

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

**Substantive Meeting
Friday, 2 October 2026 - Monday, 5 October 2026**

Virtual Meeting

Name of Registrant:	Dadu Ewhagwu Fearn
NMC PIN:	01E0056E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 (10 May 2004)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Graham Coulston-Herrmann (Chair, lay member) Lesley Foulkes (Registrant member) Anjana Varshani (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Yousrra Hassan
Facts proved:	Charges 1a), 1b), 1c) and 1e)
Facts not proved:	Charges 1d), 2), 3) and 4)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - striking off order

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Fearn's registered email address by secure email on 3 July 2026.

The panel accepted the advice of the legal assessor.

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

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

Details of charge

That you, a registered nurse;

- 1) On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;
 - a) not informing the Hospital 1 [Priory Enfield Hospital] that you were unable to attend shifts
 - b) working at Hospital 2 [Cygnet] when you were expected to be at work at Hospital 1 [Priory Enfield Hospital]
 - c) being dishonest in that you did not tell the Hospital 1 [Priory Enfield Hospital] where you were, when missing shifts
 - d) not answering the phone when scheduled to be the on- call nurse between 19 December and 28 December 2021 at Hospital 1 [Priory Enfield Hospital]
 - e) not completing the staff rotas for Hospital 1 [Priory Enfield Hospital]

- 2) On one or more dates in December 2021 you worked shifts at Hospital 2 [Cygnet] whilst claiming to be off sick from Hospital 1 [Priory Enfield Hospital].
- 3) Your actions in charge 2 were dishonest as you lied to your employer, Hospital 1 [Priory Enfield Hospital] about your fitness to work, as you intended to work night shifts at Hospital 2 [Cygnet] on some of those dates.
- 4) During 19-28 December 2021 worked nightshifts at Hospital 2 [Cygnet] whilst you were scheduled to be on call for Hospital 1 [Priory Enfield Hospital].

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

Background

The charges arose whilst Mrs Fearn was employed as a registered nurse by Priory Enfield Hospital (Hospital 1).

The concerns arose from Mrs Fearn's conduct during December 2021. Hospital 1 alleged that she failed to attend a number of scheduled shifts without adequately notifying colleagues or senior management of her absence or whereabouts. It was further alleged that she failed to respond to telephone calls while rostered as the on-call nurse between 19 and 28 December 2021 and did not complete staff rotas as required in her Ward Manager role. Hospital 1 reported that these matters contributed to staffing pressures on the ward.

Hospital 1 subsequently became aware that, during the same period, Mrs Fearn had undertaken a number of agency shifts at Cygnet (Hospital 2), including shifts on dates when she was expected to work, was reportedly absent due to sickness, or was scheduled to be on call at Hospital 1. Concerns were therefore raised that Mrs Fearn had been

dishonest with Hospital 1 regarding her absences and fitness to work while continuing to receive her salary and undertaking work elsewhere.

On 24 January 2022, the Hospital Director, Mr Tom Ratherham, referred the matter to the NMC. The allegations arising from these circumstances concern Mrs Fearn's attendance, communication with her employer, performance of her managerial responsibilities, conflicting work commitments and alleged dishonesty.

Decision and reasons on facts

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

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

Charge 1a)

That you, a registered nurse;

On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;

- a) not informing the Hospital 1 [Priory Enfield Hospital] that you were unable to attend shifts

This charge is found proved.

In reaching its decision, the panel considered the evidence of Mr Ratheram in his witness statement, stated:

'Ms Fearn continued to be absent for the majority of December, however, with no valid explanation. Ms Fearn did not follow appropriate absence reporting procedures as per the absence reporting policy. In addition to this, Ms Fearn failed

to complete staff rotas for December meaning that managers from other departments had to step in at the last minute to ensure that the ward was fully staffed. Thankfully, no harm came to patients or staff during this time.'

