Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 9 February 2026 – Wednesday, 18 February 2026
Monday, 26 October 2026 – Friday, 30 October 2026

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

Name of Registrant:	**Reshad Allymamod**
NMC PIN:	99D0791E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nurse (Level 1) – 20 April 2002 Nurse Independent / Supplementary Prescriber – 21 May 2011
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Alan Greenwood (Chair, lay member) Penelope Howard (Registrant member) Karen Naya (Lay member)
Legal Assessor:	Richard Ferry-Swainson
Hearings Coordinator:	Adaobi Ibuaka Sabrina Khan (29-30 October 2026)
Nursing and Midwifery Council:	Represented by Richard Webb, Case Presenter 9 – 18 February 2026 Represented by Alex Radley, Case Presenter 26 – 30 October 2026
Mr Allymamod:	Present and represented by Alice Byron, Instructed by the Royal College of Nursing (RCN) 9 – 18 February 2026 Present and represented by Miranda Lickert, Instructed by the Royal College of Nursing (RCN) 26 – 30 October 2026

Facts proved:	Charge 1 in its entirety, 2 in its entirety, 3 in its entirety and 4
Facts not proved:	N/A
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**
Final outcome:	**FTP impaired - striking off order**

Application for special measures under Rule 23

Mr Webb, on behalf of the Nursing and Midwifery Council (NMC), made an application for special measures for Patient A, Patient B and Colleague A. He referred the panel to Rule 23 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules) which governs the provision of vulnerable witnesses and also to the NMC Guidance (CMT-12) "Supporting people to give evidence in hearings". Mr Webb submitted that there was already an agreement between the NMC, Ms Byron and you for some of these special measures to be put in place, however, this was ultimately a decision for the panel. He submitted that, as this case involves sensitive matters relating to alleged sexually motivated conduct by you towards the NMC witnesses Patient A, Patient B and Colleague A, they should be treated as vulnerable witnesses. Mr Webb submitted that a fair hearing could take place with Patient A, Patient B and Colleague A having these special measures in place.

He submitted that the following measures should be put in place to assist Patient A, Patient B and Colleague A to give their evidence before the Committee:

- For you not to be able to see Patient A, Patient B and Colleague A and for them not to be able to see you when they are giving evidence, by you dialling into the hearing by phone; and
- For Patient A, Patient B and Colleague A's evidence to be heard entirely in private.

Ms Byron, on your behalf, stated that she did not oppose some of the special measures proposed, in particularly, having you dial in during Patient A, Patient B and Colleague A's witness evidence, so that they could not see you and you could not see them and hearing Patient A and Patient B's evidence in private. However, Ms Byron submitted that she

opposed hearing Colleague A's evidence in private, as her evidence does not pertain to personal or health issues.

The panel accepted the advice of the legal assessor and had regard to Rule 23 of the Rules and the NMC guidance CMT-12.

Decisions and reasons on application for special measures.

Dialling in:

The panel decided to accept the application for you to dial in while Patient A, Patient B and Colleague A are giving evidence. The panel accepted that Patient A, Patient B and Colleague A were vulnerable witness, under Rule 23, and that this would enable them to give their best evidence.

Hearing evidence in private:

The panel decided to accept the application for Patient A and Patient B to have their evidence heard entirely in private as it relates to their health. The panel did not accept the application for Colleague A's evidence to be heard entirely in private as Colleague A's evidence made no mention of any personal or health issues.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Webb to amend the wording of charges 1, 2a and 3.

The proposed amendments were to remove 'and/or clinical justification' from charge 1, amend charge 2a to include 'and/or nipples' and to include 'and/or' in charge 3. It was submitted by Mr Webb that the proposed amendments would provide clarity and more accurately reflect the evidence.

The stem of charge 1 currently reads as follows:

1. *On 3 March 2013, behaved inappropriately towards Colleague A in that without consent and/or clinical justification you;*

The proposed amendment to the stem of charge 1 is as follows:

1. *On 3 March 2013, behaved inappropriately towards Colleague A in that without consent ~~and/or clinical justification~~ you;*

The stem of charge 2a currently reads as follows:

2) *'On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:*
   a) *breast;'*

The proposed amendment to the stem of charge 2a is as follows:

2) *'On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:*
   a) *Breast* ***and/or nipples****,'*

The stem of charge 3 currently reads as follows:

3) *'On 6 October 2018, during a routine examination, touched Patient B inappropriately and without clinical justification in that you touched Patient B's:..'*

The proposed amendment to the stem of charge 3 is as follows:

3) *'On 6 October 2018, during a routine examination, touched Patient B inappropriately and/**or** without clinical justification in that you touched Patient B's:..'*

Ms Byron submitted that she did not oppose the proposed amendments.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the amendments, as applied for, were in the interests of justice. The panel noted your lack of opposition to the proposed amendments and was satisfied that there would be no prejudice to you and no injustice would be caused to either party. It was therefore appropriate to allow the amendments requested since this would ensure the charges more accurately reflected the evidence relied on by the NMC.

Details of charge (as amended)

That you, a registered nurse:

1) On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
    a) touched Colleague A's cheek;
    b) hugged or attempted to hug Colleague A on one or more occasion;
    c) grabbed Colleague A by the wrist;

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
    a) breast and/or nipples;
    b) vagina;
    c) bottom

3) On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:

a) nipples;
b) breast;
c) pubic bone;

4) Your conduct at any or all of charges 1 to 3 was sexually motivated in that you sought sexual gratification;

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

Background

The NMC received two referrals in regards to you in October 2018. It was reported that you had been arrested by Surrey Police following two separate complaints made by two patients alleging that you had inappropriately touched them during an examination regarding a possible Urinary Tract Infection (UTI). The complaints are of a similar nature and were made within a week of each other.

You saw Patient A on 29 September 2018 and it was alleged that during the examination you touched Patient A's breast, nipple, vagina and bottom. It was also alleged that this was clinically inappropriate as it was not clinically indicated.

You saw Patient B on 6 October 2018 and it was alleged that during the examination you touched Patient B's breast, nipples and top of their pubic bone. It was also alleged that this was clinically inappropriate as it was not clinically indicated.

A criminal trial took place in May 2023 relating to Patient A and Patient B and you were acquitted. The allegation in relation to Colleague A was not mentioned in either referral to the NMC. At the time, no further action was taken but police re-opened the investigation into this matter following the above two incidents.

Decision and reasons on application to amend the charges

After the conclusion of Patient B's evidence, the panel heard an application made by Mr Webb to add an additional sub charge to charge 3.

The proposed amendment was to add 'labia majora' as a fourth sub charge to charge 3. It was submitted by Mr Webb that the proposed amendment would provide clarity and more accurately reflect the evidence, having heard from Patient B.

Charge 3 currently reads as follows:

3) '*On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:*
    a) *nipples;*
    b) *breast;*
    c) *pubic bone;'*

The proposed amendment to charge 3 is as follows:

3) *'On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:*
    a) *nipples;*
    b) *breast;*
    c) *pubic bone;*
    d) *labia majora'*

Ms Byron opposed the proposed amendment. She submitted that Patient B did not use the word labia majora in her police statement or NMC statement and this is therefore new information which goes beyond the application to amend the charge on a factual basis. Ms

Byron further submitted that this new information goes towards a part of the anatomy being touched that has never been particularised.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 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 this was not new evidence/information as there was mention of this area, but it had not hitherto been shown to Patient B with the benefit of a diagram. The panel was of the view that there would be no prejudice to you, as you were aware this amendment would likely be made during Patient B's evidence and you therefore had the opportunity, via Ms Byron, to cross examine on this issue. Accordingly, the panel was satisfied that 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 and accuracy and also to ensure there was no undercharging in this case.

Details of charge (as amended)

That you, a registered nurse:

1) On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
    a) touched Colleague A's cheek;
    b) hugged or attempted to hug Colleague A on one or more occasion;
    c) grabbed Colleague A by the wrist;

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
    a) breast and/or nipples;
    b) vagina;

c) bottom

3) On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:
    a) nipples;
    b) breast;
    c) pubic bone;
    d) labia majora

4) Your conduct at any or all of charges 1 to 3 was sexually motivated in that you sought sexual gratification;

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

Decision and reasons on application to amend the charge

After the conclusion of the NMC's case, the panel heard an application made by Mr Webb to amend the wording of charge 2b.

The proposed amendment was to replace 'vagina' with 'vulva'. It was submitted by Mr Webb that the proposed amendment would provide clarity and more accurately reflect the evidence, having heard the oral evidence of Patient A as clarified by the expert witness, Ian Wall (Professor Wall).

Charge 2b currently reads as follows:

2) *'On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:*
    a) breast and/or nipples;

b) vagina;

c) bottom'

The proposed amendment to charge 2b is as follows:

2) 'On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:

a) breast and/or nipples;

*b) ~~vagina~~ **vulva**;*

c) bottom'

Ms Byron did not oppose the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel noted your lack of opposition to the proposed amendment and was satisfied that there would be no prejudice to you and no injustice would be caused to either party. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
   a) touched Colleague A's cheek;
   b) hugged or attempted to hug Colleague A on one or more occasion;

c) grabbed Colleague A by the wrist;

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
   a) breast and/or nipples;
   b) vulva;
   c) bottom

3) On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:
   a) nipples;
   b) breast;
   c) pubic bone;
   d) labia majora

4) Your conduct at any or all of charges 1 to 3 was sexually motivated in that you sought sexual gratification;

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

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 both Mr Webb and Ms Byron.

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:

- Witness 1: Patient A
- Witness 2: Patient B
- Witness 3: Colleague A
- Ian Wall: Independent General Practitioner and Specialist in Forensic and Legal Medicine.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. That advice included reference to cross-admissibility of evidence and the case of the *PSA v GMC & Garrard* [2025] EWHC 318 (Admin). The panel also took into account your good character and the advice of the legal assessor about how to approach your evidence in light of your good character.

It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 1a)

1) On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
   a) touched Colleague A's cheek;

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, as well as the oral evidence of Colleague A and you.

When considering charge 1a, the panel had regard to Colleague A's initial statement made the day after the incident occurred on 3 March 2013 and her undated police witness statement, believed by Colleague A to be made in 2020.

The panel acknowledged that the police statement was made some seven years after the event and was more detailed than the original statement. The panel accepted Colleague A's evidence that the reason for this was because she was asked questions by the police, prompting more detail, whereas in her first account she was recalling what had happened the day before, without any questions being asked of her. What was apparent to the panel was that her account remained largely consistent on the key elements from the initial complaints, the subsequent police statement and her oral evidence at this hearing.

> *'However, there was one point in the shift when [You] approached me and touched my cheek with his hand, saying "oh your blushing". I remember saying, quite clearly "no I'm not, it's just hot in here."*
>
> *'At one point he got a little over friendly and told me I was blushing. However I was just hot from running around. I think when he said that to me he also touched my cheek.'*

The panel also considered the oral evidence of Colleague A, where she confirmed what she had written in her statement.

> *'I do get flushes, I do get red cheeks, I'm on HRT and I have Raynaud's. It is not unusual for me…[I told him no I'm not], I'm just hot and he went to touch my cheek at the same time, it happened in passing in the corridor… I recall the red cheek*

comment standing in the corridor, I'm sure I was stood up in the corridor when he touched my cheek…the cheek touch on its own wouldn't bother me, I'd brush it off. I may have been red cheeked in the office, I recall him saying your blushing, and I said no I'm hot''

The panel also had regard to your evidence. It noted that in your written statement dated 9 March 2013 you stated that:

'At that point I have noticed that both her cheeks were very red. I asked her if she was feeling unwell because her cheeks were red. She said that it was hot there which was strange because the temp has not changed all the time we have been sitting in the office. She kept denying that her cheeks were red and she asked me to show where. With her consent I had touch her cheek with my finger to show the area where it was red and it was warm to touch. I thought she was having hot flush and that she was tired. She insisted that her temp was hot and it was also hot in the room.'

