Independent review of the NMC's regulatory handling of fitness to practise cases raised by a whistleblower, by NMC colleagues, and in the media

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A Introduction

1 In 2023, the Nursing and Midwifery Council (NMC) commissioned two separate independent investigations arising from concerns raised by a whistleblower in connection with the NMC's fitness to practise activities: a review into the culture of the NMC, and a review into the whistleblower's concerns and the treatment of the whistleblower.

2 The Independent Culture Review was conducted by Nazir Afzal OBE and Rise Associates and was published in July 2024.[1] It concluded that there was a "*toxic culture*" with "*a long history at the NMC, but while it might have previously been contained, our concern is that it is now widespread*".[2] The review made a number of recommendations, which included steps being taken to reduce the backlog of Fitness to Practise (FtP) cases and to speed up decision-making, and to ask the Professional Standards Authority for Health and Social Care (PSA) to carry out detailed annual reviews of the NMC's performance.

3 The PSA published the report of its 2023/24 annual performance review of the NMC in June 2025.[3] It found that the NMC had failed to meet a number of the required Standards of Good Regulation. Of particular relevance to this review, the PSA found that the NMC had failed to meet the required standard for equality, diversity and inclusion, saying that:

> *"The whistleblowing concerns included concerns about discrimination and the organisational culture of the NMC. We saw that the NMC has processes in place to promote EDI, but given the findings of the ICR, we could not be assured that these processes were working effectively. The NMC has acknowledged that it needs to develop its capability in EDI, and has begun work on a range of improvement actions. We saw that the NMC's standards and guidance promote non-discriminatory, respectful, compassionate, and kind care.*

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1 Available at https://www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf, accessed 21 August 2025.

2 Page 111.

3 Available at https://www.professionalstandards.org.uk/sites/default/files/attachments/Periodic%20Review%20-%20NMC%202023-24.pdf, accessed 21 August 2025.

However, we were not assured that the NMC has effectively embedded EDI into its work."

4 The separate investigation into the whistleblowing concerns was to be conducted by Ijeoma Omambala KC. Her review, which was commissioned in late 2023, had two elements – the handling of a number of identified FtP cases, and the treatment of the whistleblower. We understand that for personal reasons, Ms Omambala has not been able to deliver her reports within anticipated timescales.[4] The whistleblowing element of her review is being taken over by Lucy McLynn of Bates Wells. We were instructed by the NMC in July 2025 to carry out an independent review of the FtP concerns in the handling of the identified cases.

5 The original terms of reference for Ms Omambala[5] included consideration of the identified FtP cases to identify whether decisions and outcomes at each stage of the case sufficiently protected the public and whether the NMC was operating in a person-centred way. There was a particular focus on whether the handling of the identified FtP cases demonstrated sufficient understanding, awareness and cultural competence regarding issues related to sexual misconduct, domestic abuse, discrimination and safeguarding issues. Ms Omambala was asked to consider the extent to which any failings were due to gaps in guidance or training, and to make recommendations accordingly. Any evidence of organisational culture or behaviour impacting on the handling or outcome of cases was to be fed into the Independent Culture Review.

6 Our instructions were necessarily slightly different, as the Independent Culture Review has been completed and published, as has the PSA's 2023/24 annual performance review of the NMC. We were asked by the NMC to conduct a review by the end of September 2025 which addressed:

"our regulatory handling of the cases raised by the whistleblower, together with other cases that were raised subsequently. This review will seek to

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[4] NMC, "Update on Omambala investigations", dated 14 July 2025, available at https://www.nmc.org.uk/news/news-and-updates/update-on-omambala-investigations/, accessed 17 September 2025.

[5] Available at https://www.nmc.org.uk/globalassets/sitedocuments/news/terms-of-reference-for-ijeoma-omambala-kc-15-nov-2023-.pdf, accessed 21 August 2025.

establish whether there are any evident concerns with our decision-making in these cases, and consider whether there were cultural issues which may have influenced our approach to fitness to practise cases. Where possible, it will draw out common themes and areas for improvement in our handling of our fitness to practise casework and guidance." [6]

7 We are Victoria Butler-Cole KC and David Hopkins, self-employed barristers at 39 Essex Chambers in London. We have both previously acted for and advised the NMC (separately) in other matters. Neither of us has previously been instructed in connection with any of the identified cases. We have also (separately) acted for or advised other regulators in the field of health and social care including the General Dental Council, the General Medical Council, the Health and Care Professions Council, and the PSA. Reported judgments in which we were instructed are available on public legal databases such as the National Archives.[7]

8 We issued this report in draft to the NMC on 1 September 2025. We received a number of queries and requests for clarification, and were provided with additional documentation concerning the identified cases and the NMC's policies and activities which we considered before providing this final report.

[6] A copy of the full text of our instructions, subject to redactions, is provided as an appendix to this report in section G.

[7] https://caselaw.nationalarchives.gov.uk/.

B Executive summary

9 Our review of the 20 identified cases has found problems in the way some FtP cases were dealt with by the NMC in the period 2018–2023. In broad terms, the problems concern an overly restrictive approach being taken to what may constitute misconduct, in particular where the behaviour in question occurred in the private, non-working life of registrants. In the 'private life' cases we reviewed, we did not find any evidence that this erroneous approach resulted in the wrong outcome in those cases – internal and external systems operated to ensure that, ultimately, serious concerns were properly addressed. We do not consider that further steps are required by the NMC in respect of any of the identified cases.

10 Whether or not the 20 identified cases revealed problems in the way they were handled, and whether or not the right outcome (or a reasonable outcome) was eventually reached, the concerns raised by the whistleblower and through the Independent Culture Review demand to be taken seriously. We note that the NMC already has an extensive programme of work underway aimed at addressing the recommendations of the Independent Culture Review and other elements of its FtP work that require improvement. We do not expect the points of criticism we have made in this review to be a surprise to the NMC, as many have already been recognised internally and efforts made to address them. There have already been changes to the NMC's guidance and internal protocols since these cases were referred. We have made a number of recommendations which could feed into the NMC's existing programme of improvement to its FtP processes, to the extent they have not already been incorporated, which we have listed following the conclusion in section F below.

11 Perhaps the most important message from the work we have carried out is that whatever a piece of written guidance says, there needs to be a shared understanding of what it means and how it should be applied throughout the various parts of the NMC's FtP process. In our view, there also needs to be a mechanism for people to raise concerns about diverging approaches or disagreements 'on the ground', not just in relation to particular cases (as with the Case Clinics) but more generally, so that divergences in approach or other systemic problems can be picked up early and addressed.

C The identified FtP cases

12 We were asked to consider 20 identified FtP cases. Of these, 7 were linked to each other and 13 were entirely separate. The cases involve referrals made in the period 2015 to 2023. Some of the cases have concluded and others are still in progress. Most of the cases concern nurses rather than midwives. All but one are cases in which concerns have been raised about how decisions had been made as part of the FtP process, with regard to the action taken in respect of registrants.[8] Some have been reported in the press.

13 It would not be appropriate for us to refer to the individual cases in detail in this review, since that would be likely to enable the individual registrants to be identified, if not by the general public, by people who know or work with the registrants. In cases which did not progress to action being taken, that would breach the NMC's policy in respect of the publishing of information about FtP cases.[9] For each of the cases, we have, however, closely reviewed the detail of decision-making at each stage of the FtP process within the NMC. This included examining:

13.1 the information provided to the NMC at the time of referral;

13.2 decisions taken at the Screening stage, including regulatory concerns identified during Screening;

13.3 decisions taken throughout the process as to whether to apply for an interim order and the outcome of any such applications;

13.4 decisions taken at the Investigations stage, including seeking further evidence and the recommendation made to the Case Examiners;

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8 One of the 20 identified cases was cited by the whistleblower as an example of good advice having been given.

9 Available at https://www.nmc.org.uk/globalassets/sitedocuments/ftp_information/publication-guidance.pdf, accessed 21 August 2025.

