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Reviewing cases after they are referred to the FtPC

Reference: PRE-1 Last Updated: 19/06/2023

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 review the regulatory concerns identified by the case examiners, then draft a charge, which sets out the particular facts in the case. We'll also review the documents that have been gathered during the investigation and decide which should be used as evidence in the hearing bundle, if the case goes to a full panel hearing or meeting. We'll also create an 'evidence matrix' which explains what evidence we think supports each charge.

We'll also set out why we think the nurse, midwife or nursing associate is not fit to practise and, if the facts were to be found proven, what sanction we think would be appropriate. Although any final decision is for a panel, we think it's helpful for the nurse, midwife or nursing associate to understand our position on these so that they can better tell us their views.

What we send to the nurse, midwife or nursing associate

After our legal review, we'll send the nurse, midwife or nursing associate the draft charge and our view on impairment and sanction 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
- whether we think the case should be considered virtually or at a physical hearing
- how the witnesses' evidence will be given to the panel
- whether we think the case needs to be joined together with another case.
- the evidence matrix, if one has been created.

Opportunities to respond

We give the nurse, midwife or nursing associate 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, midwife or nursing associate 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 agreed 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.

If we think a case should go to a meeting, we'll draft a statement of case which sets out a detailed explanation of what we think went wrong, what the evidence is and why we think the nurse, midwife or nursing associate is impaired.

We'll include any information on relevant contextual factors that we think may have a material impact on the incident(s)

and explain why. We'll also set out what sanction we think the panel should make. This is sent to the nurse, midwife or nursing associate in advance and provided to the panel at the meeting so that everyone can clearly see our position on the case.

However, if the nurse, midwife or nursing associate wants a full hearing by the committee they do have a right to it. We usually won't create a statement of case if a hearing is needed because our case presenter will be available to set out our position for the panel. We seek to hold case conferences in advance of a hearing to make sure our position is clear on outstanding issues and we understand the nurse, midwife or nursing associate's position.

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, midwife and nursing associate, 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, midwife or nursing associate 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 hearings, 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, midwife or nuring associate 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: 06/05/2025

In this guide

- Allegations
- Regulatory concerns
- Charges

Allegations

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

Regulatory concerns

During the early stages of a case we draft regulatory concerns to summarise what appears to have happened in a particular case, that raises questions about whether the professional's practice poses a risk to either of the following so that we need to take regulatory action:

- public safety
- the public's confidence in the professions generally or to professional standards.

Charges

A charge only comes into existence when we send the nurse, midwife or nursing associate 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, midwife or nursing associate's fitness to practise is impaired.

It will allege that the nurse, midwife or nursing associate'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, midwife or nursing associate'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: 01/10/2024

In this guide

- Proportionality
- Particulars of the charge
- Repeated conduct

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, midwife or nursing associate has denied allegations of misconduct during an investigation conducted by an employer may be considered oppressive, particularly if the nurse, midwife or nursing associate 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, midwife or nursing associate's response, when faced with allegations of misconduct or lack of competence. An example of this might be where the nurse, midwife or nursing associate 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, midwife or nursing associate's conduct falls below the standard to be expected of a registered professional. It must contain enough detail to enable both the nurse, midwife or nursing associate and the panel to be aware of the seriousness and extent of the issues to be determined, and to enable the nurse, midwife or nursing associate 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, midwife or nursing associate hit patient A) that should be charged, rather than what a particular witness observed (the nurse, midwife or nursing associate was seen hitting patient A).

t 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, midwife or nursing associate'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.

Narratives describing any facts leading up to or following the conduct in question, including description of contextual factors 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.

f there are relevant contextual factors that the panel need to be aware of these should be set out in the opening statement for the case. If the panel are making the decision at a meeting, they should be set out within the written statement of case. A factor will be relevant if it would have a material impact on the outcome of the case. It should be set out in the statement of case or opening statement whether a contextual factor is agreed between parties or whether t is in dispute and will need the panel to make a finding on it.

n cases where the regulatory concern relates to an exercise of professional judgement under the Code, it will be necessary to set out which aspects of the nurse, midwife or nursing associate's decision-making went wrong. For example, a charge that a nurse, midwife or nursing associate did not attempt cardiopulmonary resuscitation would need to specify why this was inappropriate, such as because it was not in line with the best available evidence, policies or guidelines or in the best interests of the patient. Where the regulatory concern is that it is not possible to identify whether the nurse, midwife or nursing associate exercised their professional judgement appropriately because inadequate records were made this should be charged separately.