However, during oral evidence, you provided two explanations for your conduct. The first explanation was that you were concerned for the welfare of Colleague A and felt that she may have had a temperature. You stated that when you touched her cheek it was done with her consent in order to establish how hot her cheek was and also concern that she was unwell, to show her precisely where she was red. In addition, you said in oral evidence that you took the redness of her cheeks to be a symptom of her lying to you, from your earlier conversation.

You said that you felt vindicated because you had felt that she had been lying about coping with being a mother of six, working full time and your career aspirations and you had caught her out. You gave evidence that you touched Colleague A's cheek with her consent after asking her a specific question as to whether you could touch her cheek, to which she replied '*yes'*.

It was thus common ground that you did indeed touch colleague A's cheek. The allegation is that you did it without consent. You said that Colleague A consented to the touching, she said that was not true and she had not consented.

The panel concluded that it preferred the evidence of Colleague A, who had remained clear and consistent in her evidence, and the panel had no reason to doubt her evidence, which was written down the day after the event when matters were fresh in her mind. It found Colleague A to be a credible witness whose evidence had been consistent throughout. This was in contrast to your evidence which was inconsistent and confusing. On the one hand you seemed to be saying that you were concerned for Colleague A's welfare as she was saying she was hot and was flushed and thus the reason for your touching her cheek was for you to indicate to her where she was red. However, in your oral evidence you said how Colleague A was very self-centered, thought very highly of herself and you hated it when people make out they are better than you. You said you had caught her out in a lie and she was blushing as a consequence. That was why you offered to take her temperature and you felt you were vindicated when it showed she did not have a temperature.

The panel concluded that when you touched Colleague A's cheek, you were not doing so for any reason connected with her welfare, nor for any medical reason. The panel also concluded that it was done without her consent.

The panel took account of the inconsistencies between your written and oral evidence and concluded, that the evidence from you about your state of mind was true, to the extent that your concern was to establish that she had been lying to you, as you felt that she was blushing and you had caught her out in what you said you believed were her lies. However, in regard to your evidence about you touching her cheek with her consent, the panel concluded that you did it without her consent and therefore your behaviour was inappropriate. The panel, in accepting the evidence of Colleague A, was persuaded by her evidence that she did get hot flushes, she does get red cheeks which is not unusual for her and she just brushed it off. Furthermore, when you pointed out she was red, you went

to touch her cheek at the same time, and consent was not asked for by you, and Colleague A would not have given it as she knows it was a non-issue. The panel accepted that she answered your question on whether she was hot or blushing by saying *no I m not* and just carried on walking.

Accordingly, the panel accepts the unchallenged evidence that you touched her cheek but does not accept that you asked her whether she consented to the touching. Accordingly your touching was without consent and your behaviour was inappropriate. Therefore, the panel found this charge proved on the balance of probabilities.

Charge 1b)

1) On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
   b) hugged or attempted to hug Colleague A on one or more occasion;

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, as well as the oral evidence of Colleague A and you.

When considering charge 1b, the panel had regard to Colleague A's initial statement taken the day after the incident occurred on 3 March 2013 and her police witness statement.

> *'…after everything had been cleaned up and cleared away, I was stood in the doorway (of either the paediatric room or the first treatment room) and went to leave, when Rashad touched my arm and gave me a hug. He said I was a busy woman and needed to look after myself. I said that everything was fine and went to leave. I thought it unusual at the time that he wanted to hug me, but didn't think too much of it. As I went to leave the second time, Rashad then grabbed me by the writ, quite forcefully, and pulled me into another hug. I remember feeling very*

uncomfortable this time and trying my hardest to avoid eye contact with him. I feel that he was trying to make eye contact in order to kiss me, so I made sure I did not at him and I said "come on now, we have to close up and leave" numerous times. After an uncomfortably prolonged hug, he let me go.'

'He was putting his hands on my back and all over me trying to squeeze me tightly. I had to pull away from him and it took several attempts to do so. He was blocking my exit from leaving and said how lovely it was to work with me. I ended up putting my hands on his shoulders trying to push him away, he tried to pull me closer and said it was lovely. I must have used force to push him away to get through the doorway. As I left he grabbed my wrists and tried to pull me back in towards him. I managed to get away and said that's enough.'

The panel also considered the oral evidence of Colleague A, where she confirmed what she had written in her statement.

'I just remember him grabbing my wrist and when holding me I had my head turned away and he was trying to lift his head towards me as if to kiss me. It was very unprofessional and awful and at the time I just wanted to forget it and run away … we were cleaning down rooms for the following day. He grabbed my wrist and pulled me in, I thought to pat my back and it was prolonged. He pulled me back, lowered his head as if to kiss. I just wanted to leave I averted my eyes to not try to make light hearted of it, to make it as easy as possible and I just wanted to leave… not many times have I been hugged by a colleague, unless it was to say goodbye or for a long parting. Not in this case, that is not what he did to me… I turned my head away not to kiss him, I was not reciprocating, I did not want him to do this or more, I know what happened.'

The panel also had regard to your evidence. It noted that in your written statement dated 2013 you made no mention of a hug or any attempted hug. However, during your oral evidence you told the panel that *'it is possible I did touch her shoulders to console*

/reassure her, but using a light touch after I said she needed support' and then made a gesture of raising both hands from the front to demonstrate how you were touching Colleague A's shoulders.

During your evidence you also went on to state the following:

> *'I was reassuring her, I used a light touch on both shoulders, I said you need to ask for help, can't be 100% … I never went that close to her to hug… that never happened, I never went that close to her … we were never that close, she had to go as a patient came to book in'*

The panel concluded that it preferred the evidence of Colleague A and rejected your account that you had tried to reassure her. The panel considered that Colleague A had remained clear, consistent and detailed in her account of what happened. It noted that Colleague A also spoke about how it made her feel and how, when leaving the car park, she drove over a '*curb'*, due to the shock and trying to *'get away'* after you both had left at the end of the shift.

The panel noted that Colleague A was indignant and firm about refuting any suggestions made during cross examination that there was no hug. The panel accepted her emphatic insistence that you did hug her and noted there was no evidence to suggest that she was upset and needed reassurance from you.

The panel further noted that you had not made any mention of hugging or attempting to hug her in your initial statement in 2013. However, you denied this during your oral evidence and stated you had only touched her shoulder in oral evidence. The panel found your evidence to be inconsistent.

The panel concluded that a non-consensual hug was inappropriate and, therefore, the panel found this charge proved.

Charge 1c)

1) ‘On 3 March 2013, behaved inappropriately towards Colleague A in that without consent you;
   c) grabbed Colleague A by the wrist.’

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, the oral evidence of Colleague A and you, and its decision on charge 1b.

The panel considered that charge 1b and 1c were similar in that they had occurred within the same sequence of events.

The panel considered your evidence. It noted that you had not made any mention of grabbing Colleague A’s wrist in your written statement. It then went on to consider your oral evidence. When questioned about grabbing Colleague A’s wrist, you stated that *‘you would never do that with a colleague’* and that you ‘*respect their professional boundaries’.*

The panel also considered the evidence of Colleague A. In the written transcript police interview dated 3 March 2018, Colleague A stated that:

> *‘As I went to leave the second time Reshad pulled me by the wrist and pulled me into a second hug.’*

Colleague A reiterated this in her oral evidence. It was put to her that you did not grab her arm but she insisted that you did and stated the following:

> *‘He did touch my arm and he’s lying all these years later and he did hug me… he did, I remember my right wrist…he did both, he hugged me and I pulled away, he grabbed my wrist and pulled me to give me another hug’*

When Colleague A was questioned about why she mentioned you grabbing her wrist in one statement and not the other, she said the following;

> *'Yes I did, I said he grabbed my wrist, it is slightly different, I gave the police more detail, I think I probably did verbally, I did I said he grabbed me forcefully, I agree that blocking the exit is not mentioned in my first statement, but it did happen, the wrist grab is when I tried to walk away he grabbed my wrist and he pulled me back in again after I pushed him away.'*

The panel concluded that it preferred the evidence of Colleague A as she had remained clear, consistent and detailed in her account of what happened.

The panel noted that it was only you and Colleague A on the unit and that you had hugged her and then grabbed her wrist to pull her in for another longer hug when she had tried to pull away, all without Colleague A's consent. Colleague A was fearful of what was going to happen when left alone with you, which led her to report this incident the next day and decide not to work with the agency again.

The panel considered that this raised the issue of a more aggravated feature and emphasises the forceful aspect of the hug.

The panel taking into account its findings on charge 1b) and the above, concluded that grabbing Colleague A's wrist was inappropriate. Therefore, it found this charge proved.

Charge 2a)

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
   a) breast and/or nipples;

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, the oral evidence of Patient A and your evidence. It also took account of the expert evidence of Professor Wall.

The panel considered the witness statement of Patient A, dated 4 March 2025, stating the following:

> *On 29 September 2018 I attended Ashford Walk in Centre for treatment for symptoms of a urinary tract infection. At the appointment I was seen by the registrant. Straight after the appointment I told my boyfriend and my mum about my experience. My mum felt that what happened at the appointment didn't feel right. She told me to contact the police. A few hours after the appointment I called 101 to raise my concern with the police.*

The panel also considered Patient A's evidence in the Transcript of ABE (Achieving Best Evidence) interview with the police, dated 1 October 2018, stating the following:

> *He asked me if I could roll my sleeve up, but I wasn't able to, because my jumper I was wearing was too tight round my arm, so I had to take it off and I was wearing a black crop top underneath. And then he did my blood pressure and that was fine and then after he said Do you mind leaving that off, so I can do an examination?" and I said That s fine." Then I sat onto the bed and he put some gloves on and he got I think it s a stethoscope and was listening to my chest and then he said I m just gonna have a feel" and was feeling my chest and just underneath my breast and around and was asking me if it was tender and I replied It s a little bit tender, but I m taking new Pill, so I assumed it s because of that." And then he asked me if I could lift my black crop top up that I was wearing or if I would like a female doctor present and I said I didn't mind, cause I thought he just wanted to feel a little bit*

more under my rib or that the crop top was in the way that he couldn't feel what he needed to feel, so I lifted it up and he was like feeling my nipples and around that area, asking me if it was sensitive and like prodding around and I said the same thing, that it s fine it s just a bit sensitive.

This was then confirmed by Patient A in her live evidence where she was asked to be specific about where she was touched and she said:

'around my boobs and my nipple area, under my boobs, in between, in the middle here as well and just all around my boobs.'

She was asked whether the nipple was touched and she said yes. When asked whether it was both nipples or one, she said, *'I can't, I can't remember to be sure. I know definitely one. It could have been both.'*

In cross-examination it was put to Patient A that you did not touch her breasts at all, to which Patient A said, *'He definitely touched my nipples and my breast.'* She agreed that she was sure it was at least one nipple that was touched. It was put to Patient A that you did not at any time touch one or both of her nipples. Patient A disagreed and said that you did.

Under cross-examination Patient A was asked how sure she was that you touched her in these areas, she said *'I know for a hundred percent because it's something that will stay with me for the rest of my life and has made my doctors and hospital visits way difficult since. So yeah, that's why I know for sure'.*

Patient A was then asked if it was possible that when you were feeling and palpating around her chest and at her sides, her sports bra perhaps moved and she had mistaken that sensation for you feeling her breasts and nipples. Patient A said *'definitely not.'* She also said she was sure about where she was touched because she was looking.

