Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 22 July 2026 – Thursday 30 July 2026
Wednesday, 4 November 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Stephen Gumise
NMC PIN:	00I5102E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA, Registered Nurse – Adult (16 December 2003)
Relevant Location:	Bedford
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, lay member) Katrina Maclaine (Registrant member) Richard Mann (Lay member)
Legal Assessor:	Robin Ince
Hearings Coordinator:	Monsur Ali (Wednesday, 22 July 2026) Hazel Ahmet (Thursday, 23 July 2026 – Thursday, 30 July 2026) Shazmeen Uddin (Wednesday, 04 November 2026)
Nursing and Midwifery Council:	Represented by Harry Piercy, Case Presenter Rowena Wisniewska (Wednesday, 04 November 2026)
Mr Gumise:	Not present and not represented
Facts proved:	Charges 1a, 1b(i), 1b(ii), 2a, 2b, 2d, 2e, 2f, 2g, 2h, 2i, 2j,

Facts not proved:	Charges 1c, 2c.
Fitness to practise:	Stage not yet reached.
Sanction:	Stage not yet reached.
Interim order:	**Interim suspension order (6 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of the hearing that Mr Gumise was not in attendance and that a Notice of Hearing letter had been sent to his registered email address by secure email on 9 June 2026.

Mr Piercy, on behalf of Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practice) Rules', as amended (the Rules) in respect of service of the Notice of the Hearing.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing was sent more than 28 days prior to the Hearing and that it provided details of the charges, the time, dates and that the hearing was to be held in person. The notice also included information about Mr Gumise's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all the information available, the panel was satisfied that Mr Gumise has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Gumise

The panel next considered whether it should proceed in the absence of Mr Gumise. It had regard to Rule 21 and heard the submissions of Mr Piercy who invited the panel to proceed with the hearing in the absence of Mr Gumise. He submitted that Mr Gumise had voluntarily absented himself.

Mr Piercy directed the panel to an email dated 8 October 2025 which was sent to Mr Gumise and his representative informing them of amended hearing dates. He also directed the panel to another email dated 9 June 2026 which shows that the Notice of Substantive hearing was served on Mr Gumise.

Furthermore, Mr Piercy also directed the panel's attention to a telephone transcript wherein the NMC Case Officer received a call from Mr Gumise and spoke with him which is dated 15 July 2026 is as follows:

> *"Call received from the Registrant, Stephen Gumise on. He informed me that he will not be able to attend the hearing on 22 July but is happy for the hearing to proceed in his absence."*

The panel accepted the advice of the legal assessor. He referred to the cases of *R* v *Jones (Anthony William) (No.2*) [2002] UKHL 5 and to the *General Medical Council v Adeogba* [2016] EWCA Civ 162 as relevant case law.

The panel recognised that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones.*

The panel decided to proceed in the absence of Mr Gumise.

In reaching this decision, the panel has considered the submissions of Mr Piercy and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v Jones* and to *GMC v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Gumise had called the NMC in which he stated that he will not be attending the hearing.
- No application for an adjournment has been made by Mr Gumise;

- There is no reason to suppose that adjourning would secure his attendance at some future date.
- Witnesses are due to attend during the hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, and their employers;
- The allegations relate to events that occurred seven years ago; further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is strong public interest in the expeditious disposal of the case and it is in the interests of Mr Gumise and the NMC for the case to proceed.

The panel, in its determination, considered that there is some disadvantage to Mr Gumise in proceeding in his absence. However, the evidence upon which the NMC relies has been sent to Mr Gumise and he has responded, stating he will not be attending. In the panel's judgement, it decided that this can be mitigated. The panel can make allowance for the fact that Mr Gumise's evidence and that of the NMC's witnesses will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The panel also took into consideration its obligation to hear cases expeditiously.

In these circumstances, the panel has decided that it is fair and in the interests of justice to proceed in the absence of Mr Gumise.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Piercy, on behalf of the NMC, to amend the wording of charge 2, as follows:

*'Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on **or around** 4 June 2020'*

This application is based on the evidence of Patient A. At paragraph 8 of her witness statement, she states that she arrived at the hospital at 2:00 pm on 4 June 2020. At paragraph 12, she states that at around midnight a member of the surgical team came to see her. The NMC's case is that this interaction forms the basis of Charge 2.

Mr Piercy submitted the evidence therefore suggests that the alleged incident occurred during the night of 4 June and into the early hours of 5 June 2020. The proposed amendment simply reflects the evidence and does not alter the substance of the allegation or the NMC's case.

Mr Piercy submitted it is a technical amendment which causes no prejudice to Mr Gumise.

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

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Gumise and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity, accuracy and better reflect the evidence.

Details of charges as amended

That you, a Registered Nurse

1. Whilst employed at Hull University Teaching Hospital NHS Trust:
    a. On 22 July 2019, stood over Colleague A and shouted
    b. On 30 July 2019:
        i. Shouted 'you don't understand he needs to go now' at Colleague B

ii. Said ‘do you know what I really don’t give a shit’, or words to that effect, to Colleague C regarding Colleague B being upset at your actions in charge 1(b)(i)

c. On an unknown date, went to the Chief Executive’s office and banged on the door

2. Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on or around 4 June 2020:
    a. Told Patient A that if she went home, she would be fined £10,000 or arrested
    b. Told Patient A ‘well that’s a catch 22 if you go home and feed her, you could kill her’ upon her explaining that she needed to go home to breastfeed her daughter
    c. Your advice to Patient A in charge 2b had no clinical basis
    d. On multiple occasions, tried to prevent Patient A from going home
    e. Your actions in charge 2d had no clinical basis
    f. Raised your voice to Patient A when speaking with her
    g. Shouted to Patient A ‘do not go out there you are not allowed, everywhere you go and everything you touch needs to be sterilised and washed’ upon her trying to walk outside the doors to make a phone call
    h. Moved Patient A to a red zone despite having no Covid-19 symptoms
    i. Refused to give to Patient A the name of the surgical doctor who first attended to her
    j. Did not take Patient A’s observations upon arrival and every two hours thereafter

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Piercy under Rule 31 to allow the hearsay evidence of Richard Chalmers (employed as a porter at the time of the allegation) into evidence with regard to charge 1b(i). Richard Chalmers was not present at this hearing and the NMC had not made any efforts to secure his attendance at this hearing, due to an oversight.

Mr Piercy submitted that, contained within the Investigation Report, is an account given by an individual named Richard Chalmers; this account matches that given within the live witness evidence of Colleague B. Mr Piercy highlighted the following relevant passages from the Investigation Report, which the NMC seeks to put before the panel as hearsay evidence:

> *'The Porter Richard Chalmers and Auxillary Nurse Salih both agreed in their interviews on the following course of events'*
> *…*
> *'The Porter Richard Chalmers, described the patient as 'very distressed and didn't want to be sent back to his care home as he said they were mistreating him'.'*
> *…*
> *'The Porter Richard Chalmers also felt that the patient should have been left to calm down a bit before trying to move him to the patient lounge.'*

Mr Piercy acknowledged that Richard Chalmers has never been identified by the NMC as a witness, that he is not present before the panel today, and that he is unable to be questioned during the course of this hearing. Mr Piercy also acknowledged that Richard Chalmers was not asked for a statement at the Investigation Stage.

However, Mr Piercy submitted that the hearsay evidence as applied for is clearly relevant, as Richard Chalmers was present during the alleged incident, and had given an account of what had occurred within the Investigation Report. Mr Piercy submitted that this hearsay evidence is not the sole and decisive evidence in relation to this case or the relevant

charge, nor does it add anything new to the evidence before the panel. Mr Piercy submitted that the hearsay evidence of Richard Chalmers merely corroborates the evidence which has already been given before the panel, by Colleague B.
Mr Piercy referred to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Mr Piercy therefore submitted that it would be fair to admit this hearsay evidence, and that the panel can give it the appropriate weight.

