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Reviewing cases after they get referred to the FtPC

Reference: PRE-1 Last Updated: 26/11/2018

Once our case examiners make the decision to send a case to the Fitness to Practise Committee our legal team reviews it.

Reviewing the case

Our legal team will consider the regulatory concerns identified by the the case examiners, then draft a charge, which sets out the particular facts in the case.

In some cases, the lawyer will also draft a statement of case, based on the information we hold. This explains our position on the things that have gone wrong, identifies the evidence about the concerns, explains why we say the nurse or midwife is not fit to practise, and what sanction order we think the panel should make. We don't do this in every case, because we are working to assess how helpful it is in cases where the nurse or midwife hasn't asked for a hearing, or given us a clear response to the concerns about their fitness to practise.

When we don't use a statement of case, we recommend to the Committee that a meeting would be the best way to resolve the case, but we don't provide our fuller, more detailed explanation of our position earlier on in the process.

If we do provide a written statement of our position (which we call an 'opening') before the panel considers the case at a final meeting, it will be much later in the process than if we were using a statement of case.

What we send to the nurse or midwife

After our legal review, we'll send the nurse or midwife the draft charge, and our statement of case, if we've drafted one, along with information about:

- which documents we gathered through the investigation that will be used as evidence (called the 'hearing bundle')
- the number of days we expect a hearing to last
- which witnesses we plan to rely on
- how the witnesses' evidence will be given to the panel
- whether we think the case needs to be joined together with another case.

Opportunities to respond

We give the nurse or midwife this information so that they have the opportunity to respond and tell us if they disagree with any of our decisions.

At this point the nurse or midwife can tell us whether they admit or deny any of the allegations.

They can also tell us of any other information that may help with our decision-making on the case. For example, whether they are currently working or have retired, or if they disagree with the evidence we are presenting about the case, or whether they want to apply for voluntary removal.

Finding the best way forward

We always look at our options to end the case in the way that best protects the public at the earliest opportunity.

Sometimes we may decide we don't need a full hearing, because nobody disagrees about the important issues in the case. When this happens, we'll usually seek to send the case to a private meeting of the Fitness to Practise Committee.

However, if the nurse or midwife wants a full hearing in their case by the committee they do have a right to it.

Find out more about how we deal with cases at meetings and hearings.

Once we understand whether or not there are clear issues between us and the nurse and midwife, we'll know how lengthy and complex the hearing is likely to be before the case gets to the Fitness to Practise Committee.

For example, if the nurse or midwife admits some of the allegations, we may not need to hear evidence from so many people which will enable us to keep the time, cost and complexity of fitness to practise, and the impact on the people involved in them, to a minimum.

Why do we have guidance on charges?

Reference: PRE-2 Last Updated: 26/11/2018

When we draft charges, we need to be consistent and transparent.

It's important that we are consistent and transparent when we draft charges in fitness to practise cases. This helps us make sure that:

- All of the people involved in our process are aware of the approach we'll take when we formulate charges about allegations of impaired fitness to practise; people such as:
  - case examiners
  - practice committee panels
  - the nurse or midwife facing an allegation
  - patients, families and loved ones, and members of the public
- We adopt a proportionate approach when we draft charges.

Jargon buster

Reference: PRE-2a Last Updated: 12/10/2018

In this guide

Allegations

One of our key statutory functions is to investigate allegations about the fitness to practise of nurses and midwives, or their entry in the register. Fitness to practise allegations involve us alleging that the nurse or midwife's fitness to practise is 'impaired'.

For this reason, when we first assess, investigate, and when our case examiners consider 'allegations', we define 'allegation' as meaning simply an allegation to the effect that the nurse or midwife's fitness to practise is impaired.

Regulatory concerns

During the early stages of a case we draft regulatory concerns to express what appears to have happened in a particular case, and why this set of facts justifies us intervening in the nurse or midwife's practice.

Charges

A charge only comes into existence when we send the nurse or midwife notice of their final hearing or meeting before the Fitness to Practise Committee.

Before then, if we any refer to a charge, we mean a 'draft charge'.

The notice of a substantive hearing will contain a charge 'particularising' (or setting out) the alleged facts on which the allegation of impaired fitness to practise is based.

The charge is the public statement of the basis on which we are saying the nurse or midwife's fitness to practise is impaired.

It will allege that the nurse or midwife's fitness to practise is impaired because of one or more of the following (as set out in our legislation):

- misconduct
- lack of competence
- a conviction or caution
- health
- not having the necessary knowledge of English
- a determination by another health or social care organisation.

So, the meaning of 'charge' within our rules is:

- an assertion that a nurse or midwife's fitness to practise is impaired, making particular reference to one of the kinds of impairment from our Order (for example, 'your fitness to practise is impaired by reason of your lack of competence'); and
- the schedule of alleged facts which we send together with a notice of hearing, which 'particularises' the allegation of impaired fitness to practise.

Additionally, in everyday language, people taking part in Fitness to Practise Committee hearings will often refer to one or more of the individual ‘alleged facts’ within a schedule of charge as ‘charge 1’, ‘charge 6(a)(ii)’, and so on.

General approach

Reference: PRE-2b Last Updated: 28/07/2017

In this guide

Proportionality

We will formulate proportionate charges which agree with our statutory functions of protecting the public and upholding the public interest, including the maintenance of public confidence in the professions and the regulatory body, and declaring and upholding proper standards of conduct and behaviour. Right-touch regulation emphasises the need to identify, quantify and understand risk, assess whether regulation is the right way to address the risk, and be proportionate and targeted in regulating the risk (applying only the right amount of 'regulatory force', having regard to the desired outcome of public protection).

