Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
21 - 23 & 27 - 30 July 2026

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Kenneth Macadaeg**
NMC PIN:	23K1962O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 27 November 2023
Relevant Location:	Redbridge
Type of case:	Misconduct
Panel members:	Caroline Rollitt (Chair, Lay member) Catherine McCarthy (Registrant member) James Kellock (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Tom Hamilton, Case Presenter
Mr Macadaeg:	Present and represented by James Lloyd, instructed by Royal College of Nursing (RCN)
Facts proved:	Charges 1, 2(a-b), 3, 4
Facts not proved:	Charges 5, 6, 7
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application for hearing to be held in private

Mr Hamilton, on behalf of the Nursing and Midwifery Council (NMC), made an application for this case to be held partly in private on the basis that proper exploration of your case involves the health conditions of Patient A and Patient B and makes reference to your [PRIVATE] private life. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

Mr Lloyd, on your behalf, did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to Patient A and Patient B's health conditions and your [PRIVATE] private life, the panel determined to hold parts of the hearing in private as and when such issues are raised. The panel bore in mind that while their privacy is protected by their anonymity jigsaw identification might result in their identities becoming known.

Decision and reasons on application for Special Measures

Before hearing evidence from Patient A and Patient B, Mr Hamilton made an application pursuant to Rule 23 of the Rules. He told the panel that, in a previous hearing, a fitness to practise panel had made directions about special measures for Patient A and Patient B, permitting them to give evidence virtually, and allowing a [PRIVATE] to support Patient B.

Mr Lloyd said that special measures directions had been made by a previous panel and therefore he could not object in principle to the application.

The panel accepted the advice of the legal assessor who referred the panel to Rule 23.

The panel had regard to Rule 23 and was mindful of the directions previously made in a directions hearing. The panel was satisfied that Patient A and Patient B are vulnerable witnesses and that the special measures directions would help enable them to give their best evidence. The panel therefore decided to grant this application.

Decision and reasons on application to admit the document entitled Investigation Report authored by Julie MacPherson, the investigation manager, dated 15 March 2024 as hearsay evidence

Mr Hamilton told the panel that a previous Fitness to Practise panel had also admitted this report into evidence. However, as a precaution, he made the application under Rule 31 to allow the investigation report by Julie MacPherson (Ms MacPherson) into evidence. He submitted that the investigation report includes witness statements, investigation meeting notes, Patient A's local witness statement and the Trust's suspension from work letter dated 20 February 2024.

Mr Hamilton submitted that it would be fair to rely on this report as the documents all came from the Trust's local investigation and were created immediately after the events.

Mr Lloyd did not oppose the application but asked the panel carefully to consider the weight to be given to the documents attached to the report, as the panel was not going to hear from the people interviewed by Ms MacPherson, nor from Ms MacPherson herself.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered that as you had been provided with a copy of the investigation report there was also a public interest in the issues being explored fully, which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to admit the Trust's investigation report dated 15 March 2024 as hearsay evidence. The panel would decide what weight to give it once it had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse:

1. Between 15 and 16 February 2024 on one or more occasions touched Patient A's penis without clinical justification. **[PROVED]**

2. On 16 February 2024 said to Patient A:

   (a) "you have a very strong erection" or words to that effect **[PROVED]**
   (b) "this is a very strong erection" or words to that effect **[PROVED]**

3. Your conduct in Charge 1 was sexually motivated. **[PROVED]**

4. Your conduct in Charge 2 was sexually motivated. **[PROVED]**

5. On or about September 2023 touched Patient B's penis without clinical justification. **[NOT PROVED]**

6. Your conduct in Charge 5 was sexually motivated. **[NOT PROVED]**

7. On 10 May 2025 whilst your registration was subject to an interim conditions of practice order, breached the conditions of the said order, in that you provided intimate care to a patient without a chaperone present. **[NOT PROVED]**

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

Background

The charges arose whilst you were employed as a registered nurse by Spire Hospital Southampton (the Hospital). You were recruited from the Philippines, starting work in June 2023 and being supernumerary until you obtained your UK nursing registration and were allocated a Personal Identification Number (PIN) in November 2023. During that time you were working as a Health Care Assistant (HCA). You said that during that period you wore green scrubs, not a nursing uniform.

Patient A

On 4 March 2024 the NMC received a referral from Patient A.

Patient A had an operation on his spine on 15 February 2024. Post-operative care was given in the afternoon by a female nurse, including sensation testing on his legs, without incident. You came on duty and continued to care for Patient A, carrying out observations and sensation testing. This included going into Patient A's room a number of times during the night and into the early hours of 16 February 2024. It was alleged that on two or three separate occasions while conducting proper sensation testing you had also stroked Patient A's penis and touched his genital area.

At 1.30 am on 16 February 2024, it was alleged by Patient A that you came to do observations and asked if you could wash his legs. Patient A agreed and it is alleged that you then cleaned Patient A's genital area including the penis with his foreskin pulled back

and after doing so for some time said, ‘Oh you have a very strong erection’ and then, after continuing that activity said, “Oh this is a very strong erection”. Patient A said that he asked you to stop and you did and left the room. Patient A said this lasted for 5 – 10 minutes.

On being discharged on 16 February 2024, Patient A reported the incident to the senior staff nurse in charge of ward 2. On 17 February 2024, Patient A submitted an email complaint via the Hospital’s complaint portal.

After the complaint was made, the Director of Clinical Services, Karen Willoughby (Ms Willoughby), spoke to you about the allegations on 19 February 2024. You said that you were washing Patient A’s legs in the early hours because there was some dirt on his legs. You were subsequently suspended.

On 22 February 2024, you were interviewed by Ms MacPherson. In this meeting, you said that you were cleaning dirt off Patient A’s upper left thigh, that you did not touch his genitals and did not say anything about an erection. You said that this was not a word you would use.

When the local investigation concluded, it was decided that there was not enough evidence to support these concerns and accordingly you were reinstated.

