Conduct and Competence Committee
Substantive Hearing
6 – 13 December 2016
and
27 – 29 March 2017
Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant Nurse: Carol Marston
NMC PIN: 88E0311E
Part(s) of the register: Registered Nurse – Sub Part 1 (28 July 1991)
Registered Midwife (2 August 1999)
Area of Registered Address: England
Type of Case: Misconduct
Panel Members: Joy Julien (Chair - Lay member)
Julie Tindale (Registrant member)
John Liddington (Lay member)
Legal Assessor: Leighton Hughes
Panel Secretary: Zara Raza
Mrs Marston: Present and represented by Wendy Hewitt, Counsel, instructed by Richard Nelson
Solicitors
Nursing and Midwifery Council: Represented by Monwara Shah, Case Presenter, instructed by the NMC Regulatory Legal Team (December 2016)
Represented by Tania Dosoruth, Case Presenter, NMC Regulatory Legal Team (March 2017)

Facts proved: Charges 2 and 6
Facts proved by admission: Charges 1, 3, 4 and 5
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This is a joint registrant case. Your case is linked with the case of Mrs Anne Mather.

Charges:

That you, a registered midwife, whilst employed by the Mid-Staffordshire NHS Trust, on the night shift covering 23 to 24 December 2012:

1. Did not administer 150mg Ranitidine to Service User A every six hours during her labour, and/or did not record the reason for not administering 150mg Ranitidine to Service User A;
2. Between 19:30 and 22:45 on 23 December 2012 did not offer and/or did not document that you offered Service User A the opportunity to use the toilet or a bedpan;
3. Did not record the hourly assessment stickers of Service User A’s baby’s cardiotocography (the CTG) at or around one or more of the following times:
   3.1. 22:30;
   3.2. 00:30;
4. At or around 22:30 on 23 December 2012:
   4.1. misclassified the CTG as suspicious when it ought to have been classified as pathological;
   4.2. failed to report your assessment that the CTG was suspicious to the Registrar on duty;
5. From 00:00 until Service User A gave birth at 01:06:
   5.1. did not recognise that the CTG was pathological;
   5.2. failed to report your assessment that the CTG was ‘suspicious’ to the Registrar on duty;
6. By your conduct at charges 4 and/or 5, contributed towards the death of Service User A’s baby and/or caused Service User A’s baby to lose a significant chance of survival;
7. Between 00:50 and 01:00 on 24 December 2012 did not auscultate the fetal heart rate for a full minute;
And, in light of the above, your fitness to practise is impaired by reason of your misconduct.
Background:

The NMC received a referral in relation to you and Mrs Mather on 11 April 2014.

The allegations relate to your care of the referrer when she was in labour. The referrer, Service User A, is also a qualified midwife.

At the time of Service User A’s labour and the birth of her son, you were employed as a Band 6 midwife for the Mid-Staffordshire NHS Foundation Trust (‘the Trust’). You were the midwife allocated to provide midwifery care to Service User A from 19:15 on 23 December 2012 until after the baby’s birth.

Mrs Mather was a Band 7 midwife and was the labour ward co-ordinator who also acted as a ‘buddy’ to check the CTG during the shift.

Service User A was admitted to the Maternity Unit at the Stafford Hospital on 23 December 2012 at 14:25 following a spontaneous rupture of the membrane (SROM). She gave birth to a baby boy at 01:05/01:06 on 24 December 2012. Her baby boy was born severely acaedemic and hypoxic with an Apgar’s score of one at 1 minute, zero at 5 minutes and two at 17 minutes and then was intubated. He was white and limp at the time of his birth and had the umbilical cord wrapped twice around his neck and shoulder. He received extensive resuscitation, two doses of adrenaline and two bolus of saline. The baby boy had multiple organ failure and died 3 days after his birth, shortly after care was withdrawn.

Both you and Mrs Mather were involved in the care of Service User A. You are alleged to have made a series of failures throughout the night and particularly in the hours before the baby’s birth and during the actual birth of the baby. It is alleged that you missed warning signs of Service User A’s son’s deteriorating condition and failed to escalate and that this therefore led to a missed opportunity for medical intervention.
Mrs Mather is alleged to have made a number of failures during the period of approximately 1 hour 40 minutes immediately prior to the birth of the baby.