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 took into account that, although Mr Gumise had chosen not to attend this hearing, it was likely that he was not aware at the time of making that decision that there would be an application to have Richard Chalmers' hearsay evidence put before the panel.

The panel then considered that no efforts had been made by the NMC to secure the attendance of Richard Chalmers, in order to give evidence on his hearsay evidence. The panel also noted that Mr Gumise contests this specific section of the incident, which relates to the hearsay evidence where that evidence goes to a serious charge.

Although the panel acknowledged that there is some relevance in the hearsay evidence, as applied for by the NMC, on balance, it found that it would not be fair in the absence of Mr Gumise, to admit such evidence.

The panel determined that in fairness to Mr Gumise that he should have had notice of Mr Piercy's application and thereby would have been given the opportunity to factor this into any defence Mr Gumise chose to present to the panel.

In these circumstances the panel refused the application.

Decision and reasons on the NMC's second application to admit hearsay evidence

The panel heard an application made by Mr Piercy under Rule 31 to allow Paragraph 13 of Patricia Prady's witness statement, into evidence. This reads as follows:

> '*There was also an incident where he went to the Chief executives office and banged on the door wanting to see them as they weren't helping him enough with his schedule. However, we could only help him with his schedule if he helped up with knowing when he could work'*

Mr Piercy submitted that this statement given by Patricia Prady is evidence that goes directly to Charge 1c. He acknowledged that it was not entirely clear how Patricia Prady had heard of the details of the alleged incident, until she had stated in her oral evidence on 23 July 2026 that she had *'heard'* about it from both Mr Gumise during an investigation interview, and also second-hand through another member of staff. Mr Piercy therefore highlighted that Patricia Prady did not hear this evidence herself directly, and that this only became apparent to the NMC during her live evidence.

Mr Piercy acknowledged that Mr Gumise is not in attendance but noted that the initial account within this hearsay evidence was allegedly derived from Mr Gumise himself. Mr Piercy submitted that it is Mr Gumise who decided of his own volition to not attend this hearing. Mr Piercy highlighted that, if Mr Gumise had attended this hearing, he would have been given the opportunity to cross examine Patricia Prady on her evidence. Mr Piercy once again reiterated that it was not clear that this evidence was hearsay until Patricia Prady gave live evidence and therefore submitted that it was appropriate for this hearsay application to be made at this stage of the proceedings. He maintained that little could have been done by the NMC to pre-empt this application.

Mr Piercy submitted that this hearsay evidence goes to a charge which presents a pattern of behaviour and misconduct in this case; he stated that this should not influence the panel's decision on admissibility. Mr Piercy submitted that this evidence is relevant, goes directly to Charge 1c, and is the sole and decisive evidence for this charge. Mr Piercy submitted that it would be fair to admit this hearsay evidence before the panel, and that the admission of paragraph 13 of Patricia Prady's statement should be given appropriate weight.

The panel was of the view that, although Mr Gumise had voluntarily chosen to absent himself from this hearing, he was not aware at the time of making that decision, that there would be an application to admit the hearsay evidence of Patricia Prady, namely, paragraph 13 of her statement dated 26 September 2023. The panel acknowledged that the NMC would not have had the ability to have pre-empted this application.

The panel took account of the fact that the hearsay evidence of Patricia Prady is the sole and decisive evidence; the only evidence which goes to Charge 1c. The panel determined that Charge 1c is a serious charge and noted that Patricia Prady had only provided information relating to Mr Gumise having spoken on this specific incident during her live evidence, 34 months after her written statement.

The panel determined that in fairness to Mr Gumise, he should have had notice of Mr Piercy's application and thereby been given the opportunity to factor this into any defence he may have chosen to present to the panel.

The panel determined that it would be unfair to admit this evidence as hearsay.

In these circumstances the panel refused the application.

NMC's application to further amend the charges

Mr Piercy made two additional applications to amend charge 2h and charge 2j.

In relation to Charge 2h, Mr Piercy applied to amend the charge to read as follows:

'2. Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on or about 4 June 2020:

h. Moved Patient A ***or allowed Patient A to be moved*** *to a red zone despite having no Covid-19 symptoms'*

Mr Piercy submitted that the amendment as applied for would reflect the evidence of all of the witnesses who have given evidence before the panel, including Patient A; the charge would reflect the evidence that it was not Mr Gumise who had moved Patient A, but Hannah Bye.

Mr Piercy noted that Mr Gumise was the nurse in charge and highlighted the evidence of Alun Mountjoy who had said that it was Mr Gumise who was responsible for managing any transfers and performing handovers of patients. Mr Piercy submitted that there is a clear regulatory concern when considering Charge 2h, given the fact that Patient A was moved to a red zone, despite having no Covid-19 symptoms. Mr Piercy submitted that, the fact that Mr Gumise did not move Patient A himself makes little difference to the gravamen of the

allegation, and that to include *'allowed Patient A to be moved'* within the amended charge would better reflect the evidence before the panel.

Mr Piercy acknowledged the fact that Mr Gumise is not in attendance at this hearing but noted that he has had copies of all of the witness statements and would have had sight of what each witness had said in relation to Patient A having been moved to the red zone.

Consequently, Mr Piercy reiterated that there is a clear regulatory concern in relation to this charge, and if the amendment were not allowed, this charge may fail on a simple technicality of wording and would not adequately protect the public.

In relation to Charge 2j, Mr Piercy applied to amend the charge to read as follows:

'2. Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on or about 4 June 2020:

j. Did not take ***and or record and or verify*** *Patient A's observations upon arrival* ***and or*** *every two hours thereafter.'*

Mr Piercy submitted that the panel has heard evidence from witness Hannah Bye, who stated that she did take the observations of Patient A, albeit these were not recorded. This witness had said that it was acceptable to delegate taking observations but reiterated that the nurse in charge (in this case, Mr Gumise), remains responsible for making sure all observations are recorded. Hannah Bye stated within her live evidence that the observations, which were reportedly taken every two hours, were not recorded.

Mr Piercy submitted that the amendments as applied for, better reflects the evidence which had been heard by the panel. This amendment, he submitted, causes no injustice to

Mr Gumise, and, if this charge were not to be amended, it may fail on a technicality and potentially fail to protect the public adequately.

In relation to the applications to amend Charge 2h and Charge 2j, the panel decided that it would allow both amendments in order to better reflect the evidence provided by the witnesses.

The panel was of the view that a member of the public would expect the panel to look at charges which reflect the evidence before it and to ensure that any amendments which provide clarity, are made. The panel determined that neither of the amendments as

applied for materially change the nature or scope of the charges, and neither amendment creates any unfairness to Mr Gumise.

Whilst the panel acknowledged Mr Gumise was not in attendance, it considered its overarching objective to protect the public, and consequently, allowed the application for both Charge 2h and Charge 2j, to be amended.