Patient B

Another nurse learned of Patient A’s complaint against you. She reported that on 8 January 2024 Patient B was attending the hospital, had seen you and recognising you made a complaint to her. Patient B had a hip replacement in September 2023. He said that after the operation you had washed his legs and genital area, including the penis with the foreskin pulled back, for a long time. He said that at the time he had no sensation there but had looked down to see what you had been doing for a long time. He had felt this was wrong and had asked you to stop. Patient B had been groggy and sleepy from

the anaesthetic at the time and was unsure about what had happened and did not make a complaint at that time. The nurse did not escalate the reported concern in January 2024 but, following learning of Patient A's allegations, raised this concern on 19 February 2024.

You denied this allegation and said that you would only clean Patient B's genitals if he was having a catheter fitted and said that you had no recollection of Patient B.

An interim conditions of practice order was imposed on 9 May 2024 for a period of 18 months. Condition 4 stated:

> '4. You must have a chaperone with you at all times when providing intimate care to patients.'

On 21 August 2025, you were dismissed from your role as a registered nurse for changing a patient's incontinence pad (incopad) on 10 May 2025 without a chaperone present.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Hamilton and Mr Lloyd. The panel also accepted the advice of the legal assessor. In connection with the charges of sexual motivation, the legal assessor referred the panel to the case of *Haris v General Medical Council (Rev 1)* [2021] EWCA Civ 763. The Legal Assessor's advice including the following:

> *'You will bear in mind that the defence to the charge involving Patient B is primarily that there is insufficient evidence to show that Mr Macadaeg attended to Patient B in September 2023. You will take into account that Patient B fully accepted that he was "woozy" from anaesthetic at the time. Is there sufficient evidence to show that*

he was on duty that night? What do you make of the evidence about the wearing of glasses or a white coat?

If you conclude that there is not sufficient evidence to prove that Mr Macadeag attended Patient B you need form no view as to whether Patient B was accurate in his evidence about what happened, or did not happen, to him in September 2023.

As to the charge relating to Patient A, should you find that the charge concerning Patient B is not proved for the reason that it has not shown that he attended that patient on that occasion there can be no point that there are two similar incidences.

For that reason, I suggest that you take Patient B and charges 5 and 6 first. If you find that you do need to evaluate the care Mr Macadeag provided to Patient B then the conclusion can be relevant to your assessment of the evidence relating to charges 1 and 2, and you may want to approach them together rather than coming to a conclusion on 1 before the other.

Or you may feel that if the evidence for one is strong you may want to take that first, but without reference to the weaker charge. If you find that stronger charge proved without reference to the other that may help you with the weaker charge.

It is a matter for you to decide on your approach. However, I would advise against using the matter of the weaker charge, relating to Patient B, to support the proving of those relating to Patient A and then working back to the charges relating to Patient B.'

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

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

- Patient A:

- Patient B:

- Karen Willoughby: Director of Clinical Services at the Spire Southampton Hospital.

The panel also heard evidence from you under oath.

It considered the witness and documentary evidence provided by both Mr Hamilton and Mr Lloyd, and their detailed submissions.

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

The panel first considered whether you provided care to Patient A and Patient B. It noted that you do not dispute providing care for Patient A, but do not accept that you provided care to Patient B on the day in question.

The NMC submitted that there was a degree of correlation between the allegations regarding Patients A and B. You accepted that you had treated Patient A, but not that you had treated Patient B. The panel considered that before it could evaluate the NMC's submission that the allegations supported one another it must first consider whether there was credible evidence that you had attended Patient B after his operation in September 2023.

It therefore first considered charges 5 and 6, in relation to Patient B, to determine whether there was sufficient evidence that you provided care to Patient B.

Charge 5

5. On or about September 2023 touched Patient B's penis without clinical justification.

This charge is found NOT proved.

The panel first considered whether there was sufficient evidence that you provided care to Patient B on or about September 2023. In reaching this decision, the panel took into account the documentary and oral evidence of Patient B, Ms Willoughby, and the evidence provided by you.

In an investigation meeting dated 22 February 2022, the panel noted:

> '[Julie MacPherson]: *Since this incident we have had another concern raised to us relating to a patient who had spinal anaesthetic for a knee replacement. The patient stated that you washed his genital area a few hours after he came back from surgery. Do you have any recollection of this?*
>
> [Kenneth Macadaeg] *I have some. There are many patients I help to wash or wipe. When they need to pee and they use the bed pan I need to wipe them afterwards.'*

In the Hospital's investigation interview dated 28 February 2024 with Nurse A, the panel noted that Nurse A stated:

> *'It was a regular night shift and I received a patient who was a post-operative knee replacement. He has received spinal anaesthetic so was sedated from the hip down.*
>
> *He had returned to the Ward at approximately 4.30pm. At 9.00pm I went to do his second observation, at this point he was a little bit more conscious, and he started by describing the nurse. I thought he was going to praise him, but he asked if we*

usually wash legs and the pubic area. I explained that we would just wash his legs on the first day post-op and when he was mobile with the physio.

I asked the patient what happened, and he said he thinks the nurse he had described was washing this area and had been rubbing his genitals.

I was shocked. The patient said, "I was groggy but I think that it what he was doing". The patient then said "never mind. I am not sure".

[…]

Then, as I was putting the patient to sleep, he said, "I won't make a fuss. I am an 80-year-old man. Just watch that nurse as I don't want him to do it to others".

Kenneth Macadaeg (KM) was my colleague from the Philippines and nothing like this has happened before. I didn't know what to do. I kept it to myself and thought if something comes up again then I would raise it.'

The panel noted from Nurse A's local statement dated 20 February 2024:

'I was an incoming night shift nurse on that day. [Patient B] *was a 80 yrs. old male who has undergone a right knee replacement under spinal anaesthetic which means he came back numb from hip down. I was doing my 2nd set of observations around 9pm when he asked me if we usually do wash the patient's leg and pubic area. Which then I answered "Yes, the legs, but during Day 1 post op after the physio mobilizes you the first time." He then described me this nurse which I recognized immediately. It was RN K.M from the day shift who handled him during the days. I asked him what happened and he stated that he thinks RN K.M was washing him with wet towelettes first on his legs then his pubic area and genital area he was scrubbing it way too long. He then said "Well, I was numb down there*

and I was dizzy and groggy for I just came back (from recovery), so I am not so sure anyway never mind I might just be sleepy."