The panel considered that Mr Ratheram's evidence was clear that Mrs Fearn had been absent for the majority of December 2021 and that no valid explanation for those absences had been provided. His evidence also indicated that the appropriate absence-reporting procedure had not been followed.

The panel also had regard to the evidence of Ms Mabel Okendor of her witness statement, she stated:

'In relation to Mrs Fearn's attendance during December 2021, I cannot recall when we realised she was not turning up to work. Ms Fearn should have been clocking in and out at the main reception desk, but she was not doing that so we don't have any records of where she was or was not in attendance for her shifts.'

The panel considered that Ms Okendor's evidence supported Mr Ratheram's account, insofar as it demonstrated the uncertainty within Hospital 1 regarding Mrs Fearn's attendance and whereabouts during December 2021.

The panel further considered the investigation report, which recorded:

'Dadu had no annual leave booked during the month of December and did not phone in to report sick at any point. The Director of Clinical Services was sent a text on one occasion citing that she had "childcare issues" and that she wouldn't be in. There were reports from the ward that they could not get hold of Dadu when she was allocated on-call manager (she was scheduled to be on call from 19th – 28th December'

The panel noted that this evidence identified only one occasion on which Mrs Fearn communicated that she would not be attending work, namely when she sent a text message referring to childcare issues. The panel considered this significant when viewed

alongside the evidence that she was absent for a substantial part of December and had not otherwise telephoned to report herself sick or absent.

The panel also took account of the further passage in the investigation report:

‘...When I said to her I needed to speak to her about her absences in December, she said she couldn’t speak to me. She then proceeded to walk off the ward, she got into her car and drove off. She had not been back to the ward since her last date of work was 28th January 2022.’

The panel considered that this evidence was consistent with their findings concerning Mrs Fearn’s absences in December 2021 and an absence of an adequate explanation for them.

The panel also considered Mrs Fearn’s rota for December 2021. It noted that the rota identified days on which Mrs Fearn was rostered to work, as well as other entries relating to work and other leave. The panel considered the rota alongside the witness and documentary evidence when determining whether there were occasions on which Mrs Fearn was expected to attend Hospital 1 but did not do so and failed to notify the Hospital appropriately.

The panel considered all of the evidence in the round. It took into account the possibility that Mrs Fearn may have communicated with other individuals about some of her absences and also considered the staffing issues arising from the rota. However, the panel was satisfied that these possibilities did not outweigh the combined evidence of Mr Ratheram and Ms Okendor, the rota and the investigation report. In particular, the evidence that Mrs Fearn was absent for much of December, that only one communication concerning childcare issues was identified, and that no adequate explanation was otherwise provided was sufficiently compelling.

The panel therefore found Charge 1(a) proved.

Charge 1b)

That you, a registered nurse;

On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;

- b) working at Hospital 2 [Cygnet] when you were expected to be at work at Hospital 1 [Priory Enfield Hospital]

This charge is found proved.

In determining this charge, the panel had regard to the documentary evidence, including Mrs Fearn's rota at Hospital 1 and the payslips relating to her agency work at Hospital 2. The panel noted that the documentary evidence identified a number of dates in December 2021 on which Mrs Fearn was rostered to work at Hospital 1 while also undertaking paid shifts at Hospital 2. In particular, the panel noted instances where Mrs Fearn was rostered for a day shift at Hospital 1 and worked a night shift at Hospital 2.

The panel considered the evidence of Mr Ratheram, he stated:

'Around the beginning of December, I noted that Ms Fearn had not been in for a couple of days and I was made aware from Mabel Odonkor that Ms Fearn had called in sick. For completeness, I produce a copy of our absence reporting policy as exhibit TR/04.

Ms Fearn continued to be absent for the majority of December, however, with no valid explanation. Ms Fearn did not follow appropriate absence reporting procedures as per the absence reporting policy. In addition to this, Ms Fearn failed to complete staff rotas for December meaning that managers from other departments had to step in at the last minute to ensure that the ward was fully staffed. Thankfully, no harm came to patients or staff during this time.'