The charges, as amended, now read as follows:

That you, a Registered Nurse:

1. Whilst employed at Hull University Teaching Hospital NHS Trust:
    a. On 22 July 2019, stood over Colleague A and shouted
    b. On 30 July 2019:
        i. Shouted ‘you don’t understand he needs to go now’ at Colleague B
        ii. Said ‘do you know what I really don’t give a shit’, or words to that effect, to Colleague C regarding Colleague B being upset at your actions in charge 1(b)(i)
    c. On an unknown date, went to the Chief Executive’s office and banged on the door

2. Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on or about 4 June 2020:
    a. Told Patient A that if she went home, she would be fined £10,000 or arrested
    b. Told Patient A ‘well that’s a catch 22 if you go home and feed her, you could kill her’ upon her explaining that she needed to go home to breastfeed her daughter
    c. Your advice to Patient A in charge 2b had no clinical basis
    d. On multiple occasions, tried to prevent Patient A from going home
    e. Your actions in charge 2d had no clinical basis
    f. Raised your voice to Patient A when speaking with her

g. Shouted to Patient A ‘do not go out there you are not allowed, everywhere you go and everything you touch needs to be sterilised and washed’ upon her trying to walk outside the doors to make a phone call

h. Moved Patient A or allowed Patient A to be moved to a red zone despite having no Covid-19 symptoms

i. Refused to give to Patient A the name of the surgical doctor who first attended to her

j. Did not take and or record and or verify Patient A’s observations upon arrival and or every two hours thereafter

Background

The NMC received a referral on 10 July 2020 from a member of the public [Patient A] in relation to the nursing practice of Mr Steven Gumise. The concerns raised involved Mr Gumise’s understanding of policy and procedures; it was alleged that Mr Gumise had exhibited aggressive behaviour towards Patient A and also failed to carry out, record and or verify observations to an adequate standard.

The allegations raised, in summary, are as follows:

1. Mr Gumise allegedly aggressively told Patient A that if she left the hospital, she risked killing people including her child;
2. Mr Gumise allegedly attempted to prevent Patient A from leaving the hospital by shouting at her;
3. Mr Gumise allegedly moved Patient A to a high-risk Coronavirus ward, despite her having no symptoms.
4. Mr Gumise allegedly refused to give his name, or the name of the doctor, when asked by the patient.
5. Mr Gumise allegedly did not correctly conduct or record or verify observations whilst working as the Nurse in Charge.

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 Piercy on behalf of the NMC.

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

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

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

- Patient A: A member of the public who was a patient in Bedford Hospital on 4 June 2020.
- Marta Malek-Salih: Registered Band 5 Nurse on the Elderly Medicine Ward at Hull Royal Hospital.
- Patricia Prady: Senior Matron in Medicine at Hull Royal Hospital, Hull University Teaching Hospitals NHS Trust.
- Hannah Bye: Clinical Support Worker at the Same Day Emergency Care, Bedfordshire Hospitals NHS Foundation Trust.

- Alun Mountjoy: Band 7 Unit Manager for the Same Day Emergency Care ward, Bedfordshire Hospitals NHS Foundation Trust.
- Abigail Rilatt: Staff nurse at Hull Royal Hospital.

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

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

Charge 1) *Whilst employed at Hull University Teaching Hospital NHS Trust:*

Charge 1a) *... On 22 July 2019, stood over Colleague A and shouted*

This charge is found proved.

As a preliminary matter, the panel took into account that there is no dispute that, at the relevant times, Mr Gumise was employed at Hull University Teaching Hospital NHS Trust, and therefore the stem of Charge 1 is proved.

In considering Charge 1a, the panel took into account Jayne Scott's written witness statement and live evidence given before the panel on 22 July 2026. It also considered her statement provided during the investigation into Mr Gumise's alleged intimidating actions, dated 15 August 2019. The panel noted the following passage from the investigation meeting notes:

> *'Stephen was talking over JS, shouting and raising his voice. JS explained that she was sitting near the wall and felt fine at first. This was not normal behaviour*

and so she asked him to stop. At this point Stephen stood up and JS thought he was going to leave but he didn't move and so she told him he was being intimidating and asked him to sit down, which he did briefly.'

The panel also considered the written witness statement of Jayne Scott, in which she wrote the following:

'An incident occurred in July 2019 where Stephen became intimidating towards me.'

And

'At the time, I have never had that type of experience before. I was very upset; I had to ring my colleague. I felt so bad.'

The panel also took into consideration the live evidence given by Jayne Scott on 22 July 2026, in which she said:

'I can't remember how long the shouting went on for, a couple of minutes maybe less. He stood over me not far from me… he was quite close to me. For some of the meeting he was sat down but he stood up and shouted over me. I was very upset and did not know how to handle the situation at the time. I was crying. I have never experienced a situation like that before. He was standing over me and shouting. It was intimidating. The office is not very big, its like a square box. It stayed with me for a couple of months. I was concerned about approaching other members of staff with him shouting and his physicality. It was intimidating at the time'

And

'The incident remained in my mind for a couple of months'

The panel also considered Mr Gumise's account of the alleged events within the Investigation Summary and Report, dated December 2019:

> *'In his interview Staff Nurse Gumise denied that he had stood up … When asked why Sister Scott would say he was aggressive, Staff Nurse Gumise stated he wasn't sure…'*

The panel determined that Jayne Scott was a credible and measured witness, having given a consistent account of her experience both within her live evidence and her witness statement. The panel noted that Jayne Scott was a Ward Sister with over four years' experience of working within the emergency department. The panel noted that Jayne Scott consistently throughout her evidence had stated that Mr Gumise had caused her distress, ~~and~~ that she had cried after the alleged incident, and that she needed to contact a friend.

Consequently, given the consistency of Jayne Scott's documentary and oral evidence, the panel found her to be credible, reliable, and consistent in relation to this allegation and charge, and therefore placed significant weight on her evidence.

The panel therefore determined that on the balance of probabilities, this charge is found proved.

Charge 1b, i)

b. On 30 July 2019:

i. Shouted 'you don't understand he needs to go now' at Colleague B

This charge is found proved.

In considering this charge, the panel took into account the written witness statements and live evidence of Marta Malek-Salih and Patricia Prady. The panel also considered the oral

evidence of Abigail Rilatt, the Investigation Report dated 15 August 2019, and the Confidential Record of Meeting dated 29 August 2019.

The panel considered the following passages from the written statement of Marta Malek-Salih:

> *'I attended an investigation meeting on 29 August 2019 in relation to Stephen's intimidating behaviour towards me on 20 July 2019. A copy of the meeting notes is exhibited to this statement as Exhibit MS-1, I confirm the notes are true and accurate to the best of my knowledge.'*

And

> *'Reading my meeting notes brought back bad memories of this day. From what I can recall, I had a few patient transfers to do, and it was a busy day. I went to a cubicle with the porter and was going to take an elderly patient to the patient lounge and Stephen was there prepping the patient for transfer. The patient was agitated and was saying that he didn't want to go home. Stephen was trying to reason with him. I was going to give Stephen time to calm the patient down and I told him I would go and transfer another patient whilst he spoke to the agitated patient.'*

And

> *'Stephen shouted at me saying 'this patient has to go home now'. I felt like Stephen really lashed out at me. I was happy the porter was in the room with me, so I wasn't on my own. It was an awful situation.'*

The panel also considered the following from the live evidence given by Marta Malek-Salih:

'Steven was quite stressed. He kept saying to the patient that he has to go. He was trying to convince the patient. I said shall I do another transfer and come back later? He became angry and lashed out at me. He raised his voice at me and said he has to go now, that I don't understand. He was very angry. He leaned towards me, but I can't say how close he was. He raised his arms and was making gestures, he was impatient. I would not expect a health care professional to act in this way. I was shocked… I felt intimidated, I did not expect this. It should not happen in an NHS hospital. After this incident he became openly angry with me. I was trying to avoid contact with him. He got angry in an uncontrolled way. His behaviour, raising his voice, talking shouting, he was definitely aggressive… never witnessed anything like this from a nurse.'

And

'I wanted to give him more time, he [Mr Gumise] wanted the patient out as soon as possible.'