We will make decisions about whether to include a particular factual assertion within a charge on the basis of the available evidence. The only factual assertions which should be included are those which can be proved on the basis of admissible evidence. Relevance and fairness are the criteria for determining whether any evidence should be admitted at a hearing. The more serious the charge, the stronger the evidence will need to be to prove it.[1]

Over-charging a case (including factual assertions which are unnecessary or oppressive) adds unnecessary complications to a hearing, and may be procedurally unfair.

For example, alleging dishonesty where a nurse or midwife has denied allegations of misconduct during an investigation conducted by an employer may be considered oppressive, particularly if the nurse or midwife continues to deny the conduct at the hearing. Such conduct can in any event be taken into account by the panel at the impairment and sanction stages of the fitness to practise hearing, whether or not it has been included in the charge.[2]

There may nevertheless be instances when it will be appropriate to include within the charge an assertion related to the nurse or midwife's response, when faced with allegations of misconduct or lack of competence. An example of this might be where the nurse or midwife has sought to deliberately cover up their conduct or its effects, or to implicate a colleague. In such cases the evidence may support a charge of dishonesty. In any event such conduct would (if supported by evidence) constitute a serious departure from professional standards, such as to justify its inclusion in the charge.

Under-charging a case (in the sense that the seriousness of the allegation is not reflected in the charge, for example because a particular factual assertion has been left out) means we may not have properly fulfilled our duty to protect the public and uphold the public interest. It may also lead to the High Court finding that the panel's decision has been unduly lenient and/or procedurally irregular.

Particulars of the charge

A charge must adequately capture the seriousness and extent of the allegation. It should specify how and why a nurse or midwife's conduct falls below the standard to be expected of a registered professional. It must contain enough detail to enable both the nurse or midwife and the panel to be aware of the seriousness and extent of the issues to be determined, and to enable the nurse or midwife to prepare their defence.

At the same time, the charge should be worded as clearly and simply as possible, avoiding unnecessary

background narrative. As a general guide, it is the conclusion to be drawn from the evidence (that the nurse or midwife hit patient A) that should be charged, rather than what a particular witness observed (the nurse or midwife was seen hitting patient A).

It is generally enough to describe a clinical failing without referring to any document (such as a trust policy) which may be relied upon as evidence of the nurse or midwife's obligations or standard of care required. Similarly, it is not necessary to refer to the sections of the Code which could be referred to by the panel when determining misconduct.

Where possible, it is preferable to use terms that are capable of objective, rather than subjective assessment. For instance, it is preferable to allege that an examination was 'not clinically justified' rather than to say it was 'inappropriate'.

Narratives describing any facts leading up to or following the conduct in question, which do not in themselves describe misconduct, lack of competence or any other conduct which can form a ground of impairment, should be left out of the charge. Where it is necessary to include such facts in order to make the charge clear, they should be described as concisely as possible.

Where the charge needs to assert the use of sexually explicit language or swear words, it may or may not be necessary to set out the language used. In some cases, a generic charge simply asserting that sexually explicit language was used to communicate may be enough to notify the nurse or midwife of the seriousness of the allegation. If more detail is needed, for instance in a case based on the sending of sexually explicit text messages, and the language used may be capable of more than one interpretation, the precise words used may be set out in a separate, private schedule.

It is only necessary to specify the nurse or midwife's place of employment or professional role at the time during which the alleged conduct took place if this helps to make the charge easier to understand, or is relevant to the seriousness of the charge. For example:

- if the allegation concerns patient neglect in a care home, the fact that the nurse or midwife was employed as a manager in that care home will be relevant to the charge.
- if the charge is of dishonesty concerning previous disciplinary proceedings brought against a nurse or midwife by a number of different employers.
- if the conduct in question has taken place in more than one setting. For example, the fact that a nurse or midwife is said to have sexually harassed colleagues or patients in more than one place of employment is relevant to the seriousness of the allegation as a whole.
- in a lack of competence case where it is necessary to describe where a formal capability assessment took place. See the lack of competence section for examples.

Including the places of employment in the charge in these particular circumstances brings out the full seriousness of the allegation and makes the charge easier to understand.
The dates on which the alleged conduct took place are always relevant to the charge, and wherever possible should be specified in relation to each incident. If it is not possible to specify dates then the charge should make this clear, for example by stating:

"On an unknown date between [date] and [date]…"

Repeated conduct

It is important not to overload a charge with assertions that add nothing to the overall seriousness of the allegation. The criteria for determining whether to include a particular assertion within the charge will be the seriousness of the conduct in question. This will be based on whether it has created or could create a risk or actual harm to patients, or whether it could impact on public confidence in the professions and the regulator. For example:

- in a charge concerning an inappropriate relationship between a nurse or midwife and a patient, it may not be necessary to particularise every inappropriate interaction between the nurse or midwife and patient that has taken place, since such a level of detail may not be needed to prove the full seriousness of the charge.
- on the other hand, the fact that any sexual misconduct has been repeated (particularly if against a number of

different people) is relevant to any allegation. It should be particularised as fully as is necessary to enable a fitness to practise panel to properly consider any public interest considerations, including risk to the public, as well as the reputation of the profession and the NMC.

In a serious dishonesty case where the evidence is strong and the level of public interest high, it may not be necessary to include more minor incidents in the charge, if these do not add to its overall seriousness. Repeated dishonesty will however always make any misconduct more serious, particularly where it has taken place in different contexts or against different persons or bodies. The fact that serious dishonesty has been repeated should therefore be reflected in the charge.