The panel considered that Mr Ratheram's evidence was relevant in establishing that Mrs Fearn was absent from Hospital 1 for a significant part of December 2021 and that, save for the initial report that she had called in sick, there was no valid explanation provided for the majority of her absences. The panel also took into account the evidence of Ms Okendor that Mrs Fearn did not call in sick and there was also no sickness absence recorded on the roster. The panel took the view that it didn't impact on their decision in relation to her working at Hospital 2 and not Hospital 1 during this period.

The panel also considered the evidence of Ms Okendor, who stated:

'In relation to Ms Fearn's attendance during December 2021, I cannot recall when we realised she was not turning up to work. Ms Fearn should have been clocking in and out at the main reception desk, but she was not doing that, so we don't have any records of when she was or was not in attendance for her shifts.

If I needed to speak to Ms Fearn, I would call her on her mobile or the office. Where she did answer her phone, she just said that she was just coming in, or she had just popped out to do something. There were no formal recordings of when she was in or not in, but I recall that I did not see her throughout December. I remember that it became serious enough to speak to Tom Ratheram about it.'

The panel considered that Ms Okendor's evidence was consistent with that of Mr Ratheram regarding Mrs Fearn's lack of attendance at Hospital 1 during December 2021. In particular, the panel attached weight to Ms Okendor's recollection that she did not see Mrs Fearn throughout December and that her concerns regarding Mrs Fearn's attendance became sufficiently serious for her to raise the matter with Mr Ratheram.

The panel placed particular weight on the Hospital 1 rota and the time sheets signed by Mrs Fearn when working at Hospital 2. Taken together, those records demonstrated that there were dates on which Mrs Fearn was expected to work at Hospital 1 while she was also undertaking work at Hospital 2. The panel was satisfied that the evidence of Mr Ratheram and Ms Okendor concerning Mrs Fearn's absence from Hospital 1 was consistent with, and supported by, those documentary records.

The panel noted that Mrs Fearn was rostered for day shifts at Hospital 1 and the agency shifts during the same period at Hospital 2 were night shifts but considered it was not feasible that she would manage to do both.

The panel therefore found Charge 1(b) proved.

Charge 1c)

That you, a registered nurse;

On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;

- c) being dishonest in that you did not tell the Hospital 1 [Priory Enfield Hospital] where you were, when missing shifts

This charge is found proved.

The panel considered its findings in relation to Charges 1(a) and 1(b), together with the witness and documentary evidence. It was satisfied that there were occasions in December 2021 when Mrs Fearn was expected to work at Hospital 1 but was instead working at Hospital 2, without informing Hospital 1 of her whereabouts.

The panel took into account that Mrs Fearn was an experienced registered nurse and Ward Manager who would have been familiar with the relevant absence reporting procedures. The investigation report recorded that she had no annual leave booked during December and had not called in sick, save for one occasion when she referred to childcare issues. The panel also noted that, when subsequently approached about her absences, Mrs Fearn declined to discuss the matter and left the Hospital. If there had been an explanation this would have been the opportunity for her to air it. The panel drew the inference from her not answering the question that she had no honest explanation.

In considering dishonesty, the panel was satisfied that Mrs Fearn knew she was expected to attend work at Hospital 1 and knew that she was instead working at Hospital 2. Her failure to disclose her whereabouts was therefore not an oversight but a deliberate withholding of that information.

The panel therefore found Charge 1(c) proved.

Charge 1d)

That you, a registered nurse;

On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;

- d) not answering the phone when scheduled to be the on- call nurse between 19 December and 28 December 2021 at Hospital 1 [Priory Enfield Hospital]

This charge is found NOT proved.

The panel considered Mr Ratheram's evidence in his witness statement:

'Cygnnet responded stating it was easier if they provided us with the dates she had NOT worked during December. Those dates were 6, 20, 22, 23, 24, 25 and 27 December 2021. I produce a copy of the email chain as. These dates coincided with dates that Ms Fearn was not off sick, but she was also not contactable. Ms Fearn was due to be on-call on those days, specifically 19 – 28 December but was simply not answering any calls. Ms Fearn did not take annual leave on those days either. Her line manager made regular attempts to contact her during this time to make sure that she was OK, but we did not receive any response.'