[…]

When I was about to send him to sleep, he opened up again about RN K.M and said "I know he's not a male, the first nurse. I am an 80 yrs. old man; I will not make a fuss about it. I am letting you know about this for he might do it to another patient. Watch him".'

The panel had regard to Patient B's witness statement dated 8 May 2025:

'2. To the best of my memory, when I was a patient at the Spire hospital in Southampton in September 2023, for a right hip replacement. After the surgery when I was still rather woozy from the anaesthetic, a male nurse came to wash me with what I thought were wet wipes from the bathroom. After wiping my chest, he then proceeded to do my groin and clean my penis with the foreskin pulled down. Unfortunately, I had no feeling as I was still numb but when I saw what he was doing I asked him to stop.

3. In January 2024, I returned to Spire hospital for a right knee operation and saw in the corridor the same male nurse and I mentioned to the female nurse who was attending me what had happened on the previous visit. I said that "/ thought he should not be left with small boys on his own as he likes playing with men's penis."

4. I do not know the male nurses name but can describe them as an asian male nurse.'

The panel also took into account the oral evidence provided by Patient B who told the panel that he recognised you, wearing a white jacket and round glasses, when, in January

2024, he came in for his second operation and then decided to tell another registered nurse that you touched his penis in September 2023.

The panel had regard to your undated statement:

> *'He said that on September 2023, a male nurse came to wash him with wipes from the bathroom. If he was referring to me it makes no sense because at that time, I was still supernumerary as I don't have my pin yet so I work under an RN's supervision. I received my pin November 2023*
>
> *But as far as I can remember, probably this patient might be that patient back in January 2024. If I'm not mistaken, that patient was the one with a history of Alzheimer's or dementia and If I am not mistaken as much I can remember that patient was rude to me as I didn't allow him to get up the bed when his legs were still numb from the anaesthesia.*
>
> *Based on his statement, he was still woozy when the incident happened as he had just returned from recovery so he must be confused and wasn't sure. This questions reliability of any of his recollection and statement. Also, he did not report directly to Spire or made a proper complaint after his two admissions if the allegations really happened.*
>
> *Otherwise, I still strongly deny all the allegations from this patient. I assure that I work professionally and follow NMC code at all times. I always ask for consent and treat patients with dignity and respect.'*

In your oral evidence, you told the panel that you were not aware who Patient B was until seeing him at this hearing.

The panel noted that Ms Willoughby had a misunderstanding as to when Patient B had alleged that you had touched his penis. She had thought it was in January 2024, not

September 2023. She also confirmed to the panel that it would not be appropriate for you to wear a white jacket and she does not recall you wearing round glasses. She told the panel that Nurse A identified you as the nurse Patient B was talking about as you were the only Asian male nurse on the ward in January 2024. However, Ms Willoughby was clear that in September 2023 you were not the only male Filipino nurse on the ward, albeit that you did not have a similar build to the other male Filipino nurse.

The panel noted from your evidence and Ms Willoughby's evidence that, in September 2023, while waiting for your PIN you were working as if you were an HCA. However, the NMC had provided no contemporaneous documentary evidence, such as the date of Patient B's surgery, his patient notes or the ward's roster, to demonstrate that you were providing care to Patient B at this time.

Furthermore, Patient B told the panel that he was under anaesthetic and was 'woozy' at the time he alleged that a nurse had touched his penis. The panel noted that Patient B identified you as the person some four months after the event and provided the NMC with a witness statement some 18 months after that.

Accordingly, the panel had no evidence that you were on shift that night, or that you wore a white jacket or wore glasses. Your uncontradicted evidence was that you wore only green scrubs prior to getting your PIN in November 2023, and that you never wore glasses at work, not needing to do so.

The panel determined that the NMC had not provided sufficient evidence that you were the person providing care to Patient B in September 2023.

The panel did not doubt the honesty of Patient B's evidence, although his recollection was to some extent vague as, in his own words he was "groggy" or "woozy" from the anaesthetic and was sleepy. The accuracy of his identification of you some four months later is not strong evidence given the passage of time and his condition at the time of the alleged incident.

The NMC provided no evidence that you were on shift when Patient B was in the hospital in September 2023. The date of the operation was not provided by the NMC and Patient B could not recall the date.

These reasons meant that the panel could not find, on the balance of probabilities, that Patient B's identification of you as the person he complained about was accurate.

Accordingly, the panel decided that the NMC had not discharged the burden of proving that you had acted as alleged in charge 5.

It therefore found charge 5 not proved.

Charge 6

6. Your conduct in Charge 5 was sexually motivated.

This charge is found NOT proved.

As charge 5 was not found, charge 6 falls away.

Charge 1

1. Between 15 and 16 February 2024 on one or more occasions touched Patient A's penis without clinical justification.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Patient A and Ms Willoughby, and the evidence provided by you.

The panel discounted the evidence relating to Patient B entirely, as, whatever had or had not occurred, charges 5 and 6 were not proved.

The panel first considered whether you were on duty overnight on 15 and 16 February 2024 and whether you provided care to Patient A.

The panel noted that you accept that you were providing care to Patient A as a registered nurse on that night shift.

The panel also had regard to the roster, which was provided by the Hospital and demonstrated that you were on shift and carried out care for Patient A. Therefore, the panel was satisfied that you agreed you were on duty that night and provided care to Patient A between 15 and 16 February 2024.

The panel next considered whether you touched Patient A's penis.