The panel considered that Patient A's evidence was consistent and clear from the time she spoke to the police and throughout this process. Her account was matter of fact, without any apparent embellishment and she was prepared to concede when she could not be sure about matters, for example whether you had touched one or both of her nipples. When considering the likelihood that Patient A could have invented this allegation, the Panel took into account the complaint made by Patient B, which was of a very similar nature. There was no evidence that Patient A and Patient B knew each other or had ever met or spoken about you. The Panel was thus satisfied it could safely exclude collusion or contamination as an explanation for the similarity of these two complainants' evidence. Accordingly, each lent support to the other, thereby rebutting any likelihood of it being mere coincidence that they should both have made such similar complaints.

The panel then went on to consider your evidence. You denied this charge and in live evidence told the panel that you did not *recall this appointment* . However, notwithstanding your pronouncement that you could not recall this appointment, you did then go into significant detail about what you say happened during this consultation with Patient A.

You told the panel that Patient A refused a chaperone. Patient A accepts that she declined offers of a chaperone on a number of occasions and said this was because she did not realise or expect the extent of the examinations that would occur. You told the panel that you recall doing a chest wall examination but did not touch her breasts and or nipples and that she was wearing her crop top during the examination. You said you asked her to lift her breasts up so that you could get access to palpate underneath her breasts. You were emphatic, however, that you had not carried out a breast examination. When asked how you could be sure you said '*There was no clinical indication for me to carry out a breast examination.'*

You were interviewed by the police on 10 October 2018 and 2 July 2019. The panel noted that you were not in possession of the medical records for either consultation at the time you were interviewed, which the panel accepted was a disadvantage. However, you were

interviewed within a matter of days after seeing Patient B and just 11 days after seeing Patient A. The panel was not provided with copies of those interviews. However, Professor Wall was provided with those interviews and he quoted large parts of them in his report, dated 26 June 2020. Accordingly, the extracts of your police interviews are taken from Professor Wall's report. In the first interview, on 10 October 2018, you said to the police:

> *'Part of the examination is I've not continued to touch her breasts, it s just palpation and sometimes what happen is infection of something, the nipple can be red, it can be tender and sometimes it can have leakage…So with consent I've examined it and it was tender that's why I think she was putting it…I think her* [menstrual] *cycle was coming… When you palpate, then you ask if there is tenderness …*
>
> Question: '*So on this occasion do you actually remember asking whether her breasts were tender before you touched them?'*
>
> Answer: *'Yeah I asked her in case she got pain there…Because if there was no tenderness I would not even go there …'*

Then in your second interview you were asked did you examine Patient A and Patient B's breasts? Your response was:

> *'Not completely, not the whole breast, around the area, we're talking about breast examination completely touching the nipples, all this stuff, feeling for cancerous lump, this is what I have not done. I've check around the lymph node area, which is part of the side of the breast.*
>
> *…when I'm saying I'm touching the breast on the side, I classify it as a breast examination. It's not like a hands on, full on breast examination I'm taking, for me breast examination even touching the side is part of breast examination. This is what I am trying to say…so if I'm touching there, that for me that's a breast examination.'*

You stated that you only touched the complainants for purely professional reasons and not for any sort of sexual gratification.

As part of your oral evidence you suggested that Patient A was disgruntled at your refusal to refer her for an ultrasound, giving the impression this could be a possible motive for Patient A lying about what happened during that consultation. This was put to Patient A in her evidence and she emphatically denied such a suggestion and said that she had made no reference to an ultrasound.

Professor Wall's evidence was that by your own evidence you have confirmed that you are not trained to undertake vaginal examinations or examine breasts. He also said that *'Under normal circumstances, most healthcare professionals faced with a patient presenting with typical symptoms of a urinary tract infection who did not appear unwell would often be assessed by history alone and treatment based on the results of urine dip testing.'* This is clearly what both Patients A and B were expecting. With regards to touching Patient A's breasts, Professor Wall said: *'Her evidence is that he felt her breasts including the nipple area. Mohamed Allymamod s evidence is again confusing, initially stating that he palpated her breasts but later stating that he did not undertake a breast examination and later still stating that he only examined the side of the breast(s).'*

Whilst Patient A was clear and consistent in her evidence (as indeed was Patient B), by contrast your evidence was muddled, inconsistent and at times confused. Furthermore, the panel had to consider the overall context in relation to both Patients A and B, in that they attended the Walk-In Centre with suspected UTIs. They were both familiar with the expected process, having suffered with a UTI before and were thus essentially expecting to provide a urine sample that would be tested and if positive they would be prescribed antibiotics. Instead, they were both subjected to a prolonged consultation that involved an extensive physical examination, whereby they say you touched their breasts, nipples, genitalia and in Patient A's case her bottom. When first interviewed by the police in relation to Patient A you admitted palpating her breasts, but by the second interview you had resiled from this and thereafter your case has been that you did not touch both

patients' intimate parts, as alleged. The panel has already found that there was a sufficient connection and similarity between the complaints of Patients A and B to rebut any coincidence that they should both complain of such similar behaviour. For all these reasons, the panel preferred the evidence of Patient A and was satisfied, on the balance of probabilities, that you touched her breasts and at least one nipple in the way she described.

Professor Wall's expert opinion was that if a breast examination were carried out, it was not clinically justified. Accordingly, having found that you did touch Patient A's breasts and at least one nipple, this was inappropriate and without clinical justification and the Panel found charge 2(a) proved.

Charge 2b)

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
    b) vulva;

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, the oral evidence of Patient A and your evidence. It also took account of the expert evidence of Professor Wall.

The panel considered the witness statement of Patient A, dated 4 March 2025, which states:

> *On 29 September 2018 I attended Ashford Walk in Centre for treatment for symptoms of a urinary tract infection. At the appointment I was seen by the registrant. Straight after the appointment I told my boyfriend and my mum about my experience. My mum felt that what happened at the appointment didn't feel right.*

She told me to contact the police. A few hours after the appointment I called 101 to raise my concern with the police.

The panel also considered Patient A's evidence in the Transcript of her ABE interview with the police, dated 1 October 2018, stating the following:

And then he started to prod lower to my groin to the left, like a bit closer to my vagina and then did the same and was asking me if that was sensitive, or did that have any pain and I said No." And then he started to prod the top bit of my vagina and then asked if I could spread my lips and he was feeling there inside there, not actually inside my vagina, but like I don t really know what it is like. Just like around there basically near the wee hole or whatever… So he asked me to separate my lips and then he said, he asked me if I get discharge and then. No I said it the wrong way round, he asked me if I get discharge and then he asked if I could separate my lips, so he could have a look. So he said Do you get discharge?" and I said Yes." And he said Could you separate your lips, so I could have a look." So I said That s fine, so I separated it and then he was just looking and then feeling what I said… It wasn t like that high up, it was a bit lower than that, so it was like not as high up as like my wee hole and it wasn t as low down, it was in the middle.

This was then reiterated by Patient A in her live evidence, where she told the panel that:

First of all, that they [Patient A's leggings] *were pulled down to my pubic bone. Then I was asked to pull them down further to do a vaginal examination… I'm just saying that he looked at my vagina after… Yeah, I remember my bone being pushed, on the pubic bone… he asked me to separate. He went like this to me and asked me to separate so he could feel internally.* When saying this, Patient A demonstrated with her hands a separating of her labia.

The panel then went on to consider your evidence. You denied this charge and in your oral evidence told the panel that you did not *recall this appointment* . Notwithstanding your

lack of recall, when asked about the consultation with Patient A, you were able to provide significant detail about what you say occurred. You spoke about carrying out an abdominal examination and that you checked Patient A's groin as part of that. It was put to you that Patient A, in her evidence, said that you had visually demonstrated by parting your fingers that she should spread her labia. You were asked what you had to say about that and you replied: telling Patient A to spread her labia, you stated the following:

> *I've asked a question if in case you got any PV vaginal discharges or rash, because that's also a different treatment, according if you look at the flow chart.*
>
> *…*
>
> *She was not very sure, so she said, "How do you do it?" This is why I explained to her, "If you want to examine yourself, you just need to open your labia and just have a look in case there's any rash, discharge or redness."*
>
> *…*
>
> *I just asked her if in case she wanted to do it yourself, I turned around. I didn t see what she had done, and she told me there was nothing. I don t know if she's looked, I don t know because I did not even look there.*
>
> *…*
>
> *She told me there was no -- she could not see anything.*

Patient A denied that you suggested she examine herself.

It was then put to you by Ms Byron that there is an allegation that you touched Patient A's vulva and you denied this happened. When asked how you could be sure you said because to do an examination of the vulva you need to have the knickers down so the

area is exposed, but you said Patient A's leggings and knickers were still on, up to the suprapubic area. The panel noted that this was contrary to the evidence you gave to the police in your first interview where you said:

> *'It is not because of the water infection, it could be around the genital area. There could be rash, redness, burning sensation or swelling or tender or something like that…so afterwards I ve asked in case I can palpate around the area, the groin and the upper thigh area…So I press around the groin area. She was quite tender in the groin. Then I ve asked her if in case she doesn t mind I have a look there the vagina area to see if there is any rash, redness, because sometimes that can cause a problem when people think they ve got a UTI…So I had a look and each, I press on the pubic bone area and it was a bit tender, then I ask her if in case it s tender from the sexual history we ask also if in case she s been playing because it could be because of trauma…'*

To be able to have *'had a look'*, as you say you did, Patient A's knickers must have been down sufficiently to expose her vagina and not, as you said in oral evidence, pulled up to the suprapubic area.

The account in your first interview was then changed when you were interviewed by the police on the second occasion and where you said, in respect of the genitalia, that you did not look any lower down than the pubic bone and you did not look for a vaginal discharge.

Thus, whilst Patient A's evidence on the touching of the vulva was consistent and clear, your account continually changed and was inconsistent, thereby lacking credibility. The panel had regard to the expert report of Professor Wall dated 26 June 2020, where he stated that your evidence from your first interview is that you denied looking or touching Patient A in her vulval area and in your second interview, you stated that you *did not look for vaginal discharge...* and you did not *ask [Patient A] to look for a rash on her genitalia .*

The panel considered that there were inconsistencies in your evidence, noting that in the first and second interview you had denied asking Patient A to look for a rash on her genital areas but in your live evidence stated the opposite. The panel considered that Patient A's evidence was consistent and reliable. The panel also took into account the similarity between the complaints made by both Patients A and B about your touching their genitalia, rebutting any realistic possibility of coincidence. The panel also reiterates the observations it has made in relation to charge 2a) above, about the expectations of Patients A and B of a brief visit on attending the clinic and your extended consultation and physical examination. In all the circumstances, the panel therefore preferred Patient A's evidence and determined that on the balance of probabilities, it was more likely than not that you touched Patient A's vulva. Since you deny having done so, it follows that there cannot have been any clinical justification for touching Patient A's vulva and you do not suggest one. If the touching was not clinically justified it was clearly inappropriate and accordingly, the panel found 2b) proved.

Charge 2c)

2) On 29 September 2018, during a routine examination, touched Patient A inappropriately and/or without clinical justification in that you touched Patient A's:
    c) bottom

This charge is found proved.

In reaching this decision, the panel took into account the documentation before it, the oral evidence of Patient A and your evidence. It also took account of the expert evidence of Professor Wall.