Where clinical errors are repeated it will be important for this to be reflected in the charge in order to demonstrate the potential risk to the public. In many instances however, more minor errors will not add to the overall seriousness of the charge and will not need to be included. Where serious errors are very high in number it may be necessary to include these in a schedule.

1 See Re H (Minors) [1996] 2 WLR 8 per Lord Nicholls
2 Nicholas-Pillai v General Medical Council [2009] EWHC 1048 (Admin), paragraphs 19-21

How a charge becomes final

Reference: PRE-2c Last Updated: 12/10/2018

Once our case examiners have considered an allegation, they decide there whether there is a case to answer, based on the statement of regulatory concern which we prepare during our investigation, drawn from the evidence we've gathered.

They will then refer the case to the Fitness to Practise Committee.

Once the case has been referred to the Fitness to Practise Committee, we'll identify which category of fitness to practise allegation the case falls into:

- misconduct,
- lack of competence
- criminal offences
- health
- not having the necessary knowledge of English
- or decisions by other health or social care organisations

We'll then draft a charge explaining this, and set out all the relevant facts on which the allegation is based.

When does the charge become the final version?

When we send the nurse or midwife the notice of hearing, it will contain the charge.

We must send this to the nurse or midwife no later than 28 days before the date fixed for the hearing.

If we've sent a notice of hearing more than 28 days before the date fixed for the hearing, and we want to change the charge contained within the earlier notice, we're allowed to do so, as long as we send a further notice of hearing containing the revised charge, no later than 28 days before the date fixed for the hearing.

If we do this, we'll always make it clear that the second notice is meant to replace the first notice.

Can the charge be changed less than 28 days before the hearing?

If we want to amend the charge contained within the notice of hearing, and the hearing is less than 28 days away, we'll have to make an application to the panel once the hearing begins. The panel, at any stage before making its findings of fact, may allow an amendment to the charge or the facts set out within the charge.

If we don't want to proceed with our case on all or part of the charge, we have to offer no evidence.

Practical drafting issues

Reference: PRE-2d Last Updated: 12/10/2018

In this guide

How we structure the charge

The charge follows a chronological order wherever possible. There may be exceptional cases where a different order will make it clearer to the reader, helping them to understand the charge.

For example, in a lack of competence case, it may be clearer to group the different facts by the type of clinical practice, rather than listing events chronologically.

We'll aim for a simple structure and try to avoid multiple clauses and sub-clauses where we can.

We use plain English whenever possible

Where we need to do so and it's appropriate, we'll briefly explain any clinical terminology.

The preamble, or introduction to the charge

As a general rule, the charge will start with:

> *"That you, a registered nurse [or registered midwife]…"*

Where it's relevant or necessary, the charge may refer to the nurse or midwife's professional role, or their workplace. For example, where a midwife's level of experience is relevant to the seriousness of a misconduct charge, the charge might read:

> *"That you, while employed as a band 6 midwife…"*

Another example of where a nurse or midwife's professional role might be relevant is in a charge of neglect or abuse of vulnerable patients in a care home. The preamble might then read:

> *"That you, while employed as a manager at Sandythorne Care Home…"*

Sometimes, we'll specify the dates between which we say the facts happened, at the beginning of the charge.

For example:

> *"That you, between 14 February and 30 June 2015…"*

Alternatively, where we identify the dates of particular incidents in the main part of the charge itself, we won't need to specify any dates in the preamble.

Except in the particular circumstances described above, it's rarely necessary for us to specify the dates of a nurse or midwife's employment in a particular place, since it's the dates of the period during which the conduct took place, rather than the dates of employment, which are relevant to the charge.

Charging facts in the alternative - 'and' 'or'

Sometimes, it may be appropriate for us to present the alleged facts in the alternative. For example, if the evidence shows that a nurse or midwife has either not administered medication, or has failed to record that they have administered medication, we may draft the charge to make this clear.

For example:

> *"On 1 January 2018, you failed to administer medication to Patient X or, in the alternative, failed to record that you had administered medication to Patient X."*

In other circumstances, where it's appropriate, we may use 'and/or'. We'll use this where the nurse or midwife could have done one thing or the other, or both.

For example:

> *"On 1 January 2018 you punched and/or slapped Patient A."*

We may also use 'and/or' where we want to allege that one or more of the things we say the nurse or midwife did, or failed to do, show that they had a motive or state of mind that makes the case more serious than it would be if it just made up of the actions themselves.

For example:

> *"On 1 January 2016 you kissed Colleague A.*
>
> *On 2 January 2015 you put your arm around Colleague A's shoulder.*
>
> *Your actions in charge 1 and/or 2 were sexually motivated."*

Schedules

We can use schedules to make the charges easier to understand.

For example, if we're alleging that a nurse or midwife has claimed sick pay while working elsewhere on a number of different dates, we'll include a general factual statement within the main body of the charge, alleging that the nurse or midwife has claimed sick pay while working elsewhere on one or more of the occasions set out in the schedule.

We'll then list all the dates in the schedule.

Where there are so many alleged facts that the charge could become unnecessarily long, we may condense these by the use of a 'sample charge'. By using a sample charge we'll keep the number of factual decisions the Fitness to Practise Committee needs to make to a minimum, while making sure that the charge captures the seriousness of the allegation.

For example, in a lack of competence case, a nurse may have failed to properly record appointments on hundreds of occasions over a period of years.

In a cases like this, we might only need to include a proportion of the incidents; the appropriate number will vary from case to case.

Occasionally, it may be necessary for us to include information in the charge which shouldn't be in the public domain. In such cases, a separate schedule may be used. This will be appropriate if we need to describe the nurse or midwife's state of health or, in rare cases, to particularise sexually explicit or offensive language.