The panel also considered the investigation report, which stated:

'Dadu had no annual leave booked during the month of December and did not phone in to report sick at any point. The Director of Clinical Services was sent a text on one occasion citing that she had "childcare issues" and that she wouldn't be in. There were reports from the wards that they could not get hold of Dadu when she was the allocated on-call Manager (she was scheduled to be on call from 19th - 28th December).'

The panel noted the evidence that Mrs Fearn worked night shifts at Hospital 2 on 19, 21, 24 and 26 December 2021 and that there was evidence suggesting that she was not contactable during the relevant period. However, the panel considered that the central issue was whether it could be satisfied that Mrs Fearn was aware that she had in fact been scheduled to be the on-call nurse at Hospital 1 between 19 and 28 December 2021.

The panel noted that the on-call rota produced was unsigned and undated, and there was no evidence before it as to how or when that rota had been circulated to Mrs Fearn. Although the panel had previously found that Mrs Fearn was absent during December 2021, this did not establish that she knew she was scheduled to be on call during the period alleged. The panel also considered the relevant job description but noted that it post-dated the events and therefore could not safely be relied upon as evidence of Mrs Fearn's responsibilities at the relevant time. The panel also took into account when she was asked about her absences by Mr Ratheram, she had alleged that her email was not working. On balance the panel decided that the NMC has not fulfilled its burden of proof in relation to this charge.

The panel therefore found Charge 1(d) not proved.

Charge 1e)

That you, a registered nurse;

On one or more dates in December 2021 whilst employed by Hospital 1 [Priory Enfield Hospital] as a ward manager did not co-operate with your colleagues by;

e) not completing the staff rotas for Hospital 1 [Priory Enfield Hospital]

This charge is found proved.

The panel considered Mr Ratheram's evidence regarding Mrs Fearn's responsibility for completing the staff rotas, he stated:

'Ms Fearn was contracted to work 37.5 hours per week, 9am to 5pm, and was responsible for overseeing the management of the ward, which included being on call and creating staff rotas...'

The panel also considered Ms Okendor's evidence:

'Ms Fearn's non-attendance on shift led to issues with the staff rotas. It was Ms Fearn's responsibility to manage the rotas, but she did not complete the rotas so we often had to scramble around and find staff to cover. There was never any clinical risk to patients as we always managed to ensure shifts were covered, but it could have been a problem if we had not been able to do to this.'

This was supported by Mr Ratheram, who stated:

'...Ms Fearn failed to complete staff rotas for December meaning that managers from other departments had to step in at the last minute to ensure that the ward was fully staffed. Thankfully, no harm came to patients or staff during this time.'

The panel noted that the job description before it post-dated the events in question and therefore did not rely upon it as evidence of Mrs Fearn's duties in December 2021.

Nevertheless, the panel considered the consistent evidence of Mr Ratheram and Ms Okendor sufficient to establish that completing and managing the staff rotas formed part of Mrs Fearn's responsibilities as Ward Manager. Ms Okendor's evidence further demonstrated the practical difficulties caused by Mrs Fearn's failure to complete them.

The panel therefore found Charge 1(e) proved.

Charge 2)

On one or more dates in December 2021 you worked shifts at Hospital 2 [Cygnet] whilst claiming to be off sick from Hospital 1 [Priory Enfield Hospital].

This charge is found NOT proved.

The panel noted Mr Ratheram's evidence that he had been informed by Ms Okendor that Mrs Fearn had called in sick. However, Ms Okendor, who was said to have provided that information, did not support this account. The panel therefore considered that Mr Ratheram's evidence on this point was not sufficiently reliable.