The panel had regard to Patient A's undated statement provided to the Hospital on the 17 February 2024, which stated:

> '[…] *He then performed my observations. He did this in exactly the same way as* [Nurse 1]*, but in addition, he lifted up the duvet and stroked his finger across the length of my penis, asking "can you feel that?". To which I reported yes, I can. He came to visit me several times during the night shift and did the same routine, including the penis touching* […]'

The panel had regard to Patient A's witness statement:

> '[…] *8. Mr Macadaeg then completed my observations, which included blood pressure check, pulse check, eye response and muscle strength testing. Mr Macadaeg also completed sensation testing, where they touched my feet, knees*

and thighs. Mr Macadaeg also stroked the length of my penis. I was wearing netting underwear for surgery, and he touched me on top of the underwear. Mr Macadaeg asked me if I could feel him touching me, to which I replied I could. Mr Macadaeg did not ask me for consent before placing his hand under my duvet to touch my penis. Mr Macadaeg was in the room for around 10 minutes. Initially I thought this was a bit weird but thought nothing of it, despite [Nurse 1] *not doing this. I thought maybe female nurses could not undertake this kind of sensation testing, whereas a male nurse could. I had never had this kind of observation undertaken, however, I did not know what the correct protocol was and thought maybe this is something he has to do. Prior to my surgery, there had never been any suggestion by my surgeon about the necessity of touching my genitalia as part of the sensation testing.*

9. For the next two to three hours, Mr Macadaeg came in at one to one and a half hour intervals and completed the same routine which included touching my genitalia as part of the sensation testing […]

10. […] *Mr Macadaeg got some wipes and cleaned my thighs and knees, and across my stomach. Mr Macadaeg then asked me if he could clean my genital area. I said yes if he thought it would help. I was in a vulnerable position and I assumed Mr Macadaeg was acting in my best interests. Mr Macadaeg pulled down my underwear but did not fully remove them. Mr Macadaeg then cleaned my genitalia, including over the foreskin, and pulling back the foreskin to clean the glans. Mr Macadaeg then cleaned over my testicles.*

[…]

19. The first two to three nights after my interactions with Mr Macadaeg, I had sleepless nights. We took to closing and locking our front door, which we do not normally do for fear that Mr Macadaeg may visit our property […] *however, when we did begin to engage in sexual relations again, I had some flashbacks to Mr Macadaeg touching me, which was strange.'*

In the investigation meeting notes dated 22 February 2024, the panel noted:

> ‘[Julie Macpherson] *This particular patient has stated that you stroked his penis, and you did that on each occasion you checked for sensation?*
>
> *[Kenneth Macadaeg] I am a very sensitive person and so when someone tries to accuse me it is upsetting. But I didn’t do it. I have never touched any patient if they didn’t tell me to.*
>
> *Throughout my entire nursing career I would never do this. It is the first I have had an accusation like that* […]
>
> *I didn’t touch his private parts, I just touched his legs and it’s quickly.*
>
> [Julie Macpherson] *When would you normally wash your patients when they have had surgery?*
>
> *[Kenneth Macadaeg] After surgery, I usually assess the patient since they are day 0. I assess and check their wound. I normally wash patients after giving medication during the morning shift. I help clean the iodine off their legs or where they have put the iodine in the hip replacement. And you must help them to be clean.*
>
> *Then I saw the dirt on this patient’s leg and I helped him to be clean.*
>
> [Julie Macpherson] *Do you mean iodine?*
>
> *[Kenneth Macadaeg] No it was dirt.*
>
> [Julie Macpherson] *Was it just on one leg?*

[Kenneth Macadaeg] Yes

[Julie Macpherson] *When did you notice the dirt?*

[Kenneth Macadaeg] At 1.30am/2am.

[Julie Macpherson] *You hadn't noticed it during your 10pm observation or at the start of your shift?*

[Kenneth Macadaeg] No. And I have been thinking why I did not notice it before. But from 7pm until I noticed it he had the table over his bed and his gown was low, so they were covering this area. At 1.30am-2.00am the table was to the side of the bed and his gown was pulled up. I saw he had dirt on his leg and I asked him if it was okay to clean the dirt off. He said it was okay. If he had said no then I would have left.

[Julie Macpherson] *Where on the thigh was the dirt?*

[Kenneth Macadaeg] On his upper left thigh.

[Julie Macpherson] *Was his thigh the only place you cleaned?*

[Kenneth Macadaeg] I wiped his left leg then I asked if he wanted me to clean his other leg and said it would be like a massage and would help his blood pressure. So I wiped his leg like, 1, 2, 3 ,4 wipe and then the other.

[…]

[Julie Macpherson] *The patient's memory is different and states it was for a longer period of me during which you stroked his penis. Then he said you cleaned across his tummy and into genital area?*

[Kenneth Macadaeg] I didn't touch his genitals […]'

Ms Willoughby in her witness statement wrote:

'15. Patient A alleged that Mr Macadaeg said he should massage Patient A's legs as this would help with blood flow, and Patient A agreed. Mr Macadaeg then allegedly touched Patient A's penis inappropriately. Patient A alleged Mr Macadaeg lifted up the duvet to Patient A's chest to wash his legs. Mr Macadaeg asked for consent to wash Patient A's genitals, to which Patient A said okay. Mr Macadaeg then cleaned the area for a long period to the point where Patient A had an erection. Mr Macadaeg then commented on said erection and Patient A made light of the situation by making a joke. Mr Macadaeg continued to wash Patient A's genitals and Patient A then said to Mr Macadaeg that he had done enough. I am not aware of if Mr Macadaeg left Patient A uncovered. Mr Macadaeg said 'okay I'll see you in the morning' and left the door open to the corridor. I acknowledged Patient A's email, the same day, and also spoke with him on the phone.'

The panel had regard to your witness statement in which you stated:

'[…] *Looking back, the only fault that I can think of was the time of the day that I cleaned the dirt on his leg. I know that it is not the usual time of giving a patient a quick clean and I know that I should have let the patient do it himself as he is able. But, I was only thinking for the patient to receive proper care and service. It is one of my values as a nurse to make the patients feel care and compassion and that they are well taken care of* […]'

The panel also had regard to your oral evidence where you said that Patient A's blood pressure was low, and to increase his blood pressure you started massaging his legs upwards. You said that you then saw 'dirt' on top of Patient A's thigh and decided to clean his legs and thighs.

The panel took into account Ms Willoughby's oral evidence, in which she told the panel that if a patient's blood pressure is low, elevating their legs is sufficient to increase their blood pressure and there is no clinical reason to massage the legs.

The panel noted that Patient A had provided a detailed written complaint the next day. It noted that Patient A was a healthcare professional, and as such he would be conscious of the treatment he would receive and the seeking of consent prior to touching an intimate area, which he said had occurred. The consent was given due to his understanding that it was clinically justified.

The panel also noted that these events took place at least 6-11 hours after Patient A's surgery. There was no evidence which indicated that Patient A's memory was unreliable because of anaesthesia or any other medication.