The panel considered the witness statement of Patient A, dated 4 March 2025, which states:

On 29 September 2018 I attended Ashford Walk in Centre for treatment for symptoms of a urinary tract infection. At the appointment I was seen by the registrant. Straight after the appointment I told my boyfriend and my mum about my experience. My mum felt that what happened at the appointment didn't feel right. She told me to contact the police. A few hours after the appointment I called 101 to raise my concern with the police.

The panel also considered Patient A's evidence in the Transcript of ABE interview with the police, dated 1 October 2018, stating the following:

Then he asked me to lower my bottoms again a little bit and if I wanted a female doctor present and I said How far do you want to lower them?" and he said Just a little bit," so I said That s fine." And then he was feeling across my lower back and then he started to like feel the bottom of like my bum cheek and was asking me if that was tender.

…

I laid on my front and he asked if I could lower the bottoms again slightly. So I did ever so slightly, so the top part, so the bottom of my back was on show, but not enough that my bum or anything was on show and he started to feel my back and ask me if it was tender and to which I replied Yes." Then he started to feel my bum as he went underneath my bottoms and was feeling my bum cheeks and was like, almost like, I wouldn't say groping, but feeling underneath like that, almost like squidging. I can t really explain, but doing that and then asked me if that was tender, which I said No." At this point I was kind of thinking I don t think this is necessary …'

This was further confirmed by Patient A in her live evidence, where she told the panel the places you had touched her:

On my under-boob area around my chest, my tummy, my lower tummy, my vagina, just below my wee hole, my bum, and also my legs… It was just like not a light sort of -- it wasn't hard or pushing down or anything like that. Just a light touch like this and around the area.

The panel considered that Patient A in her evidence was consistent and clear. When asked if she remembered the examination in detail she said, '*I know that what I'd experienced in that walk-in center with the registrant that I've never had that and I've never had that since*.' The panel determined that Patient A's evidence was supported by her contemporaneous evidence and that her overall experience was very similar to that of Patient B, albeit Patient B did not allege that you touched her bottom.

The panel had regard to the live evidence of Professor Wall. When asked if there was any clinical justification for a light touch on the buttocks, he stated the following:

Well, the other nerve issues in the back are issues related to the sciatic nerve. And you're wanting to check for power and sensation over the relevant areas of the sciatic nerve. And there are areas that you would be more interested in in the leg as opposed to the buttock… If it was felt necessary to do that, I would expect that to be recorded, yes.

The panel then went on to consider your evidence. You denied this charge and stated the following in live evidence:

So when I was doing the light touch technique, I asked her if she can feel the touch, the light touch going from the back all the way to the other leg and asked her to bring her leg up to push against me so that you can see the muscle tone. I asked to contract the check buttock, and when she was doing the abdominal assessment, there is two tests -- one test, which ruled out two things, is also for sciatica, is lift he leg against my hand, at the same time, check for appendicitis. This is the two things you do… I did not feel it, I asked her to contract the cheek bottom to check the

muscle tone of the buttock because if that is a positive sign, this means you can rule out the cauda equina.

It was put to you that Patient A alleged that you, *'… felt her bum as you went underneath her bottom and was feeling her bum cheeks with almost like a squidging motion',* what do you say about that?'

You replied, *'I did not feel it, I asked her to contract the cheek bottom to check the muscle tone of the buttock because if that is a positive sign, this means you can rule out the cauda equina.'*

The panel had regard to the expert report of Professor Wall dated 26 June 2020, where he stated that in your first interview you stated that you *denied putting* [your] *hands down* [Patient A's] *trousers and feeling her buttocks* .

With this allegation you have been consistent in saying that you did not touch Patient A's bottom. Patient A has also been consistent in saying that you did. In this instance the panel was unable to rely on any similarity with Patient B, because she had not alleged you touched her bottom. It was, therefore, a case of deciding whose evidence the panel preferred and why. The panel preferred the evidence of Patient A. This was because she had been consistent throughout her evidence in relation to all the matters alleged against you by her. You, however, had been inconsistent and confusing in your evidence and the panel has already found you to be an unreliable witness. The panel could see no reason why Patient A should have made up the allegation that you touched her bottom and her description was detailed and convincing. The panel could see why you would have touched her bottom as you had already taken the opportunity to touch her breasts, nipple or nipples and vulva, all without clinical justification. This demonstrated a pattern of behaviour that the panel was satisfied extends to the touching of Patient A's bottom.

There was no evidence before the panel of a clinical justification for your touching her bottom and you had not suggested one. The panel was thus satisfied that the touching of Patient A's bottom was inappropriate and not clinically justified.

Accordingly, on the balance of probabilities, the panel found this charge proved.

Charge 3a and 3b)

3) On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B's:
    a) nipples;
    b) breast;

These charges are found proved.

In reaching this decision, the panel took into account the documentation before it, the live evidence of Patient B and your evidence. It also took account of the expert evidence of Professor Wall.

The panel also took into account its findings in relation to Patient A. The legal assessor had advised the panel that where it has made positive findings in relation to one set of allegations and is satisfied that there is a sufficient connection and similarity between the facts of the allegations, which it is, then this may establish a propensity to commit the kind of conduct alleged. The panel therefore had this in mind when considering the allegations made by Patient B. In addition, the panel has already found that there is no evidence of collusion between Patients A and B and that the allegations they have made against you are very similar in nature and occurred within days of each other, thereby rebutting any realistic possibility of coincidence.

The panel considered the witness statement of Patient B, dated 13 September 2024, which states;

On Saturday evening, 6 October 2018 at approximately 18:30 my friends … drove me to Ashford Walk in Centre for treatment for symptoms of a urinary tract infection. At the appointment I was seen by the registrant. I am not a Registered Nurse. A few days later on 9 October 2018 I saw my boyfriend at the time and the appointment was playing on my mind and he could tell I was upset and he asked me what happened and he were aware that I was holding back and that something wasn t right but eventually I explained what happened at the appointment and although my ex-boyfriend isn t a medical professional he confirmed what I was feeling that the appointment wasn t normal. My ex- boyfriend called my mum with me in the car and we told her what had happened to me during my appointment at Ashford Walk in Centre. My mum also agreed that it didn t sound like a standard practice for a UTI infection, and she was very concerned at what had happened. My mum and my ex-boyfriend agreed that I needed to report the incident, so my ex-boyfriend turned the car around and drove me to the walk-in centre.

The panel also considered Patient B's Transcript of ABE interview with police, dated 10 October 2018. Patient B stated the following:

'And then for some reason, I don t know why, but I thought it was part of the procedure that he had to do, he asked if he could feel my breasts for any lumps at all. … And I don t know why at that point I kind of froze a bit, if that makes sense, I just said Yeah ok that s fine." And so he was feeling my breast to see if there s any pain at all, which I thought was a bit strange, because I literally just went there to ask if I had a UTI, not if I had any lumps in my breasts. I never complained about any breast pain or anything to do with my breasts at all and so he felt around my breast area for a while and then asked if he could touch my nipple and feel my nipple as well and I consented, cause I said Yeah that s fine" cause I just thought that was the normal. Well I did deep down I knew it was a bit weird, but when a doctor s asking like you don t really say no to someone that s qualified in that profession. So I said That s fine" and he pressed down on my boob, on my nipple

to see if there was any lumps for about 2 to 3 minutes I d say around my boob and then on my nipple it wasn t for long, but it was long enough for it to be a bit… I can only my nipple being touched on my right breast, but I know that both breasts as a whole were touched and then he, cause before that he asked me to take off my jumper and my top, but I know that I didn t take off my bra, but I m not sure whether I took off my top or whether I just kind of lifted the bra up. I know I definitely took my jumper off, but I m not sure whether I took off the top, I can t quite.

Patient B confirms this in her live evidence, stating the following;

So chronologically from the top to the bottom I remember my breasts being touched, my nipple. And I think I said it in the statement that it was just the right nipple that I remember being touched. Under my armpit to assess my glands I think. I'm not sure if it was on both sides or just the one side... He was saying that he was trying to assess for any lumps on my breasts, so it was just pressing on the breasts to identify any lumps. Yeah, so just feeling around the breasts, kind of, with fingers rather than, like, a full hand. Like, just fingers to press for different points… Yeah. So the side, top. Not sure I remember beneath. And also, yeah, nipple. So basically covering the whole breast… From just having looked at my police statement I believe I said it was only one nipple on the right breast… Well, he asked if he'd be able to check my breast. So initially he felt under my armpit to see if my glands were maybe swollen. And then he asked to touch my breasts and also asked if he was allowed to touch my nipple. And throughout this, he would ask if there was pain when he touched and I'd have to say yes or no… Not specifically but something along those lines. And can he touch my nipple kind of thing.

The panel considered that Patient B in her evidence was clear and her oral evidence was consistent with the account she gave to the police just four days after the alleged incident. Furthermore, her experience was very similar to that of Patient A, a week earlier, as already detailed above.

In Professor Wall's report he said:

> '*It also needs to be considered whether examination of [Patient B's] breasts was also clinically justified. Her evidence is that she had not complained of any breast problem or breast lumps and that Mohamud Allymamod examined both breasts touching the skin and that this lasted for 2 to 3 minutes. His evidence is that he initially stated that she was tender around the axilla and breast area and later stated that he only examined the sides of the breast.*
>
> *…*
>
> *I am of the opinion that an examination to check for swollen glands was just about indicated but certainly not the examination of the breasts. The latter would only being justified if there were swollen glands in the axilla and whilst Mohamud Allymamod recorded right axillary tenderness, he specifically recorded that no glands were present. In consideration of all of this, I am of the opinion that if a breast examination were carried out, it was not clinically justified.'*

The panel had regard to Professor Walls live evidence, in which he stated the following;

> *In relation to Patient B, my recollection is that she was not complaining of pain in her chest. So there would be no indication to palpate her chest. …Unless the patient was complaining of pain in her nipples, there would be no indication to want to touch them at all. In relation to Patient B, I'm just looking as I'm speaking at my report, and Patient B I think was complaining of a sore throat. And if that was the case, it would be reasonable to palpate under the neck to see if there's any glands that were enlarged or were tender. So it would be quite reasonable to palpate the neck to check if there's any tenderness.*

When asked if there would be any reason to palpate the breast, Professor Wall stated: '*No, there would not be.*

The panel then went on to consider your evidence.

You were asked, having taken Patient B's history, what your concerns were and you said: *'So, in her case, it was more like a normal UTI because she was not complaining of any other pain or anything. She did not mention any other pain, so it will just be abdominal examination and see where it leads us to, what will be my findings and take it from there.'* Notwithstanding that assessment you then went on to carry out a prolonged and detailed physical examination in the absence of any apparent justification.

You denied these charges and stated in live evidence that there was no possibility that you touched Patient B's breast. You said that you were examining Patient B's axilla (armpit) and when asked to describe how her bra was on her, you said:

> *'When I was palpating on top, the bra was on, but when I go to the side, I have to also loose it up so that can get my hand -- because I think I couldn t get to the side, so you just palpate around the area there.'*

You were then asked: *'What do you mean by "loose it up"?*' and you responded, *'Undo the strap at the back.'*

You denied asking to check Patient B's breasts for lumps. You were asked, *'Did you touch Patient B's breasts?'* and you said '*No'.* You also said you never checked her nipples, saying her bra was *'always on top of it.'*

You have been consistent in your evidence that you touched Patient B's axilla and areas around the sides of Patient B's breasts. You have also been consistent in denying ever touching her breasts or nipples. Equally, Patient B has been consistent in her evidence that you did touch her breasts and at least one of her nipples. The panel thus had to decide whose evidence it preferred and why. In making this decision the panel took into account the inherent implausibility of Patient B fabricating an account of having her

breasts and nipple touched that was so similar to the allegation made by Patient A, a week earlier. Furthermore, the positive findings the panel had already made with respect to Patient A was, the Panel considered, evidence of propensity on your part to touch female patients inappropriately under the guise of some legitimate examination.