13.5 decisions taken at the Case Examiners stage, including whether to refer the matter to Adjudication.

14 Where a case had reached a final substantive hearing before a panel of the NMC's FtP Committee, we also had regard to the outcome of that hearing. However, the NMC's FtP Committee is independent of the NMC acting in its capacity as regulator of the professions. Therefore, at the general level, we observe that the outcome at a substantive hearing is not determined by the NMC (as regulator) and nor is it determinative of whether or not the NMC (as regulator) has discharged its functions adequately in respect of that particular case. To give two hypothetical illustrations: (1) a registrant may be struck off following hearing despite the fact the NMC failed to investigate the case properly and present evidence of further misconduct the registrant had committed; (2) a registrant's fitness to practise may be found not impaired because, although the NMC investigated and presented its case properly, the panel preferred the registrant's evidence over that of the NMC's witnesses.

15 In the four business years ending 2022–2025, the NMC received a total of 22,672 FtP referrals,[10] equating to an average of 5,668 FtP referrals each year. We are conscious that a review, however detailed, of 20 cases cannot provide a full picture of the way FtP cases are handled generally within the NMC. In 2017, the NMC published a report which examined the progress and outcomes of Black and Minority Ethnic nurses and midwives through the NMC's FtP process, authored by academics at the University of Greenwich and the London School of Hygiene and Tropical Medicine.[11] In 2019, the NMC launched Ambitious for Change, which it describes as "*a programme of research aimed at understanding - and ultimately reducing - disparities experienced by professionals with different protected characteristics in our regulatory processes*".[12] Three reports have

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10 Page 28 of NMC, *Annual Fitness to Practise Report 2024–2025*, available at https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/2025-annual-ftp-report/annual-fitness-to-practise-report-20242025.pdf, accessed 17 September 2025.

11 West, E., S. Nayar, T. Taskila, and M. Al-Haboubi (2017), "The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process", available at https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/bme-nurses--midwives-ftp-research-report.pdf, accessed 17 September 2025.

12 https://www.nmc.org.uk/about-us/equality-diversity-and-inclusion/edi-research/, accessed 17 September 2025.

been published as part of that programme.[13] The most recent of those reports found "*direct evidence of bias, as well as indirect consequences of uneven practices that explain differences in outcomes between Black professionals and White professionals and between male professionals and female professionals*".[14] We note that the Independent Culture Review found widespread concerns among staff about FtP decision-making. We have conducted our review on the basis that whether or not a concern raised in relation to a particular identified case in fact affected the decision-making in that case in a way that led to a poor outcome, the concern should be taken seriously, as, at the very least, it reflects a lack of shared understanding and consistency between the various actors in the FtP process in respect of the matter, and suggests that there is a risk of poor outcomes being reached in other cases.

16 We also note that it is not unusual for different people to have different views about the same case. That is particularly the case in the regulatory context where reference is made to concepts which are intrinsically linked to value judgments, such as whether the behaviour of a registrant would affect public confidence in the regulated profession. Nurses, midwives, and nursing associates will not always agree with each other on such matters. Nor will lawyers or judges. It is not surprising to us that, within the NMC, people involved in the FtP process may reach different conclusions about the same case. What is important, however, is that the guidance people are working to accurately reflects the relevant caselaw, is clear and easy to understand, and is applied in a consistent manner across cases and across the different stages of the FtP process.

17 In conducting our review, we were aware that Ms Omambala had already carried out a number of interviews, and we received information directly from Ms Omambala which she had amassed during her work, including transcripts of interviews with NMC staff, the whistleblower and other stakeholders, which we were able to consider.

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13 NMC (20 October 2020), *Ambitious for change: Research into NMC processes and people's protected characteristics, Full report*, available at https://www.nmc.org.uk/globalassets/sitedocuments/edi-docs/nmc_edi_research_full.pdf, accessed 17 September 2025; NMC (2022), *Ambitious for change: Phase two report*, available at https://www.nmc.org.uk/globalassets/sitedocuments/ambitious-for-change/nmc-ambitious-for-change-report.pdf, accessed 17 September 2025; Cinpoes, R. and J. Azah (April 2025), *Ambitious for Change: A Review of the Nursing and Midwifery Council's (NMC) Fitness to Practise Process*, available at https://www.nmc.org.uk/globalassets/sitedocuments/edi-docs/ambitious-for-change-report.pdf, accessed 29 August 2025.

14 Cinpoes, R. and J. Azah (see fn 13), p 40.

We also considered the numerous documents provided to us by the NMC in connection with the identified FtP cases, as well as guidance, policies, operating procedures, internal reviews of decision-making, training programmes and other materials. We recognise that reading the transcript of an interview cannot be the same as conducting an interview in person, but we found a number of the interview transcripts to be helpful. We formed the view that, given the transcripts and information already available to us, the scope of our instructions, and the fact that this report had been subject to delay, it was not necessary or proportionate for us to carry out any of our own interviews.

18 We are aware that other criticisms have been made of the NMC in connection with its FtP activities, outside the identified cases, including to Ms Omambala. We were not instructed to consider these wider issues or other cases and do not comment on them.

D Issues arising from the identified FtP cases

19 We have drawn together the concerns arising from the identified cases as raised by the whistleblower, the press, past and present NMC staff, and from our own consideration of the identified cases. We will address the substantive issues under the following headings, although there is some overlap:

19.1 Private life
19.2 Racism
19.3 Sexual misconduct
19.4 Domestic abuse
19.5 Family court proceedings
19.6 Criminal proceedings

D.1 PRIVATE LIFE

20 We have found evidence in the period 2018–2023 of significant confusion within the NMC about the circumstances in which acts or omissions in the private life of a registrant might constitute misconduct for FtP purposes. We consider that the guidance published by the NMC on this topic in that period was inadequate, and that the way it was interpreted and applied, in some cases, was wrong.

21 We note that the Independent Culture Review also found that there had been a failure to take seriously misconduct outside the work context: "*The reported claims of racism, people being afraid to speak up and nurses accused of serious sexual, physical and racial abuse being allowed to keep working on wards were all repeated to us on multiple occasions*".[15] Their report also records one person saying that "*although it's not in our guidance, there's an unwritten rule that 'we don't deal with these cases'*",[16] which suggests that how written guidance is understood and applied by those 'on the ground' may be equally if not more important than the guidance itself.

[15] Page 111.

[16] Page 101.

22 In 2018, the NMC launched a new strategic direction for FtP which was aimed at moving away from a culture of blame. Twelve policy principles were published, which included the following:

> *"Principle 10: in cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a nurse, midwife or nursing associate as a professional."*

23 It appears to us that this change of strategic direction coincided with the NMC underplaying the possibility that acts or omissions in the private lives of registrants might be relevant to the FtP process. As can be seen from the 2018 version of Principle 10, the possibility of taking action in a 'private life' case was tied to the question of trustworthiness as a professional. Some of the guidance used by the NMC in the period 2018–2021 also contained what appeared to be limitations in respect of behaviour in a registrant's private life. For example, the guidance on criminal convictions published in August 2018 stated that "*Nurses and midwives' fitness to practise can be affected by very serious offending in their private life for which they are convicted. But if they aren't convicted, it's not our role to fill in any perceived gaps in the criminal justice system by taking regulatory action against them if there isn't a clear link to patient safety, clinical practice, or professional standards*." There was no explanation as to the type of offences which might be clearly linked to professional standards or any guidance on how to assess the answer to this question. It appears to us that the main part of this paragraph that was applied internally was the shorthand phrase that "*it's not our role to fill … gaps in the criminal justice system*", without there always being sufficient focus on whether the allegations in particular cases were linked to professional standards.

24 The NMC itself recognised that its guidance in respect of private life issues was inadequate and made various changes. In 2021 and 2022, guidance in respect of harassment, discrimination and victimisation was updated to make it clearer that these types of behaviour might be linked to professional standards even if they occurred outside the workplace. There were changes to the guidance on Misconduct[17], Serious concerns

[17] Reference: FTP-2a.

based on public confidence or professional standards[18], Serious concerns which could result in harm to patients if not put right[19], and Serious concerns which are more difficult to put right[20].