During the course of her oral evidence, the panel put to Marta Malek-Salih, that Mr Gumise had entirely denied having shouted at her, to which she responded the following:

'It is completely untrue what he is saying. He raised his voice completely'

The panel then considered the following passage from the written statement of Patricia Prady:

'During the investigation, Stephen wanted to interview this patient but that wasn't possible as the patient was vulnerable. The incident was also observed by another staff member who agreed that Stephen had shouted in front of the patient. This was unprofessional behaviour from Stephen. Stephen denied that he had acted inappropriately. However, it was clear that he had acted in this way even though he denied it. A lot of little concerns had been raised during my

investigation, including that Stephen would just disappear for 30 minutes at a time. When Stephen was asked about this, he just stated that everyone was ganging up on him.'

The panel also considered the oral evidence of Abigail Rilatt who confirmed that Marta Malek-Salih was indeed upset with the manner in which she had been spoken to by Mr Gumise, in the presence of a patient.

The panel considered the following passage from the Confidential Record of Meeting dated 29 August 2019:

'MMS said she felt intimidated and did not think it was fair on her and it was bad for the patient who was already anxious. TP asked MMS how she thought the patient was feeling at that moment. MMS stated that the patient was lying down and was already anxious and stressed and hearing staff shouting could have made him more stressed.'

The panel also considered the account of Mr Gumise:

'When staff Nurse Gumise was asked to describe what happened on 30th July he confirmed that he remembered the patient who was 'paranoid, delusional and had fixated behaviour' and that he had dealt with the same patient before. He denied that he shouted but that 'Marta had been putting things on the patient and he went to help… she was going to move him anyway but Staff Nurse Gumise asked if he could have 2 minutes with the patient to calm him down as he was irate'.

The panel was of the view that Marta Malek-Salih was clear and consistent when giving her account, both in her written and live evidence. The panel took into account that the evidence provided by Marta Malek-Salih was also corroborated by witness Abigail Rilatt.

The panel therefore placed more weight on the evidence and account of Marta Malek-Salih and preferred her account of the allegations.

Consequently, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1b, ii)

b. On 30 July 2019:

ii. Said 'do you know what I really don't give a shit', or words to that effect, to Colleague C regarding Colleague B being upset at your actions in charge 1(b)(i)

This charge is found proved.

In considering this charge, the panel took into account the written and oral evidence of both Marta Malek-Salih and Abigail Rilatt. It also considered the Confidential Witness Investigation Meeting, Confidential Record of Meeting notes, dated 29 August 2019, and the Investigation Meeting on 21 August 2019.

The panel considered the Witness Investigation Meeting notes, dated 21 August 2019. The panel noted that Abigail Rilatt in her oral evidence had referred to a hand-written note that she had made at the time of the alleged incident, as directed by her line manager. She confirmed orally that she had this contemporaneous note with her to assist her memory, when formally participating in the Witness Investigation Meeting on 21 August 2019.

The panel considered the following passage from the Witness Investigation Meeting:

> *'AR stated that she went to speak to Stephen to say that Marta was upset. He had looked at her and said, 'do you know what, I really don't give a shit' AR said he put his hand up to stop her speaking any further.'*

The panel also considered the oral evidence of Abigail Rilatt, dated 28 July 2026. The panel assessed her evidence as being measured and well balanced in relation to those aspects that she was able to remember. Abigail Rilatt stated in her oral evidence to the panel:

> *'Marta was very upset. If he [Mr Gumise] had said I don't care instead of I don't give a shit, I'd still have escalated it because nurses should support each other.'*

The panel further noted that Abigail Rilatt did not appear to exaggerate any details, but rather impressed upon the panel that it was not the direct words that Mr Gumise had spoken which had caused her any offence. Abigail Rilatt confirmed that the culture of the unit was to use swear words between nurse colleagues, within safe spaces. She, however, did state that she felt the need to escalate the incident due to Mr Gumise's attitude, and the fact that he had caused upset to another nurse. Abigail Rilatt stated that Mr Gumise did not show any consideration about having upset his colleague. She stated that she had told him:

> *'If you upset someone, you should apologise and support one another'*

The panel then considered the account of Mr Gumise in relation to this charge:

> *'Staff Nurse Gumise stated that he could not remember Staff Nurse Rilatt speaking to him but denied that he had responded to her in that way, but said that she was friends with Auxiliary Nurse Salih.'*

The panel took into account that when the above was put to witness Abigail Rilatt during her oral evidence, she confirmed that she and Marta Malek-Salih were not friends, but colleagues.

The panel preferred the evidence of Abigail Rilatt; it found her to be consistent throughout the Witness Investigation Meeting, her witness statement and within her oral evidence, given before the panel.

Consequently, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1c) *… On an unknown date, went to the Chief Executive's office and banged on the door*

Mr Piercy offered no evidence on behalf of the NMC, in relation to Charge 1c. Consequently, the panel determined that this charge is found not proved due to the lack of evidence given by the NMC.

The panel, prior to deliberating on Charge 2, conducted a broad assessment on the main witnesses who had given evidence in relation to any and all of the matters arising from this charge.

The panel assessed Patient A to be a credible, reliable and consistent witness, when giving a general overview of what had allegedly occurred on or around 4 June 2020.

In relation to Hannah Bye, the panel assessed her to be confident in her perception of what had allegedly occurred on or around 4 June 2020. The panel noted, however, that in her oral evidence, she had stated that she had worked with Mr Gumise for roughly 7 hours of her 12-hour shift. Therefore, given the nature of Hannah Bye's duties in that she would be transferring patients in between wards, the panel considered that it is unlikely that she could have been present for the entirety of Patient A's stay at Same Day Emergency Care 'SDEC', and therefore that it is less likely that her focus would have been on the entirety of Mr Gumise's and Patient A's interactions.

Finally, when assessing Alun Mountjoy, the panel found him to be a consistent, reliable and credible witness who had provided clear evidence. The panel found him to be able to provide evidence of procedures which were being used on the ward at the time, and what would have been considered the standard operating procedures, both locally and nationally. The panel found that Alun Mountjoy, as an experienced senior nurse and Mr Gumise's line manager, gave a balanced and objective view on how nurses should conduct themselves whilst practising.

Charge 2) *Whilst employed at Bedfordshire Hospitals NHS Foundation Trust, on or about 4 June 2020:*

Charge 2a) *… Told Patient A that if she went home, she would be fined £10,000 or arrested*

This charge is found proved.

In considering this charge, the panel took into account the initial complaint made by Patient A to the Hospital, and the NMC referral made by Patient A alongside the live and written evidence of Patient A. It also considered the written and live evidence of Hannah Bye, and the written account of Mr Gumise within the Investigation Report dated 15 August 2019.

The panel considered the initial complaint made by Patient A on 10 July 2020 in an email sent to PALS titled '*Complaint'*:

> *'Stephen then went on to tell me I wasn't allowed home because I would be fined 10k and the government takes this very seriously.'*

And

'He also said that I would be arrested and fined 10k several more times during this conversation, despite the fact that I was visibly distressed and upset.'

Patient A also made reference to a conversation she had had with a member of staff by the name of Marc [sic], after having been moved to the red ward:

'*I told him that I was told if I go home I would be fined 10k to which he said 'who said that?' I said Stephen on SDEC and he said no that's ridiculous'*

The panel highlighted an email sent from Mark Henson, a member of staff at the hospital, dated 09 August 2020, he stated:

'She [Patient A] also said that she wanted to self discharge but was told by SDEC's Nurse in Charge that she would face a £10,000 fine.'

And

'When Nurse in Charge was asked about his comment regarding the £10,000 fine by the Bed Manager and I, he shrugged his shoulders and said that's what he had read on the internet.'

The panel then considered the following passages from the written witness statement of Patient A:

'Whilst talking to Stephen he stated several times that if I went home, I would be fined £10,000 and arrested. I felt Stephen was aggressive in his demeanour towards me. I told him my baby had not been fed for a long time, and he would

just say if I went home to feed her, I could kill her. He was speaking loudly and would not back down. I felt intimidated, upset and scared.'