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, midwife or nursing associate 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.

t is only necessary to specify the nurse, midwife or nursing associate'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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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.

ncluding 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

t 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 n 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, midwife or nursing associate and a patient, it may not be necessary to particularise every inappropriate interaction between the nurse, midwife or nursing associate 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.

Similarly, for other types of misconduct allegations where the same or similar conduct has been repeated over a prolonged period of time, it may not be necessary to include a charge for every single incident. The incidents selected for the charges should accurately reflect the overall seriousness of the allegations and the potential risk that the professional presents if they are left to practise without restriction. The evidence available will be an important consideration when selecting which incidents to proceed with charging.

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.

Proportionality and avoiding unnecessary charges

Where there are multiple examples of assertions relating to the nurse, midwife or nursing associate's conduct, we want to ensure that the charges we ask the Fitness to Practise Committee to make a decision about are necessary and proportionate. Proportionate charging means we should select for charging those assertions which:

- properly reflect the seriousness of the conduct alleged;
- reflect the period of time over which the alleged conduct has occurred; and
- if found proved, allow the Committee to deal appropriately with issues of impairment and sanction[3].

This approach means there may be evidence in our possession which could amount to misconduct but in respect of which we will not lay any charges because it would not be proportionate to do so. The decision not to include a charge which could amount to misconduct needs to be taken with considerable care; any evidence relating to matters not charged should not be included in the evidence bundle for the hearing or will need to be redacted out of the bundle. This means we won't be overcharging and will avoid the hearing becoming unnecessarily lengthy and complicated.

The decision as to what constitutes proportionate charging in any particular case will ultimately be a matter for the NMC's discretion.

Drafting charges where the nurse, midwife or nursing associate has not complied with undertakings

Where undertakings were agreed with the nurse, midwife or nursing associate but the nurse, midwife, or nursing associate doesn't comply with those undertakings; the case examiners may decide to revoke the undertakings and refer the concern to the Fitness to Practise Committee.

In these circumstances, the charges drafted should relate to the original regulatory concern rather than the failure to comply with undertakings[4]. We'll usually use evidence of the professional's non-compliance with the undertakings to show the Committee that they're not currently fit to practise.

There may be some cases where the failure to comply with the undertakings is so serious that it warrants referral to the Fitness to Practise Committee in addition to the charges relating to the original regulatory concern. For example, where the nurse, midwife, or nursing associate deliberately ignores the undertaking, and patient safety is put at risk.

For more information about failure to comply with undertakings, please see our guidance on undertakings.

[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

[3] This guidance reflects the advice given by the Court of Appeal in the case of Tovey & Anor v R [2005] EWCA Crim 530. Although *Tovey* is a criminal case we consider that the guidance given in that case is properly applicable to charges in fitness to practise proceedings.

[4] See Rule 6E(7) of the Fitness to Practise Rules

How a charge becomes final

Reference: PRE-2c Last Updated: 23/06/2021

Once our case examiners have considered an allegation, they decide 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.

If they decide there's a case to answer, they will 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 (or categories) of fitness to practise allegation the case involves:

- 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, midwife or nursing associate the notice of hearing, it will contain the charge.

We must send this to the nurse, midwife or nursing associate 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, we're allowed to change the charge that's contained within the earlier notice. We're allowed to do this, as long as we send a further notice containing the revised charge no later than 28 days before the date of 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 in 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, can allow an amendment to the charge or the facts set out within the charge. When considering whether to amend a charge, the panel will consider fairness and the overarching objective to protect the public.

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
- We use plain English whenever possible
- The preamble, or introduction to the charge
- Charging facts in the alternative - 'and' 'or'
- Schedules
- Anonymity

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 or nursing associate]…"*

Where it's relevant or necessary, the charge may refer to the nurse, midwife or nursing associate'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, midwife or nursing associate'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, midwife or nursing associate'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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate'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: 31/07/2026

In this guide

- Misconduct
- Serious clinical outcomes
- Motivation

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, midwife or nursing associate'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, midwife or nursing associate.