25 Unfortunately, it appears to us that these changes did not fully remedy the problems. We have seen evidence in more than one of the identified cases that the revised guidance published in late 2021 and 2022 was interpreted as meaning that the NMC would only pursue matters which occurred in a registrant's private life if they involved discrimination. For example, in one case we reviewed, NMC legal advice in in 2023 was that "*although our guidance can be interpreted in different ways, the general thrust of it is that we should not be investigating registrants for incidents which occur in the domestic/ private sphere, unless there is some evidence of discrimination*."

26 The Independent Culture Review records that:

> *"In the last year there has [sic] been multiple Serious Event Reviews relating to the potential failure of the NMC to appropriately handle allegations of physical or sexual abuse against children occurring outside of clinical settings. Some of these cases were closed at screening due to allegations that include accessing category A child pornography. When staff questioned why these cases were not being pursued, senior leaders responded that, "this is our guidance"."*[21]

27 The guidance on Criminal convictions and cautions[22] that was in place from 1 July 2022 to 27 March 2023 included the following:

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18 Old reference: FTP-3c. Current reference: SAN-2. Current title: "Serious concerns which raise risks to the public's confidence in the professions generally or to professional standards".

19 Old reference: FTP-3b. Current reference: SAN-2. Current title: "Serious concerns that could result in harm if not put right".

20 Old reference: FTP-3a. Current reference: SAN-2. Current title: "Cases that we regard as being particularly serious".

21 Page 99.

22 Reference: FTP-2c.

"Concerns such as using discriminatory language or inciting racial hatred via social media are matters we are likely to look into even if they were not reported to the police as this behaviour is likely to amount to a breach of the Code and affect patient safety. […]By contrast, if we received concerns that nurse, midwife or nursing associate had committed a sexual offence in their private life and there was no evidence to suggest there was a risk to patient safety, we would usually say that the matter would be best investigated by the police in the first instance. […]

If the criminal offending took place in the nurse, midwife or nursing associate's private life, and there's no clear risk to patients or members of the public, then it is unlikely that we'll need to take regulatory action to uphold confidence in nurses, midwives or nursing associates, or professional standards. We'd only need to do that if the nurse, midwife or nursing associate was given a custodial sentence (this includes suspended sentences), or the conviction was for a specified offence."

28 This guidance does not include reference to considering whether the conduct was linked to professional standards, in the absence of a custodial sentence or conviction for a specified offence in the realm of sexual offending in particular. Indeed, it strongly suggests that, in the absence of such features, the NMC need not take regulatory action to uphold confidence in the profession or professional standards. It appears to have contributed to a view that private life matters were largely not for the NMC to become involved in, even if they involved the criminal justice system.

29 We have been provided with a large number of NMC guidance documents which touch on the question of conduct in the private life of registrants and which have been in place in various forms since 2017. We do not think it productive to go through every item of previous guidance in detail, not least as all the guidance has been amended at least once and some is still in the process of being further amended. While the various pieces of guidance did explain correctly in multiple places that matters outside a registrant's professional life may constitute misconduct, we consider that there were also defects in the guidance in other places, and that it was often wrongly interpreted.

30 It is well established that conduct in a registrant's private life may constitute misconduct, regardless of the nature of that conduct:

30.1 "*It has … always been recognised that misconduct may qualify even though committed in the professional's private life, so long as it has a sufficient impact on his professional reputation or that of the profession as a whole*": ***Gleeson v Social Work England***[23], citing ***R (Remedy UK Ltd) v GMC***[24], in which Elias LJ said that misconduct "*can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practise itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession*".

30.2 Three relevant points of principle were set out in ***Beckwith v SRA***[25]: "*The first is that in the context of the regulation of a profession there is an association between the notion of having integrity and adherence to the ethical standards of the profession. This is consistent with the ordinary meaning of the word, namely adherence to moral and ethical principles. The second is that on matters touching on their professional standing there is an expectation that professionals may be held to a higher standard than those that would apply to those outside the profession. The third is that a regulatory obligation to act with integrity "does not require professional people to be paragons of virtue"*."

31 In the NMC's case, the *Code* requires that registrants uphold the reputation of their profession at all times, including for example acting with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment, keeping to the laws of your country, and using spoken, written and digital communication responsibly.[26] Behaviour in a registrant's private life could conflict with these duties in such a way as to damage public trust or confidence and thus the reputation of the profession.

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23 [2024] EWHC 3 (Admin).

24 [2010] EWHC 1245 (Admin); [2010] ACD 72.

25 [2020] EWHC 3231 (Admin); [2021] IRLR 119.

26 NMC, *The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates*, effective from 31 March 2015 and updated on 10 October 2018, at paragraph 20.

32 At some points, we saw evidence of the right approach being taken to 'private life' cases, including express recognition that conduct which takes place outside a clinical setting may still require action, depending on its nature and seriousness. But we consider that the general concerns raised by the whistleblower and other NMC staff about the approach taken to private life matters were well founded. The guidance was not sufficiently clear, it was not always consistent across guidance documents, and it was frequently interpreted and applied in an overly restrictive manner.

33 Many of the identified cases that concerned behaviour in a registrant's private life concerned one of the specific topics we address below such as sexual misconduct and racism. We consider those cases in the relevant section of our review.

34 Two of the identified cases concerned behaviour in the private life of the registrant which had the obvious potential to affect their working life as they concerned the use of controlled drugs, or alcohol misuse. In those two cases, we did not see any evidence that an erroneous approach was taken to private life issues. In other words, we did not consider that in those cases there was reason to think that the fact the conduct occurred in the registrants' private lives was relied on when making decisions whether to pursue the concerns. However, in one of the cases, the NMC had not been able to make any contact with the registrant over a period of around 33 months, which appeared to have led to the referral fizzling out, in that the NMC offered no evidence at the substantive hearing. We were surprised the registrant's lack of engagement did not, by itself, lead to restrictions on his registration. Registrants are required to inform the NMC in writing within one month of any change in their name or address.[27] We suggest that some thought is given to guidance on what should happen if the NMC is unable to elicit any engagement from a registrant, irrespective of the nature of the concerns raised about the registrant or the reasons that it appears to the NMC are leading to the registrant's non-engagement. Non-engagement, for any reason, impairs the NMC's ability to regulate that registrant.

[27] Rule 16(1) of the Nursing and Midwifery (Education, Registration and Registration Appeals) Rules 2004, set out in the Schedule to the Nursing and Midwifery (Education, Registration and Registration Appeals) Rules Order 2004 (SI 2004/1767).

35 We will consider the adequacy of the NMC's current guidance in respect of private life cases later in our review.

D.2 RACISM

36 Our discussion of 'private life' cases above includes cases where racist behaviour occurred outside professional practice. In light of our findings about the guidance and the way it was interpreted, there may have been referrals involving racist behaviour in a registrant's private life which were wrongly not pursued, even though we did not find that to be the situation in any of the 20 identified cases we have examined.

37 Where referrals are pursued and reach the stage of being considered by a FtP panel, if the wrong approach is taken or the sanction is insufficient, the PSA can appeal the decision to the High Court. We have seen evidence in one of the identified cases of the NMC (and registrant) conceding an appeal in such a situation, properly accepting that the FtP panel were wrong and that the registrant's fitness to practise should have been found impaired and a sanction imposed, even though it was a one-off incident outside work, and there were personal testimonials in support of the registrant's character. In that case, the panel appeared to apply a test of whether the racist conduct reflected a 'deep-seated attitudinal problem' and decided that it did not, as it was an isolated incident. We will return to this phrase when we consider the current NMC guidance. In this particular case, we note that the internal FtP decision-making stages all correctly identified that the case should move to the next stage of the process[28]: the error arose at the panel stage.