Furthermore, Patient A told the panel that he could feel an erection, so although he was not able to see what you were doing, he was able to feel you touching his penis. The panel had no evidence which indicated that Patient A had a reason to fabricate this event, nor any reason to think that he was mistaken about what had occurred.

Patient A would be aware of the possible consequences of his complaint and was highly unlikely to have made it frivolously. Patient A had provided a consistent account from the making of his complaint through to the end of his cross examination. He described longer term psychological effects this had on him.

The panel also heard evidence from you that you used your hands to massage Patient A's legs and thighs. The panel did not accept that you carried out sensation testing by touching his legs with a pen top or toothpick. Your evidence was that you had touched Patient A with your hands to massage his legs. The panel did not accept that, if you had done this, it was to increase blood pressure.

The panel did not find credible your account that you were washing “dirt” from Patient A’s thigh. There was no reason to think that Patient A had been incontinent. You did not describe this in any detail. You denied that it was iodine. It would be unusual to wash a patient in the middle of the night. You did not dispute Patient A’s account that the “washing” of his genitalia caused him to have an erection.

The clarity and consistency of the account of Patient A and the lack of credibility of your explanation led the panel to find that the NMC had proved that it was more likely than not that you had touched his penis on a number of occasions.

The panel then considered whether there was a clinical justification for touching Patient A’s penis. Patient A was clear that the previous nurse had carried out sensation testing without touching his penis.

The panel was of the view that there was no clinical reason for you to be massaging Patient A’s legs or washing him in the middle of the night.

The panel accepted Patient A’s account that you touched his penis on a number of occasions. You did not say that the touching was accidental. The panel could see no clinical justification for you touching his penis.

On the balance of probabilities, the panel found this charge proved.

Charge 2(a-b)

2. On 16 February 2024 said to Patient A:

(a) “you have a very strong erection” or words to that effect
(b) “this is a very strong erection” or words to that effect

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Patient A, Ms Willoughby and the evidence provided by you.

The panel had regard to the 'Managing Allegations Against People In A Position Of Trust Notification Form':

> *'Patient has alleged Kenneth woke the patient up at 0130 to complete routine observations. Kenneth asked the patient if he could wash his legs following 'massage of the legs to help increase blood pressure'. Patient consented. Kenneth proceeded to wash genital area for a 'prolonged period, including glands and foreskin' and then commented on the erection the patient sustained. Patient suggested this prolonged period of washing went well beyond clinical care and had to point this out to Kenneth.'*

The panel had regard to Patient A's witness statement:

> *'11. Mr Macadaeg then said to me 'Oh you have a very strong erection'. I made a joke of it, saying 'oh well, it least it's still working'. Mr Macadaeg then continued cleaning my genitals for a further 10 to 15 seconds, and said 'oh this is a very strong erection'. I then thought this had gone too far and asked him to stop. Mr Macadaeg stopped and pulled back down the duvet. Mr Macadaeg left the room and said he would see me in the morning. Mr Macadaeg had spent around five to ten minutes cleaning my genitalia. I checked my watch and saw it was 01:55, meaning Mr Macadaeg had been in my room for 25 minutes.'*

Ms Willoughby in her witness statement wrote:

> '15. [...] *Mr Macadaeg then cleaned the area for a long period to the point where Patient A had an erection. Mr Macadaeg then commented on said erection and Patient A made light of the situation by making a joke. Mr Macadaeg continued to*

wash Patient A's genitals and Patient A then said to Mr Macadaeg that he had done enough […]'

In your oral evidence, you told the panel that the word 'erection' was not a word you used ordinarily as this was complicated English. However, the panel did not accept your account on this. It was of the view that your command of English was such that the word erection was one likely to be known to you.

The panel was of the view that Patient A had given a consistent and coherent account of the fact that he initially assumed that your touching of his penis was clinically justified. However, after some time his evidence is that he became uncomfortable with what you were doing and asked you to stop after you said these words, as separate phrases. The panel accepted this evidence.

Taking all the evidence into account, the panel determined that, on the balance of probabilities, you had said to Patient A, "you have a very strong erection" and "this is a very strong erection", or words to that effect.

It therefore found charges 2(a) and 2(b) proved.

Charge 3

3. Your conduct in Charge 1 was sexually motivated.

This charge is found proved.

In reaching this decision, the panel took into account all the documentary and oral evidence, and the guidance in the case of *Haris*.

The panel in charge 1 determined that you touched Patient A's penis without clinical justification on more than one occasion.

The panel did not consider that you had touched Patient A's penis accidentally. That was not your explanation. It noted that you touched Patient A's penis on more than one occasion during the night and therefore determined that the touching was not accidental. The panel then considered whether there was any other plausible non sexual explanation for the touching, and there was none. Having found that there was no clinical justification, and in the absence of any plausible non-sexual explanation, the panel concluded, on the balance of probabilities, that your conduct in Charge 1 was sexually motivated. It therefore found Charge 3 proved.

Charge 4

4. Your conduct in Charge 2 was sexually motivated.

This charge is found proved.

In reaching this decision, the panel took into account all the documentary and oral evidence, and the guidance in *Haris*.

The panel, in charge 2(a) and 2(b), determined that you had stated to Patient A that he had 'a strong erection' and 'this is a very strong erection', or words to that effect.

The panel considered whether these comments could have been conversational and was satisfied that they could not be professionally justified. If in these circumstances a nurse saw a patient having an erection the nurse would ordinarily not comment upon it. The comments were directed specifically at Patient A's erection and were made in the context of the conduct found proved in Charge 1. In the absence of any plausible non-sexual explanation, the panel concluded, on the balance of probabilities, that your conduct in Charge 2 was sexually motivated. It therefore found Charge 4 proved.

Charge 7

7. On 10 May 2025 whilst your registration was subject to an interim conditions of practice order, breached the conditions of the said order, in that you provided intimate care to a patient without a chaperone present.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence provided by you.

The panel noted that an interim conditions of practice order was imposed on 9 May 2024 for a period of 18 months and remained in force on 10 May 2025. It also noted that the interim conditions of practice order was later replaced by an interim suspension order on 9 June 2025, because of the matter charged as charge 7.
Condition 4 stated:

'4. You must have a chaperone with you at all times when providing intimate care to patients.'