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

Guidance on charging dishonesty can be found in the Dishonesty guidance.

Serious clinical outcomes

If a person receiving care died or suffered serious harm because of a nurse, midwife or nursing associate's clinical failings we may include the fact that the nurse, midwife or nursing associate's misconduct caused the death or serious harm 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 that we will only charge a nurse, midwife or nursing associate with causing death or serious harm to someone receiving care if, in those particular circumstances, any reasonable and competent professional would have known that the misconduct alleged could have resulted in serious harm. Evidence that the nurse, midwife or nursing associate's failings caused death or serious harm will only be admissible if we bring a charge stating that the misconduct caused death or serious harm.[1]

In cases where a patient died or suffered serious harm, but we have decided not to bring an additional charge of causing death or serious harm, we may refer to the death or harm as part of the background of the case. We will, however, make it very clear to the panel that we are not suggesting that the nurse, midwife or nursing associate's misconduct caused the death or serious harm.

Motivation

This section provides detailed guidance about the circumstances where it will be appropriate to charge a racial or discriminatory motivation. Guidance on charging sexual motivation can be found in Sexual Misconduct.

Racially motivated misconduct

There may be times when we are concerned that the actions or behaviour of one of the professionals on our register demonstrates an underlying hostility or discriminatory attitude relating to race.[2]

If that is the case, then we are likely to need to consider charges that:

1. Specify the alleged misconduct, and
2. Specify that the misconduct was "racially motivated".

Racially motivated misconduct could cover a broad range of behaviour or situations, for example:

- Where somebody has said overtly racially abusive words to another person with the clear purpose of causing offence
- Where somebody has posted comments of a derogatory nature online as a means of "humour", or where somebody has engaged in conduct with a colleague that they consider to be "banter".
- Where a person has routinely singled out a more junior colleague for certain difficult or unpleasant tasks at work, and where the underlying concern is that the person setting the tasks is bullying the person based on their race or perceived race.

When deciding whether an act is "racially motivated" it is likely to be helpful to consider the following questions:[3]

- Did the act in question have a purpose behind it which at least in significant part is referable to race? and;
- Was the act done in a way showing hostility or a discriminatory attitude to the relevant racial group?[4]

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.[5] 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.[6]

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.

There may be cases in which a Panel could decide that the evidence of an underlying racial motivation is not made out, but nevertheless that the use of objectively racist language by the professional still constitutes serious professional misconduct. In those cases, it would be the potential impact of the use of the language that would be of concern to the Panel, irrespective of what the professional had in mind when they said it. Such a finding is likely to depend on the specific facts of an individual case.

Discriminatory motivation

The Equality Act 2010 makes it unlawful to discriminate against anyone based on the nine characteristics protected by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

In our guidance above we have talked about charging racially motivated misconduct. However, it's important to recognise that similar principles apply to the other characteristics protected by the Equality Act.

So, for example, where we consider that misconduct demonstrates an underlying hostility or a discriminatory attitude to people with disabilities, or based on a person's religion or belief or sexual orientation, the discriminatory motivation will need to be charged separately.

R (El-Baroudy) v General Medical Council [2013] EWHC 2894 (Admin)

s.9(1) of the Equality Act 2010 provides that Race includes (a) colour; (b) nationality (c) ethnic or national origins

The term "act" includes language (spoken or written) as well as behaviour.

See Lambert-Simpson v HCPC [2023] EWHC 481 (admin)

See PSA v GPhC and Ali [2021] EWHC 1692 (Admin)

See PSA v GPhC and Ali [2021]

Drafting charges in health cases

Reference: PRE-2f Last Updated: 30/10/2026

In this guide

- Health allegations where a nurse, midwife or nursing associate appears responsible for incidents
- Separate concerns in cases involving health
- Exceptional cases: health-related conduct incompatible with continued registration
- Privacy
- Failure to engage with an investigation into health

Health allegations where a nurse, midwife or nursing associate appears responsible for incidents

In cases where the concern about the professional's practice involves their physical or mental health, we draft a charge only if their health condition has presented a risk to public protection.Where health has played a part in the behaviours or conduct that led to a caution or conviction, we'll treat this as context rather than a separate charge.

