LAMPARD INQUIRY

FIRST WITNESS STATEMENT

of

Paul Rees, Interim Chief Executive and Registrar

Nursing and Midwifery Council

1. I, Paul Rees, make the following statement to the Lampard Inquiry on behalf of the Nursing and Midwifery Council (NMC). The statement, along with the accompanying exhibits, responds to two requests from the Inquiry under Rule 9 of the Inquiry Rules 2006, which were submitted to the NMC on 31 January 2025 and 14 March 2025 respectively.

2. I am the Interim Chief Executive and Registrar of the Nursing and Midwifery Council, having taken up this role on a 12-month contract on 20 January 2025. My predecessor Helen Herniman held the role of Acting Chief Executive and Registrar from 3 July 2024 until my appointment (and has since returned to her substantive role as Executive Director of Resources and Technology Services). Prior to that, Andrea Sutcliffe was the most recent permanent Chief Executive and Registrar of the NMC and held this role from January 2019 until July 2024.

3. I would first like to express my sincere condolences to the individuals who have suffered harm and to the families and loved ones of inpatients who have died. The NMC welcomes the opportunity to participate in this Inquiry and is committed to supporting its investigation to help deliver the changes necessary to protect the public and ensure such events do not reoccur.

4. This is my first statement to the Inquiry. The Inquiry has requested details of relevant NMC reports, referrals, investigations and fitness to practise proceedings in respect of NMC registrants working in, or in close connection with, the provision of Mental Health inpatient care in Essex between 1 January 2000 and 31 December 2023. Per the Rule 9 request dated 31 January 2025, we have provided

these details in the form of a spreadsheet titled "*NMC Fitness to Practise Cases in scope of the Lampard Inquiry"* (referred to in this statement as the "original Case List") [**Exhibit NMC/1**]. In response to the following Rule 9 request dated 14 March 2025, we have provided a revised version of this spreadsheet (referred to in this statement as the "revised Case List") [**Exhibit NMC/183**]. In this accompanying statement, I will explain how the information in these exhibits was obtained and give an overall summary of the materials.

5. I will set out this statement in two parts. To provide appropriate context, I will first explain the role and functions of the NMC (Part A), including an overview of the stages of our fitness to practise process and definitions of key terms, as specified in the Rule 9 request dated 31 January 2025. I will then summarise the data, evidence and materials provided to the Inquiry (Part B) with respect to the Rule 9 Request Annex, explaining the nature of the information shared, providing background on our approach to data management and historical changes to our fitness to practise processes, and highlighting any caveats or gaps in the data provided. I will title exhibited documents according to the Inquiry's Protocol on Witness Statements, using sequential numbers and the NMC's initials in the form "NMC/1", "NMC/2" etc.

Part A: The role and functions of the Nursing and Midwifery Council

6. The Nursing and Midwifery Council (NMC) is the regulatory body for nursing and midwifery professionals in the UK. We are a statutory body, established and governed by the Nursing and Midwifery Order 2001 ('the Order'), in accordance with s60 and s62(4) Health Act 1999. We hold a register of 841,367 nurses and midwives in the UK and nursing associates in England.[1]

7. Our over-arching objective is the protection of the public.[2] Our Order provides for us to pursue this objective in three ways:[3]

   a. Protect, promote and maintain the health, safety and wellbeing of the public

[1] Data correct on 30 September 2024, published on 2 December 2024
[2] Article 3(4) of the Order
[3] Article 3(4A) of the Order

b. Promote and maintain public confidence in the nursing and midwifery professions, and

c. Promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions.

8. These objectives are central to everything we do, and we want to make sure every nurse, midwife and nursing associate can provide good and safe care.

9. Our statutory obligations and powers are set out within the Order, which sets out that our principal functions are to establish standards of education, training, conduct and performance for nurses, midwives and nursing associates, and to ensure the maintenance of those standards.[4] Rules made under the Order regulate the performance of these statutory functions.[5]

10. Our core role is to regulate. We set, monitor and promote high education and professional standards for nurses and midwives across the United Kingdom, and nursing associates in England. We maintain the register of professionals eligible to practise, ensure that professionals continue to meet our standards throughout their careers, and investigate concerns about nurses, midwives and nursing associates.

11. To regulate well, we support both the public and the nursing and midwifery professions. We create resources and guidance that are useful throughout the career of the professionals on our register, helping them to apply our standards in their day-to-day practice and to use their professional judgement and decision making when addressing new challenges. We support both the public and individual professionals when they are involved in our fitness to practise investigations.

Our fitness to practise process and key terms

12. When a concern is raised about the conduct, health, or competence of a professional on our register, we investigate through our fitness to practise (FtP) process. We take regulatory action where needed to protect people who use health

[4] Article 3(2) of the Order

[5] The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (the Registration Rules) provide the powers to develop education standards.

and social care services and to preserve public trust and confidence in the professions.

13. Our fitness to practise process is set out in the Order and the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (SI2004/1761). The Order sets out that we can take action where a nurse, midwife or nursing associate's fitness to practise is alleged to be impaired by reason of misconduct, lack of competence, criminal conviction or caution, physical or mental health, not having the necessary knowledge of English, or where other relevant organisations have determined that their fitness to practise is impaired. To aid understanding of these terms and their regulatory application, we note the following:

    13.1. **Impairment:** In determining whether a professional's fitness to practise is currently impaired, our primary consideration is whether they can practise kindly, safely and professionally.[6] In making this assessment, we will consider the nature of the concern raised, including whether the professional has breached or is liable to breach a fundamental tenet of the profession (as outlined in the Code [**Exhibit NMC/2**]), whether they have acted or are liable to act dishonestly, and whether their actions have put or are liable to put a person receiving care at unwarranted risk of harm.[7]

    13.2. **Misconduct:** Nurses, midwives and nursing associates must act in line with the professional standards set out in the Code. If their conduct falls short of these standards so as to pose a risk to the public, undermine our professional standards or damage public confidence in the professions we regulate, this can be considered misconduct.[8]

[6] The concept of impairment is not defined in our legislation but has been developed over the years through a number of legal cases. Through these cases, we have established certain factors that should be considered when assessing a professional's fitness to practise. For more information, see the 'Impairment' guide in our online FtP guidance library (Reference: DMA-1).