Anonymity

We'll always anonymise the identity of individuals such as patients, colleagues, or members of the public in the charge.

We use standard formats such as: 'Patient A', 'Resident A', 'Colleague A' and so on.

We'll draw up an identification key, sometimes called a 'schedule of anonymity', to be used by all parties at the hearing and this is kept separate from the charge.

Particular features of misconduct charging

Reference: PRE-2e Last Updated: 06/04/2018

In this guide

Misconduct

A misconduct charge will usually start with a short preamble. The body of the charge should then contain a series of concise descriptions of the nurse or midwife's acts or omissions, which individually or cumulatively we say amount to misconduct, and wherever possible, the dates on which or periods of time during which we allege the acts or omissions occurred.

We will generally not refer to the sections of the Code that may be relevant to the Fitness to Practise Committee panel's consideration of misconduct. The Code will instead be used at the hearing as evidence of the obligations of the nurse or midwife.

The charge should conclude with an allegation that the nurse or midwife's fitness to practise is impaired by reason of their misconduct.

Serious clinical outcomes

If a patient died or suffered serious harm because of a nurse or midwife's clinical failings we may include the fact that the nurse or midwife caused that in the charges. Our guidance on investigating what caused the death or serious harm of a patient explains when we will do this, and why. It explains why we will not charge a nurse or midwife with causing death or serious harm to patients unless they deliberately chose to take a risk with the safety of patients or service users in their care. Evidence that the nurse or midwife's failings caused or contributed to the outcome will only be admissible if that is what we say in our charge.[1]

In cases where a patient died or suffered serious harm, but we have decided that is not part of our case against the nurse or midwife, applying the guidance on this question, we will still refer to the death or harm as part of the background. When we do this, we will make it very clear to the panel that we are not saying this made the nurse or midwife's clinical failing more serious.

Motivation

In general, we will only charge the motivation underlying a nurse or midwife's misconduct where either it is a necessary element of the misconduct, or it can separately be said to amount to conduct serious enough to impair a nurse or midwife's fitness to practise. For example, where inappropriate behaviour is sexually or racially motivated, the motivation must be separately charged, as it is a necessary component of the charge.[2]

There may be instances where the motivation for a particular act or omission in itself constitutes misconduct. For example, a failure to report a serious safeguarding concern could be motivated by a poorly judged decision to protect a colleague. In another case, such a failure may have been motivated by dishonesty (deliberately and knowingly misleading an employer with the intention to deceive). In the latter case, dishonesty should be alleged. In the former case, it may be appropriate to include a charge that the nurse or midwife deliberately put the interests of the colleague before those of the patient. This clearly demonstrates the alleged conduct is considered to be more serious than a negligent omission.

Dishonesty

Where we need to allege that a nurse or midwife has acted dishonestly, we will always identify the act or omission that we say was dishonest, and we will specifically allege that the nurse or midwife behaved dishonesty. Except where it is obvious from the conduct itself, we will also clearly explain why we say the alleged conduct was dishonest.

We will generally need to specify the nurse or midwife's dishonest intention. Dishonesty describes a state of mind rather than a course of conduct, and the nurse or midwife's acts or omissions will only be considered to be dishonest if they demonstrate they were intentionally seeking to mislead or wrongly take advantage of another person.

By way of example, if it is alleged that a nurse deliberately failed to disclose a conviction they received in 2010 for assault in an application form for work at a care setting, the charge may read:

> *"That you, a registered nurse:*
>
> *On 1 January 2017, failed to disclose on an application form to the General Nursing Home that you had been dismissed from your previous employment.*
>
> *Your actions as set out in charge 1 were dishonest in that you deliberately sought to mislead the nursing home by withholding this information."*

This describes the nurse's deliberate decision not to disclose the information to the nursing home in order to conceal their former dismissal from employment. It makes clear that on our evidence, the omission was not accidental or the result of confusion or poor judgment.

Another example might be where a midwife incorrectly documents the administration of medication. This may be due to simple carelessness, or it may be a deliberate attempt to conceal an error. In the latter case, the charge might read:

> *"That you, a registered midwife,*
>
> *Failed to administer Oxycodone to Patient A on four occasions on [date].*
> *Incorrectly signed Patient A's MAR chart indicating that you had administered Oxycodone on four occasions on [date].*
>
> *Your conduct in signing the MAR chart as described in charge 2 was dishonest in that in doing so you deliberately sought to represent that you had administered Oxycodone when you knew that you had not."*

In this example, it should be noted the term 'incorrectly' is used in charge 2 rather than 'falsely'. Use of the term 'falsely' to describe inaccuracy may cause confusion (because it implies dishonesty) and be unnecessarily duplicitous, given that dishonesty has been separately charged.

1 R (El-Baroudy) v General Medical Council [2013] EWHC 2894 (Admin)
2 See Council for the Regulation of Health Case Professionals v General Medical Council and Rajeshwar [2005] EWHC 2973 (Admin), in which the omission of an allegation that inappropriate conduct was sexually motivated was found to be procedurally irregular, and to have caused the panel's decision to be unduly lenient

Drafting charges in health cases

Reference: PRE-2f Last Updated: 12/10/2018

In this guide

Health allegations where nurse or midwife appears responsible for incidents

In cases where the concern about the nurse or midwife's practice involves their physical or mental health, we draft the charge depending on how their health condition has presented a risk to patients.

It is important that we are able to provide details and specific examples in the health charge, in order to explain to the nurse or midwife and the panel of the Fitness to Practise committee why we say the health condition is a source of concern.

For example:

- the nurse or midwife has done things as a result of their health condition,
- there is strong evidence about the incidents themselves, and
- sound medical evidence that the incidents would not have happened if the nurse or midwife did not have the health condition.