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

For example:

- the nurse, midwife or nursing associate 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, midwife or nursing associate 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; it is never about blaming the nurse, midwife or nursing associate 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 professional's health, we could allege that their fitness to practise 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, midwives or nursing associates if there was not an immediate striking-off order. An immediate striking-off order is not a sanction that is available to a panel when they are only considering a health allegation, therefore the allegation should be about misconduct or a conviction even if the incidents would not have happened had the nurse, midwife or nursing associate not had a particular health condition.

This is because in this small number of very serious cases where the professional's health is a factor, the immediate removal from the register, through a striking-off order, 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 professional could not be allowed to continue practising, for example, in cases where a nurse, midwife or nursing associate has deliberately harmed a patient because of a health condition they had.

Privacy

We respect the privacy of nurses, midwives and nursing associates 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.

Failure to engage with an investigation into health

A professional on our register should co-operate with the NMC if they are under investigation.

If a professional 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. We will give the professional every opportunity to engage and also seek to understand why they may be unable to.

Ultimately, if they still do not engage and continue to decline to do so, we may need to consider adding further allegations. If there is a crisis in their health and they wish to engage but are currently unable to, we will consider if we can pause our process to allow them the time to participate in an informed way.

When considering adding a misconduct allegation in relation to a failure to co-operate, we will first consider whether the panel could instead take the failure to cooperate into account when considering impairment by reason of health.[1]

Taking the failure to cooperate into account at the hearing is likely to be more appropriate if the reason for the failure to cooperate is ill health, as this is in line with the NMC's values of being kind and fair. Our guidance on engaging with your case sets this out.

[1] Rule 31(5)(b).

Other fitness to practise charges

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

In this guide

- Lack of competence
- Conviction and cautions
- Not having the necessary knowledge of English
- Decisions by of another health or social care professional regulator or licensing body overseas

Lack of competence

Where we're alleging that the nurse, midwife or nursing associate'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, midwife or nursing associate was being supervised, either formally or informally.

In some cases we might need to explain that the nurse, midwife or nursing associate has failed to demonstrate the skills needed when they were 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, midwife or nursing associate 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, midwife or nursing associate's fitness to practise is impaired by reason of their lack of competence.

Conviction and cautions

If we're alleging that the nurse, midwife or nursing associate'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, midwife or nursing associate's fitness to practise, we don't need to include details of the sentence 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, midwife or nursing associate's fitness to practise.

We'll end the charge with a statement that the nurse, midwife or nursing associate'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, midwife or nursing associate 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, midwife or nursing associate'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, midwife or nursing associate's fitness to practise is impaired.

For example if the nurse, midwife or nursing associate 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, midwife or nursing associate'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, midwife or nursing associate'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: 01/10/2026

In this guide

- Overview
- The ‘fair and relevant’ test
- Findings of other organisations or bodies
- Witness statements
- The nurse, midwife or nursing associate’s documents and evidence
- Documents not originally in the hearing bundle
- Informing the nurse, midwife or nursing associate
- Sending documents to the panel in advance

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. This is 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 Fitness to Practise Committee, one of our lawyers will review the evidence and decide which documents, or parts of documents, should be included in the document bundle.

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

We’ll only put material in the document bundle that we consider relevant to the charges being considered by the panel, and fair to include.

At a hearing, if there’s a disagreement about if evidence can be admitted, the panel will be provided with independent advice from the legal assessor. However, the panel will make the final decision about if the evidence, including all or part of the document bundle, can be admitted.This may also include refusing to admit evidence which, without good reason, has not been served in accordance with case management directions.[2]

Findings of other organisations or bodies

Often another body or organisation[3] will have carried out some form of investigation into the matters being considered by the panel.

The underlying evidence relied on by another body or organisation are admissible and can be presented to a panel and may form part of the bundle) if they’re relevant to the issues being considered or the wider background.[4]

The weight that a panel will give to this evidence, which can include statements of fact and expressions of expert opinion, is a matter for the Fitness to Practise Committee to decide using its expertise and experience as an independent panel.

The findings of other bodies or organisations may be admissible as evidence before a panel.[5] However, before seeking to rely on them, we’ll carefully consider their relevance and the fairness of doing so.