On your own account, Patient B presented with what appeared to be “normal UTI symptoms” and she was not complaining about any other pain. Notwithstanding this presentation, you took it upon yourself to carry out a prolonged and detailed physical examination, including intimate areas of Patient B’s body, just as you had done with Patient A. In all these circumstances, the panel preferred the evidence of Patient B. It found her to be a compelling and honest witness. This was in contrast to how the panel assessed your evidence, which throughout this hearing has been questionable, confused and at times inconsistent.

Accordingly, the panel was satisfied, on the balance of probabilities, that you did touch Patient B’s nipples or nipple and her breasts. As to whether it was one or both nipples the panel did not consider this to be material, since the mischief alleged was met in either case.

The panel was also satisfied to the requisite standard that there was no evidence to support this touching as clinically justified and you had not suggested otherwise. If the touching was not clinically justified, then it was clearly inappropriate.

Therefore, the panel finds these charges proved.

Charge 3c and 3d)

3) On 6 October 2018, during a routine examination, touched Patient B inappropriately and/or without clinical justification in that you touched Patient B’s:
    c) pubic bone;
    d) labia majora.

These charges are found proved.

In reaching this decision, the panel took into account the documentation before it, the live evidence of Patient B and your evidence. It also took account of the expert evidence of Professor Wall.

The panel considered the witness statement of Patient B, dated 13 September 2024, which states;

> *On Saturday evening, 6 October 2018 at approximately 18:30 my friends … drove me to Ashford Walk in Centre for treatment for symptoms of a urinary tract infection. At the appointment I was seen by the registrant. I am not a Registered Nurse. A few days later on 9 October 2018 I saw my boyfriend at the time and the appointment was playing on my mind and he could tell I was upset and he asked me what happened and he were aware that I was holding back and that something wasn t right but eventually I explained what happened at the appointment and although my ex-boyfriend isn t a medical professional he confirmed what I was feeling that the appointment wasn t normal. My ex- boyfriend called my mum with me in the car and we told her what had happened to me during my appointment at Ashford Walk in Centre. My mum also agreed that it didn t sound like a standard practice for a UTI infection, and she was very concerned at what had happened. My mum and my ex-boyfriend agreed that I needed to report the incident, so my ex-boyfriend turned the car around and drove me to the walk-in centre.*

The panel considered Patient B's Transcript of ABE interview with police, dated 10 October 2018. Patient B stated the following;

> *'And then he told me to, he wanted to assess my gland in my groin area and asked me if I could pull down my trousers, so I pulled down my trousers, but not fully off, I*

just kind of pulled them down enough for them to be able to access that area and he was feeling my gland for a while and asking throughout whether there was pain or no pain and I'd say yes or no. Well it was "No" the answer remained "No" throughout, apart from at one point where it slightly hurt, but it didn't hurt, only if you pressed it, it would hurt, so it wasn't as though I would have thought that it would have hurt there, if that makes sense?

...

but he wanted me to access my leg I think this area, I can't quite remember, but I had to do pushing exercises, so pushing against his hand up and down sort of thing and saying if there was pain or no pain and stuff like that. But as I was and I think that might have been before I even had that accessed, but it's not clear

...

On my skin yeah so that he never touched the actual part of the vagina, I don't know how to describe it, but the actual skin really close around to where it is. That was a bit strange for me

…

And then he asked if I could pull my pants down lower, so that he could assess more in that area and my lower pubic area, I think that's the correct term to describe where I've spoken to the lady, I don't know. And so he pressed down on that area and while he was doing all this, he was saying like cause it was I felt really uncomfortable obviously with a man doing that to me, but when it's a doctor you just kind of think it's alright it's a doctor, he knows what he's doing and so as he was doing it he kind of was saying "Oh sorry, sorry" like that constantly. I'm not sure whether it was causing me pain, as though it was hurting me or whether it was because I was finding it so awkward and uncomfortable that he was apol.., I'm not sure why he was saying

sorry, but he said it throughout the whole examination. And then he kept kind of clarifying where the pain was, so I would have already have said "Yeah ok there" and he was like "So not there, but there." And at that point I felt a bit awkward, cause it was as though I'd already said yes that that was where the pain was. It didn't need to be clarified over and over, but he was pressing kind of near, not never like penetration or anything like that, but just near the top and kind of round the sides of the area and I did find it a bit awkward, especially as and if that is what doctors need to do about a UTI, but I've never, I've had a UTI before and it was quite a simple process of whether I had an infection or not and I got anti-biotics and then left, but the fact that he was there for a while I did find it a bit, I wasn't not very at ease.'

Patient B confirmed this in her live evidence. She was asked where she meant when she had referred to being touched on her vagina and she said, *'it's quite hard to explain. Like, the top part of the vagina and the sides. So I think it's called the labia, like the outer part of the labia. So around the sides rather than the middle bit, the pink bit.'* She was then able to clarify this when she was shown a diagram of the female genital area and was able to mark the parts where she said you touched her. The areas she identified were the upper outer quarter of the labia majora, to just above the urethral meatus and below the clitoris. She was clear that she was not touched inside the labia minora. From these indications the panel was satisfied Patient B was referring to her pubic area and labia majora.

The panel went on to consider your evidence. In oral evidence you were asked the following, *'Do you accept that when conducting examinations of Patient B, that you touched the area around her pubic bone?'* You then said:

Her knickers are coming to the area of the pubic bone because this is a suprapubic area, so part of the abdominal examination, which [Professor Wall] *described, it is -- the pubic bone is part of the suprapubic area, so you have to examine that.*

If, for example, I've been charged for that, this means everyone has to be charged for that because part of the abdominal examination is the pubic bone area. And

yesterday I did explain in the diagram, I did show to the panel everything where the line is. This is where the bone finishes on top. So the pubic bone, with the abdominal one, this is it, this is part of it. So to conduct an abdominal examination, you have to put your hand on the pubic bone…I palpated the pubic bone, I palpated.

You confirmed this by marking on an identical diagram to the one shown to Patient B, exactly where you say you were examining Patient B. It was thus apparent that you accepted you touched Patient B's pubic bone, but you did not accept that you touched her labia majora.

With regards to touching her pubic bone your oral evidence was as follows:

'Q. So in respect of the charge that you touch Patient B's pubic bone, did you touch Patient B's pubic bone?
A. Yeah, it's part of the abdominal examination.
Q. Was it your view that at that time, that was something that was appropriate or inappropriate?
A. Appropriate.
Q. And was it your view at that time that that was something that was clinically justified or not clinically justified?
A. Yes.
Q. Which one?
A. Clinically justified.'

In his report, Professor Wall said, *'Under normal circumstances, most healthcare professionals faced with a patient presenting with typical symptoms of a urinary tract infection who did not appear unwell would often be assessed by history alone and treatment based on the results of urine dip testing.'* Whilst Professor Wall accepted an abdominal examination could be justified in certain cases, and that an abdominal examination would include the suprapubic area, this was only so if the Patient reported

abdominal pain or tenderness. However, Patient B had not done so. Patient B said she only had discomfort when you palpated her, she did not have any pain prior to you pressing her. You say you had been pressing hard and Patient B said how you kept apologising, no doubt because you were pressing hard and aware you were causing the pain.

With regards to 3c), you accepted you touched her pubic bone but claimed it was clinically justified. In accordance with the expert evidence an abdominal examination, including the suprapubic area, would only have been clinically justified if Patient B had reported pain or tenderness in her abdomen. Since she had not done so your touching of her pubic bone was not clinically justified and therefore inappropriate. The panel was in no doubt that it was part of your course of conduct in taking the opportunity to touch Patient B in intimate areas when this was not clinically indicated. Accordingly, the panel found charge 3c) proved.

With regards to 3d), you say you never touched Patient B's labia majora. Patient B was equally clear that you did. Her account, particularly once she had the benefit of a diagram so that she could point out exactly where she said you touched her, was convincing. She did not attempt to embellish her account in any way and was clear that you did not actually touch her vagina. For the reasons already given in this determination, the panel preferred the evidence of Patient B. Your actions in relation to Patient A suggested a propensity to touch female patients in intimate areas without clinical justification. The evidence in relation to Patient A makes the possibility of a coincidence extremely unlikely. Your evidence had been confusing and at times contradictory and accusatory, without justification. With regards to Patient B your initial history taking was that she had no issue beyond a typical UTI presentation and she was not complaining of any pain, nor did she have any abnormal presentations. However, from that initial assessment you then, without clinical justification, proceeded to conduct a prolonged and detailed physical examination, raising unjustified concerns about appendicitis, suggesting she was seriously unwell and might need to be referred to the surgical team. None of this was supported by the

evidence and there was no such referral. It was, in the panel's view, all part of your overall conduct of apparently inventing symptoms to justify your course of illegitimate conduct.

In all the circumstances, the panel was satisfied that Patient B was telling the truth and that you did touch her labia majora. There was no evidence that touching her labia majora was clinically justified and you did not suggest it was, having denied it happened. The panel was thus satisfied on the balance of probabilities that the touching of Patient B's labia majora was not clinically justified and it followed that it was, therefore, inappropriate. Accordingly, the panel found charge 3d) proved.

Therefore, the panel found charges 3c and 3d proved.

Charge 4)

4) Your conduct at any or all of charges 1 to 3 was sexually motivated in that you sought sexual gratification;

This charge is found proved.

Charge 4 in relation to charge 1

The panel went on to consider whether your behaviour in respect of Colleague A was sexually motivated in that you sought sexual gratification. Colleague A certainly thought so. She described how you held her close and from the way you were looking down at her she feared you were going to kiss her, so she looked away to avoid eye contact. She described you putting your hands all over her and trying to squeeze her tightly. It took her several attempts to pull away from you and she ended up putting her hands on your shoulders to push you away. Even after that you grabbed her wrist and tried to pull her back in towards you. She was convinced you were trying to have sex with her. she described how you were *'trying to be all lovely'* but she did not want anything like that. She said she felt uncomfortable the whole evening, starting from when you touched her cheek. You denied acting in a sexually motivated way, but the panel considered your actions

could only be interpreted as sexually motivated. The panel was satisfied on the consistent account given by Colleague A that your conduct towards her was indeed sexually motivated. Accordingly, the panel found charge 4 insofar as it related to charge 1 proved.

Charge 4 in relation to charges 2 and 3

The panel went on to consider whether your behaviour in respect of Patient A and Patient B was sexually motivated in that you sought sexual gratification. When considering this allegation, the Panel noted some of the comments you made to these patients, for example you asked Patient A if she *'played with herself*', which she found uncomfortable and which Professor Wall considered *'intrusive and unnecessary'*. With regards to Patient B you commented on her tan lines. Patient B said;

> *'He made quite a, well I was pulling up my pants and my trousers, he made quite an inappropriate comment at the time, which I thought I didn't really like that, because I've got tan lines from when I went away over the summer and so my stomach's quite tanned, but my vagina area's not at all and so he kind of made a comment about "Oh it looks like you must have been sunbathing a lot this summer." And even though I felt already really awkward about it, the fact that there was a male doctor kind of looking down there and then said about my tan lines, I just felt really kind of awkward and I did think at that moment this is a bit unusual, but like I said before, I just kind of had in the back of my mind it's a doctor, he knows what he's doing sort of thing.'*

These comments were inappropriate and in light of the findings of this panel in relation to charges 2 and 3, could be viewed as being of a sexualised nature.