[7] We do not consider the consequences of the professional's conduct when determining whether a finding of impairment is appropriate. However, we will consider the context of the error or conduct involved in the concern and the likelihood that the conduct will be repeated.

[8] We do not consider all matters of misconduct to be of regulatory concern and advise that these should, in many cases, be dealt with by employers in the first instance. We only need to become involved if the professional poses a risk of harm that the employer cannot manage effectively; further, we will only take regulatory action where there is evidence of serious professional misconduct. Our online FtP guidance library includes information about how we determine seriousness (Reference: FTP-3).

13.3. **Lack of competence:** Lack of competence would usually involve an unacceptably low standard of professional performance (judged on a fair sample of the individual's work), which could pose a risk of harm to people receiving care.[9]

13.4. **Criminal conviction or caution:** Where professionals on our register (or those applying to join) are subject to criminal charges, convictions or cautions[10], we will consider the possible effect on their registration and/or fitness to practise. We may take a range of measures (such as referring the concern to a fitness to practise panel), depending on the seriousness of the offence, the potential risk to the public and other factors.[11]

13.5. **Physical or mental health**: While we do receive FtP referrals on the basis that the professional has a health condition or disability, we will only intervene where we consider there to be a risk of harm to the public or to the public's confidence in the professions; for example, if the person's condition is not being appropriately managed and is affecting the quality of the care they deliver.[12]

13.6. **Not having the necessary knowledge of English**: When considering concerns regarding a professional's knowledge of English, we will primarily seek to assess any clinical impacts and whether the language concern poses a potential or actual risk of harm to the public (for example, by leading to clinical errors or failings in care), in order to determine whether the person's fitness to practise may be impaired.

13.7. **Determinations by other health or social care organisations**: The professionals on our register may also be registered members of other health and care professions and subject to regulation by other legal or licensing bodies, either in the UK or overseas. Where a third-party organisation has

[9] For more information, see our online FtP guidance library (Reference: FTP-2b).
[10] Excluding protected cautions and convictions.
[11] Further information on our approach to dealing with criminal cautions and convictions can be found in our online FtP guidance library (Reference: FTP-2c).
[12] Cases of ill-health will likely be better managed with the support of an employer and should not require regulatory investigation where the condition is being appropriately managed. While professionals may be signed off as 'unfit for work' due to ill health, this will not necessarily mean that their fitness to practise is impaired (Reference: FTP-2d).

determined that a professional's fitness to practise is impaired, we will generally need to take regulatory action and consider the potential implications for the person's nursing, midwifery or nursing associate practice and their ability to provide safe and effective care in the UK.[13]

Raising concerns about the professionals on our register

People who use services and members of the public

14. Patients and people who use services, their families, and members of the public can raise concerns with us directly. We are required to consider whether those concerns could mean that a professional's fitness to practise is impaired and to apply all stages of our fitness to practise process as appropriate.

15. We recognise that raising a concern and engaging with the fitness to practise process can be daunting for members of the public. We provide information on how to raise concerns via our website and helpline**.** Concerns must be made in writing and may be submitted through the online referral form on our website.

16. Our public-facing information advises that concerns may be raised directly with the nurse, midwife or nursing associate in question, or their place of work, in the first instance. We also signpost to NHS website information on how to raise concerns locally and to organisations that can support people raising concerns with the NHS (such as Healthwatch and the NHS complaints advocacy service), as well as the Care Quality Commission and Patients Association. However, members of the public will always have the option to raise a concern directly with us.

17. If an individual opts to raise a concern via our online referral form, they will be asked to provide:

    a. Details of the person they are raising a concern about

    b. A description of what happened

    c. Details of what they have already done to raise their concern, and

    d. Details of any other people who saw what happened.

[13] Further information on our approach to responding to determinations by other health and care organisations can be found in our online FtP guidance library (Reference: FTP-2f).

18. We also ask people to upload relevant information including medical records, emails or letters they have already sent about their concern. We offer support, including assistance with completing the online referral form and we update them as their case progresses through our fitness to practise process.

19. Our Public Support Service (PSS) was launched in October 2018 and provides support to people who have made or are involved in a fitness to practise referral. This includes patients, carers, families, colleagues and others. The service plays a key role in ensuring that raising a concern with us is accessible for all. The PSS helps to ensure that as an organisation we fully understand the concerns being raised with us and support people's needs to enable them to engage with the fitness to practise process. Colleagues in PSS can help individuals understand who we are and how our investigative process works. We help others to understand our regulatory decisions and the reasons for decisions. We also support people to deal with the impact the process can have on them.

20. To improve the experience of members of the public when making referrals to us, we introduced our referrals helpline in December 2022. The helpline does not accept referrals over the phone but offers advice on the NMC's role and the support we offer, including:

    a. Whether we are the right regulator to consider their concerns

    b. What information we will need from them

    c. What to expect when making a referral and indicative timeframes

    d. How referrals are progressed through our process, and

    e. Reasonable adjustments and additional support we can provide.

Employers

21. Employers can engage with us through our Employer Link Service (ELS), either via the Regulation Adviser (RA) who is allocated to their region or country or by contacting the ELS advice line. Since February 2021, we also have had a dedicated area on our website called 'Managing concerns: a resource for

employers'.[14] This contains a suite of resources to support employers to respond to concerns about a nurse, midwife or nursing associate's practice.

22. Our website explains what kinds of referrals should be made to us, and the different approaches employers can take given the context and type of concerns, including how they can work with us. We provide advice on when concerns can and should be managed locally and when a referral should be made to us.

23. In line with our statutory requirements and fitness to practise principles, we make it clear that referrals should be made to us where:

    a. Concerns pose a serious risk to people who use services and would be difficult to put right

    b. Local action cannot effectively manage any ongoing risks to people who use services

    c. Concerns require us to take action to protect public confidence in the professions and uphold standards.

24. If the employer is unsure whether a concern meets the threshold for referral, they can speak to a Regulation Advisor (RA), who can support the decision-making process as outlined above. If the RA considers the concern so significant that a referral should be made without delay (and there is not sufficient assurance that the employer will do so), the RA can escalate the concern and submit a referral to our Screening team themselves.