Nurses, midwives, or nursing associates can contest charges before a panel. If there's a significant overlap between

he findings of another body and the issues before the panel, we won't usually include the other body's findings as vidence when we ask the panel to consider the charges.

he panel must not use the findings of another body as a substitute for reaching its own decision on the issues before t. The judgment or findings of another decision-maker on the issues before the panel are not relevant to the panel's lecision-making. It may also be unfair for the judgments to be a significant influence on the mind of the tribunal on the crucial issues before it for the same reasons.[6]

n these circumstances, it will be sufficient to include the underlying evidence relied on by the other body in the bundle, ather than the findings themselves.

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.

The nurse, midwife or nursing associate'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, midwife or nursing associate's evidence or documents.

The nurse, midwife or nursing associate, or their representative, will often provide their own bundle of documents to present their side of the case.

We leave it to them to decide which documents to provide to the panel because we do not always know what documents the nurse, midwife or nursing associate might choose to use for their final hearing. They may have sent us information at earlier stages which they no longer wish to rely on, and it's unfair for us to decide for them whether or not they should rely on any particular piece of evidence. We ask them to share as much as possible with us in advance. We may hold a case conference and a preliminary meeting in advance of the hearing; at the preliminary meeting the professional or the NMC may be directed to share evidence within a specific timeframe.[7]

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

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

Documents not originally in the hearing bundle

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

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

nforming the nurse, midwife or nursing associate

Before the case begins, we'll inform the nurse, midwife or nursing associate, or their representative, what we propose o 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, midwife or nursing associate can use the index because we'll already have given them copies of the documents earlier on in our nvestigation.

This allows the nurse, midwife or nursing associate 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, midwife or nursing associate objects to us using a document, and we can't agree the issue between us, we may ask for a case management direction ahead of the hearing or meeting.[8]

In other cases, we won't ask for case management directions, but instead we will apply to the panel to decide whether we can include the document as part of our evidence. The panel will be provided with the document so that they can decide whether it is fair for them to consider it as part of the evidence. If the panel agrees that the evidence is admissible it will accept the document into evidence. If the panel considers that the evidence isn't admissible, the professional panel will put the document out of its mind and will not rely on it in any way when making its decision.

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, midwife or nursing associate that we intend to give the hearing bundle to the panel in advance of the hearing.

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

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

. Rule 31(8) of the Rules

. Possibilities include criminal proceedings, civil proceedings, family court proceedings, inquests, internal investigations by employers, and external investigations or inquiries such as those conducted by ombudsmen or commissioned by local authorities or other public bodies.

. Enemuwe v NMC [2016] EWHC 1881 (Admin)

. Squier v General Medical Council [2016] EWHC 2793 (Admin) and Towuaghanste v GMC [2021] EWHC 681 (Admin)

. Hoyle v Rogers [2014] EWCA Civ 257

. Rule 17A of the FtP Rules

. Rule 17A of the FtP Rules

Gathering further evidence after the investigation

Reference: PRE-4 Last Updated: 03/03/2025

There are times when we may decide we need further evidence before the case will be ready for a final hearing. Our guidance on Our culture of curiosity sets out our approach to investigating concerns.

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.

  We have a duty[1] to make sure that we place sufficient evidence before the Fitness to Practise Committee so that it can understand what is alleged to have gone wrong in the nurse, midwife, or nursing associate's practice. If we need to gather further evidence to allow us to fulfil this duty we will do so.

  We also have a responsibility to be proportionate in our charging. This means that we should have enough evidence properly to reflect the seriousness of the conduct alleged; reflect the period of time over which the alleged conduct has occurred; and, if the charges are found proved, allow the committee to deal appropriately with issues of impairment and sanction. If we can do this with the evidence we already have then we won't need to gather further evidence because it won't be necessary or proportionate to do so.

- We have reason to think that there is evidence which was not available to the Case Examiners which shows that the nurse, midwife or nursing associate can now practise safely, kindly and effectively.

  Our overarching objective is to protect the public and our fitness to practise principles explain that this isn't about punishing people for past events. Where we consider that the best way to resolve a case may be for a nurse, midwife or nursing associate to return to unrestricted practice, we may ask the practitioner to provide us with up-to-date evidence, which was not available to the Case Examiners, to demonstrate that they are practising safely, kindly and effectively (for example, references, training records, etc). So long as the allegation against them isn't fundamentally incompatible with remaining on the register, we may then ask a panel to decide if this new information means there is still a realistic prospect of current impairment. We call this process 'offering no evidence' and have separate guidance on when we may do this.