In these cases, our concern is about the way in which the health condition manifests itself to cause risks, rather than about blaming the nurse or midwife for their actions.

This means that we should consider the charge in terms of impaired fitness to practise by reason of health.

Separate concerns in cases involving health

If a case also involves a separate concern that doesn't have anything to do with the nurse or midwife's health, we could allege that their fitness to practice is impaired for more than one reason.

We would do this if there were separate regulatory concerns about:

- misconduct
- lack of competence
- criminal offending
- not having the necessary knowledge of English
- a regulatory decision by another health or care organisation.

In these circumstances, we could ask the Fitness to Practise Committee to consider these two or more regulatory concerns, based on two or more different factual backgrounds, at the same time, as part of the same charge.

Exceptional cases: health-related conduct incompatible with continued registration

In exceptional cases, there may be alleged incidents which are so serious that there would be a real risk to the public's trust in nurses and midwives if there was not an immediate striking-off order.

In these cases, the allegation should be about misconduct (or a conviction, if the nurse or midwife was convicted after the incident), even if the incidents would not have happened had the nurse or midwife not had a particular

health condition.

This is because in this small category of very serious cases, the immediate removal from the register can only happen if the case is based on misconduct or conviction.

This very unusual situation only arises in the most serious cases where the nurse or midwife could not be allowed to continue practising, for example, in cases where a nurse of midwife has deliberately harmed a patient because of a health condition they had.

Privacy

We respect the privacy of nurses and midwives and will not publish details of health conditions on our website. This information would be provided in a private schedule that would not be published.

A nurse or midwife should co-operate with the NMC if they are under investigation.

If a nurse or midwife has not co-operated with our investigation into their physical or mental health, we can consider adding this failure to co-operate to the allegations we consider.

This may be taken into account by the Fitness to Practise Committee when it determines whether or not the nurse or midwife's fitness to practise is impaired by reason of their physical or mental health.[1]

1 Rule 31(5)(b).

Other fitness to practise charges

Reference: PRE-2g Last Updated: 12/10/2018

In this guide

Lack of competence

Where we're alleging that the nurse or midwife's fitness to practise is impaired because of a lack of competence, we'll state that they failed to demonstrate the standards of knowledge, skill and judgment required of them over a period of time.

There are a number of ways we can do this.

For example, the preamble could read:

> *"That you, between 1 January 2015 and 1 January 2017 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 6 midwife."*

We'll then set out a series of incidents, in date order, which demonstrate a pattern of failings over that period of time.

These may describe an initial error or set of errors, and where it's relevant, we'll set out any further errors or incidents that might have happened when the nurse or midwife was being supervised, either formally or informally.

In some cases we might need to explain that the nurse or midwife has failed to demonstrate the skills needed when they under formal supervision by their employer.

The charge might then read:

> *"That you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 6 midwife in that:*
>
> *While subject to a Stage 1 formal capability process at St Paul's Hospital Trust you:*
>
> *On 1 February 2017, failed to recognise and/or escalate to a doctor abnormal decelerations in Patient A's cardiotocograph (CTG).*
> *On 1 March 2017, failed to give the correct dose of syntocinon to Patient B.*
> *On 1 April 2017, failed to recognise and/or escalate to a doctor abnormal decelerations in Patient C's CTG.*
>
> *While subject to a Stage 2 Formal Capability process at St Paul's Hospital Trust you…"*

Sometimes, we'll explain why we are alleging a lack of competence by showing in the charge that the nurse or midwife failed to meet objectives or pass assessments.

For example:

> *"That you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 6 nurse as follows:*

You failed to meet your medicines administration objective, in that you:

On 1 January 2017, while under supervision at St Thomas's Hospital Trust, attempted to administer twice the prescribed dose of co-codamol to Patient A.
On 4 February 2017, could not explain what tramadol was used for.
On 16 February 2017, while under supervision, poured out the wrong dose of lactulose for Patient B."

We'll finish the charge with the statement that the nurse or midwife's fitness to practise is impaired by reason of their lack of competence.

Conviction and cautions

If we're alleging that the nurse or midwife's fitness to practise is impaired because of a caution or conviction, the preamble simply needs to state,

"That you, a registered nurse…"

After this, we'll include the court of conviction, the date of conviction, and the offence. This information will be found in the certified memorandum or certificate of conviction or caution which we'll be using as evidence.

Because we are saying that it's the conviction or caution itself that affects the nurse or midwife's fitness to practise, we don't need to include details of the in the charge.

Any comments the court might have made during sentencing, or details of what the sentence might mean, can be referred to in evidence, if these are relevant to the panel's decision about the nurse or midwife's fitness to practise.

We'll end the charge with a statement that the nurse or midwife's fitness to practise is impaired by reason of their conviction or caution.

Not having the necessary knowledge of English

In a case about a nurse or midwife not having the necessary knowledge of English, the charge will generally read:

"That you, a registered nurse, do not have the necessary knowledge of English to practise safely and effectively and in light of the above, your fitness to practise is impaired by reason of your lack of knowledge of English."

Unlike the other fitness to practise charges above, we won't need to identify specific incidents that led to the charge. This is because we will generally rely on the results of an English language assessment, or the nurse or midwife's failure to follow our direction to take a test, as evidence.

Decisions by of another health or social care professional regulator or licensing body overseas

In some cases the allegation will be about the decision of another organisation responsible for the regulation of a health or social care profession in the UK (or a licensing body elsewhere), to the effect that the nurse or midwife's fitness to practise is impaired.

For example if the nurse or midwife is also registered to practice in another country and as a result of a fitness to practise investigation in that country, they were issued conditions on their practice.