Whistleblowers

25. Where we receive whistleblowing concerns, we always act according to our legal obligations, which include giving careful consideration to a whistleblower's request that their identity should not be disclosed. However, if an issue is serious and requires a fitness to practise investigation, the information we receive and use to assess the allegations may expose the identities of referrers. We provide whistleblowing guidance for nurses, midwives, students or other members of staff

[14] Managing concerns: a resource for employers - The Nursing and Midwifery Council <https://www.nmc.org.uk/employer-resource/introduction-managing-concerns/overview/>

(both on our website[15] and as part of our *"Raising concerns: guidance for nurses, midwives and nursing associates"* [**Exhibit NMC/3**]) and we offer the same support to whistleblowers that we do to others raising concerns.

26. In the Screening section of our FtP guidance library,[16] we include guidance for referrers who wish to remain anonymous. We make clear that we may need to disclose the referrer's identity to refer a case to the Case Examiners or Fitness to Practise Committee. If the referral meets our screening requirements, we have the power to investigate and refer a case ourselves[17] without an external referrer.

Referrals made by the NMC

27. Where a concern has not been raised with us by an external referrer but it appears to the NMC that there may be a concern that requires investigation, or where we receive anonymous or whistleblowing concerns, the NMC has the power to investigate and refer a case ourselves under Article 22(6) of the Nursing and Midwifery Order.[18] We may choose to refer a case if we are made aware of information that could raise doubts about an individual's fitness to practise (for example, through the media or an anonymous complaint).

Self-referrals

28. Professionals on our register can refer themselves to us if they believe there to be a serious issue that could affect their fitness to practise or their ability to fulfil their role safely and without restriction. Under the Code, professionals are required to notify us if they have been charged with a criminal offence or received a caution or conditional discharge (excluding protected cautions and convictions), or if they have been disciplined by another regulatory or licensing body. Some professionals may also choose to self-refer for other concerns. However, our guidance is clear that in these circumstances self-referral is the individual's decision and may not be required, particularly where other measures are being taken to address the concern (for example, through local action by employers).

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[15] Whistleblowing to the NMC - The Nursing and Midwifery Council <https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/whistleblowing/>

[16] Screening - The Nursing and Midwifery Council <https://www.nmc.org.uk/ftp-library/screening/>

[17] Article 22(6) of the Nursing and Midwifery Order and Rule 2(A)(4) of the Fitness to Practise Rules.

[18] Article 22(6) of the Nursing and Midwifery Order and Rule 2(A)(4) of the fitness to practise rules

The stages of the FtP process

29. Where a concern is raised about the conduct or behaviour of a professional on our register, or their ability to meet our professional standards, we have a duty to investigate through our fitness to practise process. Based on this investigation, we will take regulatory action where necessary to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained.

30. Decisions at each stage of our fitness to practise process are made in accordance with our guidance which is publicly available on our website.[19]

Screening

31. Screening is the first stage in our fitness to practise process.[20] If we receive a concern about a nurse, midwife or nursing associate's conduct or practice, our Screening team completes an initial assessment of the referral, including an assessment of risk based on the information provided in the referral. We also have a dedicated safeguarding hub which identifies cases where safeguarding interventions are required and supports colleagues to manage and address these concerns. We assess whether a case may require an application for an interim order (see *Interim Orders*, p15 below). If we decide that an application for an interim order is necessary, we aim to list the application for a hearing to take place within 28 days of receipt of the referral.

32. We consider three questions at Screening stage:

    a. Step one – whether we have a written concern about a nurse, midwife or nursing associate on our register

    b. Step two – whether there is evidence of a serious concern that could need us to take regulatory action to protect the public, and

    c. Step three – whether there is clear evidence to show that the nurse, midwife or nursing associate is currently fit to practise.

[19] Fitness to practise library - The Nursing and Midwifery Council <https://www.nmc.org.uk/ftp-library/>
[20] Rule 2a(4) of the Fitness to Practise Rules.

33. Our Screening team can:

    a. Make enquiries to enable them to make a decision

    b. Decide to refer the matter for investigation, or

    c. Decide not to investigate at that stage.[21]

34. We are currently in the process of updating our Screening guidance,[22] with a focus on:

    a. More robust decision-making at an earlier stage, with a greater focus on risk and identifying those concerns that could require us to take regulatory action in order to ensure public safety, uphold public confidence in the professions we regulate and maintain professional standards

    b. A greater emphasis on notifying employers and other third parties about concerns which do not require action by us but may require action by others, and

    c. A more proportionate approach to making preliminary enquiries in Screening, with a view to making swifter decisions.

Investigations

35. Following a decision at the Screening stage to refer a matter for investigation, the Investigation team investigates the concerns, including gathering key information, documentation and witness statements. At both Screening and Investigation, we ask the professional to respond to the concerns made against them. This allows them an opportunity to reflect on the concerns raised and provide context to the case.

36. Once the Investigation team have concluded its investigations, the case is passed to Case Examiners to review and decide next steps.[23]

Case Examiners

[21] We also have a process where we can reconsider these decisions.
[22] We do not have a confirmed date for publication of the updated guidance but this is expected to be in Q1 of 2025-26.
[23] The process for referring an allegation falls within Article 22(1)(a) of the Order and (b) is further expanded in Rule 2A of the FtP Rules

37. Case Examiners review the concerns relating to the nurse, midwife or nursing associate's practice and the evidence gathered through our investigations. They assess[24] whether there is a realistic prospect that the Fitness to Practise Committee (FTPC) would find the professional's fitness to practise to be currently impaired.

38. To do so, they consider how likely it is that the FTPC would decide based on established evidence that:

    a. There is a case to answer on the facts, and

    b. The nurse, midwife or nursing associate's fitness to practise is currently impaired.

39. Case Examiners make decisions in pairs, with one being a registrant and one a lay person[25]. Case Examiners only decide whether there is a case to answer. They do not decide whether the case against the nurse, midwife or nursing associate is proven, whether the incidents in the case happened, or whether the nurse, midwife or nursing associate's fitness to practise is impaired.