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

[1] See PSA v NMC & Jozi [2015] EWHC 764 (admin)

Disclosure

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

In this guide

- What is disclosure?
- Is there any information that we won't disclose?
- When a nurse, midwife or nursing associate asks us to obtain evidence

What is disclosure?

It's the process we follow during the investigation of a nurse, midwife or nursing associate'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, midwife or nursing associate's case
- it makes sure that the process is fair
- it makes sure that the nurse, midwife or nursing associate 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, midwife or nursing associate asks us to obtain evidence

There are times when a nurse, midwife or nursing associate 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, midwife or nursing associate 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, midwife or nursing associate, they do 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, midwife or nursing associate may need to explain why the requested material is essential for us to get.

2. What steps has the nurse, midwife or nursing associate 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, midwife or nursing associate.

Notice of our hearings and meetings

Reference: PRE-6 Last Updated: 01/10/2026

In this guide

- Overview
- Where do we send notices?
- Notice of interim order
- Notice of preliminary meeting
- Notice of final, substantive order review or restoration hearings
- When will it be in the public interest to give less notice?
- Notice of final, substantive order review or restoration meetings
- Notice of resuming a hearing

Overview

The amount of notice we give depends on the type of hearing, and we count the number of days' notice provided to the nurse, midwife or nursing associate 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, midwife or nursing associate of any hearing in relation to their fitness to practise and give them the opportunity to attend. We will also notify a nurse, midwife or nursing associate 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 either by post or by email.

Where we send the notice by post, we use recorded delivery and provide the panel with a copy of the recorded delivery details. We send our notice of hearing to the nurse, midwife or nursing associate's address which is held on our register.[3]

Nurses, midwives or nursing associates 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, midwife or nursing associate 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 will send a notice by email where we have a confirmed email address.[6] We treat an email address as being confirmed if it is recorded on our register. If there is no email address held on our register, we can still send a notice to an email address which the nurse, midwife or nursing associate has:

- Used to communicate with us in the past;
- Told us about in the course of previous correspondence with us;
- Provided to us over the phone in response to a request for updated contact details.

We do not have to show that the nurse, midwife or nursing associate has read or accessed the notice, only that we sent it to the correct email or postal address, giving enough notice of the hearing in line with our legal requirements. However, where we have sent the notice by email, we will make reasonable efforts to contact the nurse, midwife or nursing associate where we have not been able to confirm they have accessed the notice. A letter sent by post is treated as being served on the day after it is posted. A letter sent by email is treated as being served on the day it is sent.

If a nurse, midwife or nursing associate informs us that they are unable to receive the notice of hearing electronically, we will serve it by post to their registered address. As with keeping their registered address up to date, it is the responsibility of the nurse, midwife or nursing associate to actively inform us of this in good time, otherwise we will send the notice of hearing electronically. We will, of course, provide paper copies of notices where this is necessary; this will usually be as a reasonable adjustment. Again, it is the responsibility of the nurse, midwife or nursing associate to inform

is in good time of any such reasonable adjustment.

We'll make reasonable efforts to serve the notice on the nurse, midwife or nursing associate. 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' or an email address as confirmed until the nurse, midwife or nursing associate 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, midwife or nursing associate is represented, we'll also send a copy of the notice to the representative by post or email.[7] Sending notice to the representative is not an alternative and we only do this in addition to sending the notice to the nurse, midwife or nursing associate unless we have the nurse, midwife or nursing associate's consent to send correspondence to their representative instead of themselves.

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.[8] 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, midwife or nursing associate'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, midwife or nursing associate 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.[9]

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

If a panel makes an order and the nurse, midwife or nursing associate 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 14 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, midwife or nursing associate 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 meeting

We will normally send notices of preliminary meetings to the nurse, midwife or nursing associate no less than 14 days' before the meeting is to take place.[10] The notice gives the nurse, midwife or nursing associate 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, midwife or nursing associate 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 or panel.

In some situations, we may send notice of the meeting to the professional less than 14 days before the meeting is due to take place.

This will be when:

- the professional agrees to less than 14 days' notice; or
- we think it is in the public interest for there to be a shorter period.