More broadly, there was no evidence before the panel demonstrating that Mrs Fearn had reported herself sick to Hospital 1 on any of the dates on which she worked at Hospital 2. There was no record on Mrs Fearn roster for any dates in December for absence due to sickness. While there was evidence that she was absent from Hospital 1 and worked shifts at Hospital 2 during December 2021, this was insufficient to establish that she had claimed to be off sick on those dates.

The panel therefore found Charge 2 not proved.

Charge 3)

Your actions in charge 2 were dishonest as you lied to your employer, Hospital 1 [Priory Enfield Hospital] about your fitness to work, as you intended to work night shifts at Hospital 2 [Cygnet] on some of those dates.

This charge is found NOT proved.

Having found Charge 2 not proved, the factual basis necessary to establish dishonesty under Charge 3 had not been made out. In particular, the panel had not found that Mrs Fearn had claimed to be unfit for work at Hospital 1 while intending to work night shifts at Hospital 2.

The panel therefore found Charge 3 not proved.

Charge 4)

During 19-28 December 2021 worked nightshifts at Hospital 2 [Cygnet] whilst you were scheduled to be on call for Hospital 1 [Priory Enfield Hospital].

This charge is found NOT proved.

The panel considered Charge 4 in light of its findings in relation to Charge 1(d). For the same reasons set out in relation to Charge 1(d), the panel concluded that the necessary factual basis for Charge 4 had not been established.

The panel therefore found Charge 4 not proved.

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 Mrs Fearn's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise 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, Mrs Fearn's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC directed the panel to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a ‘*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*’

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

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

The NMC invited the panel to find Mrs Fearn’s fitness to practise impaired on the grounds that her misconduct involved dishonesty directly connected to her professional nursing practice, including claiming full pay from one hospital while working and receiving payment from another. The NMC considers this particularly serious because it involved obtaining a financial benefit through dishonesty and was compounded by failures to communicate her whereabouts, availability and staff rotas, creating uncertainty over staffing levels and a potential risk of harm to patients. Such conduct breached fundamental professional duties under the Code to communicate effectively and act with honesty and integrity and was considered sufficiently serious to amount to professional misconduct and impair her fitness to practise.

The NMC invited the panel to find Mrs Fearn’s fitness to practise is impaired on both public protection and wider public interest grounds. In relation to public protection, her conduct fell below the standards expected of a registered nurse and created a risk to the health, safety and wellbeing of patients, through potential staffing shortages which could contribute to levels of unsafe and inadequate care provision which could expose patients to an unwarranted risk of harm. As to the public interest, the NMC submitted that a finding

of impairment is necessary to uphold proper professional standards and maintain public confidence in both the nursing profession and the NMC as its regulator. Mrs Fearn's failures to act professionally, with integrity and to communicate effectively.

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

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion

8 Work co-operatively

8.2 maintain effective communication with colleagues

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

20 Uphold the reputation of your profession at all times

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Fearn's conduct fell seriously short of the standards expected of a senior registered nurse and amounted to professional misconduct. Her repeated dishonesty and failures to communicate occurred on several occasions over a period of a month, placed additional pressure on colleagues and created a potential risk of harm to patients. The panel considered that this pattern of conduct, together with the identified breaches of the Code, demonstrated behaviour that was incompatible with the professional standards expected of a registered nurse. The panel found that Mrs Fearn's 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, Mrs Fearn's fitness to practise is currently impaired.

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

'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'

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

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

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

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

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

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

The panel finds that patients were put at risk and could have been caused harm as a result of Mrs Fearn’s misconduct. Mrs Fearn’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered that Mrs Fearn's conduct gave rise to significant concerns regarding patient safety. She had been dishonest with Hospital 1 about her whereabouts and failed to keep her line manager appropriately informed. As a ward manager, she held a position of responsibility and trust and was responsible for contributing to the safe and effective running of the ward, including ensuring that appropriate staffing arrangements and rotas were in place. Her failure to attend work, remain contactable and complete the necessary rotas had the potential to result in staffing shortages, placing additional pressure and anxiety on colleagues and creating a real risk of harm to patients. The panel considered this to be particularly serious given that the patients concerned were receiving mental health care and were therefore potentially vulnerable.