40. The outcomes at this stage are:

    a. **No case to answer** – if Case Examiners decide there is no case to answer (either on the facts or on the question of impairment), there will be no further action, and the case will be closed. Case Examiners may choose to give the registrant advice which will be private and will not be published on the register. They can also choose to give a professional a warning which is published on our register for 12 months.[26]

    b. **A case to answer** – if Case Examiners decide there is a case to answer, they can either refer the matter to the FTPC for final determination or they can recommend undertakings. Undertakings are measures that a nurse, midwife or nursing associate agrees to take to address an issue with their practice, such as extra training. Undertakings are reviewed by Case Examiners to make sure the nurse, midwife or nursing associate has done

[24] Rule 6C of the FtP Rules
[25] Rule 2 of the FtP rules
[26] Guidance on the publication of fitness to practise and registration appeal outcomes is included as **Exhibit NMC/4**.

what they said they would. Details of undertakings are published on our register for the duration the undertakings are in force.

Investigating Committee

41. Before the introduction of Case Examiners in 2015, case to answer decisions were taken by the Investigating Committee. That Committee still exists and meets to consider:

    a. The making and reviewing of interim orders

    b. Cases relating to fraudulent or incorrect entry to the register, and

    c. Cases where the Case Examiners disagree on what the case to answer decision should be.

Adjudications

42. Where Case Examiners have made a referral to the Fitness to Practise Committee, the case will progress to the Adjudications stage of our fitness to practise process, meaning that a panel of the FTPC will consider the case at a meeting or hearing. The FTPC panel is independent and must make its own decision about a nurse, midwife or nursing associate's fitness to practise. In both meetings and hearings, there will be an independent legal assessor to give legal advice to the panel. We will determine whether a hearing rather than a meeting is desirable based on a number of factors. For example, a hearing may be required where there is a dispute about the facts that requires us to explore aspects of the case with relevant witnesses.

43. At a meeting, the panel makes its decision in private, based only on the documents that have been submitted. The nurse, midwife or nursing associate does not attend the meeting nor do any witnesses, although their written statements will be considered by the panel. Conversely, hearings are held in public and live evidence is presented to the panel. Anyone who gives evidence can be asked questions about their evidence by the other party and the panel. Nurses, midwives and nursing associates will always be able to have a hearing if they so wish.

44. The panel must decide on the balance of probabilities whether it finds the facts proved and whether those facts prove the charges in relation to the professional. The panel must then decide whether the professional's fitness to practise is currently impaired. If a determination of impairment is made, there are a range of sanctions (restrictions) that the panel can impose, by way of a substantive order.[27] These include:

    a. **Caution order**: The professional is cautioned for their behaviour but is allowed to practise without any restriction. Cautions can last between one to five years and are published on our register for the duration of the order.

    b. **Conditions of practice order**: If the professional receives this order, they are still allowed to practise but there are restrictions to what they can do. For example, they may be supervised during work or be instructed to go on specific training and provide reflections. Conditions last between one and three years and are published on our register for the duration of the order.

    c. **Suspension order:** The professional is not allowed to practise for a specified length of time. Suspension orders can last anywhere between one and 12 months and are published on our register for the duration of the order. After this time, the suspension order might expire, or it may be reviewed again at the end of the suspension period and extended.

    d. **Striking-off order**: If the professional receives a striking-off order, they are no longer allowed to practise or represent themselves as a registered nurse, midwife or nursing associate. Their name will continue to appear on our online register with the status 'Removed by a Fitness to Practise panel' next to their entry. This information must remain on the public register for five years from the date the order takes force. An individual who has been struck off can make an application to re-join our register after five years. The application will be considered by the FTPC to determine whether the person should be permitted to re-join the register.

[27] Panels may also decide that no sanction is needed if the concern has already been addressed through other measures (for example, if the professional made a clinical error but has since taken steps to strengthen their practice).

45. Our guidance on the publication of fitness to practise and registration appeal outcomes is included as **Exhibit NMC/4.**

Substantive order reviews

46. A substantive order review is where an FTPC panel meets to review a sanction order made at a final (or substantive) hearing or meeting. There are various reasons why a substantive order review may be required. For example:

    a. If sanctions have been imposed (e.g. a striking-off order) but new evidence or information becomes available that could impact the previous panel decision

    b. If the substantive order given is subject to an expiration period (this includes suspension orders or conditions of practice orders). Such orders will usually need to be reviewed before they expire, unless the panel that made the order has instructed that a review is not necessary

    c. If the professional who is subject to sanction (e.g. a caution order) requests an early review of the order.

47. Through the substantive order review, the panel will determine whether the existing order, or a different order, is required to protect the public and uphold our professional standards and will ensure that professionals subject to substantive orders are only able to return to unrestricted practice if their fitness to practise is no longer impaired.

Interim Orders

48. Article 31 of the Nursing and Midwifery Order gives us the power to seek and impose an interim order. Interim orders temporarily suspend or restrict a nurse, midwife or nursing associate's practice while their case is being investigated and may include cases of lack of competence, misconduct, poor clinical practice, health concerns or serious convictions. They can be made at any stage of the FtP process, as information indicating risk becomes available. Our Fitness to Practise Rules 2004 provide additional procedural provisions relating to interim orders. We have published guidance for interim orders [**Exhibit NMC/5**], which is reviewed and updated to ensure it reflects current case law. We published updates to our guidance most recently in December 2024.

49. There are two types of interim orders available under Article 31(2):

    a. **Interim suspension order** – the panel suspends the nurse, midwife or nursing associate's registration for up to 18 months.

    b. **Interim conditions of practice order** – the panel imposes conditions on the nurse, midwife or nursing associate for up to 18 months.

50. We can seek an interim order at any stage of the fitness to practise process[28] before a final decision has been made on the substantive case. Where a final decision is made by our FTPC, an interim order can be made at the same time as a condition of practice, suspension or striking off order.[29] Substantive orders do not come into effect until after the expiry of the appeal period[30] so this provides an important safeguard for this period. We will also regularly review throughout the life cycle of a case whether an interim order is required, taking account of any new evidence or changes to the level of risk.