The panel had regard to the Hospital's 'Chaperone Guidelines' on intimate care, which state:

'4.2 Intimate care and examination - Intimate care or examination is defined as the care tasks associated with the sexual parts of the body, with bodily functions and personal hygiene, which demand direct or indirect contact with or exposure of the sexual parts of the body (although other body parts may also be classified as intimate relating to the patient's religious/cultural beliefs).'

The panel also had regard to your 'Summary Dismissal without Notice' dated 21 August 2025, which states:

‘You acknowledge that you did change the incopad for the patient on Saturday 10th May 2025, in the absence of a chaperone, albeit that you did not touch the patient, nor did you undertake any washing.’

You told the panel in your oral evidence that you did not touch Patient C. You said that as soon as you walked into Patient C’s room, you could smell that he had released his bowels. You said that you saw that he had diarrhoea and that it was on the incopad and a little on his hospital gown. You said that you looked to see if there was an HCA available to help you clean Patient C, but there was no one to help. You said that you then decided to ask Patient C to roll onto his side so that you could remove the incopad without touching him, with a view to coming back later with an HCA to clean him up thoroughly. You said that as you removed the incopad, you did not see Patient C’s genitalia. You said that you returned with an HCA some two hours later to give Patient C a bed bath.

The panel considered the Hospital’s definition of intimate care but was not satisfied that the evidence before it established that you had provided intimate care within the meaning of the condition. It took the view that, on the evidence available, intimate care required hands-on or direct contact in an intimate area. The panel had concerns about your account, as it considered that it would be difficult to change Patient C’s incopad without touching him. However, the panel had no further documentary evidence before it. It noted that the Matron to whom you said it was reported may have had evidence that you provided intimate care to Patient C, but that evidence was not before the panel: the matron did not provide a witness statement or give oral evidence nor did anyone else.

The dismissal letter accepted that your account was truthful and assumed that this was intimate care. Intimate care involves touching a patient in an intimate area. Although your account was unconvincing, the burden of proof is on the NMC and the NMC provided no evidence to suggest that you had touched Patient C at all. The NMC did not provide any evidence about how this came to be raised as a concern and was then investigated by the Hospital, or what investigation was carried out. All that was provided was the dismissal

letter. In the absence of any documentary or contemporaneous account or any direct evidence supporting this charge 7, the panel found it not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then considered whether the facts found proved amount to misconduct and, if so, whether your 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 safely and effectively without restriction.

In reaching its decision the panel 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, and only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

The panel received no new evidence at this stage.

Mr Hamilton's submissions on misconduct and impairment

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

its decision. He identified the following specific, relevant standards which he submitted were breached: 1.1, 5.1, 20.1, 20.5 and 20.6. He submitted that the conduct found proved is a serious departure from each of the standards and amounted to misconduct.

Mr Hamilton submitted that Patient A was a vulnerable patient at the time of these events as he was recovering from spinal surgery in the middle of the night and was dependent on your care. He further submitted that consent was given by Patient A on the basis that your touching of his penis was clinically justified either for sensation testing or to clean you, but that this consent was vitiated as these were not genuine reasons. You had exploited the patient for sexual reasons. Mr Hamilton further submitted that this was the very antithesis of treating a patient with kindness and respect.

Mr Hamilton submitted that the misconduct was serious in light of the nature of the sexual misconduct, that the sexual conduct was repeated as the touching took place on more than one occasion during the night shift of 15/16 February 2024, the “cleaning” of Patient A’s penis was sustained, during the course of which you made two separate inappropriate comments, ceasing only when Patient A told you to stop, and it had a serious impact on the patient.

For all those reasons, Mr Hamilton submitted that the facts found proved fell seriously short of the standards expected of a registered nurse and therefore amounted to misconduct.

Mr Hamilton moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He referred the panel to the NMC’s guidance on ‘Impairment’ (Reference: DMA-1, Last Updated 28/01/2026) and to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Hamilton submitted that sexually motivated touching a vulnerable patient in the middle of the night exposed the patient to unwarranted risk of harm, brought the profession into disrepute and breached fundamental tenets of the nursing profession.

Mr Hamilton also referred the panel to the case of *Cohen v GMC* [2008] EWHC 581 (Admin) and submitted that sexual misconduct is difficult to remediate as it is indicative of an attitudinal concern which cannot readily be addressed by training or supervision. He further submitted that there is no evidence before the panel that the concern had been remedied by the time of this hearing. He said that genuine insight is difficult in this case to reconcile with the continued denial of the conduct. Therefore, it would be difficult for you currently to demonstrate that you understand why the conduct was wrong and that it was highly unlikely that you would repeat such conduct.

Mr Hamilton submitted that, in fairness to you, the NMC recognises that you had submitted a reflective piece, that you have fully engaged with these proceedings and have undertaken some training and produced positive testimonials. However, that training was related to clinical competence rather than the deep-seated attitudinal concern. He therefore submitted that the risk of repetition remains. Therefore, he submitted, a finding of impairment is necessary on the ground of public protection.

In addition, Mr Hamilton submitted that a finding of impairment is also necessary in the wider public interest as members of the public would be seriously concerned that a nurse with these facts found proved would be permitted to practise unrestricted. He further submitted that the public's confidence in the nursing profession and the NMC as its regulator would be undermined should a finding of impairment not be made in these circumstances.

Mr Hamilton therefore invited the panel to make a finding of impairment both to protect the public and in the public interest.

Mr Lloyd's submissions on misconduct and impairment

Mr Lloyd told the panel that it would inevitably find a serious falling short of professional standards in the circumstances. The circumstances found by the panel were of sexually motivated non-consensual activity in the course of nursing practice, and he did not seek to argue that this was not misconduct.

Mr Lloyd moved onto impairment. In relation to the public interest ground, he submitted that the public interest involves and includes the retention of skilled members of the profession for the benefit of the public. He pointed out that you were regarded highly as a nurse. However, he accepted that sexual misconduct is rightly considered to be at the top end of the misconduct spectrum, albeit there is not a 'one size fits all' approach to sexual misconduct cases. He submitted that, given its statutory objectives, it was likely that the panel would conclude that this must be marked by a finding of impairment on public interest grounds. Not to do so could be seen as condoning such activity.