And

'Stephen came to speak with me and started telling me I needed to stay and that I couldn't go home as I needed to be tested for Covid. As I started to question his reasons, he got louder and more aggressive in his tone. He told me I would be fined £10,000 if I went home.'

The panel also considered the oral evidence of Patient A:

'I felt intimidated and attacked. He was aggressive, loud and intimidating. I felt panicked, attacked and humiliated. I was scared police would turn up at my door and arrest me.'

The panel also took into account the following passage from the Datix Report: Incident Details, dated 05 June 2020, which corroborates Patient A's account of what had allegedly occurred:

'She stated that she didn't want to be here and said that she had been bullied by the nurse in SDEC to come down to the ward. She stated that the nurse had told her she would receive a £10,000 fine if she did not stay in hospital'

The panel then considered the following paragraph from the written witness statement of Hannah Bye:

'I think that the patient's complaint that Stephen threatened her with a £10,000 fine was taken out of context. I think that Stephen said something along the lines of the government having a rule that if something happens that the fine is

the maximum penalty. He didn't say that she would be fined if she left – he was stating that it was more of a government rule.'

When questioned by the panel during her oral evidence on whether she directly witnessed the alleged exchange, Hannah Bye stated:

'Yes I did, he definitely didn't say the patient specifically would be arrested. He said the government was issuing fines up to £10,000. He did not say she would be directly fined or arrested.'

The panel heard from Alun Mountjoy's oral evidence from 27 July 2026 that there was no hospital policy or guidance in place that stated that patients with suspected covid, who left the hospital, would be fined £10,000 or arrested. Alun Mountjoy confirmed that as the nurse in charge of SDEC, Mr Gumise would have been made aware of the latest policies as they related to covid. He also stated:

'In relation to Mr Gumise, he could come across quite intimidating with the way he spoke. The way he would challenge, he would come across as quite aggressive in his voice. He kept saying 'you are trying to make me fail'. On one occasion, he banged his fist on the desk. I found it traumatic.'

The panel then took into account Mr Gumise's explanation of this alleged incident, written in an email dated 11 June 2020, to another member of staff, as follows:

'The bed managers walked through SDEC later and the gentleman asked if someone threatened the patient with a fine of £10000, to which I replied no one threated her, we only let her know that the government take the covid situation

seriously and reserve the right to fine members of the public who knowingly put other people at risk.'

The panel specifically noted that Patient A described behaviours associated to Mr Gumise, that parallelled behaviours that were referred to in the evidence and complaints by Marta Malek-Salih, Jayne Scott and Abigail Rilatt, and therefore took this into account when assessing the evidence. In any event, the panel found Patient A to be a consistent, credible, and reliable witness, who had provided both in written and oral form, a very detailed and contemporaneous complaint. The panel also considered the fact that Patient A's initial complaint to the hospital and her NMC referral remained entirely consistent with the content of her subsequent accounts. The panel therefore placed significant weight on her evidence.

On the balance of probabilities, the panel determined that it was more likely than not that Mr Gumise did tell Patient A that she would be fined £10,000 or arrested, if she were to go home.

This charge is therefore found proved.

Charge 2b) *… Told Patient A 'well that's a catch 22 if you go home and feed her, you could kill her' upon her explaining that she needed to go home to breastfeed her daughter*

This charge is found proved.

In considering this charge, the panel took into account the initial complaint made by Patient A to the Hospital, the NMC referral made by Patient A alongside the live and written evidence of Patient A. It also considered Mr Gumise's response.

The panel took into account the following passage from Patient A's initial email complaint to PALS, dated 10 July 2020, titled '*Complaint*':

‘I felt it was in my best interest to go home and feed my baby who hadn’t had any fluid for 12 hours. He asked if my husband could feed her and I explained that she has never been able to take a bottle or beaker or dummy so relies on me 100%. To which he responded ‘well that’s a catch 22 if you go home and feed her you could kill her’.

The panel concluded that the evidence provided by Patient A within her initial complaint email was further substantiated within her NMC referral, dated 10 July 2020.

The panel also considered the following passages from the written statement of Patient A:

‘I explained about my daughter needing fed, and he asked if my husband could feed her. She was breastfed so I told him, no. He said, “Well that’s a catch 22 if you go home and feed her, you could kill her”.

And

‘I was being told I could kill my family if I went home. At this point I was crying my eyes out.’

The panel then considered the oral evidence of Patient A:

‘I was utterly shocked that he had said this… I felt intimidated, my guard went up. I felt attacked, I got upset, teary and panicky. Others could hear, I felt embarrassed… he was very loud at the end of a long ward, people were listening… I was saying about my daughter that I needed to go home and that my dad was living with me who was high risk, I was being careful… what I struggled with most was that he said I could kill her… I’m a new mum, it was in front of everyone, it was devastating, brings it all back... I didn’t realise that if you went to hospital, you were not allowed to leave… I realise now that that

was not the case… I was a new mum with a second baby… my children are my priority… being told I could 'kill' my children was absolutely devastating'

The panel heard evidence from Hannah Bye, who during the course of her oral evidence, in relation to this charge, told the panel:

'I cannot recall this comment being made… She [Patient A] said we are going to kill her children… it was patient A who said we were going to kill her baby… her husband came on the phone later and was shouting abuse. She [Patient A] kept saying that Stephen was bullying her'

The panel also considered the following passage in the letter sent to Patient A on 7 September 2020 by the hospital, which corroborated to some degree, Patient A's evidence:

'I understand that you were reluctant to stay in the Trust, particularly as your baby was at home and due to be fed and that you had repeatedly asked if you could go home, whilst on the Same Day Emergency Care Unit (SDEC). I was very disappointed to read of upsetting comments made towards you when you had requested to leave and I would like to confirm that this was completely inappropriate and unacceptable and you had the right to leave the hospital at any point during your treatment.'

The panel noted that Mr Gumise was asked in general terms relating to this allegation on 17 July 2020 by Alun Mountjoy through a written email. The panel noted that on 6 August 2020, this enquiry was once again followed up through another email from Alun Mountjoy to Mr Gumise. The panel however could find no evidence that Mr Gumise has directly addressed the allegations in this particular charge.

The panel determined that, given the consistency of Patient A's written and oral evidence, over a significant period of time, alongside the lack of any alternative explanation for the

panel to consider, and the close proximity of Patient A's written complaints to the actual alleged incident, the panel placed significant weight upon the evidence of Patient A.

On the balance of probabilities, the panel found that it is more likely than not that Mr Gumise did tell Patient A '*well that's a catch 22 if you go home and feed her, you could kill her'.*

Consequently, the panel found this charge proved.

Charge 2c) *… Your advice to Patient A in charge 2b had no clinical basis*

This charge is found NOT proved.

In considering this charge, the panel determined that the NMC have not provided any evidence that Mr Gumise's advice to Patient A had or did not have any clinical basis. The panel noted that there is no direct evidence before the panel that, at the time of the Coronavirus during 2020, breastfeeding your child could have led to the child's death. The NMC did not provide the panel with any pamphlets or guidance documents that were in existence at the time of this incident: namely, on or about 4 June 2020.

The panel was therefore not satisfied on the balance of probabilities, that the NMC had discharged its evidential burden. Consequently, this charge is found not proved.

Charge 2d) *… On multiple occasions, tried to prevent Patient A from going home*

This charge is found proved.

In considering this charge, the panel took into account the initial complaint made by Patient A to the Hospital, the NMC referral made by Patient A, alongside the live and written evidence of Patient A. It also considered Mr Gumise's response during the investigation meeting, and the patient notes he had made for Patient A on 5 June 2020.

