more occasion between 14 July and 2 August 2021:

Drove under the influence of alcohol and/or drugs with Child Service User A in the car.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Ms Seabrook's own admissions.

The panel noted that Ms Seabrook accepted that she had driven whilst under the influence of alcohol and/or drugs during the relevant period, and that Child Service User A was present in the vehicle. The panel considered this admission to be clear, direct, and unequivocal. The panel found no reason to doubt the reliability of Ms Seabrook's admission. It was consistent with the wider evidential picture, including findings already made in respect of her use of substances during the relevant period and her interactions with Child service User A.

The panel considered that Ms Seabrook's admission alone was sufficient to establish the factual basis of this charge. There was no evidence before the panel which undermined or contradicted this account. Accordingly, the panel was satisfied, on the balance of probabilities, that Ms Seabrook did drive under the influence of alcohol and/or drugs whilst Child Service User A was in the car. Charge 2f) is therefore found proved.

Charge 3

That you, a registered nurse, continued to have contact with Child Service User A after being told not to by your employer on 27 July 2021.

This charge is found proved.

The panel considered whether Ms Seabrook continued to have contact with Child Service User A after being instructed by her employer on 27 July 2021 not to do so. The panel also carefully considered all the evidence before it.

Ms Hall stated as follows:

'When I first met with Caroline, we didn't suspend her, but we told her about the allegations. In the interim she told was not to contact SUA or anyone else in work for any reason. We then set up support networks for her. Caroline agreed she wouldn't contact SUA and stated she had changed her phone number so that he

couldn't contact her either.'

Ms Seabrook stated as follows when asked if she recalled contacting SUA:

'Yes, I do recall, regretfully. I don't recall saying I was going to lose my job...'

When asked if she picked up Child Service User A on 28 July 2021, Ms Seabrook stated as follows:

'I did pick him up as he wanted to go to a friend's,..'

The panel also had regard to evidence of ongoing communication, and meetings between Ms Seabrook and Child Service User A including a trip to Morrisons on 1 August 2021 and a planned trip to Scotland on 28 July 2021.

The panel found that the evidence before it supported the fact that Ms Seabrook continued to have contact with Child Service User A after 27 July 2021. It was satisfied that Ms Seabrook was aware of the instruction to cease contact and nonetheless continued to engage with Child service User A thereafter.

Accordingly, the panel found that Ms Seabrook did continue to have contact with Child service User A after being told not to by her employer on 27 July 2021. Charge 3 is therefore found proved.

Charge 4

That you, a registered nurse, failed to maintain records of your communication and interactions with Child Service User A in respect of the contact that you had with him as referenced in charge 2a.

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it. It had particular regard to the notes from the local investigation, as well as witness statements, the Consultation Information Sheet and Management Report regarding Disciplinary Investigation into allegations made against Ms Seabrook.

The panel first reminded itself of its finding in respect of charge 2a), namely that Ms Seabrook engaged in communication with Child Service User A on multiple occasions whilst not on shift.

The panel next considered whether those interactions were appropriately recorded in accordance with professional requirements. The panel took account of the Consultation Information sheet dated 2 July – 12 July 2021 and found that Ms Seabrook failed to record most of her subsequent interactions with Child Service User A. The panel had before it WhatsApp messages dated from 20 July 2021 which are not documented and nor is the occasion where she took him to Romford on 20 July 2021. These dates preceded management's advice to Ms Seabrook not to contact Child Service User A.

The panel noted Ms Seabrook's managerial position and determined that she would have been aware of the need to document interactions with Child Service User A as evidenced in the Consultation Information Sheet.

Accordingly, the panel was satisfied, on the balance of probabilities, that Ms Seabrook failed to maintain records of her communication with Child Service User A as alleged. This charge is therefore found proved.

Charge 7

Your actions at charge 2 demonstrated that you had formed an inappropriate relationship with Child Service User A and/or breached professional boundaries.

This charge is found proved.

The panel had regard to its finding in relation to charge 2. It considered the totality of Ms Seabrook's conduct towards Child Service User A during the relevant period and likely impact on the profession.