51. The grounds for imposing an interim order are set out under Article 31(2). The Committee making the order must be satisfied:

    'that it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of the person concerned, for the registration of that person to be suspended or to be made subject to conditions'.

52. When deciding whether to impose an interim order, panels must consider the evidence which relates to the concerns we have about the professional's fitness to practise. While there is no evidential threshold set out in the NMC Order, there needs to be some evidential basis for the concern for the panel to decide what risks the concern presents, and whether they need to take any action in relation to those risks.

[28] Article 31(1)(a) of the Order
[29] Article 29(5) (a-c) of the Order
[30] Article 29(10) of the Order

53. An interim order may be imposed for a maximum of 18 months. Where an interim order has been put in place before a substantive decision has been made on the case, the interim order must be reviewed every six months.[31] We also must hold an early review of the order at any time '*where new evidence relevant to the order has become available after the making of the order'*[32].

54. The Committee conducting the review has no power to vary the original length of the interim order, but they can:[33]

    a. Revoke the order or any condition imposed by the order

    b. Confirm the order

    c. Vary any condition imposed by the order, or

    d. Change the type of interim order in place.

55. If it becomes necessary to extend an interim order timeframe, we must apply to the High Court in England and Wales, the Court of Session in Scotland, or the High Court of Justice in Northern Ireland, where appropriate, for an extension. There is no limit placed in the Order on the number of times an interim order can be extended by the Court. The Court also has powers to change the type of order in place.[34]

56. Our Order also outlines the circumstances where an interim order would cease to have effect.[35]

57. Once a case has been considered by an Interim Order (IO) panel, whether they impose an order or not, it automatically progresses to investigation from screening.

Agreed/voluntary removal and lapsed registration

58. Professionals who are subject to FtP proceedings can also apply to be removed from the register without the need for a full hearing. This process was called voluntary removal until 2023, when it was replaced by a new process called agreed removal. The key differences between agreed removal and voluntary removal are

[31] Article 31(6) of the Order
[32] Article 31(6) of the Order
[33] Article 31 (7) of the Order
[34] Article 31(9) of the Order
[35] Article 31(5) of the Order

that agreed removal does not require that the registrant accept the regulatory concern(s), and that individuals may apply for agreed removal at any stage of the fitness to practise process, including during a hearing. We only accept applications for voluntary/agreed removal where the regulatory concerns raised are not so serious as to be fundamentally incompatible with being a registered professional, and where the individual provides evidence that they do not intend to continue practising. If concerns are raised about a professional who has previously been granted voluntary or agreed removal, we keep a record of the concern for future consideration if the person chooses to apply for readmission to the register.

59. The voluntary or agreed removal process only applies to professionals who are subject to an actual or potential fitness to practise allegation, or a current suspension or conditions of practise order as a result of a fitness to practise hearing. Where individuals who are not subject to fitness to practise proceedings wish to be removed from the register, they can cancel their registration or let their registration lapse. If concerns are raised about a professional who is not currently on the register (for example, because their registration has lapsed), we will keep a record of the concern but will not progress the investigation at that stage. However, if the professional subject to the allegation applies for readmission to the register, we will consider the concern and seek further information to assess whether the applicant is capable of safe and effective practice.

Maintaining effective registration during fitness to practise investigations

60. We only have legal powers to investigate fitness to practise concerns about professionals who are currently on our register; we cannot investigate concerns about people who have already left the register. To ensure that we are able to complete our fitness to practise proceedings, our legislation provides that professionals who are subject to FtP referral will remain effective on our register while they are under investigation.[36] This provision applies even if the professional fails to revalidate or to pay their renewal fee (which would usually result in their registration lapsing). This ensures that professionals cannot avoid potential FtP

[36] Our public register indicates where professionals are not currently practising or where they are subject to sanctions, warnings or other restrictions on their practice.

proceedings through non-payment of registration fees or not meeting revalidation requirements.

Third party investigations

61. Individuals subject to fitness to practise proceedings may sometimes also be subject to investigations by third parties such as the police, employers and other regulators. When this happens, we can decide to place a case on hold if there are clear and compelling reasons to do that and it is in the public interest.

62. We issue operational guidance for our colleagues on how to deal with cases that are also subject to a third-party investigation [**Exhibit NMC/6**]. The aim of the guidance is to help inform decisions about whether our own fitness to practise proceedings should be put on hold while the third-party investigation takes place. We emphasise that we will do as much as we can to progress our own case, and that we will be proactive in seeking updates and assessing risk when our case is delayed.

Part B: Evidence and materials provided to the Inquiry

63. The Inquiry has requested the disclosure of information related to referrals, investigations, and fitness to practise proceedings in respect of registrants working in, or in close connection with the provision of mental health inpatient care in Essex between 1 January 2000 and 31 December 2023.

64. We are committed to supporting the Inquiry and we endeavour to provide any information available to us that will assist with the Inquiry's investigations. After receiving the Rule 9 request on 31 January 2025, we met with the Inquiry's Legal team on 4 February to discuss our evidence submission. We advised the team at that point that our ability to provide relevant and comprehensive information across the period of interest to the Inquiry was constrained, due to the way we hold our fitness to practise data and changes in how we have captured this data over the past two decades. We anticipated that our response to the Rule 9 request would include significant data gaps and that we would likely be unable to

supply information for all potential cases in scope across the entire relevant period. We also notified the Inquiry team that the original deadline of 28 February might not be feasible for us, due to the extensive resource required to obtain the relevant data.

65. We have sought to address these challenges constructively and to work around the identified constraints wherever possible. Through these efforts, we have been able to obtain case data across a longer timespan than we had anticipated in our discussions with the Inquiry team. Nonetheless, there are important caveats to note and areas where our information remains limited or incomplete, and we wish to be fully transparent in addressing these.

66. The final part of this statement includes a high-level summary of the case data we have identified as being in scope of the Inquiry's terms of reference (provided in full in the original and revised Case List exhibits). To give context for this summary, I would like to start by briefly explaining the type of fitness to practise information we hold, how we record this information, the changes in our approach over time, and the gaps and limitations in the data we have been able to obtain.