The panel considered the following passages from Patient A's original written complaint through an email to PALS, dated 10 July 2020, titled '*Complaint'*:

'I asked her if I could go home and she said I could…'

'I called my husband straight away to let him know. I was greeted on the phone with my screaming daughter in the background and he explained she had not been fed for 12 hours. This was enough to change my decision and I told him I would self-discharge and come home.'

'Stephen came over to speak to me and advised me that I could not go home because I needed to be tested for coronavirus.'

'I said I wasn't here for potential coronavirus, and I wasn't showing any symptoms and the nurses and doctors all day hadn't mentioned it to me once. I also advised him that I was told this was a green ward and that I had seen many patients go home without being tested, so why couldn't I?'

'Stephen then went on to tell me I wasn't allowed home because I would be fined £10,000 and the government take this very seriously.'

'At this point I was crying my eyes out. I told him I needed to go home and that the doctor originally said I did have the option however made it clear that should I seek any further medication attention I would have to go through the process once again. Stephen did not give up and continued to tell me that I couldn't go home and that I would run the risk of killing thousands of people and my family should I leave the hospital. I once again informed him I showed no symptoms…'

'I felt like a prisoner and felt humiliated in front of other patients on the ward.'

'I told him I didn't need to see a doctor and that another doctor had told me I could go home so that is what I was doing. He wasn't going to let me leave so I walked away and was going to leave with my cannular still in place, but Hannah came and removed it.'

'He told me I couldn't go home as I wasn't medically fit to go home. I said I am self discharging as I feel fit and healthy and I had been told I'm allowed… I started walking out and he still went on to tell me I'm not allowed home. I said why wont you give up? I called him a bully and I said goodbye.'

The panel determined that Patient A's written witness statement corroborated the account she had given within her initial referral, dated 10 July 2020.

The panel considered the following from the oral evidence of Patient A:

'He [Mr Gumise] said I could not leave until he had spoken to the doctors… he was adamant that I could not leave… Stephen got very aggressive towards me… I was told I was not allowed to leave.'

When questioned by the panel during her oral evidence on what she meant by Mr Gumise being a '*bully*', Patient A responded:

'He was a bully because he was aggressive to me, not listening to me or anyone else. No compassion for the situation. I felt like he wanted to get the last word.'

The panel then considered the following oral evidence from Hannah Bye:

'Stephen stopped her trying to leave closed areas of the ward… at no point forced her to stay in hospital'

The panel considered Mr Gumise's account of this alleged incident in an email he had sent to Sharon Clarke dated 11 June 2020:

> *'The patient was adamant that she was not going to stay in the hospital as she needed to get home, I felt it was my duty to inform the patient that the doctors would have wanted her to stay as they may have some health concerns for her that warranted her to be in the care of the hospital overnight. As well the doctor was concerned about the possibility of a Covid 19 infection being present, the patient in this case would have an obligation to think about the safety of the community and hospital staff that may be potentially at risk if she might have the infection. The patient was very verbally aggressive with swearing and a raised voice, she did not comply with the request to remain in one place because we did not want to further compromise the green zone she was in.' [sic]*

And

> *'I received a call from a staff nurse on AAU who was talking about how wrong this was and that we should let the patient go home in the presence of the patient as I could hear the patient saying, 'they won't let me go home', the patient was then brought back to the unit (SDEC) in an even more heightened state, she was saying I was told I don't have to be hear so why were you holding me here?. I asked the patient to allow us a few minutes to bleep the surgeons again to let them know the developments and that they may want to speak to her in person, the patient agreed to wait in a Side room and had her partner on video call so he could see and hear everything. I bleeped the doctors again and this time they responded, I spoke with the male doctor who then passed me onto the female doctor who refused to come and speak with the patient as she said I have already spoken with the patient, she said the patient has to stay in the hospital as there was health concerns, when I said the patient*

is not willing to stay she said well get her to sign a self-discharge form then and put the phone down.'

The panel then considered Mr Gumise's medical notes made in relation to Patient A on 5 June 2020, at 01:40am, in which he wrote:

'a decision needed to be made if PT was allowed to go home or has to stay in hospital.'

The panel determined that Patient A had provided a consistent account of what had occurred through her initial complaints alongside her written and oral evidence. The panel heard no evidence to undermine her explanation of what had allegedly occurred on this date. The panel acknowledged Hannah Bye's oral evidence that Mr Gumise did not forcefully keep Patient A in the hospital but accepted that she was not present with Mr Gumise throughout the entirety of her shift, and therefore, may not have been present for this specific alleged incident. The panel took into consideration Mr Gumise's relative lack of comment on the allegation.

Given the consistency of Patient A's complaint, and the detailed and contemporaneous nature of the way in which this complaint was raised, it preferred Patient A's evidence to that of Mr Gumise or Hannah Bye.

Consequently, the panel found this charge proved.

Charge 2e) *... Your actions in charge 2d had no clinical basis*

This charge is found proved.

In respect of this charge, the panel considered the medical notes for Patient A dated 4 June 2020, the undated and untimed review conducted by the Surgical Registrar, the risk

assessment document completed on 4 June 2020, the evidence provided by Patient A, alongside the response made by Mr Gumise.

The panel firstly highlighted the medical notes dated 4 June 2020, which were made during the initial triage stage for Patient A; it noted that there was no mention or suggestion within these notes of any potential concern for Coronavirus. When questioned during his oral evidence, Alun Mountjoy confirmed to the panel that there was no suggestion for a Coronavirus diagnosis within these medical notes.

The panel next considered the review conducted by the surgical registrar, which it noted was not dated nor was it timed. The panel acknowledged however that the entries made by the surgical registrar noted that Patient A's diagnosis was either acute appendicitis, or mesenteric adenitis. The panel determined that there was no diagnosis of Coronavirus within this review.

The panel also took into account the risk assessment tool which was completed on 4 June 2020. It determined that this document only shows a hand drawn box with a tick through it, and the word *'covid'* beside it but no date or time was recorded alongside it. The panel determined that this was merely a reference to a coronavirus swab having been taken from Patient A. This hand drawn box/tick and written note was explored with Hannah Bye during her oral evidence, whereby she informed the panel that she had in fact written this as an indication that she had taken a covid swab from Patient A.

The panel also took into account the Confidential File Note date 27 July 2020, completed by Alun Mountjoy, which stated the following:

> *'I have also explained we have no right to keep a patient with Covid unless they were clinically unwell or did not have the capacity to understand the need to self isolate'* [sic]

Further, the panel noted the patient notes written by Hannah Bye at 23:50 on 4 June 2020 which stated the following:

> *'Dr seen patient, then came to staff to request for a red bed due to ? covid. I asked the Dr twice if a red bed was needed, she said yes.*'

The panel considered Mr Gumise's account of this alleged incident in an email to Sharon Clarke dated 11 June 2020:

> '*I felt it was my duty to inform the patient that the doctors <u>would have</u>* [the panel's emphasis] wa*nted her to stay as they may have some health concerns for her that warranted her to be in the care of the hospital overnight.'*

The panel concluded that there was no evidence before it, apart from Patient A's patient notes, which merely referred to a swab test for Covid having been taken, of any concerns regarding Patient A specifically exhibiting Covid symptoms. The panel also noted Alun Mountjoy's evidence that the turnaround for test results at that time was between 72 hours and 5 weeks. The panel determined that there was no indication from any doctor that Patient A had Coronavirus, or that there was a heavy suspicion that she had contracted Coronavirus. In any case, the panel considered the evidence of Alun Mountjoy, that if Patient A did in fact have Coronavirus, that the correct course of action would have been for the patient to go home, and isolate. The panel determined that the clinical documentation does not reflect the doctor's rationale for either a suspicion of, or confirmation of, a diagnosis of Coronavirus, in terms of Patient A.