38 Concerns about the FtP process where allegations of racist language or conduct are made within a work setting (whether to patients or colleagues) were also raised. In some of the cases we have looked at, the FtP process could not progress this type of complaint as there was no direct evidence, whether because the patient was unable to provide it, or because staff who had complained of the behaviour were not willing to

[28] That is: (1) the outcome on Screening was further investigation required; (2) the recommendation of the Investigators was that there was a case to answer; and (3) the Case Examiners certified there was a case to answer and referred the matter to the FtP Committee for final hearing.

identify themselves. Procedural fairness to registrants means the NMC, in common with other regulators, will usually be unable to bring allegations of impaired FtP against a registrant which are supported only by the evidence of witnesses who either cannot or do not wish to make themselves available for cross-examination at a substantive hearing.

39 In one case, the patient whose care was the subject of a referral had sadly died and was unable to provide evidence. We reviewed the steps the NMC took to investigate the conduct complained of by the patient's relatives, and consider that the NMC took all appropriate steps to obtain relevant evidence. We could not identify any errors in the approach taken to that evidence, which, in the end, was not sufficient to justify progressing the case further. In particular, the allegations of racially motivated failures to give appropriate care, and of insensitivity to the patient's religious beliefs, were not made out to a standard that could reasonably have led to a finding of impaired fitness to practise.

40 We have also considered a concern that the FtP process fails to take sufficient account of the context in which misconduct occurs, including where a registrant is themselves the subject of racial discrimination which might explain (if not justify) their behaviour. In one of the identified cases, we understand the relevant registrant is white and a press report raised concerns that the registrant had been subject to racist abuse from patients which was not sufficiently explored or addressed as relevant context at the hearing in the impairment stage. We have found no basis for the complaints made in the press about this case, as no allegation of racism was raised by the registrant or the registrant's legal representative in the FtP process.

41 Of course, the fact this concern does not, on the evidence before us, apply to this particular case should not be taken as a conclusion that there have been no cases where racial discrimination towards a registrant has occurred within the FtP process. We note in this regard a report[29] issued as part of the Ambitious for Change research concluded, among other things:

[29] Cinpoes, R. and J. Azah (see fn 13).

41.1 "*The research found that there is direct evidence of bias, as well as indirect consequences of uneven practices that explain differences in outcomes between Black professionals and White professionals and between male professionals and female professionals.*"[30]

41.2 "*The policies and guidance review found that while they are broadly aligned with the organisational values and demonstrate procedural fairness, there are areas in the policy and guidance that contribute to the differentiated treatment of some groups.*"[31]

D.3 SEXUAL MISCONDUCT

42 The concerns outlined about the approach to private life cases also apply to cases involving sexual misconduct.

43 In 2022, the NMC conducted an internal review of FtP cases that had reached a FtP panel and which involved sexual misconduct. This review found a host of problems including the following:

43.1 Failures to explore or charge sexual motivation which resulted in missed opportunities to demonstrate the seriousness of concerns and how the registrant's actions/ behaviour breached professional expectations.

43.2 Failure to apply or reference relevant case law when judging sexual motivation.

43.3 Failure to apply the NMC's sanctions guidance correctly.

43.4 Failures by panels to address sufficiently the risk of repetition and the impact on victims, particularly in cases where the victim was not a patient.

[30] Page 40.

[31] Page 41.

43.5 The use of inappropriate or insensitive terminology, and being influenced by myths about sexual assault.

44 This led the NMC to take steps to update its guidance and provide new training for panel members and decision-makers in the FtP process. The identified cases we were asked to consider were dealt with before these changes were made.

45 In one case pre-dating the updated guidance, the charges brought by the NMC against the registrant related to separate historic incidents of unwanted sexual activity with two patients. The charges did not appear to us to have been drafted adequately to guarantee that the fact that the sexual activity was unwanted and/or that the patients were vulnerable was captured. However, in this particular case, the panel which heard the substantive hearing recognised those underlying features of the conduct and imposed an order striking the registrant off the register. We suggest that further consideration is given to the guidance on drafting charges in connection with sexual activity.

46 In another case, a registrant had shared images of nude children online. The registrant was arrested; however, the police took no further action after concluding that the images were 'naturist'. Notwithstanding the police's decision, based on the evidence we have seen, and as the NMC was aware at the time, the registrant appeared to have admitted in police interview that his sharing of the images was sexually motivated. In 2022, NMC legal advice was that "*In line with our guidance, [the registrant]'s actions couldn't amount to serious professional misconduct*". The NMC's investigators recommended to the case examiners that the case be closed. The case examiners, however, sought for the regulatory concerns to be redrafted to reflect the registrant's "*admission obtained under caution, already available to support sexual element*". The registrant subsequently admitted the charges and was struck off. This case is a further example of the sometimes erroneous approach taken to 'private life' cases in the period 2018–2023. While the NMC's systems resulted in the right outcome in this case, it is nonetheless concerning that the application of guidance in that period led a competent lawyer to advise a registrant's actions in sharing nude images of children with a sexual motivation could not amount to serious professional misconduct.

47 In the final identified case concerning sexual misconduct, the registrant was referred to the NMC on five occasions between 2017 and 2022. The concerns referred included two serious sexual assault allegations by patients, an allegation of rape by a colleague, seeking to influence a patient to date him, and other incidents of breaching professional boundaries and inappropriate behaviour. The registrant was struck off, following a substantive hearing. However, the progression of the case through the NMC's FtP process gives rise to a number of concerns.

48 In fairness to the NMC, it recognised its own poor handling of this case. In August 2022, a senior member of staff reviewed the case and identified concerns, namely:

48.1 closing concerns because there are other serious incidents;

48.2 progressing cases separately, unnecessarily; and

48.3 interim order not sufficient to protect the public.

49 In our view, this critique was justified.

50 In this case, there is clear evidence that some regulatory concerns which had been referred to the NMC were closed because they were not considered as serious as other concerns regarding the same registrant. For example, an allegation that the registrant had phoned a patient to ask her on a date under the false pretence of giving her test results, and had thereby breached professional boundaries, was initially closed as it was not considered as serious as other allegations that had been made against the registrant. This is inappropriate as, if the concerns arguably amount to misconduct, it will be necessary for the panel dealing with the substantive hearing to be able to appreciate the full extent of the misconduct.[32] Closing regulatory concerns because they are, relatively, not as serious as other concerns regarding the same registrant deprives the panel of this opportunity and may lead to the panel imposing a sanction which is insufficient for public protection. It is also, in our view, shortsighted. The 'more serious' concern may, for good reason, later be discontinued. In those circumstances, it is

[32] The same is true, with the necessary changes, for other potential grounds of impairment of fitness to practise.

plainly unsatisfactory that what was otherwise a valid, but 'less serious', concern is no longer progressed.

51 It is also evident from a review of the documents that the various referrals made to the NMC in respect of the registrant were, for at least some of the time, progressed internally as separate cases, despite their similarity in terms of subject matter. While we do not have any evidence which points conclusively to errors or mistakes arising from this approach, it seems to us clear there is a risk that important factors in a case may be overlooked if separate allegations concerning the same registrant, and arising in similar circumstances, are managed separately. The most obvious of these is the risk that a registrant's pattern of behaviour is either not detected at all or is only detected later than it otherwise could reasonably have been detected. It may be that, at times during the progression of the case, decisions taken by the NMC as to the appropriate level of interim order were affected by the lack of any of the separate individuals responsible for the case having an overview of the potential risk posed by the registrant. Nevertheless, we emphasise we are not aware of any evidence that this, in itself, led to the registrant causing any additional harm to patients, colleagues, or others. We understand that the NMC's case management system already allows for cases to be flagged and linked where appropriate.

52 Finally, we note that one concern regarding this registrant's potential sexual misconduct was closed, based on the fact that the behaviour occurred in his private life and the police had decided to take no further action. This is a further example, in our view, of the impact of the sometimes erroneous approach to private life matters taken in the period 2018–2023.