Historical context and changes to our processes

67. The Nursing and Midwifery Council was established in 2001, replacing the former UK Central Council for Nursing, Midwifery and Health Visiting (UKCC). Our fitness to practise procedures, as well as our systems for recording FtP referrals and case information, have evolved considerably since our inception. The following procedural and system changes are of relevance to the data provided in the Case List exhibits.

Changes to our fitness to practise procedures

68. Up until 2015, FtP cases subject to full investigation were heard by the Investigating Committee, which determined whether cases should be closed or referred onwards for final decision-making. The Fitness to Practise Committee was not established until 2017, and so referrals prior to this point were made to either the Conduct & Competence Committee (CCC) or to the Health Committee (HC), depending on the nature of the case. The Case List exhibits therefore list

the CCC and HC as final decision-makers in several cases, although these committees are now defunct.

69. In 2015, we established the role of Case Examiners (see paragraph 37 above) and transferred many of the Investigating Committee (IC)'s functions[37] to the Case Examiners. As such, some case to answer decisions listed in the Case List exhibits have been taken by Case Examiners and others by the IC.

70. In 2017, we established the Fitness to Practise Committee (FTPC) as the final stage in the FtP process, replacing the CCC and the HC, and Case Examiners were given new powers to give advice, issue warnings, and agree undertakings. Previously, Case Examiners only had powers either to close a case with no further action or to refer it for a hearing or meeting. The Case List exhibits indicate whether Case Examiner decisions have been taken under the remit of their original powers or their current powers in individual cases.

Changes to our systems for recording FtP referrals and case data

71. From 2001 to 2008, we maintained a paper-based records system for FtP referrals. While we have retained our case data from this period (which has been scanned into a digital archive), the data is unstructured, and case information is stored against the relevant professional's name and PIN only.

72. In 2008-9, we introduced our electronic FtP case management system (CMS), which captures all new fitness to practise referrals. FtP referrals are dealt with by case owners and allocated a unique case reference. As of 2009, we began recording structured data for all fitness to practise referrals through the CMS, including registrant details (such as the name, PIN and registration type of the professional subject to referral) and case progression information (such as the stage their FtP investigation has reached).

73. In 2017, we began logging additional case information, including the type of allegation made against the professional and their employer details. Recording this employer data has enabled us to log and identify FtP referrals associated with a given provider in a more consistent way. As the Inquiry seeks to investigate

[37] The Investigating Committee still exists but has a more limited remit; see paragraph 41 for details.

the circumstances of deaths at specific Trusts and providers, this FtP employer data is therefore of particular importance to identify cases in scope.

Methodology for obtaining the data provided to the Inquiry

74. On 10 February 2025, the Inquiry provided us with a list of hospitals and providers in Essex established as having provided mental health inpatient care within the relevant area and time period. We have used this list to help guide our review and identification of FtP cases in scope of the Inquiry's terms of reference.[38]

75. We can provide the Inquiry with information relating to referrals received from 2017 onwards. As structured employer data has generally been recorded in these cases, we have been able to cross-reference the employer data we hold with the list of providers supplied by the Inquiry, based on either the name of the Trust or provider and/or the relevant location name and postcode. For the latter, it has been necessary to undertake further manual review of the data to rule out cases that are not relevant. Details of post-2017 referrals and FtP proceedings obtained through this process are included (per the Rule 9 request) in the attached Case List exhibits and summarised at a high level below.

76. As discussed, prior to 2017, we did not consistently capture employer information against individual FtP referrals. As such, we are largely reliant on other data points, such as registrant names or PINs, to be able to search our pre-2017 data and retrieve any cases in scope of the Inquiry. Where we are provided with names and PINs, it is generally straightforward for us to identify related FtP information, including for referrals made prior to 2017. To date, however, we have not received any disclosure requests from the Inquiry regarding specific named individual(s), so the Case List exhibits do not include cases obtained through this methodology.

77. For referrals made prior to 2017 where the Inquiry has not been able to provide us with the names or PINs of specific individuals, there is no reliable mechanism for us to retrieve all relevant cases from our case management system in a

[38] The Inquiry subsequently provided us with a revised list of providers in scope on 5 March. However, we had already compiled our original Case List for submission by the 7 March deadline, and were unable to incorporate the new additions to the provider list at that stage.

systematic way. The volume of our historical FtP caseload also prohibits us from manually sifting all cases without first narrowing the search parameters. Therefore, while we have sought as far as possible to gauge the broad scale of FtP referrals related to the Inquiry's Terms of Reference, we have far more limited means to identify cases of relevance pre-2017.

78. Nonetheless, given the nature and scope of the Inquiry, we understand the importance of identifying individual cases of interest wherever possible, even where information is incomplete. In the absence of structured employer data, we have therefore sought to identify alternative markers to flag potentially relevant referrals made prior to 2017. For this purpose, we have reviewed "case party" data, which is a more longstanding unstructured data field and indicates where specific individuals or organisations (such as witnesses, third parties and referrer organisations) are linked to a given case on our CMS. We have been able to search this unstructured data for the providers in scope and to identify a longlist of 889 cases on this basis.

79. From this list, we have attempted to identify the specific provision in scope of the Inquiry and have been able to eliminate a proportion of cases based on certain indicators – for example, where the concern related to a midwife or where the type of allegation attached to the case suggested it was unrelated to nursing practice. We manually reviewed the remainder of the cases based on key case documentation (for instance, initial referral forms and decision documents) to determine if the case was in scope. Through this process, we have been able to identify several cases of potential relevance between 2010 and 2016, which are captured in the Case List exhibits.[39]

80. Referrals received from 2001 (when the NMC was established) to 2008 pre-date the introduction of our CMS system. For such cases, we only have unstructured FtP data, which has been scanned into an archive system and stored against a registrant's name and PIN only. This makes it extremely challenging for us to identify cases of interest to the Inquiry from that period, and we are unable to obtain relevant information without manually reviewing all archived files. We do

[39] This search included legacy case data for referrals received since 2000, for which we have limited data. However, all the referrals we identified as being potentially relevant to the Inquiry were received from 2010 onwards.

not have sufficient organisational resource to undertake such an extensive review. As such, the Case List exhibits do not include any cases from the period spanning 2001 to 2008.