More specifically, however, with both these patients, who were lone young females, you touched their breasts, their nipples, areas of their genitalia and, in Patient A's case, her bottom. The panel has found that all of this touching was inappropriate and clinically unjustified. The panel thus had to decide what motivated you to behave in this way. The

legal assessor had provided legal advice that the state of a person's mind is not something that can be proved by direct observation, it can only be proved by inference or deduction from the surrounding evidence. The panel considered there to be an overwhelming inference to be drawn that your actions were sexually motivated in that you sought sexual gratification. Indeed, the panel could see no other rational explanation for your behaviour.

Therefore, on the balance of probabilities, the panel finds charge 4 proved in relation to charges 2 and 3.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Radley, on behalf of the NMC, submitted that the facts found proved in charges 1–4, in their entirety, amounted to serious misconduct. He relied upon his written submissions and addressed the applicable law, the relevant NMC guidance, the provisions of the Code and the seriousness of your conduct.

Mr Radley referred the panel to Article 22(1)(a)(i) of the Nursing and Midwifery Order 2001 and the guidance in *Roylance v General Medical Council* [1999] UKPC 16 concerning conduct which falls short of the standards properly expected of a registered professional. He also referred to *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), emphasising that the departure from those standards must be sufficiently serious to amount to misconduct and that seriousness must be given proper weight.

Mr Radley submitted that the panel would be assisted by the NMC guidance on misconduct (FTP-2a), determining seriousness (PRE-2) and sexual misconduct (FTP-2a-ii). He drew particular attention to the guidance addressing sexual misconduct involving patients and colleagues, including the different relationships and considerations arising in those circumstances.

Mr Radley identified the provisions of the Code which the NMC considered were engaged by your conduct. These concerned prioritising people, practising effectively, preserving safety, and promoting professionalism and trust. His written submissions referred to sections 1–6, 8, 13, 14, 16, 17, 19 and 20. He acknowledged that it was for the panel to determine which provisions had been breached and whether those breaches amounted to misconduct.

Mr Radley highlighted your obligations to treat people with kindness, respect and compassion; uphold their dignity and rights; listen and respond to their preferences and concerns; obtain properly informed consent; and respect their privacy. He also referred to

your duties to protect vulnerable people, reduce the potential for harm, work cooperatively with colleagues, uphold professional standards and maintain clear professional boundaries with people in your care. He submitted that the conduct found proved engaged a number of these fundamental obligations.

Mr Radley submitted that the proven conduct was at the upper end of seriousness because it directly affected patients and involved sexually motivated behaviour and sexual touching of patients. He emphasised the context in which women attended the minor injuries and walk-in services and placed their trust in you as a registered nurse. He submitted that your conduct abused that trust and was fundamentally inconsistent with the standards expected of a member of a caring profession.

Mr Radley submitted that the consequences extended beyond the incidents themselves. Your behaviour had seriously affected patients' trust and confidence in healthcare and their willingness to use hospitals and other medical services. In his oral submissions, he drew particular attention to the effect on Patient A's perception of the health service. He also referred to the impact on a colleague and the wider implications for working relationships, staff welfare and patient safety.

Mr Radley invited the panel to consider the relevant contextual factors, including your professional role, the vulnerability of the patients and the trust inherent in the relationship between a patient and a healthcare professional. He acknowledged that your practising history should be considered, rather than looking only at the period when the concerns arose. However, he submitted that some behaviour was sufficiently serious to overshadow previous good performance and that this was such a case. He maintained that the passage of time did not diminish the gravity of the conduct found proved.

Mr Radley submitted that the concerns went to the heart of your professional responsibilities, including caring for others, maintaining professional boundaries, respecting colleagues and upholding the reputation of nursing. He relied upon the sexually motivated behaviour, the abuse of patients' trust, the failure to recognise a colleague's

concerns and the resulting damage to confidence in the profession. Given the panel's detailed factual findings, he did not consider it necessary to repeat the evidence. He invited the panel to conclude that your conduct amounted to serious misconduct.

Ms Lickert, on your behalf, submitted that you accepted that the facts found proved by the panel were very likely to amount to misconduct. She emphasised that the determination remained a matter for the panel, exercising its own professional judgment in light of the facts, the evidence and the applicable legal principles.

Ms Lickert submitted that there was agreement between the parties on the relevant law. She referred to the additional authorities identified in her written submissions, including *Enemuwe v Nursing and Midwifery Council* [2016] EWHC 1881 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Roylance v General Medical Council (No 2)* [2000] 1 AC 311. She submitted that misconduct required a serious departure from the standards reasonably expected of a registered practitioner, including conduct which fellow practitioners would regard as deplorable. Whether that threshold was met was a matter for the panel's judgment in the particular circumstances.

Ms Lickert also referred to *Meadow v General Medical Council* [2007] 1 All ER 1 and *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin). She submitted that not every breach of the Code amounted to a matter of regulatory concern and that the conduct had to be sufficiently serious to constitute misconduct going to fitness to practise. Applying those principles, she reiterated that you accepted that the facts as found were very likely to amount to misconduct and left the determination to the panel.

Submissions on impairment

Mr Radley moved on to the issue of impairment and submitted that the panel should consider impairment only if it first determined that the facts found proved amounted to misconduct. If it reached that stage, he invited the panel to find that your fitness to practise was currently impaired on the grounds of public protection and the wider public interest.

Mr Radley referred the panel to Article 22(1) of the Nursing and Midwifery Order 2001 and the NMC guidance on impairment (DMA-1). He explained that impairment was not defined in the legislation and that the central question was whether you could practise safely and effectively as a registered nurse without restriction. He submitted that this required an assessment of your current fitness to practise, taking account of all relevant circumstances.

Mr Radley referred to the approach identified by Dame Janet Smith in the Fifth Shipman Report and approved in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin). He submitted that the first three limbs of that approach were engaged namely whether you had in the past acted, or were liable in the future to act, so as to place patients at unwarranted risk of harm; whether you had brought, or were liable to bring, the profession into disrepute; and whether you had breached, or were liable to breach, fundamental tenets of the profession. He emphasised that these considerations addressed both past conduct and future risk. He confirmed that the fourth limb, concerning dishonesty, was not relied upon because there were no dishonesty charges in this case.

Mr Radley submitted that your conduct had placed patients at risk, undermined confidence in the profession and breached fundamental professional obligations. He relied upon the sexual nature of the conduct, its impact on patients and the abuse of the trust placed in you. He submitted that a finding of impairment was necessary to protect patients and colleagues and to maintain public confidence and proper professional standards.

Mr Radley invited the panel to assess the concerns in context, including your position as a senior nurse, the duties associated with that position, the environment and culture in which you worked, and the vulnerability of the patients you saw. He submitted that the gravity of your behaviour raised serious concerns about your ability to practise professionally without restriction.

Mr Radley acknowledged that you had engaged with the hearing process. He invited the panel to consider any evidence of learning, insight, reflection and steps taken to strengthen your practice. However, he informed the panel that he had not seen reflective documents, references or other material demonstrating that you had addressed the concerns. He submitted that the behaviour was particularly serious and difficult to put right and expressed concern that you had not demonstrated a full understanding or acceptance of its impact.

Mr Radley submitted that the effect of your behaviour on professional relationships was also relevant. He referred to the loss of trust and confidence among colleagues and, in particular, to Colleague A's unwillingness to work with you. He submitted that your conduct had undermined the respect and support expected between colleagues, with consequences for the safe delivery of care.

Mr Radley submitted that the seriousness of the sexually motivated conduct and its consequences for patients and colleagues also engaged the wider public interest. He maintained that public confidence in you as a professional, and in the nursing profession as a whole, had been seriously affected. He submitted that the panel should mark the fundamental standards at stake by making a finding of impairment.

Mr Radley invited the panel to conclude, having considered the gravity of the misconduct, its impact, the relevant context and the evidence available concerning insight and strengthened practice, that your fitness to practise was currently impaired. He submitted that such a finding was required both to protect the public and to uphold public confidence in the profession and its standards.

Ms Lickert submitted that a finding of misconduct did not automatically lead to a finding of impairment. The panel was required to undertake a separate, forward-looking assessment of whether your fitness to practise was currently impaired. Although your past conduct was relevant, the panel had to consider whether the findings demonstrated a continuing risk to public safety, public confidence in the profession or professional standards.

Ms Lickert accepted that the correct approach was that identified by Dame Janet Smith and approved in *Grant*. This required consideration of whether you had in the past acted, or were liable in the future to act, so as to put patients at unwarranted risk of harm; bring the profession into disrepute; breach fundamental tenets of the profession; or act dishonestly. She noted that there were no allegations of dishonesty in your case.

Ms Lickert submitted that the panel had received oral and written evidence from you addressing reflection and insight. In response to the NMC's submissions, she explained that she understood documents concerning reflective practice had been submitted during the hearing in February. She indicated that you did not intend to give or call any further evidence.

Ms Lickert drew particular attention to the principles applicable where a registrant had advanced a defence which the panel had rejected. Relying on *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin), she submitted that insight concerned the future risk of repetition and was distinct from remorse for past conduct. Maintaining your innocence did not, of itself, establish a lack of insight, and admitting misconduct was not a prerequisite to demonstrating an understanding of its gravity or that it was unlikely to recur. She acknowledged that your attitude to the underlying allegations remained relevant and that continuing to deny impropriety could make insight more difficult to demonstrate. The assessment required the panel to weigh all the evidence.

Ms Lickert also relied on *Sawati v General Medical Council* [2022] EWHC 283 (Admin). She emphasised your entitlement to a fair hearing and to defend yourself against allegations you denied. She submitted that the exercise of that right should not itself be held against you or treated as demonstrating a lack of insight. The panel should consider the nature of the allegations, what you were denying, the nature and quality of the rejected defence, and whether there was evidence of a lack of insight beyond the defence itself. It should not conclude that you had been untruthful merely because it had rejected your

account. She submitted that, as dishonesty was not alleged, the rejected defence was of less relevance than it might be where dishonesty was central to the case.

Ms Lickert invited the panel to find that repetition of the conduct was highly unlikely. She relied upon your good character, your long and previously unblemished career, the length of time since the incidents and the fact that you had not been subject to interim measures since May 2024. She submitted that those factors pointed towards a substantially reduced risk of repetition and should inform the assessment of your current fitness to practise.

Ms Lickert submitted that the public interest remained a matter for the panel's professional judgment. Referring to *Giele v General Medical Council* [2005] EWHC 2143 (Admin), she submitted that the assessment of public confidence should reflect the views of an informed and reasonable member of the public. She further submitted that it was open to the panel to consider whether a finding of misconduct itself sufficiently marked your behaviour as unacceptable and reaffirmed the fundamental tenets and proper standards of the profession, without a finding of impairment necessarily following.

Nevertheless, Ms Lickert acknowledged that, in accordance with the NMC guidance on impairment, cases involving sexual misconduct were likely to require a finding of impairment. She accepted on your behalf that, on the facts found by the panel, such a finding was likely. She left the ultimate determination of your current fitness to practise to the panel.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code.

The panel considered your conduct towards Colleague A separately from your conduct towards Patients A and B, having regard to the different professional relationships and circumstances.

The panel applied the 2008 Code to your conduct towards Colleague A, as that was the version in force at the relevant time. It determined that you had breached the following provisions:

*'**Treat people as individuals***
1 You must treat people as individuals and respect their dignity.
3 You must treat people kindly and considerately.'

*'**Uphold the reputation of your profession***
61 You must uphold the reputation of your profession at all times.'