D.4 DOMESTIC ABUSE

53 Domestic abuse against a partner or child may be relevant to fitness to practise. The identified cases did not include any where domestic abuse against a partner was alleged. Where harm to children was involved, we have considered the case under the next heading.

D.5 FAMILY PROCEEDINGS

54 Registrants may be involved in proceedings in the family court for multiple reasons, including applications by local authorities to remove their children from their care, or disputes between separated couples about the arrangements for their children. The family courts may be asked to make findings of fact in respect of allegations of harm by a parent, or in respect of a parent's failure to protect a child from harm. The sorts of harm the family court may consider includes physical violence, sexual assault between parents or against children, financial abuse and emotional abuse. Most often, these acts or omissions will have occurred in the registrants' private lives, and may not be known about by their employer.

55 There is no express obligation on registrants to inform the NMC if they are the subject of adverse findings in the family court, including the permanent removal of their children from their care.[33] The NMC may nevertheless receive referrals arising from decisions made by the family courts, or may receive referrals in connection with criminal proceedings which ultimately are not progressed but where related proceedings take place in the family court.

56 We have seen evidence of a failure to appreciate that findings made by the family court concerning the physical abuse of a registrant's child would need to be considered as part of the FtP process. In part, this error appears to have been related to the issue identified above concerning the dividing line between private life and misconduct. But in the same case, we also saw evidence of a failure to appreciate the likely nature of findings by the family court, and therefore to understand how they could be relevant in the FtP process.

57 In a different identified case, a registrant self-reported to the NMC that the family court had found either she or her partner had caused an injury to their young baby by

[33] The *Code* at paragraph 23 requires that registrants inform the NMC and any employers of "*any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)*." Employers must be informed if "y*ou have had your practice restricted or had any other conditions imposed on you by [the NMC] or any other relevant body*". Employers and the NMC must be informed "*if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment*".

shaking, without the other partner's knowledge, and that it was not possible to determine whether it was the registrant or her partner who had caused the injury. In the course of its investigation, the NMC became aware that the court had also criticised the registrant and her partner for failing to seek medical attention promptly.

58 In January 2023, NMC legal advice was that "*we should not be making an application to the Family Court for disclosure of additional material in their possession*." We can understand that advice in the context of the family court's finding that it was not possible to determine whether it was the registrant or her partner who had caused the injury. However, we consider the advice was misplaced in respect of the court's criticism, which was known to the NMC, of the alleged delay in seeking medical attention. In our view: (1) the NMC needed to seek further information from the family court to understand the evidence about that criticism/ finding from those proceedings; and (2) could and should have made an application for disclosure that was limited to that topic. We note that, notwithstanding the investigators' recommendation that the case be closed, which appears to have been based in part on the legal advice received, the case examiners in fact referred the concern regarding the alleged delay to the FtP committee for substantive hearing. Subsequently, the NMC obtained an order from the family court, with the registrant's consent, for disclosure of certain documents from the family proceedings, and has taken further steps to investigate the alleged delay in seeking medical attention.

59 In the final identified case concerning family proceedings, we saw appropriate and early recognition that the family court documents were essential and needed to be obtained, although there was then some confusion about which documents should be requested and the process took a considerable time. This led on two occasions to further delays, as evidence was only obtained very shortly before hearings, causing the hearings to be adjourned.

60 In that case, however, the NMC appears to have made a basic mistake in not appreciating that the registrant's child was aged over 18 when she revealed she had been abused by her father, the registrant's husband – there were family proceedings because the registrant had other, younger children. This mistake was made despite the NMC being aware of the elder child's date of birth and led to the NMC bringing charges against the registrant which could not be supported, and which the NMC had

to drop at the substantive hearing. The panel found the remaining charge against the registrant, that she had covered up the abuse, not proved due to insufficient evidence.

61 Equally, if not more, concerningly, there appears to have been a failure by the NMC to recognise the seriousness of the family court having found the registrant was unsuitable to care for her younger children and making a care order in favour of the local authority. It seems to us that such a finding is capable of amounting to misconduct and impacting negatively on public confidence in the profession, but the NMC does not appear at any stage to have considered bringing a charge against the registrant arising out of these matters.

62 In our view, this case is an example of a poor outcome from the FtP process, which potentially undermines public protection. The root cause of this poor outcome, in our view, was an insufficient lack of understanding and awareness within the NMC regarding family proceedings and the impact of family matters on a registrant's fitness to practise, having regard in particular to the need to maintain public confidence and trust.

D.6 CRIMINAL PROCEEDINGS

63 Where criminal investigations or proceedings take place involving a registrant, there may be an overlap with the FtP process. One of the questions for the NMC will be whether to apply for an interim order, or to continue an interim order that was granted at an earlier stage. It is relevant that the standard of proof in the criminal court is beyond reasonable doubt, but in the FtP system, the lower standard of the balance of probabilities applies. This means that decisions in the criminal sphere are not determinative of FtP decisions by the NMC. The cases we have reviewed show that this difference was properly understood and the NMC made its own decisions about cases where there was an acquittal.

64 Where a registrant is cautioned or convicted of an offence, part of the FtP process will be consideration of whether the impact of that conviction or caution is that the registrant's FtP is impaired and if so, whether any sanction is required in addition to that imposed in the criminal court. We have seen concern expressed that the NMC has taken too lenient an approach in some cases. There is already a safeguard in the system

in such cases – the PSA reviews panel decisions and can apply to the High Court[34] if it considers a decision made following a substantive hearing is insufficient for public protection, whether due to sanction or otherwise. Two of the identified cases raised this potential issue. In one, as discussed at paragraph 37 above, the PSA appealed and the NMC and registrant conceded the appeal. In the other, we have seen no evidence that the PSA made an appeal. That suggests the particular decision was within the reasonable range, even if there was scope for a different panel to take a different view on the appropriate level of sanction.

65 We have discussed, above, the previously held view within the NMC that it was not their role to fill perceived gaps in the criminal justice system if there was not a clear link to patient safety, clinical practice or professional standards. We refer the reader to section D.1 of this report.

[34] Under s 29 of the National Health Service Reform and Health Care Professions Act 2002.

E The current position

66 As we have set out above, there have been problems in the way the NMC has drafted some of its written guidance and how that guidance has been understood and implemented. The main problem we have identified concerns the approach to cases about behaviour in a registrant's private life (including sexual misconduct and racist behaviour). We have also commented on problems in cases where there are also proceedings in the criminal or family court, and cases involving racist behaviour whether in or outside the work context.

67 Many of these problems are ones which the NMC had already identified for itself, as far back as 2021. We have been provided with information about the many actions that the NMC has completed or is working on to address problems with its FtP process, and this includes a range of steps that are directly relevant to the problems we have identified.

68 Although we have identified problems with decision-making in some of the 20 identified cases, we have found that in most of these cases, eventually the correct approach was taken. In the case discussed at paragraphs 59–62 above, we understand the registrant in question is no longer registered with the NMC and therefore cannot currently practise as a nurse, midwife, or nursing associate. We do not, therefore, recommend that any further steps need to be taken by the NMC in respect of the identified cases.

69 Although the concerns we have identified are largely already on the NMC's radar and already the subject of action to improve decision-making, we have independently considered whether those steps are sufficient. This has included reviewing the current guidance that the NMC uses. We understand that the NMC's FtP plan for 2024–2026 already includes reviewing its screening guidance (and that an updated version of this guidance was published in May 2025), refreshing its evidential standards framework and reviewing its decision-making about interim orders. We are also aware that the NMC is shortly to produce a handbook and protocol for internal use in cases where there are family court proceedings. We nevertheless make the following recommendations, some of which may be able to feed into those processes, and others which would require new or additional activities to be undertaken.