Caveats and limitations to the data provided

81. While we have tried to ensure the quality and completeness of data provided to the Inquiry, it is important to note a number of caveats which may impact its relevance and reliability:

    a. As discussed with the Inquiry's Legal team, we do not hold comprehensive employer data for all FtP cases. While we established structured employer data coding in 2017, these data fields are not consistently completed by our operational teams across our end-to-end fitness to practise process. As such, there are gaps in our case data both before and after 2017, where employer details have not been recorded. We also capture employer information at a high level (e.g. the name of a given Trust) rather than, for example, recording the details of individual hospital wards linked to concerns. There is therefore a risk that some FtP cases in scope of the Inquiry's terms of reference may have gone unidentified in our search to date.

    b. We do not have specific data markers for cases relating to mental health care provision. As such, we are unable to state conclusively which referrals relate to mental health inpatient settings. While the Case List exhibits indicate which referrals involve registered Mental Health nurses, this does not necessarily confirm individuals' current (at the time of the referral) scope of practice or their work setting, as explained in paragraph 84 below. While we have manually reviewed case descriptions to identify those of potential interest to the Inquiry, this is not an exact science, and it is therefore not possible to guarantee the identification of all relevant cases. Equally, not all cases included in the Case List exhibits will necessarily be of interest to the Inquiry or in scope of the Terms of Reference. However, on the Inquiry's instructions, we have opted to err on the side of providing more data of potential significance rather than less, even if there are uncertainties about the relevance of individual cases.

c. As will be evident in the Case List exhibits, there are several other gaps in various data fields across the identified cases. This is because not all data fields are mandatory to complete as part of our FtP information recording process and so have not been consistently populated. Some fields are also more recently created and will not apply to older cases (for example, our current allegation coding system was set up in 2017 and so cases received prior to that will not have codes recorded). For the purpose of this Rule 9 disclosure, we have worked to obtain additional information to fill data gaps wherever possible, for example, through manual review of original case files. We regret that we have been unable to answer the queries in the Inquiry's Rule 9 request in all cases.

d. We have sought to be fully transparent in our disclosures and to provide all relevant case information in line with the Rule 9 request. However, the structure and limitations of our data have made it challenging to provide appropriate context for certain case outcomes detailed in the Case List exhibits. The Rule 9 request seeks information about our rationale where we have decided to close cases without investigation or opted not to progress to a substantive hearing. In response, we have provided information based on the obtainable data in our case management system (for example, recorded screening closure codes). However, this high-level data omits important context and nuance relevant to individual case outcomes and therefore provides an incomplete picture of the complex factors underpinning our fitness to practise decisions. As discussed, we have not had sufficient resource to undertake a closer review of individual cases within the timespan of this Rule 9 request. We recognise that the Inquiry may have outstanding questions or wish to seek clarification about our decision-making in specific cases. We welcome such queries and will endeavour to address them through more targeted review of our historical case records, wherever this is required.

Revised list of providers in scope of the Inquiry

82. On 5 March 2025, the Inquiry provided us with a revised list of hospitals and providers in Essex identified as being within scope of the Inquiry, to help guide our case review. As noted in email correspondence with the Inquiry Team, we

have not had sufficient time or resource to incorporate the additional providers into our case review at the time of writing. This means that there may be further FtP cases in scope of the Inquiry which have not been included within this Rule 9 submission. Noting the urgency of the Inquiry's investigation, we have committed to reviewing the additional providers as soon as possible to identify any other cases in scope. We will provide any further disclosures in the form of a supplementary statement in due course.

Additional notes to assist interpretation of the data

Registration of nurses and nursing associates

82. We regulate two nursing professions: nurses and nursing associates. There are key differences between the two roles[40]. Nurses will manage and coordinate care, taking the lead on assessment, planning and evaluation. Nursing associates will contribute to most aspects of care, including delivery and monitoring. We set education and proficiency standards for both nurses and nursing associates, and we maintain a separate part of the register for each profession.

83. In the nurses' part of the NMC register, there are four different fields of nursing practice which nurses can register in. These are Adult, Children, Mental Health and Learning Disability nursing. All nursing professionals will register in an intended field when they first join the register, based on their pre-registration qualification. Some nursing students may complete a dual award qualification (for example, a qualification that leads to practice in both Adult and Mental Health nursing). Alternatively, nurses may complete a post-registration qualification, enabling them to register in an additional field at a later date.

84. Notwithstanding their recorded registration field, the scope of an individual's practice may change over the course of their career through continued education, training and experience. As such, many nurses will work in a different area from the field they are registered in, meaning that their recorded registration field is not necessarily an indicator of their current role or scope of practice (for example, a

[40] For more information, please see Blog: Role differences between nursing associates and nurses - The Nursing and Midwifery Council <https://www.nmc.org.uk/news/news-and-updates/blog-whats-a-nursing-associate/>

registered Adult nurse may work in a mental health care setting). However, there are some legal powers that can only be exercised by nurses registered in certain fields; for example, only registered Mental Health and Learning Disability nurses may use the Nurse's holding power to detain patients under section 5(4) of the Mental Health Act 1983.

Allegation codes

85. As part of our FtP record keeping, since 2017 we have used a system of allegation coding [**Exhibit NMC/7**] to help capture the specific concerns raised through FtP referrals and investigations. These codes indicate the nature of the allegations made and the particular focus of the referral (whether this is made by an employer, member of the public or other third party). How we apply the codes in individual cases does not amount to any judgement by us as to the seriousness of the case, the perceived risk to patient safety, or (until a final case decision has been reached) whether or not the concerns are substantiated.

86. We may record multiple allegation codes against individual cases and the allegation codes we apply may change through the trajectory of a case. We apply allegation codes at three main decision stages:

    a. Screening (before or as part of the initial assessment decision)

    b. Case Examiners (as part of case to answer decisions), and

    c. Adjudications (as part of the substantive hearing or meeting outcome).

87. While allegation codes can be applied to a case at any of these stages, the allegations can only be proven at the adjudication stage, once a case has been decided by an FTPC panel via a substantive hearing or meeting.