The panel found that your sexually motivated conduct towards Colleague A was a serious breach of the standards expected of a registered nurse. You took the opportunity of working together to engage in unwanted physical contact. Colleague A described feeling uncomfortable and frightened, wanting to leave, and shaking as a result of the incident. She feared that you would seek further sexual contact. The panel considered that your conduct failed to respect her dignity or treat her with kindness and consideration and seriously undermined the reputation of the profession.

The panel determined that your conduct towards Colleague A, considered on its own, crossed the threshold of seriousness required for a finding of misconduct. Its assessment took account of both the sexually motivated nature of your behaviour in the workplace and its significant impact on her.

The panel applied the 2015 Code to your conduct towards Patients A and B. It determined that you had breached the following provisions:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.1 treat people with kindness, respect and compassion'

*'**20 Uphold the reputation of your profession at all times***
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel considered the conduct towards Patients A and B together because of the similarities between the incidents. Both occurred in the course of your professional practice, when the patients believed that you were undertaking a legitimate clinical examination and/or assessment. They placed their trust in you as the healthcare professional responsible for examining them. You exploited that trust and the opportunity presented by the clinical setting to engage in sexually motivated touching of intimate areas of their bodies.

The panel found that the circumstances made your conduct particularly serious. The patients were vulnerable within the professional relationship and relied upon your clinical judgment. You used the appearance of a legitimate examination to facilitate your sexual misconduct. The methodical manner in which you presented your actions as clinical assessment added to the seriousness of the abuse of your professional position.

The panel also took account of the effect on the patients. Their evidence demonstrated significant distress and a lasting impact on their trust in healthcare. One patient described

an experience which she would not forget for the rest of her life. The panel recognised that sexual misconduct of this kind could make patients reluctant to seek healthcare in the future, extending its consequences beyond the incidents themselves.

The panel found that the similar conduct towards two patients on separate occasions demonstrated a pattern of behaviour. Your actions involved a deliberate abuse of trust and a serious failure to uphold the dignity and wellbeing of those receiving care. The panel considered that your behaviour would be regarded as deplorable by fellow practitioners and was at the upper end of seriousness.

The panel determined that your conduct towards Patients A and B amounted to serious misconduct. Having separately reached the same conclusion in respect of Colleague A, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

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. They must make

sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that limbs (a), (b) and (c) were engaged. Your sexually motivated conduct placed Patients A and B at unwarranted risk of harm and caused significant emotional distress. You exploited their trust during what they believed were legitimate clinical examinations. Your conduct towards Colleague A also caused fear and distress. The panel found that your misconduct breached fundamental tenets of nursing, including prioritising people, respecting their dignity and promoting professionalism and trust, and brought the profession into disrepute. Limb (d) was not engaged as there were no allegations of dishonesty in this case.

Regarding insight, the panel recognised your right to deny the allegations and to defend yourself. It did not equate your continued denial, or the rejection of your defence, with a lack of insight. It considered whether the evidence demonstrated an understanding of the seriousness of the conduct found proved, its impact on those affected and its implications for the profession. Such understanding could be demonstrated without admitting the misconduct.

The panel found that your reflection was limited and focused principally on developing your clinical knowledge and using chaperones in the future. It did not demonstrate meaningful insight into the sexually motivated behaviour, the abuse of patients' trust or the distress experienced by Patients A and B and Colleague A. There was little acknowledgment of the lasting impact of such conduct and/or its potential to discourage patients from seeking healthcare.

The panel considered that, even while maintaining your denial, you could have reflected upon the distress described in the evidence and explained why conduct of this nature was unacceptable. You had heard the evidence concerning its impact and had had further time to reflect since the earlier hearing. The panel had not been provided with further reflection

demonstrating that those matters had been addressed. Its assessment of your insight was therefore based on the substance of the material before it.

The panel carefully considered whether the misconduct was capable of being addressed, whether it had been addressed and whether repetition was highly unlikely. It found that your conduct involved serious attitudinal concerns and opportunistic, predatory behaviour, which are difficult to remediate. It therefore examined whether the steps you had taken demonstrated relevant learning and a change in the attitudes underlying the misconduct.

The panel acknowledged your engagement with continuing professional development and your efforts to maintain clinical knowledge. It recognised that your training in chaperoning had some relevance. However, the proposed use of chaperones did not address the underlying sexually motivated behaviour or demonstrate that the attitudes giving rise to it had changed. Much of the remaining training concerned clinical knowledge, safeguarding children or general workplace requirements. The course materials and evidence of participation did not demonstrate sufficient learning relevant to the misconduct or how such learning had been applied. The panel was not satisfied that the misconduct had been remedied.

The panel also took account of your good character, your long and previously unblemished career, the testimonials, the age of the incidents, the absence of further reported concerns and the absence of interim measures since May 2024. However, these matters did not provide sufficient reassurance when weighed against the seriousness and pattern of the misconduct and the lack of meaningful insight and demonstrated remediation.

The panel was of the view that there remained a risk of repetition. It could not conclude that repetition was highly unlikely and remained concerned that you could engage in similar behaviour if the opportunity arose. It therefore found that you remained liable to place patients at unwarranted risk of harm, bring the profession into disrepute and breach its fundamental tenets. The panel decided that a finding of impairment was necessary on

the grounds of public protection, as it was not satisfied that you could practise safely and effectively without restriction.

The panel bore in mind the overarching objectives of the NMC namely to protect, promote and maintain the health, safety and wellbeing 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 proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds was required because your misconduct involved sexually motivated behaviour towards a colleague and patients and the deliberate exploitation of their trust in a clinical setting. It represented a serious departure from the standards at the heart of the nursing profession. Patients and the public must be able to trust nurses to respect their dignity and protect them from abuse. The panel concluded that a finding of misconduct alone would not adequately uphold those standards in the circumstances of this case.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

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.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley submitted that a striking-off order was the only appropriate and proportionate sanction in your case. He referred the panel to the NMC's sanctions guidance, including the guidance on the purpose of and approach to sanctions (SAN-1). He submitted that the panel was required to strike a fair balance between your rights and interests and the NMC's overarching objectives of protecting the public, maintaining public confidence in the profession and upholding proper professional standards.

Mr Radley submitted that the panel should consider the available sanctions in ascending order of seriousness and identify the least restrictive outcome sufficient to meet those objectives. He emphasised that the purpose of a sanction was not to punish you, although it could have a punitive effect. He submitted that the seriousness of the proven conduct justified restricting your right to practise.

Mr Radley identified a number of aggravating features and submitted that, taken together, they made this a particularly serious case. He placed particular emphasis on the pattern of behaviour and its significant impact on both the patients and Colleague A. He submitted that Colleague A had experienced fear and distress and had had to work elsewhere. Patients A and B had suffered significant emotional distress and a lasting loss of trust in healthcare. He referred to the evidence that one patient would not forget the experience for the rest of her life and submitted that the consequences extended to patients' willingness to seek healthcare in the future.

Mr Radley submitted that you had abused the position of privilege and trust occupied by a registered nurse. Patients A and B had believed that you were undertaking legitimate clinical examinations, and you had exploited their trust and the opportunity presented by the clinical setting to engage in sexually motivated touching. He relied upon the panel's finding that the methodical manner in which you presented your actions as clinical assessment added to the seriousness of the abuse of your professional position. He submitted that your conduct had failed to uphold dignity and wellbeing, exposed patients to unwarranted risk of harm and breached fundamental tenets of the profession.

Mr Radley further relied upon the panel's findings that fellow professionals would regard your behaviour as deplorable and that it involved serious attitudinal concerns and opportunistic, predatory behaviour which was difficult to remediate. He submitted that your conduct raised fundamental questions about your professionalism, judgment and approach to women as patients and colleagues. He relied upon the panel's finding of impairment on both public protection and public interest grounds and the damage caused to the reputation of nursing.

Mr Radley acknowledged, in mitigation, your engagement with the proceedings and the absence of previous findings against you. He also acknowledged that the panel had considered your reflection and training.

Mr Radley submitted that taking no further action or imposing a caution order would be insufficient given the gravity of the misconduct. Neither outcome would adequately protect the public, uphold professional standards or maintain public confidence in the profession.

Mr Radley next considered a conditions of practice order. He submitted that no conditions could be formulated which would adequately address the public protection and public confidence concerns arising from your conduct. Given the serious attitudinal issues and the nature of the misconduct found proved, he submitted that conditions of practice would not be an appropriate or sufficient sanction.

Mr Radley submitted that a suspension order would also be insufficient. He referred to the NMC guidance on suspension orders (SAN-2d), which identified that suspension might be appropriate where the misconduct was not fundamentally incompatible with continued registration and the regulatory objectives could be met without permanent removal. He submitted that your proven conduct was incompatible with remaining a registered professional. Although suspension would prevent you from practising for a period, it would not adequately address the serious attitudinal concerns identified by the panel or provide sufficient protection against the concerns arising from your conduct.

Mr Radley submitted that a striking-off order was therefore the only sanction capable of adequately protecting the public, maintaining professional standards and safeguarding public confidence in nursing. He submitted that the seriousness of the conduct and the fundamental questions it raised about your professionalism made permanent removal the appropriate and proportionate outcome.

Mr Radley referred the panel to *Bolton v Law Society* [1994] 1 WLR 512. He relied upon the principle that maintaining the reputation of a profession and public confidence in it could outweigh the interests and personal circumstances of an individual practitioner. He submitted that, when balancing your interests against the need to protect the public and the reputation of the profession, the balance in this case fell in favour of those wider objectives.

Mr Radley invited the panel to impose a striking-off order, submitting that no lesser sanction would adequately meet the requirements of public protection and the wider public interest.

Ms Lickert submitted that a suspension order was the most appropriate and proportionate sanction in your case. Her written submissions proposed a 12-month suspension, although in her oral submissions she left the duration to the panel. She submitted that remediation remained possible and that you had begun that process. She acknowledged

what the panel took to be her interpretation of the panel's finding that further demonstration of insight was required before remediation could be completed.

Ms Lickert referred to Article 29 of the Nursing and Midwifery Order 2001 and the relevant NMC sanctions guidance. Relying on the approach in *R (Uddin) v General Medical Council* [2012] EWHC 1763 (Admin), she submitted that the panel must consider sanctions in ascending order of seriousness and select the least restrictive sanction sufficient to achieve public protection. This required consideration of the reasons for impairment, the risk you posed and the relevant aggravating and mitigating factors. She submitted that a sanction must be proportionate and that punishment should not be its underlying purpose.

Ms Lickert repeated her earlier submissions concerning rejected defences, relying on *Sayer v General Osteopathic Council* and *Sawati v General Medical Council.* She submitted that your right to defend yourself should not itself be held against you, that denial was not a reason to increase sanction and that maintaining innocence should not automatically be equated with a lack of insight. She acknowledged that continued denial could make insight more difficult to demonstrate but emphasised that an admission was not a prerequisite to demonstrating an understanding of the seriousness of the conduct and a reduced risk of repetition. She also relied upon the absence of any finding that you had been untruthful or deliberately sought to mislead the panel.

Ms Lickert acknowledged that the findings concerning sexual harassment of Colleague A engaged the aggravating factor of failing to work collaboratively with colleagues. However, she submitted that this was not alleged to be a widespread attitudinal issue in your relationships with colleagues. She emphasised that the allegations concerned a single incident involving one colleague during your long career and invited the panel to attach limited weight to that factor. She also acknowledged the panel's findings of deliberate abuse of trust and predatory behaviour.