E.1 PRIVATE LIFE

70 We note that Principle 10 was amended in February 2024 and now states:

> *"**10. In cases about conduct outside professional practice, taking action is only likely to be needed if the concerns raise fundamental questions about the ability of the nurse, midwife or nursing associate to uphold the standards and values set out in the Code.***
>
> *We know that the public take concerns which raise fundamental questions about the standards and values set out in the Code particularly seriously. Our research told us that these cases are likely seen by the public as serious breaches of professional standards. In addition to criminal convictions, conduct requiring action by us could include behaviour such as discrimination, harassment, sexual misconduct or any other conduct involving cruelty, exploitation or predatory behaviour."*

71 We are not sure whether giving a non-exhaustive list of conduct that might require action in connection with an overarching principle is helpful, given the previous history of guidance being interpreted literally and restrictively. For example, the list above does not expressly include violent behaviour or the use of racist language, although the Misconduct guidance makes clear that violent behaviour and domestic abuse may well be relevant, and 'discrimination' could be understood as including racist language as well as behaviour. If there is to be a list, it either needs to include all the types of conduct that might be viewed as a breach of professional standards, to avoid inadvertently restricting the approach that is taken, or must make very clear that the examples given are non-exhaustive.

72 The Screening guidance currently in place[35] also lists examples of concerns that are likely to lead to regulatory action. This includes concerns arising in a registrant's private life – for example, the guidance lists "*Sexual misconduct, whether or not it relates to professional practice*", "*Deliberately causing harm to vulnerable people/children, whether in or*

[35] Reference: SCR-1.

outside of professional practice" and "*Discriminatory behaviour (whether or not this relates to professional practice*".

73 This is a great improvement on the previous guidance. We can, however, think of examples of behaviour in a registrant's private life that are not in the list, but are given in the Misconduct guidance, such as violent behaviour or domestic abuse, and we are worried that even though the list in this guidance document is not stated to be exhaustive, it could be interpreted in that way – we have seen that previously, very narrow interpretations of guidance documents have been adopted, particularly by lawyers. We note that the Misconduct guidance[36] does refer to the "*relationship between a professional and their partner*" as a possible source of misconduct, which would incorporate domestic abuse irrespective of whether the partner was a vulnerable adult, and says that "*Depending on the particular facts, violent behaviour can be serious enough to indicate a risk to the public and seriously undermine public confidence in the professions we regulate, irrespective of where it occurs. This includes in a domestic setting*." Again, we suggest that lists of this sort need to include all the types of relevant behaviour, and to make very clear that any misbehaviour in a registrant's private life **may** be relevant, so any allegation made will need to be considered.

74 We note the following features of the General Medical Council's (GMC) guidance *Decision on whether regulatory action is required (Doctors)*[37] which we think could be usefully included in the NMC guidance, with the necessary changes:

74.1 A statement that misconduct is '"*about behaviour. It could be an act or omission arising in or outside of a doctor's working 'life*"[38]. This makes very clear that any behaviour is potentially relevant, rather than tying it to a list of specific examples, and does not include any caveats.

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36 Reference: FTP-2a.

37 In effect from 30 May 2025, available at https://www.gmc-uk.org/-/media/documents/dc23656---decision-on-whether-regulatory-action-is-required--doctors-_pdf-110174110.pdf, accessed 29 August 2025.

38 Page 4.

74.2 An explanation of why certain types of conduct in a registrant's private life might constitute misconduct. For example, the GMC spells out in clear terms that:

74.2.1 "*Sexual misconduct may impact the physical, emotional and / or psychological wellbeing of a patient, relative, colleague* ***or member of the public. This impact can be long lasting and may affect how a patient accesses health services in the future***"[39] (emphasis added); and

74.2.2 "*All types of discrimination may result in a breakdown of trust and undermine public confidence in the professions*"[40].

75 We therefore recommend that the NMC reviews its Screening guidance to ensure it has a clear and unambiguous statement about misconduct covering both private and professional life; a more comprehensive list of examples that aligns with other pieces of guidance; and an account of why certain types of private conduct may be relevant to FtP.

E.2 RACISM

76 The Misconduct guidance[41] contains a statement that the NMC has "*made clear that no form of discrimination including, for example, racism, should be tolerated within healthcare*".

77 The current guidance on Criminal Convictions and Cautions[42] says that if offending behaviour is outside professional practice or "*isn't closely related to it*" and isn't a specified offence or a custodial sentence, then it might be pursued if it is "*so serious as to: indicate deep-rooted attitudinal issues which could pose a risk to people … or be capable of undermining public trust and confidence in the profession or raise fundamental questions about the person's ability to uphold the standards and values set out in the Code.*"[43] The phrase

[39] Pages 31–32.

[40] Page 37.

[41] Reference: FTP-2a.

[42] Reference: FTP-2c.

[43] Paragraph breaks and bullet points removed.

'deep-seated personality or attitudinal problems' is also used in other guidance including in respect of sanction.

78 We have some concerns about how the phrase 'deep-rooted attitudinal issues' is used in the Criminal Convictions and Cautions guidance. The concept of a deep-seated or deep-rooted attitudinal problem is one that appears in the regulatory caselaw and may have originated in GMC guidance many years ago. We recognise that it may be important to differentiate between one-off incidents of poor judgment, and a more fundamental problem with a registrant's attitude or beliefs, particularly at the stage of sanction (and the High Court has recently considered the NMC's guidance in respect of sanction on this very issue without any criticism of the drafting: ***PSA v NMC & Shah***[44] at [74]–[79]). But we anticipate this passage in the Criminal Convictions and Cautions Guidance could be applied as imposing a threshold or test of there being evidence of a 'deep-seated attitudinal problem' which has to be passed before the NMC will even investigate, or will pursue a case to a hearing. There is no basis in the caselaw for imposing such a test. A one-off incident of racist behaviour could constitute misconduct even if it is not possible to say that it reflects a deep-seated attitudinal problem. The case discussed at paragraph 37 above gives an example, as, in fairness, both the NMC and the registrant recognised. It is also not obvious to us how the fact of a conviction or caution for a single offence could enable the decision-maker to know, at an early stage, whether a deep-rooted attitudinal issue is present or not. More generally, we think this piece of guidance needs to be reviewed to ensure it is consistent with other guidance in respect of 'private life' behaviour.

79 We have seen an internal summary of the Criminal Convictions and Cautions guidance which says "*While each case must be considered on its facts, some examples of where we may take action outside of specified offences include instances of coercive control, serious and / or repeated violence against others; stalking or harassment offences. Outside of specified offences, we are more likely to identify deep-seated attitudinal concerns where there is serious and / or repeated mistreatment, and / or the behaviour targets children or vulnerable people*." This reinforces our concern that 'deep-seated attitudinal concerns' is being used as a

[44] [2025] EWHC 1215 (Admin).

threshold test for investigation or action, and that it may result in cases being dropped that should be pursued.

80 The same phrase is used in the Freedom of Expression and Fitness to Practise guidance[45], again suggesting that a deep-seated attitudinal problem is required (or a criminal conviction) before action will be taken:

> *"Nurses, midwives and nursing associates are free to express themselves and their protected beliefs outside of work. It is not our role to monitor what people say outside of, or unrelated to, professional practice. We won't take action simply because something a professional has said or done has shocked, disturbed or caused offence to someone. We will only do so in those rare cases where the way a professional conducts themselves suggests they have a deep-seated attitudinal problem and/or results in a criminal conviction that could mean they pose a risk of harm to the public or undermine confidence in the profession."*

81 The Misconduct guidance says "*We will take action when a professional's conduct: either indicates deep-seated attitudinal issues which could pose a risk to the public in professional practice, or is capable of undermining public trust and confidence in the profession, raising fundamental questions about the nurse, midwife or nursing associate's ability to uphold the values and standards as set out in the Code.*" This wording does not tie the concept of a deep-seated attitudinal problem to the question of public confidence. But, on our reading, it continues to tie that concept to patient safety: a threshold for which, as already noted, we consider there is no basis in the caselaw.