When this happens, we won't usually need to describe the circumstances that led the other organisation to decide that the nurse or midwife's fitness to practise was impaired.

We only need to explain in the charge that this is what the organisation decided.

The charge could read:

"That you, a registered nurse on 1 January 2016 were reprimanded and made the subject of conditions by the Nursing and Midwifery Board of Australia and in light of the above, your fitness to practise is impaired by

reason of the findings of another body responsible for the regulation of nurses."

Multiple allegations

Reference: PRE-2h Last Updated: 12/10/2018

There are times when we might need to allege that a nurse or midwife's fitness to practise is impaired for more than one of the reasons set out in our legislation. For example a nurse or midwife's fitness to practise could be impaired because of misconduct and a conviction or caution.

The panel is only allowed to know about the conviction or caution once it has made a decision about the misconduct allegation.

When this happens, we'll list the allegations on separate pages and any documents about the conviction or caution will clearly state that the panel can't see them until it has decided on the facts about the alleged misconduct.

Sample document:

> *"That you, a registered nurse:*
>
> *On 6 January 2018 failed to administer insulin to Patient A as prescribed.*
>
> *Your actions as set out at charge 1 contributed to the death of Patient A. And in light of the above, your fitness to practise is impaired by reason of your misconduct.*
>
> *CONVICTION CHARGE – NOT TO BE SEEN BY PANEL UNTIL AFTER DECISION ON CHARGES 1 AND 2*
>
> *That you, a registered nurse:*
>
> *On the 7 July 2018 at the Oxford Crown Court were convicted of one count of assault occasioning actual bodily harm contrary to s47 of the Offences Against the Person Act 1861.*
>
> *And in light of the above your fitness to practise is impaired by reason of your conviction."*

We will make an exception to this approach if the misconduct has an obvious and close link with the conviction.

An example is the nurse or midwife has a criminal conviction or caution, and has deliberately concealed this from their employer, or from us. For example:

> *"That you, a registered nurse:*
>
> *1. On the 1 January 2016 at the Oxford Crown Court were convicted of one count of assault occasioning actual bodily harm contrary to s47 of the Offences Against the Person Act 1861.*
> *2. Failed to disclose the conviction set out in charge 1 to your employer.*
> *3. Failed to disclose the conviction set out in charge 1 to the NMC.*
> *And in light of the above your fitness to practise is impaired by reason of your conviction as set out in charge 1 above, and your misconduct as set out in charges 2-3 above."*

Sometimes, there may be cases made up some concerns about lack of competence, and some about misconduct, such as dishonesty. When this happens, we'll make sure the charge document is clear about which charges show a lack of competence and which charges show misconduct:

> *"…and your fitness to practise is impaired by reason of your lack of competence as set out in charges 1- 6 above, and your misconduct as set out in charges 7-8 above."*

Generally a panel will only consider one or two kinds of allegation, such as lack of competence or misconduct, but

there’s no formal limit to the number or combination of multiple allegations that a panel can consider.

Documents panels use when deciding cases

Reference: PRE-3 Last Updated: 12/10/2018

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Overview

In order to help panels of the Investigating and Fitness to Practise Committees consider allegations and make fair decisions, we provide them with the information we’ve obtained throughout the investigation in a group of documents called the document bundle.

This helps the smooth running of the decision-making process at a hearing or meeting.

In order to comply with our duties under information law we sometimes need to remove information from documents which are going before a panel. We do this in line with our information handling guidance.

The ‘fair and relevant’ test

Once a case has been referred to the Committee, one of our lawyers will review the evidence and decide which documents should form the document bundle.

The test as to whether information should be used in a hearing is that it is ‘fair and relevant’.[1]

This means that the hearing bundle should only contain material that is relevant to the charges being considered by the Committee.

At the hearing, if there is a disagreement as to whether evidence can be admitted, the panel will be provided with independent advice from the legal assessor. However the panel will make the final decision.

Witness statements

Where we have obtained witness statements, and we want to use those statements in evidence, we will provide the panel with a copy of the witness statement. If the case is at a hearing, we will do this when the witness gives their evidence.

We will also provide witness statements to the panel as evidence, if it has been agreed with the nurse or midwife. If the case is being decided at a meeting, we will provide the panel with all the witness statements in advance.

The nurse or midwife’s documents and evidence

The document bundle we give the panel contains the documents we are relying on to prove the allegations. It does not usually contain the nurse or midwife’s evidence or documents.

The nurse or midwife, or their representative, will often bring their own bundle of documents to rely on for their defence.

We leave this to them because we do not always know what documents the nurse or midwife might choose to use for their final hearing. They may have sent in information at earlier stages which they no longer wish to rely on, and it's unfair for us to make that decision for them.

However, as set out in the notice of hearing, if the nurse or midwife has sent in admissions or responses to the allegations, we'll give these to the panel.

The panel can then consider whether the nurse or midwife admits or denies any allegations, and may find allegations proven on the basis of the admissions.

Documents not originally in the hearing bundle

Sometimes, documents that are not originally included in the hearing bundle become relevant during the course of the hearing. This could be as a result of evidence given by a witness or the nurse or midwife. In these circumstances we try to provide the document to the panel.

If the nurse or midwife, or their representative, does not agree on the addition of the document, the panel, after hearing the advice of the legal assessor, will consider whether it is fair and relevant for it to be considered as evidence.

Informing the nurse or midwife

Before the case begins we'll inform the nurse or midwife, or their representative, what we propose to provide to the panel as the document bundle.

We do this either by sending a copy of the bundle, or an index, listing the documents. The nurse or midwife can use the index because we'll already have given them copies of the documents earlier on in our investigation.