Ms Lickert relied, in mitigation, upon your extensive training, including safeguarding training, and your continued efforts to maintain your clinical knowledge during the years since the incidents. She submitted that this demonstrated your commitment to keeping up to date with your area of practice.

Ms Lickert submitted that there was no evidence of further incidents of concern between the incident involving Colleague A in 2013 and those involving the patients in 2018. She invited the panel to infer that you had worked safely and professionally during that period. She characterised the incidents as isolated occurrences within an otherwise long and unblemished career. She further submitted that the opportunistic, rather than premeditated, nature of the behaviour was relevant to the assessment of repetition and the potential for remediation.

Ms Lickert outlined the history of interim restrictions. She submitted that you had been subject to interim conditions of practice between 2018 and 2020, suspension between 2020 and 2023, and conditions of practice thereafter until the order lapsed in May 2024. She relied upon your compliance with those orders and submitted that the NMC guidance recognised that such compliance could demonstrate insight and a lower current and future risk.

Ms Lickert submitted that, although you had been free from interim restrictions since May 2024, you had not had a meaningful opportunity to demonstrate safe nursing practice. She explained that you had made hundreds of applications for nursing employment but had been unable to secure a post while the proceedings remained ongoing. She submitted that this lack of opportunity was not your fault and should not be held against you when assessing your ability to practise safely or remediate.

Ms Lickert addressed the panel’s findings on insight. She noted that your reflective statement had been prepared while you were defending the allegations and acknowledged that you had not submitted a further reflective statement in the intervening period.

Nevertheless, she submitted that the existing statement demonstrated the beginnings of relevant insight and provided a foundation for further remediation.

Ms Lickert submitted that your reflection went beyond proposing the use of chaperones. She relied upon your recognition that a chaperone did not remove the need for adequate explanation and courtesy or guarantee that an examination was appropriate. She submitted that this demonstrated awareness of your continuing duties of care and of the relationship between consent and trust. She also referred to your understanding that patients could have different thresholds for what they considered intimate and that valid consent required attention to individual circumstances. She submitted that your revision of assessment and examination steps for different parts of the body was relevant to the findings that your actions had not been clinically indicated.

Ms Lickert further relied upon your consideration of possible communication barriers, including accent and language, and how these might have affected your recognition of patients' discomfort and your explanation of what you intended to do. She submitted that you had expressed regret that the patients felt taken advantage of, recognised the damage to their trust in you and the profession, and expressed gratitude that they had felt able to complain. She relied upon these matters as demonstrating an appreciation of the potential impact on patients and public confidence.

Ms Lickert submitted that your acceptance that the facts found were likely to amount to misconduct and impairment itself demonstrated an understanding of the seriousness of the panel's findings. She emphasised that you had never sought to minimise the seriousness of the allegations or suggest that sexual misconduct was acceptable. She submitted that your defence had concerned your account of events and that your approach nevertheless demonstrated an emerging level of insight which should be given weight.

Ms Lickert submitted that the panel's finding that the conduct would be difficult to remediate did not amount to a conclusion that remediation was unrealistic. She argued

that the panel's consideration of your training and its finding that you had not yet demonstrated sufficient learning were consistent with the possibility of further progress. She relied upon the suspension guidance concerning professionals who had engaged with proceedings and demonstrated some meaningful insight, with a realistic possibility of developing that insight and returning to practice.

Ms Lickert submitted that suspension would protect the public by excluding you from practice while providing an opportunity for further reflection and remediation. Now that the factual findings had been made, you could take concrete steps to address the panel's concerns, guided by clear expectations about the insight, learning and changes required. She submitted that the lengthy proceedings had left you in uncertainty for approximately eight years and had already had a significant punitive impact. She argued that this delay also went some way towards marking the unacceptable nature of the conduct.

Ms Lickert submitted that, if a review were directed, a future panel could assess the steps you had taken and determine what further action was required, including whether striking off was necessary if you had not demonstrated sufficient improvement. Suspension would therefore not simply mean a fixed period followed by an automatic return to practice without scrutiny. She left the question of review to the panel but indicated in her oral submissions that a review would be a reasonable and likely outcome. She invited the panel to give clear guidance on what you would need to demonstrate at any review and acknowledged that responsibility for doing so would rest upon you.

Ms Lickert acknowledged that protecting the public and maintaining confidence in the profession were paramount. However, she submitted that there was also a public interest in retaining skilled nurses with good records where there was a realistic possibility of remediation. She submitted that you had demonstrated that possibility and invited the panel to impose a suspension order as the least restrictive sanction sufficient to achieve the regulatory objectives.

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 and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust, including the trust placed in you as a senior nurse working with a high degree of autonomy.
- Deliberate conduct placing Patients A and B at unwarranted risk of harm.
- A pattern of sexually motivated misconduct over a period of time.
- Lack of meaningful insight into the misconduct and its impact.
- The vulnerability of Patients A and B within the clinical examination setting and the imbalance of power between you and them.
- An element of premeditation, reflected in the method used to present your sexually motivated conduct as clinical examination.
- Predatory behaviour and the exploitation of opportunities to engage in sexually motivated conduct.
- Failure to work collaboratively with a colleague, through your sexually motivated conduct towards Colleague A.
- The significant and lasting impact on Colleague A and Patients A and B, including fear and emotional distress.

The panel did not accept that describing your behaviour as opportunistic excluded an element of premeditation. The similar and methodical approach used with Patients A and B demonstrated an approach which could be employed when the opportunity arose. The panel also rejected the characterisation of the misconduct as isolated occurrences: the

findings concerned three occasions, with particularly strong similarities between the incidents involving the patients.

The panel also considered the matters advanced in mitigation, including your CPD training, reflective statement, the passage of time and the absence of further reported concerns. It assessed the weight those matters could bear in light of the nature of the misconduct and the continuing risks it had identified.

The panel found that the training and reflection did not demonstrate meaningful steps to address the underlying sexually motivated behaviour. Much of the training concerned clinical knowledge or general professional requirements, and the material concerning chaperoning did not address the attitudinal concerns. There was no evidence of subsequent safe nursing practice which demonstrated that the concerns had been resolved. The panel did not consider that your difficulty securing employment had prevented you from undertaking relevant reflection or addressing your attitudes. It was not persuaded that the passage of time or the absence of further reported incidents established a reduced risk of repetition.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the continuing risk of harm. 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 and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice 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 concerns involved sexually motivated, predatory behaviour and serious attitudinal issues, rather than identifiable deficiencies in clinical knowledge or skills which could be addressed through supervised practice or retraining. The panel determined that there were no relevant, proportionate, workable or measurable conditions which could adequately protect patients and uphold professional standards. A conditions of practice order would not sufficiently address either the underlying concerns or the damage to public confidence.

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 also considered the NMC Guidance on 'Deciding between suspension and strike off' (Reference: SAN-3, last updated 28/01/2026). It recognised that suspension could be subject to review and could be extended. However, the panel needed to consider whether suspension would serve a constructive purpose and whether there was a realistic prospect of a positive change in your insight and attitudes during that period.

The panel carefully considered Ms Lickert's submissions that you had shown developing insight and begun a process of remediation. It did not accept that the material demonstrated meaningful insight into the gravity of the misconduct or its impact on Patients A and B and Colleague A. In particular, the panel considered the following passage from her written submissions:

'…on page 9 of his statement he reflects on various things which might have gone wrong with the patient appointments, including an acknowledgement that his accent and language may have affected both the patients' ability to express valid consent, and affected his own understanding of their discomfort.'

The panel found that this passage did not demonstrate insight into the conduct found proved. Neither patient had suggested that an inability to understand your accent or language explained what had happened. The findings concerned sexually motivated conduct, not a misunderstanding about communication or consent to a legitimate clinical examination. The explanations advanced did not address the abuse of trust, the sexual nature of your actions or their impact on the patients.

The panel bore in mind your right to contest the allegations. It did not increase the sanction because you had exercised that right or treat the rejection of your defence as an additional finding of dishonesty. It considered the substance of the reflection relied upon. A general acknowledgment that sexual misconduct was unacceptable, and an acceptance that the facts as found were likely to amount to misconduct and impairment, did not establish meaningful personal insight into your behaviour.

The panel also noted that, despite hearing the evidence of Patients A and B and Colleague A, you had not provided further reflection demonstrating an understanding of the distress they described. You had had a substantial period since the earlier hearing to address these matters. The material before the panel did not show that the underlying attitudes had changed or that you had taken meaningful steps to remediate the sexually motivated behaviour.

The panel acknowledged that suspension would prevent you from practising, thus protecting patients, while it was in force. However, it was not persuaded that a further period of suspension, including the 12 months proposed in the written submissions, would produce the necessary change in your insight and attitudes nor would it satisfy the public

interest in light of the seriousness of your misconduct. The availability of a review did not itself provide a basis for concluding that the concerns could realistically be addressed during suspension. The panel considered that suspension would defer the necessary decision without serving a constructive purpose.

The panel further determined that temporary removal would not sufficiently uphold public confidence or professional standards. The misconduct involved repeated sexually motivated behaviour, the exploitation of patients during purported clinical examinations and a significant, lasting impact on those affected. Your conduct was fundamentally incompatible with continued registration. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 31/07/2026). In the section concerning sexual misconduct, the guidance states:

> *'Any professional who is found to have behaved in this way will be at risk of being removed from the Register.'*

The panel considered the particular circumstances of your case, including the repeated conduct, your abuse of professional trust and power, and the exploitation of patients' vulnerability. It also took account of the risk to those receiving care and the effect on public confidence. 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 charges raised fundamental questions about your professionalism and your ability to uphold the standards and values of nursing. You had used the clinical setting and the appearance of legitimate examination to facilitate sexually motivated touching of patients. This was a profound breach of the trust which patients must be able to place in a registered nurse. Your conduct towards Colleague A also breached the dignity and safety expected within professional working relationships.

The panel was not satisfied that there was a realistic prospect that, following suspension, you would have gained sufficient insight and strengthened your practice so that the risk had reduced. It had not been presented with evidence of meaningful insight or relevant remediation despite the time available. Further, the seriousness and nature of the misconduct meant that public confidence and professional standards could not be adequately maintained through a lesser sanction.

The panel determined that your actions were significant departures from the standards expected of a registered nurse and were fundamentally incompatible with remaining on the register. Allowing you to continue practising would not protect the public and would undermine confidence in the nursing profession and the NMC as its regulator.

The panel considered the serious consequences that striking off would have for you and balanced your interests against the need to protect patients, uphold professional

standards and maintain public confidence. It concluded that those wider objectives required your removal from the register and could not be met by a lesser sanction.

Balancing all of these factors and taking account of all the evidence before it, the panel determined that the appropriate and proportionate sanction was a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute and adversely affecting the public's view of how a registered nurse should conduct themselves, the panel concluded that nothing short of this would be sufficient.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession and to send a clear message to the public and the profession 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.

Submissions on interim order

The panel took account of the submissions made by Mr Radley.

Mr Radley submitted that, following the panel's decision to impose a striking-off order, an interim suspension order should be imposed for a period of 18 months.

Mr Radley submitted that you would receive written notification of the striking-off order and would be given an opportunity to appeal the decision. He explained that, during the appeal period, you would otherwise remain free to practise unless an interim order was imposed.

Mr Radley submitted that an interim suspension order was necessary for public protection and in the wider public interest. He relied on the panel's findings and the reasons set out in its decision delivered that day.

Mr Radley submitted that, if you appealed the decision, a considerable period of time could elapse before the appeal was heard in the High Court. He therefore sought an interim suspension order for 18 months, which he identified as the maximum period permitted, to cover the potential duration of the appeal process.

Ms Lickert made no submissions.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.