82 We therefore recommend that the NMC review all relevant guidance to ensure that the concept of a deep-seated attitudinal issue or problem is not framed as a test or threshold that must be met before a concern about racist language or behaviour is pursued. In any revisions it undertakes, the NMC should be careful to ensure the guidance does not suggest there are any aspects of public protection[46] which can never be

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45 Reference: 2ai (sic).

46 The protection of the health, safety and well-being of the public; the maintenance of public confidence in nurses, midwives, and nursing associates; and the maintenance of proper professional standards and conduct for nurses, midwives, and nursing associates.

engaged by conduct in a registrant's private life in the absence of a deep-seated attitudinal issue or problem.

83 The guidance on Particular Features of Misconduct Charging[47] has been recently updated to take account of caselaw. Charges in this area should "*(1) Specify the alleged misconduct, and (2) Specify that the misconduct was "racially motivated"*." The guidance further provides that:

> *"When deciding whether an act is "racially motivated" it is likely to be helpful to consider the following questions:*
>
> *(a) Did the act in question have a purpose behind it which at least in significant part is referable to race? and;*
>
> *(b) Was the act done in a way showing hostility or a discriminatory attitude to the relevant racial group?*
>
> *If we are considering actions or behaviour that includes words, we may first need to assess whether what was said was in fact racist in nature. It is important that when we assess the meaning of words we do so from an objective perspective. This means that we consider what the reasonable person, with all the information in front of them, would conclude. This part of the assessment of what was said does not include taking into consideration what the professional intended when they said it. If the professional said multiple things, then it is important that we consider cumulatively what was said, and not necessarily just focus on individual words or phrases in isolation.*
>
> *Whether the purpose behind an act is "referable to race" is likely to depend on the evidence we have in a particular case. When considering "racial motivation" we are primarily focused on what the professional had in mind at the time they said or did the thing in question."*

[47] Reference: PRE-2e.

84 It may assist registrants if the guidance clarified that an 'act' in the extract above includes language (spoken or written) as well as behaviour.

85 We consider that if objectively racist language is used, then, in an appropriate case, use of racist language should be charged either instead of or in addition to the use of the language being racially motivated. A registrant's use of objectively racist language could constitute misconduct even if there is no, or insufficient, evidence the registrant was 'racially motivated'. More generally, on the subject of drafting charges, we suggest that it may be helpful for those dealing with cases in the early stages (including at the screening stage) to have an understanding of the way in which such charges are ultimately likely to be drafted, in order to ensure that the right evidence is obtained. We note that the initial screening team already receive training on drafting regulatory concerns.

86 We have also looked at the NMC's *Guidance on using social media responsibly*[48], as use of social media is an area where there is very likely to be an overlap with a registrant's private life. We think it could be helpful to include in the social media guidance some reference to the courts having found that there is no reasonable expectation of privacy in connection with closed Facebook or WhatsApp groups or similar, if the content that is being posted amounts to a breach of professional standards, so that registrants are aware of the approach that is likely to be taken to what they may view as private communications.[49]

E.3 SEXUAL ABUSE

87 We consider that the current guidance in respect of sexual abuse does not require amendment beyond the points already identified under the heading Private Life above. We understand that the NMC is providing guidance and training to panel members in relation to sexual abuse, and has involved external organisations with

[48] Available at https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/social-media-guidance.pdf, accessed 31 August 2025.

[49] See for example *Cobban & Anor v DPP* [2024] EWHC 1908 (Admin); [2025] 1 WLR 256 at [84]–[100], in particular [93]–[95]; *R (Fijten) v GMC* [2020] EWHC 3800 (Admin); and *C v Chief Constable of the Police Service of Scotland* [2020] CSIH 61; 2021 SC 265.

expertise in this area to provide that training. Panel members have also been provided with the Crown Prosecution Service rape myths as part of the NMC's efforts to promote good quality decision-making in this sphere.

E.4 CRIMINAL PROCEEDINGS

88 The guidance on Investigating at the Same Time as Other Organisations[50] was last updated in February 2024. It says that "*if the police were investigating alleged criminal offending … the outcome could be relevant to on [sic] our own decision on whether we need to take regulatory action at all*". We do not doubt that the outcome could be relevant, but are concerned that this phrasing could lead to errors in decision-making. It might, for example, be read as prioritising the option of doing nothing if the outcome is acquittal. We suggest that the NMC considers the GMC guidance on this topic, which is more detailed and may include guidance that the NMC could usefully adopt, with the necessary changes.

89 We note the Independent Culture Review recommended[51] that there should be a clearly defined process for managing FtP cases when a criminal case is underway, including when they end with no further action. We understand this recommendation is in the process of being implemented.

E.5 FAMILY PROCEEDINGS

90 We have seen drafts of a new handbook and SOP to support decisions about referrals where there are also family court proceedings which are ongoing or which have been completed. These should ensure that careful thought is given to whether disclosure of family court documents and orders is needed. We note that the drafts at present focus on cases where there are findings of harm to a child, and we suggest that further guidance may be helpful in respect of cases where the allegations are of domestic abuse, in particular physical or sexual abuse of a partner. It appears to us that such behaviour

50 Reference: INV-6.

51 Recommendation 28, at page 120.

towards a partner may be potentially relevant in the FtP context even if there is no direct harm to a child. The draft documents rightly point out that each case will need to be considered individually.

91 We refer to the Independent Culture Review's recommendation in respect of concurrent criminal proceedings noted at paragraph 89 above. We suggest consideration is given to a similar task being undertaken in respect of referrals where there are family proceedings underway.

E.6 APPLYING GUIDANCE

92 We have seen evidence that guidance, particularly in the context of private life cases, was interpreted and applied very narrowly at various points in the FtP process. As set out, there have been a number of important changes to relevant guidance which should address this concern, and we have identified a few additional changes which may improve the guidance further.

93 Whatever the guidance says, it appears to us to be particularly important that everyone involved at each stage of the FtP process has the same shared understanding about what it means and how it should be applied.

94 The Independent Culture Review reported concerns from staff that legal opinions were over-prioritised. As lawyers, we can understand why legal opinions are prioritised in some circumstances, as they are usually sought in order to get a definitive answer or piece of advice on a difficult question, and are given with knowledge of the relevant caselaw. We think, from the information we have reviewed, that the overly restrictive approach to private life cases was encouraged by internal legal opinions. However, it is probably unsurprising that mistakes were made, given that the lawyers were seeking to apply guidance that was not sufficiently clear and consistent, and in a context where the wider strategic approach of the NMC appears to us to have been consistent with that restrictive approach.

95 We think that the NMC should ask itself the question, in particular, whether the views of the in-house lawyers about what the current guidance means and how it should be applied are shared by the NMC's non-legal decision-makers. We are not experts in

how to evaluate the understanding and application of the guidance across the different parts of the FtP process, but suggest that one possibility as part of any training for staff and panel members on the current guidance or any amended versions, would be for people from different parts of the process – case examiners, screeners and so on – to each consider the same fictitious scenarios to test for consistency and to unpick any differences in approach. Training provided across internal teams covering the entirety of the FtP process may be helpful in ensuring consistency of understanding and approach. We note that one idea put forward by a staff member was for training to take place not just across internal teams but across different health and social care regulators, who may well be grappling with similar issues.

96 We note that the Case Clinics which the NMC now runs, in which complex or difficult cases can be discussed in a group setting with people from across the FtP process, and the quarterly feedback on thematic learning from these clinics, has generated positive feedback from staff. We consider that any steps the NMC can take to monitor the implementation of guidance, in particular in the context of private life cases, would be valuable, to check that the change of approach has been embedded throughout the organisation. This could include asking staff for feedback on whether any of the guidance is unclear or confusing.

97 On the subject of training, we have seen that panel members received anti-racism training in 2023. It appears that this may have been a one-off, although broader training on EDI is given to all panel members as part of their induction process. We consider that anti-racism training should be an essential requirement before a new panel member sits on their first case. We are told that there is a mechanism by which panel members can raise concerns about other panel members if they identify concerning attitudes or behaviour, the effectiveness of which will need to be monitored carefully, given the known difficulties in obtaining this type of feedback, as reflected in the Independent Culture Review.