The panel considered that it has been suggested that Patient A may have required a scan to exclude the possibility of appendicitis. However, the panel heard evidence from Alun Mountjoy, having been shown the medical notes, that there was no entry stating that Patient A had to remain in hospital overnight and therefore nothing preventing Patient A from going home and returning in the morning in order to have any appendicitis scan completed on the SDEC ward.

The panel determined that, given all of the information before it and on the balance of probabilities, there was no clinical basis in your actions, in having prevented Patient A from returning home.

This charge is consequently found proved.

Charge 2f) *… Raised your voice to Patient A when speaking with her*

This charge is found proved.

In considering this charge, the panel noted the written evidence of Patient A, alongside the oral evidence of Hannah Bye.

The panel considered the following passage from the written statement of Patient A:

> *'He was raising his voice and I had raised mine as I was crying a lot.'*

The panel noted that Patient A's claim of Mr Gumise having raised his voice at her was corroborated by the oral evidence of Hannah Bye, in which she said:

> *'He raised his voice at her only after numerous times of her being rude and saying unpleasant things… she [Patient A] had no right to speak to us like that… he raised his voice after about 10 to 15 minutes of verbal abuse… he spoke sternly… he asked her not to speak to him 'like that''*

On the balance of probabilities, and in considering Patient A's evidence alongside the corroborating evidence of Hannah Bye, the panel determined it was more likely than not that Mr Gumise did raise his voice at least once when speaking to Patient A.

Charge 2g) *… Shouted to Patient A 'do not go out there you are not allowed, everywhere you go and everything you touch needs to be sterilised and washed' upon her trying to walk outside the doors to make a phone call.*

This charge is found proved.

In considering this charge, the panel took into account Patient A's original written complaint, written and oral evidence, alongside the evidence of Hannah Bye, and Mr Gumise's response to this allegation.

The panel considered the following passage from Patient A's original written complaint through an email to PALS, dated 10 July 2020, titled '*Complaint':*

> *'I was sobbing and I wanted to call my husband for advice, I started to walk to the door that I and all the other patients had been walking in and out off all day long and he shouted through the whole ward 'DO NOT GO OUT THERE YOU ARE NOT ALLOWED, EVERYWHERE YOU GO AND EVERYTHING YOU TOUCH NEEDS TO BE STERLISIED AND WASHED'.'*

The panel determined that Patient A's claim was consistent with both her witness statement and the oral evidence she had given before the panel.

The panel further considered the email sent by Hannah Bye to Sharon Clarke on 05 June 2020:

> *'The patient said she was going to leave, it was then explained to her that because the doctor said she was ? Covid we had a duty of care to isolate her onto the ward.'*

The panel also considered the oral evidence of Hannah Bye:

> *'He [Mr Gumise] said 'do not go out there' but nothing about 'everything you touched needs to be sterilisied… he did give an explanation but I cant remember exactly what was said.'*

The panel then considered Mr Gumise's comment within an email he had sent to Sharon Clarke on 11 June 2020:

> *'The patient was very verbally aggressive with swearing and a raised voice, she did not comply with the request to remain in one place because we did not want to further compromise the green zone she was in. The patient tried to walk through AECU to get out and we had to explain that that area was locked and that she could not walk through departments as we needed to limit the places she went.'*

The panel heard evidence from Alun Mountjoy, who had informed the panel that

> *'Stephen was extremely fearful around Covid… it was acceptable… he said lots of black and BAME people were contracting Covid and dying… he was fearful*

that the patient had Covid... I can understand black and ethnic minority staff being anxious at the time… Stephen is BAME.'

The panel noted that Patient A had raised her concern within her initial complaint email, which was then corroborated by both her written statement, and the oral evidence she had given before the panel. The panel highlighted that Patient A's oral evidence was very precise and detailed.

The panel determined that, especially given Mr Gumise's reported anxiety as expressed by Alun Mountjoy, alongside the apparent suspicion that Patient A may have contracted Coronavirus, it was more likely than not that that Mr Gumise did shout to Patient A *'do not go out there you are not allowed, everywhere you go and everything you touch needs to be sterilised and washed'* upon her trying to walk outside the doors to make a phone call.

Consequently, the panel determined that it preferred the evidence of Patient A, and found this charge proved.

Charge 2h) *... Moved Patient A or allowed Patient A to be moved to a red zone despite having no Covid-19 symptoms*

This charge is found proved.

In considering this charge, the panel first noted that a doctor was reported by Hannah Bye as having given the instruction to her that Patient A was to be moved to the red zone and considered the nursing notes written by Hannah Bye on 04 June 2026, whereby she wrote:

'I asked the Dr twice if a red bed was need, she said yes.'

The panel then considered the DATIX report dated 05 June 2020, where it was confirmed that Patient A was in fact taken to a red zone. The panel considered the following passage, as written by Alun Mountjoy:

> *'I called the nurse down in SDEC and asked why he had not come down with the patient and given a handover. He said the doctor stated that the patient needed to be on a red ward so he sent her down with a CSW.'*

The panel further considered the oral evidence of Alun Mountjoy who told the panel that, as Mr Gumise was the nurse in charge, it was his duty to take and hand over the patient when transferring them from the green zone to be admitted to the red ward. He did not expect Patient A to be taken to the red ward by a Clinical Support Worker (CSW).

The panel also considered Hannah Bye's oral evidence whereby she accepted that she had taken Patient A to red zone.

The panel therefore initially determined that it was satisfied that Patient A was moved to a red zone.

The panel heard from Alun Mountjoy that as the nurse in charge, Mr Gumise was responsible for the care of the patients in SDEC and therefore when he was told by Hannah Bye that a doctor had requested the transfer of Patient A to the red ward, he should have checked the medical records to confirm this instruction and whether Patient A had now been confirmed as having covid. If Mr Gumise had been uncertain about this instruction and had noted no such request in the medical records, Mr Gumise should have contacted the doctor who had made the request and/or contacted the site manager to clarify if this was necessary. Alun Mountjoy confirmed in oral evidence that the risk of Patient A being admitted to the red ward without a diagnosis of covid was that there was a significant likelihood of Patient A contracting covid and passing on that infection to her family.

The panel then determined that it was satisfied that Patient A presented no Coronavirus symptoms, as per is reasoning in Charge 2e. The panel also determined that on the balance of probabilities, it was more likely than not that Mr Gumise did allow Patient A to be moved to a red zone, despite having no Covid-19 symptoms.

Consequently, this charge is found proved.

> ***Charge 2i)*** *… Refused to give to Patient A the name of the surgical doctor who first attended to her*

This charge is found proved.

In relation to Charge 2i, the panel initially considered the following passages from Patient A's original written complaint through an email to PALS, dated 10 July 2020, titled '*Complaint'*

> *'I asked for Stephens surname. She [Hannah Bye] said she couldn't give I to me but I could ask him. My husband who was still on the phone could hear everything and he advised me to ask him as I need as much information as possible. I asked Stephen for his surname and he refused to give me this information so I asked for his position to which he aggressively pointed to his name badge. Bearing in mind I had been crying uncontrollable my eyes were haze so I had to get close to read his badge. I asked for the surgical doctor's name who advised she wasn't concerned about appendicitis and had said I*

could go home. He refused to give me her name but said her bleep number was 545.' [sic]

The panel determined that this complaint was supported by both Patient A's witness statement, and her oral evidence given before the panel; all three of these were consistent with and corroborated one another.