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, midwife or nursing associate.[11] Normally this will be 28 days' notice of the hearing. However in some situations, we may send notice of the hearing to the professional less than 28 days before the hearing is due to take place. This will be when:

- the professional agrees to less than 28 days' notice; or;
- we think it is in the public interest for there to be a shorter period.[12]

When will it be in the public interest to give less notice?

There will only be limited occasions where we will give reduced notice of a meeting or hearing without the consent of the professional. Before doing so we will need to decide that there are strong reasons why it would not be in the public interest to give the usual notice. Examples of when this might be include:

- The professional has been clear that they will not participate in the FtP proceedings or attend any hearing. In this situation there is no benefit to giving the full 28 days' notice;
- We know that the professional cannot attend the hearing, and this would not change if the hearing were delayed (or it cannot be delayed). For example, if the professional is expected to be a hospital inpatient for the foreseeable future;
- A shorter notice period is highly unlikely to prevent the professional from engaging in the hearing;
- There is a heightened risk to public protection, which outweighs the benefit to the professional of having the full notice period, and which can only be mitigated by the hearing being held. For example, we have received new information which increases the risk to the public very shortly before an order is due to expire.

There may be other occasions when it is in the public interest not to give the usual notice period. However, when deciding to give less notice than is usually required, the Chair must always consider the professional's right to a fair hearing, and consider whether the shorter notice period would disproportionately infringe on that right.

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, midwife or nursing associate in writing where possible.

The letter also gives an explanation of the nurse, midwife or nursing associate'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, midwife or nursing associate 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.

What's in the notice letter?

In cases where the allegations relate solely to a nurse, midwife or nursing associate's health, which mean that we hold hearings in private, the notice letter also gives the nurse, midwife or nursing associate 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

vill consider.

Ve ask the nurse, midwife or nursing associate to respond to the allegations and let them know that any admissions nade will be taken into account by the panel considering their case.

Ve also tell the nurse, midwife or nursing associate of possible actions that the panel may take at the hearing. This ncludes the sanctions that a panel may impose on the nurse, midwife or nursing associate if their fitness to practise is ound impaired.

For substantive order review or restoration hearings, the notice must contain a copy of the order made against the nurse, midwife or nursing associate 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, midwife or nursing associate that the order is being held nder the panel's power of early review.

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

When we tell the professional of a hearing where the notice period has been shortened, we will explain the reasons for his in the letter, for example why we consider that this is in the public interest, or that the professional consented to the shortened notice.

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 o the professional normally no later than 28 days before the meeting. However in some situations, we may send notice of the meeting to the professional less than 28 days before the meeting takes place. This will be when:

- the professional agrees to less than 28 days' notice; or
- we think it is in the public interest for there to be a shorter period.[13]

What's in the notice letter?

The notice doesn't give the exact date of the meeting, but it tells the nurse, midwife or nursing associate 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 o the nurse, midwife or nursing associate.

We ask the nurse, midwife or nursing associate 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 nterim order, and the sanctions it may impose on the nurse, midwife or nursing associate if their fitness to practise is ound impaired.

n the case of a substantive order review meeting, the notice will contain a copy of the order made against the nurse, midwife or nursing associate at the final hearing, and the panel's reasons for making that order. The meeting will be held before the substantive order expires. When we tell the professional of a meeting where the notice period has been shortened, we will explain the reasons for this in the letter, for example why we consider that this is in the public nterest, or that the professional consented to the shortened notice.

Notice of resuming a hearing

Where a hearing has been postponed or adjourned to resume at a later date, we must notify the nurse, midwife or nursing associate 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,[14]

however, we will send the nurse, midwife or nursing associate 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, midwife or nursing associate, 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, midwife or nursing associate 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.

. Rule 34(5)(a) the Rules

. The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules")

. Rule 34(1)(a) of the Rules

. General Medical Council v Olufemi Adeyinka Adeogba, General Medical Council v Evangelos-Efstathios Visvardis, [2016] EWCA Civ 162, paragraphs 21-23

. Rule 34 (1)(b) of the Rules

. Rule 34(1)(c) of the Rules

. Rule 34(2) of the Rules

. Rule 8(4) of the Rules

. Rule 8(6) of the Rules

0. Rule 18(4) of the Rules

1. Rule 11(1) of the Rules

2. Rule 11(2) of the Rules

3. Rule 11A 1 of the Rules

4. Rule 32(3) of the Rules