The panel found that Ms Seabrook engaged in repeated and sustained communication with Child Service User A outside of her professional duties and working hours. It further

found that she met with him in person on several occasions, provided him with lifts in her car, invited him to her home, and continued contact notwithstanding an explicit instruction from her employer to cease such contact.

The panel also found that Ms Seabrook provided and/or permitted Child Service User A to take cocaine in her presence and drove whilst under the influence of alcohol and/or drugs with him in the car. The panel found this conduct to be of particular concern given the vulnerability of Child Service User A and Ms Seabrook's position as a senior nurse. The panel considered that this pattern of behaviour went far beyond what could be considered appropriate professional engagement. The frequency, the inappropriate nature, and context of the interactions demonstrated a significant blurring, and ultimately a disregard, of professional boundaries and the Professional and Personal Boundaries and Chaperones Policy set out by her employer which she would have been aware of.

The panel also considered Ms Seabrook's own admission that her conduct was outside of her job role and that her behaviour was unprofessional. It took into account that Ms Seabrook was employed as a Band 7 nurse, a role which carries heightened responsibility to model appropriate professional conduct to junior colleagues and maintain clear boundaries with service users. In addition, evidence from other professionals involved with Child Service User A stated that this relationship and behaviour was inappropriate. The panel determined that her actions were wholly incompatible with those responsibilities.

The panel concluded that Ms Seabrook's conduct taken as a whole, amounted to the formation of an inappropriate relationship with Child Service User A and a serious breach of professional boundaries. Accordingly charge 7 is found proved.

Misconduct [PRIVATE]?

[PRIVATE]

The panel, in reaching its decision on misconduct, 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.

Representations on misconduct

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.’

[PRIVATE]

The NMC submitted that the following provision(s) of the Code have been breached.

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.

20.4 keep to the laws of the country in which you are practicing.

*20.6 stay objective and have clear professional boundaries at all times with
People in your care (including those who have been in your care in the
past), their families and carers.*

*20.8 act as a role model of professional behaviour for students and newly
Qualified nurses, midwives and nursing associates to aspire to.*

20.9 maintain the level of health you need to carry out your professional role.

Decision and reasons on misconduct

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

The panel was of the view that Ms Seabrook’s actions did fall significantly short of the standards expected of a registered nurse, and that Ms Seabrook’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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

- 13.4 *take account of your own personal safety as well as the safety of people in your care*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

- 17.1 *all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*
- 17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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*

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

20.4 keep to the laws of the country in which you are practising

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role.'

The panel considered all the charges together rather than individually as this was considered a single course of conduct over a short period of time.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Seabrook abused her position of trust. It considered that her actions exposed Child Service User A to high-risk behaviours including placing him at risk of serious harm, exposing him to illegal substances, being in his presence whilst under the influence of alcohol and transporting him in circumstances which posed a risk to his safety. The panel also considered that these actions created a real risk of significant harm.

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

Conviction charge

Following the panel's finding impairment in relation to charges 2,3, 4 and 7, the panel turned to the charges in regard to allegations of Ms Seabrook's conviction.

Details of charge:

That you, a registered nurse;

- 5) Were convicted on 30 September 2021 for driving whilst intoxicated on 6 August 2021
- 6) Were convicted on 21 September 2021 for driving whilst under the influence of drugs namely Cocaine on 8 August 2021.

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

Decision and reasons on facts relating to the conviction charge.

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

The panel was aware in terms of Rule 31 (2) of the Rules production of a certificate of conviction was 'conclusive proof of the conviction'

The panel had sight of the memoranda of convictions dated 21 September 2021 for driving whilst under the influence of drugs namely cocaine and 30 September 2021 for driving whilst intoxicated. These documents showed that Ms Seabrook's was convicted of the offences named in charges 5 and 6 above.

Therefore, the panel was satisfied that the convictions alleged in charges 5 and 6 are proved by way of the certificates of conviction.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and convictions, Ms Seabrook's fitness to practise is currently impaired [PRIVATE].

The NMC invited the panel to find impairment in respect of the first three limbs in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)*

In coming to its decision, the panel had regard to the NMC Guidance on '*Impairment*' (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

'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.'