This allows the nurse or midwife the opportunity to object to any documents or request further material be added to the bundle with the result being the content of the hearing bundle may change through the preparation of the case.

Where a nurse or midwife objects to us using a document, and we can't agree the issue between us, we won't include the document in the bundle we give to the panel in advance of them deciding the case.

Instead, we will have to apply to the panel to include the document as part of our evidence. If the panel agrees that the evidence is admissible and it accepts the document, we'll provide it to the panel separately.

Sending documents to the panel in advance

In some circumstances we may also send the document bundle to the panel in advance of the case.

We do this if the panel is deciding the case at a meeting.

If we do this for a substantive hearing, we will inform the nurse or midwife that we intend to give the bundle to the panel in advance of the hearing.

If the panel does not see the document bundle in advance, the panel will be provided with it during the course of the hearing. Our case presenter, and the nurse or midwife or their representative, will guide the panel as to the best way to be go through the bundle as they hear the evidence in the case. The legal assessor can also give advice about this.

1 Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules")

Gathering further evidence after the investigation

Reference: PRE-4 Last Updated: 12/10/2018

There are times when we may decide we need further evidence before the case will be ready for a final hearing.

There are a number of reasons for this:

- We have received new information that we need to investigate fully.
- We need further information that clarifies or expands on earlier evidence we obtained.
- A witness who wasn't previously available is now able to give us a witness statement about the events.

If a nurse or midwife is being investigated due to concerns that their health affects their fitness to practise, we may need to get up-to-date tests or medical reports. We may need these even if we already have a report, because the panel may need to know if anything has changed since the first report.

If we do have to get further information in order to prepare the case properly, we'll give the nurse or midwife a copy of any new evidence we've obtained and tell them if we plan to put this evidence in front of the Fitness to Practise Committee.

If the nurse or midwife has asked us to try and obtain further information to assist their case, we will consider this as part of our duties under disclosure.

Disclosure

Reference: PRE-5 Last Updated: 12/10/2018

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What is disclosure?

It's the process we follow during the investigation of a nurse or midwife's case and means we provide them with the evidence we've obtained.

We provide it because:

- we're going to rely on it to support our case
- it could undermine our case or support the nurse or midwife's case
- it makes sure that the process is fair
- it makes sure that the nurse or midwife is given enough information to properly respond to the allegations against them

We may also provide them with evidence that we don't intend to rely on to support our case. We call this 'unused material'.

Is there any information that we won't disclose?

We won't disclose any material that's subject to legal privilege. This means it contains confidential legal advice, or we could need to keep it confidential for other reasons.

When a nurse or midwife asks us to obtain evidence

There are times when a nurse or midwife may ask us to obtain evidence on their behalf.

This is because we, as a regulatory body, have the power to request the disclosure of documents from organisations or people that the nurse or midwife may not be able to get themselves.

Our legal team will consider whether the request meets our criteria for disclosure.

Although we don't have a duty to gather evidence asked for by a nurse or midwife, the nurse or midwife does have a right to a fair hearing and so we'll consider the following three criteria:

1. Is it relevant or essential?

For example:

A request for patient notes over a month period may not be relevant or essential if the allegation only concerns a medication error that occurred on one day. The nurse or midwife may need to explain why the requested material is essential for us to get.

2. What steps has the nurse or midwife taken to obtain the material themselves?

They should:

- have made attempts to get the information themselves before requesting us to get it for them.
- let us have the contact details of who to contact for us to make the request.

3. Are we better placed to obtain this material from the organisation or person that holds it?

It may be that because we have a statutory power to request information for the purposes of our investigation, we may be better placed to request the material than an individual nurse or midwife.

Notice of our hearings and meetings

Reference: PRE-6 Last Updated: 12/10/2018

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The amount of notice we give depends on the type of hearing, and we count the number of days' notice provided to the nurse or midwife from the day after the notice is sent.[1]

Our Rules specify how many days' notice we should give and the information the notice should contain.[2]

We will notify a nurse or midwife of any hearing in relation to their fitness to practise and give them the opportunity to attend. We will also notify a nurse or midwife of certain meetings and give them the opportunity to send in a written response.

Where do we send notices?

We have to send the notice of hearing by post. We use recorded delivery and provide the panel with a copy of the recorded delivery details.

We do not have to show that the nurse or midwife has read the notice, only that we sent it to the correct address, giving enough notice of the hearing in line with our legal requirements.

We send our notice of hearing to the nurse or midwife's address which is held on our register.[3]

Nurses and midwives are required to provide us with an up to date address for our register and they should inform us within 28 days of any change of details.[4] If the nurse or midwife hasn't given us their up to date address, we'll send any notice to the last known address, if it's more likely to reach them there.[5]

We'll make reasonable efforts to serve the notice on the nurse or midwife. However, information from a third party, for example from an employer or the police, won't mean we'll treat a new address as a 'last known address' unless the nurse or midwife has confirmed to us that it's the right address for us to communicate with them. We may have to send confidential and sensitive documents and need to comply with data protection requirements.

If we've been told that the nurse or midwife is represented, we'll also send a copy of the notice to the representative by post or email.[6] Sending notice to the representative is not an alternative and we only do this in addition to sending the notice to the nurse or midwife.

Notice of interim order

There's no minimum notice period for an interim order hearing, but the notice we give must be reasonable in the circumstances of the case.[7] There is no definition of what 'reasonable' notice is, but our interim order guidance gives more details on the approach we take.