F Conclusion and list of areas for improvement

Our review of the 20 identified cases has found problems in the way some FtP cases were dealt with by the NMC in the period 2018–2023. In broad terms, the problems concern an overly restrictive approach being taken to what may constitute misconduct, in particular where the behaviour in question occurred in the private, non-working life of registrants. In the 'private life' cases we reviewed, we did not find any evidence that this erroneous approach resulted in the wrong outcome in those cases – internal and external systems operated to ensure that, ultimately, serious concerns were properly addressed. We have made a number of recommendations about further steps the NMC could take, to the extent that these areas are not already being addressed, which are summarised below.

F.1 REVISIONS TO GUIDANCE OR OTHER DOCUMENTS

1 Consider revising the explanatory text alongside principle 10 so that it is not read as an exhaustive list of relevant behaviour.

2 Consider amending the screening guidance to ensure it has a clear and unambiguous statement about misconduct covering both private and professional life, and a more comprehensive list of examples that aligns with other pieces of guidance.

3 Consider including in the screening guidance or elsewhere an account of why particular types of behaviour in a registrant's private life (such as sexual assault, physical violence, domestic abuse, racism and so on) might constitute misconduct and be relevant to FtP.

4 Revise all guidance that uses the term 'deep-seated attitudinal problem' in connection with racist behaviour to ensure that it cannot be interpreted as a threshold test for investigating or pursing a concern, and ensure that staff are updated on this change.

5 Consider amending the guidance on charging racism to make clear that an act includes written and spoken language as well as behaviour, and to ensure that use of racist language is charged if the language in question is objectively racist.

6 Consider providing further guidance to staff at the screening and investigation stage of the FtP process on how charges are drafted, in particular in the context of racism allegations, in order to ensure that the right evidence is obtained.

7 Consider reviewing the draft family court handbook to ensure that there is guidance in respect of cases where the allegations concern domestic abuse to a partner.

8 Consider guidance on what should happen if the NMC is unable to elicit any engagement from a registrant, irrespective of the reasons it appears to the NMC which are leading to the registrant's non-engagement.

F.2 OTHER AREAS

9 Consider adopting the recommendation of the Independent Culture Review for a clearly defined process for cases where there are ongoing criminal proceedings to cases where there are ongoing family court proceedings.

10 Consider additional strategies for evaluating and monitoring how guidance is understood and applied across the FtP process, to ensure a common understanding and approach. Consult staff for their ideas on this question.

11 Ensure that anti-racism training is carried out before any new appointee sits as a FtP panel member.

12 Identify to panel members a mechanism for raising concerns about the conduct or approach of other panel members, should they arise.

Victoria Butler-Cole KC
David Hopkins
39 Essex Chambers, London
September 2025

G Appendix: Instructions to Victoria Butler-Cole KC and David Hopkins

Introduction

1. In 2023 the NMC commissioned Ijeoma Omambala KC to conduct independent reviews of fitness to practise cases raised by an NMC whistleblower, and our handling of the whistleblowing itself. The agreed plan was to receive the reports in early 2024. There were a number of factors that caused delays in receiving a completed report, including waiting for the report of the Independent Culture Review and a subsequent wide-ranging grievance. For personal reasons, Ms Omambala KC was not able to deliver her reports within anticipated timescales. The reports have now been recommissioned. You have been formally appointed by our Council to investigate concerns raised by the whistleblower about the NMC's handling of a number of regulatory cases and Lucy McLynn, Partner at the law firm Bates Wells and Chair of the UK's leading whistleblowing charity Protect, has been appointed to investigate our treatment of the whistleblower, including the handling of their concerns. Further details are set out below. The concerns raised by the whistleblower have been raised internally and externally with the Charity Commission, the Professional Standards Authority and the Equality and Human Rights Commission, and a journalist at The Independent, Rebecca Thomas. Articles about the whistleblowing concerns were subsequently published in The Independent newspaper and other media outlets.

Investigating the concerns

2. The lines of investigation into the concerns raised are:

   2.1. **A review of our regulatory handling of the cases raised by the whistleblower, together with other cases that were raised subsequently.** This review will seek to establish whether there are any evident concerns with our decision-making in these cases, and consider whether there were cultural issues which may have influenced our approach to fitness to practise cases. Where possible, it will draw out common themes and areas for improvement in our handling of our fitness to practise casework and guidance.

   2.2. We will share with you information about regulatory casework research, policy development and training that we have undertaken since Autumn 2023 as this may

assist with your investigation. Examples of this include our Ambitious for Change research, the review of our guidance for decision makers in cases involving sexual misconduct, domestic abuse and safeguarding issues, training of panel members and NMC colleagues. We will publish your investigation report in full.

Terms of reference for the whistleblowing and casework investigations

3. The Terms of Reference for the original investigations were published in October 2023. You will conduct your investigation having regard to these.

4. Since the original investigations were commissioned, there have been a number of significant developments which impact on the relevance of the original terms of reference. Specifically:

   4.1. The People and Culture Investigation (now known as the Independent Culture Review, or "ICR") has now concluded, with the report published in July 2024. The outcome of this investigation will therefore not contribute to the ICR, but instead regard should be given to the ICR's findings, and their relevance to any issues identified within this investigation.

   4.2. The Professional Standards Authority have now completed their annual performance review of the NMC. The published report can be found here. The PSA will be updated with the outcome of this investigation, but it will therefore not feed in to their 2023-24 performance review of the NMC. It may however be referenced in their 2025 review.

5. You will lead the investigations about the regulatory casework, as set out in paragraphs 2.1 and 2.2.

6. Please review the information provided to you for the purpose of this investigation and identify and advise on any further information you require for the purpose of conducting a full and fair investigation. Please draft a report including your conclusions about our handling of the issues concerned, identifying key learning and making recommendations for improvement. The report is intended for publication and should therefore appropriately respect the privacy of individuals.

7. In addition to materials provided by the NMC, you will need to consider relevant material gathered by Ijeoma Omambala KC as part of the original investigation, including relevant records of interviews and other documents created in the course of the investigation. Ijeoma Omambala KC has been asked to provide documents and information directly to maintain the independence and integrity of the investigation.

Investigations

8. During the period leading to the publication of your report, we would like to keep our Council and stakeholders informed and would therefore ask that you periodically report on progress. Should any issues arise which may impact upon the delivery of the report to time, please notify us at the earliest opportunity.

9. Should you require contact details of key stakeholders within the organisation to speak with directly, these can be provided.

10. We have a duty of care to all NMC employees and all those affected by our regulatory processes. We need to ensure that we provide support for all those engaged in this investigation. If you identify anyone else you need to speak to once you have considered the documents provided to you by us and passed on by Ijeoma Omambala KC, if you identify anyone you would like to interview/re-interview as part of the investigations, we will work with you to ensure we provide appropriate support to all those taking part. All communications with those participating will need to be clear as to the approach of the investigation and its potential outcomes.

11. Ijeoma Omambala KC engaged with the whistleblower throughout the original investigation. Should you wish to speak directly with the whistleblower we will seek permission to share their contact details with you.

12. As outlined above, Lucy McLynn, partner at Bates Wells, has been instructed to conduct the separate investigation into the treatment of the whistleblower. It may be necessary to share information and/or findings from your respective investigations which you consider relevant. Contact details will be provided should you wish to discuss this.

Confidentiality

13. The whistleblower in this case has asked for their identity to be kept confidential and we are conscious that there are potentially aspects for this investigation where we will need to bear in mind our obligations under UKGDPR.

Materials

14. Bundles of documents have previously been prepared for the investigation. We will be providing material relevant to your aspect of the investigation.

Further information

15. We look forward to working with you and please let us know if you have any queries.

21 July 2025