Employer locations

88. As detailed at paragraph 82 of this statement, on 5 March 2025 the Inquiry provided us with an expanded list of hospitals and providers to help guide our case review. In the follow-up Rule 9 request received on 14 March, the Inquiry requested that we review our original Case List [**Exhibit NMC/1**] and remove locations which are not within the expanded list and/or which appear to be

community-based units. Where there is a particular reason for a location not within the list to remain, the Inquiry requested that we provide a brief explanation as to why.

89. In the revised Case List [**Exhibit NMC/183**], we have retained cases linked to a number of locations that we believe may be of interest or relevance to the Inquiry, but which are not named on the list of providers shared 5 March. One such location is Goodmayes Hospital, which is managed by North East London NHS Foundation Trust. We have identified 38 cases linked to this location, relating to the provision of mental health inpatient care. We consider that these cases have the potential to fall within scope of the Inquiry's Terms of Reference and have therefore included them in the revised Case List for the Inquiry's consideration.

90. The revised Case List also includes a number of locations which are not named in the list of providers shared 5 March, but which are managed by one of three providers in scope of the Inquiry: North East London NHS Foundation Trust (NELFT), Essex Partnership University NHS Foundation Trust (EPUT) and The Priory. As these providers are in scope and the cases in question relate to the provision of mental health inpatient care, we have elected to include them. The cases are linked to the following locations: South Forest Centre (NELFT); Barking Community Hospital (NELFT); Clacton Hospital (EPUT); Grays Court Community Hospital (NELFT); Lakes Acute Inpatient Unit (EPUT); Latton Bush Centre (EPUT); Mayflower Community Hospital (NELFT); Priory Hospital Colchester (The Priory); Rectory Lane Health Centre (EPUT); Robin Pinto Unit (EPUT); The Gables (EPUT); and Wanstead Hospital (NELFT).

Overview of fitness to practise case data in Exhibit NMC/183

91. As of 31 January 2025, we have identified a total of 149 historical and current fitness to practise cases that may be in scope of the Inquiry's terms of reference, noting the caveats above. Of the cases identified, the earliest referral was received on 15 September 2010 and the most recent on 2 June 2023.

92. Of the 149 total cases, 124 are now closed, while 24 remain open due to ongoing FtP proceedings. One further case requires a substantive order review and therefore remains open on our systems for monitoring and compliance purposes.

Of the cases subject to ongoing FtP proceedings, three are currently at Screening stage, 15 are under investigation, and 6 have reached the adjudication stage and are pending a substantive hearing or meeting outcome.

93. The referrals in scope involved 133 nurses. There are a further 16 referrals where the individual's registration type is unknown as there is no NMC PIN linked to the case. Of the nurses subject to referral, 117 are or were registered as Mental Health nurses, 14 as Adult nurses, two as Children's nurses and three as Learning Disability nurses.[41] One was recorded as being a General nurse, which is not a current registration field. Five nurses are also recorded as holding a specialist community public health nurse (SCHPN) qualification, in addition to their primary registration field.[42]

94. Employer details have been recorded for all referrals. In the majority of these referrals (136), the recorded employer was an NHS Trust. In 13 cases, the recorded employer was an independent health and care provider. The providers linked to the highest number of FtP referrals (as the recorded employer rather than as the referrer) are North East London NHS Foundation Trust (48 referrals) and Essex Partnership University Trust (43 referrals).

95. The majority of referrals in scope were made by employers (84 referrals). 30 referrals were made by patients, family members or members of the public, while eight referrals were made by the professional's colleagues or other medical or health professionals. Four referrals were made by the police and in one case, a professional self-referred to the NMC. In 14 cases, we used our powers under Article 22(6) to make a referral ourselves. Five other referrals were made by anonymous or unknown referrers.

96. In terms of the broad allegations that have formed the basis of initial referrals,[43] 140 allegations have related to misconduct, six to lack of competence, three to

[41] Four nurses in the Case List are recorded as being registered in both the Adult and Mental Health nursing fields.
[42] This is a post-registration qualification which leads to an additional entry in the part of the register for Specialist Community Public Health Nursing (SCPHN).
[43] Some referrals have been made on the basis of multiple allegations. The noted allegations reflect how referrals have been broadly categorised for the purpose of our records. They do not reflect the nuances of individual cases, where there may be a variety of complex concerns raised.

physical or mental health concerns and one to police charges, cautions or convictions.

97. Across the 146 referrals that have received an initial assessment decision to date, 65 were closed at screening and 81 were progressed for further investigation. Three cases currently have an initial assessment decision pending.

98. Across the cases that were closed at screening and did not progress to investigation, we have recorded reasons for the case closure in 50 cases (the remaining 15 cases do not have reasons recorded). Of those with reasons recorded, 49 cases were closed either due to insufficient evidence to substantiate the concerns, or because the concerns were not considered to be serious enough to meet the threshold for potential FtP impairment (in these cases, the professionals involved may still have been subject to other measures, such as local action by an employer or a criminal sanction). In six cases, the investigation was not progressed either because the individual subject to allegations could not be identified or was not on our register. In three cases, the concerns were seen to have been remedied, meaning that there was clear evidence to show that the individual was currently fit to practise. Other cases were closed for administrative reasons (for example, duplicate cases).

99. In 30 cases, the Case Examiners or the Investigating Committee (IC) acted as the final decision-maker and did not refer the case on to the Fitness to Practise Committee or the Conduct & Competence Committee, having found that there was no case to answer. In all of these cases, Case Examiners decided that no further action was required.

100. Following case to answer decisions, 36 cases were referred on to the Fitness to Practise Committee or the Conduct & Competence Committee for adjudications. One of these cases remains open for a substantive order review. 29 cases have been heard and decided by the FTPC or CCC, and of these, the Committee determined there was no fitness to practise impairment in five cases. Of the 24 cases where the Committee found there to be a fitness to practise impairment, one or more sanctions were issued in all cases (in four of these cases, the Committee issued a caution, four received a conditions of practice order, 13 received a suspension order and six received a striking-off order). There

are 6 cases remaining, as of 31 January 2025, which currently await a Committee hearing or decision.

Statement of Truth

I, Paul Rees, believe the content of this statement to be true.

I/S

21 March 2025