We try to give at least seven days' notice of an initial interim order hearing, however this may be shorter in certain

cases where we need to restrict a nurse or midwife's practice as a matter of urgency. For instance, if the allegations are particularly serious, or we feel there are urgent public protection needs, we may need to send the notice less than seven days before the hearing.

If the nurse or midwife does not attend the interim order hearing a panel will decide whether the notice given is reasonable. A panel will consider:

- the nature of the allegation
- the primary objective of public protection, and
- the fairness of the interim order procedure as a whole.[8]

Because we will ask for interim orders only where there's an urgent need to restrict the nurse or midwife's practice, it may be reasonable to continue with a hearing even though the nurse or midwife might only have been given a few days' notice of the hearing.

If a panel makes an order and the nurse or midwife was unable to attend the hearing or provide detailed submissions because of the shorter notice period, we can schedule an early review of the order.

For review hearings we try to give fourteen days' notice, but there may be instances where we provide a shorter timeframe. Our guidance on interim order reviews gives further details.

We will usually review interim orders at private meetings if we are not aware of any changes in circumstances since the order was made. The nurse or midwife will not be sent a notice of this meeting in advance, and if they want their review to take place at a hearing, then we will arrange one.

Notice of preliminary hearing

We must send notices of preliminary meetings to the nurse or midwife no less than fourteen days' before the meeting is to take place.[9] The notice gives the nurse or midwife details of the date, time and venue of the preliminary meeting, and that they may attend in person, over the telephone, or provide written responses.

To help the nurse or midwife to prepare for the meeting, this notice will also include our reasons for holding the preliminary meeting, and a copy of any documents that we intend to show the Chair.

Notice of final, substantive order review or restoration hearings

We have to send notice of final (or 'substantive') hearings, and substantive order review or restoration hearings to the nurse or midwife no less than 28 days before the hearing.[10]

What's in the letter?

The date, time and venue of the hearing. If we have to change the venue for the hearing after the notice has been sent, we'll inform the nurse or midwife in writing where possible.

The letter also gives an explanation of the nurse or midwife's right to:

- attend, be represented and present their own evidence
- call witnesses to give evidence on their behalf
- cross-examine any witnesses that we call to give evidence.

It also states that a panel of the Fitness to Practise Committee (the panel) can proceed in their absence if they don't attend, and impose an interim order where appropriate.

We ask the nurse or midwife to tell us within 14 days of the notice being received, whether they plan on attending the hearing, and if they will be represented, or if they aren't attending, whether they'll be represented in their absence. We ask them to tell us this.

What's in the notice letter?

In cases where the allegations relate solely to a nurse or midwife's health, which mean that we hold meetings in private, the notice letter also gives the nurse or midwife the option to request that their hearing is held in public.

The notice of final hearing will contain a charge that sets out the allegations in detail, including the facts that the

panel will consider.

We ask the nurse or midwife to respond to the allegations and let them know that any admissions made will be taken into account by the panel considering their case.

We also tell the nurse or midwife of possible actions that the panel may take at the hearing. This includes the sanctions that a panel may impose on the nurse or midwife if their fitness to practise is found impaired.

For substantive order review or restoration hearings, the notice must contain a copy of the order made against the nurse or midwife at the final hearing, and the panel's reasons for making that order. If an early substantive order review is required, we will inform the nurse or midwife that the order is being held under the panel's power of early review.

In addition to our legal requirements, we include other information that we feel will help the nurse or midwife to prepare for their hearing. This includes links to our website about the hearing process.

Notice of final, substantive order review or restoration meetings

As with the notice of hearing, we send a notice of final (or substantive), substantive order review or restoration meeting to the nurse or midwife no later than 28 days before the meeting.

What's in the notice letter?

The notice doesn't give the exact date of the meeting, but it tells the nurse or midwife the earliest date the meeting could be held.

A charge that sets out the allegations in detail and includes any documents or evidence that we have not already sent to the nurse or midwife.

We ask the nurse or midwife to respond to these allegations within 28 days and inform them that any admissions they make will be considered by the panel considering their case.

We also set out the possible actions the panel may take at the hearing, which includes the panel's power to make an interim order, and the sanctions it may impose on the nurse or midwife if their fitness to practise is found impaired.

In the case of a substantive order review meeting, the notice will contain a copy of the order made against the nurse or midwife at the final hearing, and the panel's reasons for making that order. The meeting will be held before the substantive order expires.

Notice of resuming a hearing

Where a hearing has been postponed or adjourned to resume at a later date, we must notify the nurse or midwife of the date, time and venue of the resuming hearing as soon as we are able to do so.

There is no minimum notice period and there is no legal requirement for a resuming hearing notice to be in writing,[11] however, we will send the nurse or midwife confirmation of the date, time and venue following the adjournment, in writing where we can.

Before the hearing adjourns, we will try to agree the date, time and venue of the resuming hearing with the nurse or midwife, if they've attended. If everyone agrees during the hearing, the panel Chair will announce the details of the resuming hearing before the hearing adjourns.

If the nurse or midwife didn't attend the hearing, or it wasn't possible to agree on a resuming date, we'll confirm the details after the hearing, and send people the details as soon as we can.

1 Rule 34(5)(a) the Rules
2 The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules")
3 Rule 34(1)(a) of the Rules
4 General Medical Council v Olufemi Adeyinka Adeogba, General Medical Council v Evangelos-Efstathios Visvardis, [2016] EWCA Civ 162, paragraphs 21-23
5 Rule 34(1)(b) of the Rules
6 Rule 34(2) of the Rules
7 Rule 8(4) of the Rules
8 Rule 8(6) of the Rules

9 Rule 18(4) of the Rules
10 Rule 11(1)(b) of the Rules
11 Rule 32(3) of the Rules