In this regard the panel considered the test approved by Mrs Justice Cox in the case of *CHRE v NMC and Grant* in paragraph 76

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) ...'*

The panel considered that limbs a to c were engaged by Ms Seabrook's misconduct and conviction in this case.

The panel bore in mind the vulnerability of Child Service User A. Whilst all children are inherently vulnerable, the panel determined that Child Service User A was particularly vulnerable due to him being a look-after child [PRIVATE]. In those circumstances he required a high level of professional care, safeguarding, and clear boundaries. The panel found that Ms Seabrook failed to recognise and appropriately respond to this heightened vulnerability. Instead, her conduct caused him emotional harm and placed him at significant risk of physical harm. This included exposing him to inappropriate and unsafe situations, involving him in high-risk behaviours, and failing to maintain professional

safeguards designed to protect him. The panel noted observations from Ms Showell that *'...he started going missing again, doing drugs and alcohol and everything else that went along with it. His behaviour got worse again.'*

The panel considered that Ms Seabrook's actions brought the profession into disrepute. The panel considered that this behaviour would be likely to cause significant harm to the reputation of the nursing profession. It was of the view that Ms Seabrook's conduct had breached the fundamental tenets of the nursing profession, namely to *"Uphold the reputation of your profession at all times"* and to *"Uphold your position as a registered nurse, midwife or nursing associate."*

The panel recognised that it must make an assessment of Ms Seabrook's fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether she would pose a risk of repeating the conduct found proved in the future.

The panel carefully considered the evidence before it in determining whether the concerns identified are capable of remediation and whether or not Ms Seabrook has taken steps to strengthen her practice. However, there is no evidence before the panel of any steps taken by Ms Seabrook to address her conduct or remediate her practice. Ms Seabrook has not engaged with these proceedings and has not provided any up-to-date medical or relevant evidence. The panel noted that she did not attend arranged assessments and has not demonstrated any willingness to address the concerns identified or provide any insight into the concerns. It therefore had no evidence that that Ms Seabrook understood the impact of her actions on Child Service User A, in fact, as reported by Adam Digby, she laid blame on him stating *'...I cannot believe I have been manipulated by a sixteen year old...'*

The panel also had no evidence that that Ms Seabrook understood the impact of her actions on the profession, or public confidence. She has not produced any reflections on her misconduct or her convictions. Therefore, there was no reassurance that these matters would not be repeated.

In these circumstances, the panel concluded that there remains a real risk of repetition. The panel therefore concluded that a finding of impairment, by reason of Ms Seabrook's misconduct is necessary on the grounds of public protection.

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

The panel considered whether a finding of impairment by reason of the misconduct is otherwise in the public interest. The panel concluded that a well-informed member of the public would be concerned if no finding of impairment were made in light of the seriousness and nature of the findings made by the panel. Furthermore, it determined that confidence in the profession, and the NMC as their regulator, would be diminished and standards of nursing undermined, if no finding of impairment were to be made. Therefore, the panel concluded that a finding of impairment was otherwise in the public interest.

The panel also considered whether Ms Seabrook's fitness to practise is impaired by reason of her conviction. The panel concluded that a well-informed member of the public would be concerned if no finding of impairment were made in light of Ms Seabrook's convictions, which was found proved by the panel, as it pertains to serious criminal convictions. The panel noted that she was disqualified from driving for 34 months, required to attend an accredited programme for 12 days and carry out unpaid work in the community for 160 hours. Furthermore, it determined that confidence in the profession, and the NMC as their regulator, would be diminished and standards of nursing undermined, if no finding of impairment were to be made. Therefore, the panel concluded that a finding of impairment was otherwise in the public interest in this regard.

Having regard to all of the above, the panel was satisfied that Ms Seabrook's fitness to practise is currently impaired by reason of her misconduct and convictions.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Seabrook off the register. The effect of this order is that the NMC register will show that Ms Seabrook 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 11 February 2026, the NMC had advised Ms Seabrook that it would seek the imposition of a 12 month suspension order with review if it found Ms Seabrook's fitness to practise currently impaired.