The panel also considered that Mrs Fearn placed her own interests above her professional responsibilities to her patients, colleagues and employer. In particular, she worked across two hospitals and received payment from both while dishonestly not disclosing to Hospital 1 where she was through the period. In the panel's view, her conduct therefore exposed both patients and colleagues to an unnecessary risk of harm and demonstrated a failure to prioritise safe patient care.

The panel considered Mrs Fearn's dishonesty to be particularly serious. Her actions were deliberate, occurred over a prolonged period and were directly connected to her professional practice and financial gain. The panel considered these concerns to be attitudinal in nature and noted that dishonesty can be difficult to remediate. Mrs Fearn had not engaged with the proceedings or provided the panel with any evidence of insight, remorse, reflection, relevant training or other remediation. In particular, there was no evidence that she had recognised or addressed the seriousness of her dishonest conduct or the risks that her actions created for patients and colleagues. In those circumstances, the panel had no evidence upon which it could be satisfied that the concerns had been remediated and considered that there remained a real risk of repetition.

The panel further considered that Mrs Fearn's conduct breached fundamental tenets of the nursing profession, including the requirements to act with honesty, integrity and professionalism, to communicate effectively and to prioritise patient safety. Her conduct was capable of undermining public confidence in the nursing profession and bringing the profession into disrepute. The panel considered that members of the public would be

seriously concerned by a senior registered nurse and ward manager behaving dishonestly for financial gain while failing to discharge responsibilities that were important to the safe operation of a clinical service.

Accordingly, the panel determined that Mrs Fearn's fitness to practise is currently impaired on public protection grounds, given the unresolved concerns, the potential for harm and the resulting risk of repetition. The panel also determined that a finding of impairment was required in the wider public interest to uphold proper professional standards and maintain public confidence in the nursing profession. In particular, honesty, integrity and trust are fundamental to what patients, colleagues and the public are entitled to expect of registered nurses, and the panel considered that failing to make a finding of impairment in the circumstances of this case would undermine those standards and that confidence.

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

Sanction

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

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

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 3 July 2026, the NMC had advised Mrs Fearn that it would seek the imposition of a Suspension order for 3 months if it found Mrs Fearn's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Fearn's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust and seniority: Mrs Fearn held a senior position as a Ward Manager, with responsibility for overseeing and managing other members of staff.
- Exploitation of her senior position: Mrs Fearn's role afforded her a degree of autonomy and enabled her to come and go without the same level of scrutiny that might have applied to more junior members of staff.
- Deliberate and premeditated conduct: The conduct involved deliberate breaches of professional standards. In particular, the booking of agency shifts indicates an element of planning and premeditation rather than an isolated or spontaneous lapse in judgment.
- Risk of harm to patients: Her actions had the potential to place patients at risk of harm. This included failing to answer telephone calls and leaving the ward inadequately staffed, without an appropriate rota and without the expected registered professional being present.
- Dishonesty and unprofessional conduct: The behaviour involved dishonesty and demonstrated a lack of professionalism towards both colleagues and the wider organisation.
- Repeated conduct: The behaviour was not confined to a single incident but occurred on multiple occasions over a period over a month, increasing the seriousness of the misconduct.
- Personal financial gain: The conduct was undertaken, for personal financial benefit.

- Failure to engage with management: Mrs Fearn failed to engage appropriately with her Director and Line Manager, including failing to respond adequately to questions and failing to provide an explanation for her whereabouts when asked to do so. This demonstrated a poor and uncooperative attitude towards legitimate management enquiries.
- Failure to engage with the regulatory process: She also failed to engage with the NMC and the regulatory proceedings, limiting the opportunity for concerns to be explored and addressed.
- No evidence of insight: There is no evidence demonstrating meaningful insight into the seriousness of the conduct, its potential impact on patients and colleagues, or the wider implications for public confidence and professional standards.