Mr Lloyd accepted that you did not seek to assert a Damascene conversion on reading the panel's decision. However, he submitted that you had placed material before the panel which speaks to your reflection, and to an extent some remediation. Mr Lloyd accepted that as you denied the charges it is difficult for you to demonstrate remediation and insight. However, your reflective piece made clear that you understand the seriousness of such conduct and appreciate the need to respect patients. Therefore, Mr Lloyd submitted that the panel had before it some material which may suggest that you are not impaired on public protection grounds, while accepting that this would not bear on the decision on current impairment on public interest grounds.

Legal Assessor's advice

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*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *CHRE v NMC and Grant* [2011] EWHC 927 (Admin)*, Remedy UK Ltd, R (on the application of) v General Medical Council*

[2009] EWHC 2294 (Admin) *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) and *Cohen v* GMC [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* The panel also took note of the case law indicating that the falling short must be serious – to be regarded as deplorable - in order to result in a finding of 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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breaches 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

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

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) …

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 your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

It determined that the sexual conduct was repeated as the touching took place on more than one occasion during the night shift of 15/16 February 2024, the “cleaning” of Patient A’s penis was sustained, during the course of which you made two separate inappropriate comments, ceasing only when Patient A told you to stop, and it had a serious impact on the patient.

The panel noted that Patient A had consented to you touching his penis on the basis that you should do so if it was clinically necessary and justified. Patient A did not consent to being involved in sexual activity. Consent was given under a false pretence as there was no clinically justified reason for what you were doing.

The panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct in respect of all the charges found proved.

Decision and reasons on impairment

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

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.'*

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

The panel considered the factors set out in the cases of *Grant* [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

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

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

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

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

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

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

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

d) *...'*

The panel concluded that limbs a), b) and c) of Dame Janet Smith's test in *Grant* are all engaged in this case, looking both forwards and backwards.

The panel decided that your misconduct is liable to put patients at unwarranted risk of harm, and that the public interest required a finding of current impairment. Sexual misconduct towards patients puts them at unwarranted risk of harm, breaches a fundamental tenet of the profession and brings it into disrepute.

In coming to its conclusion that your fitness to practise was impaired looking forward the panel considered the questions posed in the case of *Cohen* namely:

1) Whether the conduct is easily remediable
2) Whether it has been remedied (or evidence to that effect)
3) Whether that conduct is highly unlikely to be repeated

In assessing these questions, the panel paid careful regard to the information before it regarding remediation and insight. It noted that attitudinal concerns are difficult to remediate. The panel noted that you had denied the charges. The panel noted the training you have undertaken and the positive testimonials. The panel noted that this training was concerned with your clinical skills rather than addressing sexual misconduct. However, the panel also took into account your short reflection in which you indicated that you only ever act with consent and that you respect patients and your elders. The panel could see no evidence of insight. The panel therefore concluded that you have not remediated the misconduct.

The panel was not persuaded that it was highly unlikely that you would repeat similar misconduct.

The panel also determined that the nature of sexual misconduct, if repeated, would bring the profession into disrepute and would breach a fundamental tenet of the nursing profession.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection on all three relevant limbs of Dame Janet Smith’s test.

The panel also decided that a finding of current impairment was required for public interest reasons.

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

The panel determined that a finding of impairment on public interest grounds is required because of the nature of the matters found proved. The public would be shocked to learn

that a finding that a registered nurse sexually assaulted a vulnerable patient and made sexual comments did not lead to a conclusion that his fitness to practise was currently impaired. The panel concluded that public confidence in the profession, and in the NMC as its regulator, would be undermined if a finding of impairment were not made in this case. The panel decided that all three relevant limbs of Dame Janet Smith's test required a finding of current impairment in the public interest – an unwarranted risk of harm (and actual harm) to Patient A, the reputation of the profession and your breach of a fundamental tenet of the profession.

Having regard to all the above, the panel decided that your 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 you off the register. The effect of this order is that the NMC register will show that you have been struck off the register.

Submissions on sanction

In the Notice of Hearing, dated 9 June 2026, the NMC advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Hamilton submitted that there were the following aggravating factors:

- the conduct was sexual misconduct against a patient in your care, and was at the top end of the spectrum of misconduct, being a sexual assault;
- in doing so you carried out your misconduct as a breach of trust, involving a vulnerable patient who had undergone spinal surgery, it was in middle of the night and the patient was wholly dependent on you;

- Patient A did not consent to what you did: it was the panel's decision that consent was vitiated as although Patient A consented to the 'cleaning' of his penis that was on the basis that it was clinically justified;
- the conduct was repeated and sustained, involving touching Patient A's penis on at least two and maybe three occasions and several minutes 'cleaning' Patient A's penis, two separate sexualised comments, and you ceased only when told by Patient A to stop;
- the panel heard how this caused real harm to Patient A: there was a serious impact on him – he had sleepless nights, locked his front door in case you came to his home and had flashbacks to you touching him; and
- lack of insight and remediation.

Mr Hamilton submitted that the NMC recognised that you have had no previous NMC referrals, that you have provided a reflective statement, albeit it speaks to your clinical skills rather than the sexual misconduct, and that you have engaged with these proceedings.

In relation to the type of order the panel should impose, Mr Hamilton referred the panel to the NMC's guidance on 'The sanctions available' (Reference: SAN-2, last updated 28/01/2026). He submitted that no order, caution order and conditions of practice order are not proportionate nor appropriate in the circumstances of this case. He further submitted that a suspension order would not be the sufficient order in this case for the following reasons:

- the guidance was that suspension was a possible sanction where misconduct would not be fundamentally incompatible with continued registration, and this sexual misconduct was such that it was fundamentally incompatible with you remaining on the register;
- this was not a single incident but occurred on more than one occasion during the shift, and only ceased when Patient A had told you to stop 'washing' his penis
- the case demonstrated that there are deep-seated attitudinal concerns, and
- you have not demonstrated insight nor that there is no risk of repetition.

Mr Hamilton submitted that, in deciding between a suspension order and a striking off order, the panel should have regard to the public interest and whether confidence in the nursing profession and the NMC as the regulator would be maintained if you were allowed to return to practice. He submitted that there is no realistic prospect that a suspension order could meet the public interest. Therefore, he submitted, a striking off order is the only sanction which would protect the public and meet the wider public interest.