The panel noted that Hannah Bye had not made mention of this alleged incident in her initial email response to Sharon Clarke, dated 5 June 2020, or in her written statement. However, the panel did note that in her oral evidence to the panel, Hannah Bye for the first time, referenced this incident, stating:

'No one knew the doctors name, she was a locum… never seen her before, I don't actually know [who she is]'

'He [Mr Gumise] wasn't being difficult… it wasn't necessarily a refusal… nobody knew her name… we don't usually give bleep numbers as multiple doctors use the same bleep.'

The panel also considered the oral evidence of Alun Mountjoy who commented to the panel that a nurse would be expected to give the name of a doctor to a patient, if asked. He said:

'if a patient asks, give them the name… it is not appropriate to give just the bleep number… a bleep number was inefficient to be provided as it gets passed around and if [Mr Gumise] had forgotten the name, there was a bleep list where he could have found out the name'

The panel noted that the name of the surgical registrar is referenced within Patient A's medical records. Therefore, the panel was satisfied that the name of the doctor who

initially attended to Patient A was easily available to Mr Gumise, and disclosable to Patient A.

On the balance of probabilities, the panel determined that it is more likely than not that Mr Gumise did refuse to give to Patient A the name of the surgical doctor who first attended to her.

Consequently, this charge is found proved.

> ***Charge 2j)*** *… Did not take and or record and or verify Patient A's observations upon arrival and or every two hours thereafter*

This charge is found proved.

In considering this charge, the panel determined that Patient A was already on the SDEC ward when Mr Gumise had commenced his shift after handover. The panel had evidence before it within the SDEC risk assessment tool that observations had been taken by the day staff. The panel also had before it evidence in the form of the Emergency Assessment Pack, which included observation records for 4 June 2020, at 18:10pm, which contained the pulse, blood pressure, respiratory rate, oxygen saturation, and temperature of Patient A when they arrived on SDEC.

The panel highlighted that Mr Gumise's shift commenced after the arrival of Patient A. Consequently, the panel acknowledged that Mr Gumise would not have had the ability to take or record the observations, upon Patient A's arrival. The panel concluded therefore that it is a matter of strict fact that Mr Gumise did not take or record observations upon the arrival of Patient A.

The panel then went on to consider whether the taking of observations every two hours was necessary. The panel noted that Alun Mountjoy had said that the NICE Guidelines were that observations should be taken every 4 hours, however, according to the

Hospital's Standard Operating Procedure, observations were to be taken every two hours, due to the nature of the patients in the SDEC ward and need to reassess their status more frequently. Alun Mountjoy further confirmed that it was Mr Gumise's responsibility to remain up to date with the procedures in the Hospital.

The panel considered the oral evidence of Alun Mountjoy:

> *'The nurse in charge is responsible for observations being conducted. They can delegate who does the observations to the Clinical Support Worker, but they need to check that they are done by looking at the Observation Chart and to ensure nothing is missed… from the NMC perspective, if its not written down, it didn't happen.'*

The panel considered the fact that when Alun Mountjoy was shown the Observation Chart during his live evidence, he said this was *'not acceptable'* as there was no evidence that Patient A had received any care during the time Patient A was under the care of Mr Gumise.

The panel further noted that Hannah Bye had stated that observations should be taken every 4 hours unless a doctor had stated otherwise. Hannah Bye confirmed she did take observations '*once or possibly twice'*, having made a note of them on a piece of paper, but had not transposed these into Patient A's handwritten medical records. This statement was confirmed through the Patient Observation Chart, which applied to the dates 04 and 05 June 2020, in which there were no entries made at all during her shift.

The panel further considered the oral evidence of Hannah Bye:

> *'As a support worker, it was my responsibility. I told him that I had done the observations. More often than not, they take your word for it, a lot is done on trust.'*

The panel finally considered the following passage from Patient A's original written complaint through an email to PALS, dated 10 July 2020, titled '*Complaint':*

> *'I heard her say that there have been no observations taken from anyone at my time on the ward and that it doesn't make sense.'*
>
> And
>
> *'Not once on this ward were any observations taken'*

The panel considered the fact that Mr Gumise had not made any comment or provided any evidence in relation to this alleged incident.

The panel determined that ultimately, it preferred the evidence of Alun Mountjoy, who had made clear through his oral evidence that Mr Gumise should have verified the observations and the recordings of these observations. The panel took account of the fact that Alun Mountjoy was a Band 7 Unit Manager of SDEC, and preferred his evidence given his level of seniority, and his explanation of what exactly best practice was, alongside his knowledge of the Standard Operating Procedures at the hospital.

Consequently, the panel found this charge proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of the hearing that Mr Gumise was not in attendance and that a Notice of Hearing letter had been sent to his registered email address by secure email on 13 August 2026.

Ms Wisniewska, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to

Practice) Rules', as amended (the Rules) in respect of service of the Notice of the Hearing.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing was sent in August 2026 which was some two and a half months from today's hearing and that it provided details of the charges, the time, dates and that the hearing was to be held in person. The notice also included information about Mr Gumise's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all the information available, the panel was satisfied that Mr Gumise has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Gumise

The panel next considered whether it should proceed in the absence of Mr Gumise. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to proceed with the hearing in the absence of Mr Gumise. She submitted that Mr Gumise had voluntarily absented himself.

Ms Wisniewska reminded the panel that it had decided that service of the notice of hearing has been effected in accordance with the Rules.

The panel accepted the advice of the legal assessor. He referred to the cases of *R* v *Jones (Anthony William) (No.2*) [2002] UKHL 5 and to the *General Medical Council v Adeogba* [2016] EWCA Civ 162 as relevant case law and to the NMC's Guidance CMT-8.

The panel recognised that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones.*

The panel decided to proceed in the absence of Mr Gumise.

In reaching this decision, the panel has considered the submissions of Ms Wisniewska and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v Jones* and to *GMC v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Gumise;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- The purpose of today's hearing is to hand down the panel's decision on facts so as to give all parties the opportunity of fully preparing for the final stages of the hearing on 1-3 February 2027; and
- There is strong public interest in the expeditious disposal of the case and it is in the interests of Mr Gumise and the NMC for the case to proceed.

The panel accepted that it would have to consider the making of an interim order as there has been a change in circumstances following its decision on facts but also noted that Mr Gumise had been advised of this possibility in the notice of hearing dated 13 August 2026.

In these circumstances, the panel has decided that it is fair and in the interests of justice to proceed in the absence of Mr Gumise.

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that an interim order is necessary to protect the public and is in the public interest. Ms Wisniewska applied for an interim suspension order for a period of 6 months. Ms Wisniewska submitted that it would be inconsistent with the decision made, if the panel did not impose an interim order.

Decisions and reasons on an interim order

The panel accepted the advice of the legal assessor, who referred the panel to the NMC Guidance titled *'Decision making factors for Interim Orders'*.

The panel considered whether an interim order is appropriate in this case. It noted that there has been no previous interim order imposed since the allegations were first made.

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. If repeated, the panel considered that Mr Gumise's behaviour could cause harm to members of the public and colleagues, and it also considered that, given its findings, members of the public would be shocked if no interim order was imposed upon Mr Gumise pending final determination of the proceedings next year.

The panel noted that many of the concerns in this case are attitudinal and wide-ranging. It also noted that there was no evidence before it to show any insight or remediation. The panel had no information before it as to whether Mr Gumise is still in practice, although it noted the Ms Wisniewska submissions that Mr Gumise was practising as a nurse in November 2023.

The panel concluded that an interim conditions of practice order would not be appropriate, workable 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 6 months to cover the period until the handing down of any final decisions scheduled for February 2027.

The panel is aware that it is not imposing a final sanction at this stage.

The panel reminds Mr Gumise that if he is dissatisfied with this decision, he can ask for an early review.

That concludes this determination.