The panel also took into account the following mitigating features:

- An undated letter from Mrs Fearn's employer indicating that there have been no concerns regarding Mrs Fearn's work or professional practice.
- A reference from a Consultant Psychiatrist, dated July 2023, similarly identifies no concerns regarding Mrs Fearn's clinical practice or professional conduct.

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

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

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

The panel considered that Mrs Fearn's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore

determined that a sanction that does not restrict Mrs Fearn's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Mrs Fearn's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). Having found that the concerns in this case are attitudinal in nature, involving dishonesty, and are therefore more difficult to remediate, the panel considered that a conditions of practice order would not adequately address the misconduct identified. The panel also took into account Mrs Fearn's failure to engage with the NMC proceedings and the absence of evidence to demonstrate that she would engage with, or respond positively to, retraining or other remedial measures. The panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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.'*

Whilst the panel acknowledged that the risks identified could be managed by Mrs Fearn being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Mrs Fearn's lack of engagement, limited insight, lack of remorse, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

The panel considered that a suspension order would not be sufficient or proportionate given the seriousness of the misconduct. The panel took into account her failure to engage with her employer or the NMC and the absence of any evidence of insight, remediation or an explanation for her conduct. There was no evidence to suggest that she would use a period of suspension constructively or engage at a later stage. In light of the seriousness of the dishonesty, the risk of repetition and the fundamental importance of honesty and integrity within the nursing profession, the panel determined that suspension would not adequately protect the public, maintain public confidence or uphold proper professional standards.

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 SAN-2e and additionally 'Sanctions for the highest risk cases' (Reference SAN-4 Last Updated: 28/01/2026). It states that:

'Honesty is of central importance to a professional's practice because of the large degree of trust placed in them. Therefore, allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy; because of this a professional who has acted dishonestly will always be at risk of strike-off. However, in every case the Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious.¹ Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):

- deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- personal or financial gain from a breach of trust*
- direct risk to people receiving care*
- premeditated, systematic or longstanding deception.'*

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 proved raised fundamental concerns about Mrs Fearn's professionalism, honesty and trustworthiness. Her failure to attend work, thereby letting down colleagues and patients, while working elsewhere for personal financial gain represented serious misconduct and was incompatible with the degree of trust placed in a registered nurse especially one who had a managerial position.

The panel considered that public confidence in the profession could not be maintained if such conduct did not result in removal from the register. Despite having had opportunities to engage and remediate, Mrs Fearn did not engage either locally with her managers or with the NMC and has provided no evidence of insight, reflection or remediation, nor any explanation of how she would act differently in the future. In the absence of such evidence, the panel could not be satisfied that the risk of repetition had sufficiently reduced and considered there to be no realistic prospect that a period of suspension would result in the necessary development of insight or strengthening of her practice.

Mrs Fearn's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Fearn's actions were serious and were purely for personal financial gain. They pose a direct risk to people receiving care and were carried out over a month as such were premeditated and longstanding. To allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the submissions made by the NMC in relation to the sanction that the NMC was seeking in this case, namely a suspension order for a period of three months. However, the panel considered that such an order would not adequately reflect the seriousness of the misconduct or address the fundamental concerns regarding Mrs Fearn's honesty and professionalism. Having regard to the NMC's Sanctions Guidance, the panel considered that there was no evidence to suggest that a three-month suspension would result in meaningful engagement or remediation. It therefore determined that a suspension order would be insufficient to protect the public, maintain public confidence in the profession and uphold proper professional standards.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs Fearn's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mrs Fearn 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 Mrs Fearn's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim suspension order is required for a period of 18 months because it is likely to take amount of time for the appeal to be heard.

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, should Mrs Fearn appeal and be permitted to practise unrestricted pending the outcome, there would be a risk to the public and the wider public interest.

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

That concludes this determination.