The NMC made the following submissions regarding sanctions:

The NMC submitted that the aggravating factors in this case are as follows:

- Actual harm caused to Child Patient A
- Ignored warning from employer to have no further contact
- [PRIVATE]

The NMC accepted that there were some mitigating factors, including:

- [PRIVATE]
- Ms Seabrook made admissions at local level

The NMC noted that Ms Seabrook is currently subject to a Disclosure Barring Service (DBS) bar and acknowledged that the DBS have excluded Ms Seabrook from working and volunteering with children and vulnerable adults by her inclusion on the Children's and Adult's Barred Lists.

The panel noted that the NMC's submissions were based on *Sanctions Guidance* which was superseded on 28 January 2026.

Decision and reasons on sanction

Having found Ms Seabrook's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- abuse of a position of trust
- the misconduct involved a particularly vulnerable child [PRIVATE]
- Actual harm was caused to Child Service User A
- the misconduct constituted a pattern of misconduct over a period of time, rather than an isolated incident
- [PRIVATE]
- failure to engage in the Fitness to Practise (FtP) process
- absence of insight
- no remorse
- no remediation
- two serious convictions, the second of which took place two days after the first offence

The panel also took into account the following mitigating features:

- Ms Seabrook's personal circumstances during the relevant period.

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

The panel next considered a caution order and had regard to the NMC Guidance on 'Caution order' (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel considered that Ms Seabrook's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Seabrook practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Ms Seabrook's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel considered that there was no evidence of engagement from Ms Seabrook. It cannot therefore be satisfied that Ms Seabrook would be willing or able to comply with any conditions imposed.

Further, the panel had sight of the letters from the DBS dated 31 October 2022 and 17 November 2022 which confirmed that Ms Seabrook is currently included on the barred list for working and volunteering with children and adults and that this decision would only be eligible for review from 31 October 2032. In these circumstances, the panel determined that there is no realistic prospect of Ms Seabrook practising in a way which would allow conditions to be formulated, implemented, or tested.

Having regard to the nature and seriousness of Ms Seabrook's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel concluded that there are no relevant, proportionate, workable or

measurable conditions that could be formulated to protect patients and to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on ‘*Suspension order*’ (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *‘the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.’*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *‘the charges found proved are at the most serious end of the spectrum and call into question the professional’s suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.’*

The panel considered that a suspension order would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness

and nature of the facts found proved. The panel also considered that Ms Seabrook's has not engaged with the NMC nor shown insight or remorse. The panel also considered the DBS' decision to include Ms Seabrook in the Children's and the Adults' Barred Lists. The panel determined that it cannot be satisfied that Ms Seabrook would develop insight, demonstrate remorse, or remediate her practice during a period of suspension. The panel concluded that there is no realistic possibility that Ms Seabrook would address the concerns to such a level where she could return to practise safely.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on '*Sanctions for the highest risk cases*' (Reference SAN-4 Last Updated: 28/01/2026). The panel considered that Ms Seabrook's conduct involved a sustained and serious breach of professional boundaries, an abuse of a position of trust, and the exposure of a particularly vulnerable child [PRIVATE] to harm and risk of harm. Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case*'.

The panel had regard to the following considerations as set out in the NMC Guidance entitled '*Striking-off order*' (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel considered whether the charges found proved raise fundamental questions about Ms Seabrook's professionalism. It determined that they do. Ms Seabrook's

misconduct involved a serious and sustained breach of professional boundaries involving a vulnerable child. It found that Ms Seabrook failed to engage with the regulatory process or provide evidence as to any reflection or steps taken to address her misconduct and convictions. The panel concluded that Ms Seabrook's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Seabrook's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the submissions of the NMC in relation to the sanction that the NMC was seeking in this case. However, the panel considered that it could not be satisfied that such an outcome would result in Ms Seabrook addressing the concerns identified or reduce the risk of repetition.

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 including the convictions and in particular the effect of Ms Seabrook's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Seabrook'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 inviting the panel to impose a suspension order for 18 month interim suspension order on the basis that it is necessary for the protection of the public and otherwise in the public interest and to cover the resolution of any appeal.

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 allow time for the appeal period before the striking-off order comes into effect.

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

That concludes this determination.

This will be confirmed to Ms Seabrook in writing.