Mr Lloyd submitted that the panel should take proportionality into account. He said that the panel heard evidence of [PRIVATE] and should you lose your job, it would have a significant effect.

Mr Lloyd asked the panel to start off with the least serious sanction and to take proportionality into account.

He submitted that the panel should carefully consider whether a period of suspension would be the appropriate sanction.

Legal assessor's advice

The legal assessor referred the panel to the NMC's suite of guidance notes:

SAN-1: The purpose of and approach to sanctions;
SAN-2: The sanctions available;
SAN-2(d): Suspension;
SAN-2(e): Striking off order;
SAN-3: Deciding between suspension and strike off; and
SAN-4: Sanctions for the highest risk cases (section headed "Cases involving sexual misconduct")

He advised that while the panel would start at the least restrictive sanction and work upwards, it was submitted by the NMC and accepted on your behalf that taking no action and a caution order would not be appropriate, and that it would not be possible to devise conditions of practice. The panel was therefore left with the two remaining sanctions: a suspension order and a striking off order. He advised that if the panel considered that a suspension order was insufficient it should, before coming to a conclusion, satisfy itself that a striking off order was the only appropriate outcome for otherwise it would have decided on a striking off order by default.

Decision and reasons on sanction

Having found your 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, proportionate and the minimum necessary. Although not intended to be punitive in its effect, sanctions may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case, and to the submissions made. It accepted the advice of the legal assessor. The panel applied the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026), and the other sanctions guidance notes referred to by legal assessor.

The panel took into account the following aggravating features:

- this was an abuse of a position of trust involving a vulnerable patient;
- the sexual misconduct of touching Patient A's penis was repeated twice or three times and two inappropriate comments were made;
- 'cleaning' Patient A's penis over a sustained period of time amounted to a sexual assault;

- this was conduct which caused Patient A, who was receiving care from you, to suffer psychological harm: the panel accepted his evidence that subsequently he was worried about his safety, had sleepless nights, was locking his doors, and had flashbacks which affected his sexual relationship;
- this was predatory behaviour as you took advantage of a vulnerable patient who was receiving care post-surgery;
- you sought and obtained 'consent' from Patient A to handle his penis deceitfully by stating that you were merely providing clinical care when you were not; and
- the lack of any insight and remediation.

The panel determined that there were no mitigating factors. It noted that you have given evidence of your [PRIVATE] but because the purpose of sanctions is to protect the public, personal mitigation is usually less relevant than other forms of mitigation. The panel also noted that you have fully engaged with this hearing and have no previous NMC referrals.

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 your actions were not at the lower end of the spectrum, and it found that there is a risk to patient safety. The panel therefore determined that a sanction

that does not restrict your practice 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 your 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 determined that a conditions of practice order would not be appropriate in the circumstances as no conditions could be devised which would address the risk to the public it had identified. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards. A conditions of practice order would not address the public interest.

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 determined that the risks identified could not be managed by your temporarily removal from the Register and considered that it 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.

Given your lack of insight and remorse, deep-seated attitudinal concerns, together with the absence of evidence of relevant development, the panel considered that there is no realistic possibility that you could, during a period of suspension, address the concerns to such a level where you can practise safely. The panel did not consider that there was at least some meaningful insight which evidences a realistic possibility that you would continue to develop insight, address the concerns and return to practice. There was no insight.

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). It noted that this has a section on sexual misconduct:

'…sexual misconduct towards people receiving care or colleagues. Sexual misconduct towards people receiving care suggests a direct risk to public safety. It

always constitutes an abuse of a position of trust or power, given the inherent imbalance in power between professionals and those they care for. Sexual misconduct towards colleagues may indirectly risk public safety through creating an unsafe workplace environment. It also risks the dignity of colleagues.

[…]

Any professional who is found to have behaved in this way will be at risk of being removed from the Register. This is because of the severe impact the conduct has on:

- *public confidence*
- *a professional's ability to uphold the standards and values set out in the Code*
- *the safety of people receiving care.'*

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 found that the facts found proved do raise fundamental questions about your professionalism. The panel concluded that public confidence in the profession could not be maintained if you were not removed from the register and that there was no realistic prospect that after a period of suspension you would have gained insight.

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in your case are of actions so serious that to allow you to continue to practise would put the public at risk of serious harm and would undermine public confidence in the profession and in the NMC as a regulatory body.

Considering all these factors and after taking into account all the evidence before it during this case, including your evidence, the submissions made to it and the legal advice the panel determined that the only appropriate, proportionate and necessary sanction is that of a striking off order.

This is because your continued practice would put the public at risk, given your lack of insight, remorse and remediation.

Your actions brought the profession into disrepute. The panel considered that this order was also 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 you 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 your own interests until the striking off sanction takes effect or the conclusion of any appeal.

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

Submissions on interim order

The panel took account of the submissions made by Mr Hamilton. He submitted that an interim suspension order is necessary and proportionate in order to protect the public and maintain the public interest over any appeal period. He submitted that this order should be imposed for a period of 18 months so as to allow sufficient time for any appeal to take place.

Mr Lloyd told the panel that the panel must only make an interim order which is grounded in the facts found proved and the risks identified. He referred the panel to the case of *Hindle v NMC* [2025] EWHC 373 (Admin) paragraphs 120 and 122 and submitted that the panel must not treat this stage as a formality and should provide clear and cogent reasons for the interim order decision. He told the panel that he does not seek to persuade the panel either way on the application.

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 having decided that there was a risk to the public arising from your practice which required you to be struck off the register it was self-evident that an interim order suspending you from practice was required. The panel also considered that an interim suspension order was required in

order to maintain the reputation of the profession, and the NMC as its regulator because of the nature of the misconduct found proved.

This order will cease either in 28 days if there is no appeal or at the conclusion of the appeal if one is lodged. As an appeal may take up to 18 months to come to a conclusion, the panel decided on an interim order for that period. This length of order is not prejudicial to you because this interim order will cease to take effect if an appeal concludes earlier than 18 months from now.

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 in order to protect the public and maintain public confidence over any appeal period.

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

That concludes this determination.