The NMC’s chronology of events leading up to the birth of Service User A’s baby can be summarised as follows:

23 December 2012

- Service User A was admitted to the delivery suite on 23 December 2012 at 14:25 for augmentation of labour following spontaneous rupture of membranes the day before.
- 14:35 - On admission a CTG was performed to assess fetal wellbeing.
- 15:10 – Service User A started to experience contractions. A vaginal examination showed that Service User A’s cervix was 1cm dilated and 1cm long.
- You took over the care of Service User A at 19:15, the beginning of the night shift. Mrs Mather was shift co-ordinator and acted as a ‘buddy’ to check the CTG during that shift. You documented that Service User A’s contractions were 3 in 10 minutes, moderate on palpation. The CTG was in progress and the fetal heart rate was 140bpm.
- 19:30 – It is alleged that you did not ask Service User A if she needed to empty her bladder yet you recorded in the partogram that Service User A had ‘NPU’ (not passed urine). You again recorded in the partogram at 20:30, 21:30 and 22:30 that Service User A had ‘NPU’ despite allegedly not having asked her if she needed to empty her bladder. This is alleged to have been despite Service User A last being documented as attempting to empty her bladder between 16:00 and 17:00 and drinking significant amounts of fluid.
- 20:50 – It is alleged that Ranitidine 150mg was not administered to Service User A, when it should have been given once the epidural had been established.
- 22:30 – An hourly assessment of the CTG was not conducted in accordance with the Intrapartum Fetal Monitoring in all Care Setting guidelines. No assessment sticker was used. By 22:45, some decelerations were evident on the CTG.
Thereafter, it is alleged that the CTG trace became ‘pathological’ and that you along with Mrs Mather missed or ignored early warning signs.

- **23:05** – Service User A was catheterized and passed 700ml of urine. You conducted a vaginal examination of Service User A at this time and she was fully dilated. The agreed plan was to leave Service User A for 60 minutes to allow descent of the baby’s head unless the CTG required action prior to this time.
- **23:30** – The CTG was alleged to have been misclassified by you as being ‘suspicious’ instead of ‘pathological’. Despite classifying the CTG as ‘suspicious’, you are alleged to have failed to report your assessment to the Registrar on duty. Mrs Mather attended to complete a second check of the CTG and is also alleged to have misclassified the CTG as being ‘suspicious’ instead of ‘pathological’ and similarly having failed to escalate to a doctor on duty.

24 December 2012

- **00:05** – Active pushing was commenced. You documented that variable decelerations continued with good variability. At 00:15 you documented that the CTG showed atypical variable decelerations, which along with the rising fetal heart baseline rate would make the CTG trace ‘pathological’. You are alleged to have again misclassified the CTG as ‘suspicious’ and no doctor was called.
- **00:10** – The CTG continues to show variable decelerations. It is alleged that neither you nor Mrs Mather called for a medical review.
- **00:19** – **00:45** – Service User A continued to push with contractions. The fetal heart rate is documented as ranging between 160 – 180bpm with good variability. The CTG shows some loss of contact which is another warning sign that is alleged to have been missed or ignored by you. Hourly assessments in accordance with the Intrapartum Fetal Monitoring in all Care Setting guidelines were not conducted. You documented that there were no audible decelerations and no assessment sticker was used. The CTG trace remained ‘pathological’ but no action was taken.
- **00:50** – The alarm on the CTG sounded nine times in the last 30 minutes before the birth of Service User A’s baby, yet this itself did not seem to alert either you or Mrs Mather to the need to inform a doctor. The alarm was cancelled each time
it was activated. Mrs Mather returned to the room whilst you were already present. You documented in Service User A’s notes that the baby’s heart rate was ‘auscultated’ at 00:50, 00:55 and 01:00. It is alleged by Service User A that neither you nor Mrs Mather checked for the full minute as required per NICE (The National Institute for Health and Care Excellence) guidelines. It is alleged that you and Mrs Mather failed to escalate by reporting to the Registrar that Service User A’s contractions were infrequent and that the CTG showed loss of contact.

- 01:05/01:06 – Service User A’s baby was born in poor condition; white and limp with the umbilical cord wrapped around his neck twice and around his shoulder. His heart rate was around 60bpm, and an alarm was sounded for a paediatric crash call. The baby’s Apgar score was 1 at 1 minute, 0 at 5 minutes and 2 at 17 minutes. His condition required transfer to a neo-natal intensive care unit in Stoke-on-Trent where he died on 27 December 2012.

At the time of her son’s birth and subsequent death Service User A was not aware that there was any indication of her son’s poorly condition or concerns in relation to the CTG trace prior to his birth and assumed that his condition had deteriorated at the last minute.

Over a year after Service User A’s son’s death, Service User A requested a copy of her intra-partum (labour) records from the birth of her son, in order to see the outcome of a vaginal swab that was taken around that time. On review of her records, Service User A realised that her son’s CTG had been misclassified, and that there were clear signs of her son’s deteriorating condition an hour and a half prior to his birth.

The Trust had conducted a Serious Incident Review into Service User A’s baby’s death.

Service User A was not aware of the outcome of this Serious Incident Review until she requested her birth records in 2014. Subsequent to this she referred the matter to the NMC.
After the conclusion of the Serious Incident Review the Trust informed the Local Supervising Authority, who conducted their own investigation into the midwife’s practice. Ms 2, Supervisor of Midwives conducted the investigation and recommended in her report that you be made subject to 150 hours of a Local Supervising Authority Practice Programme with protected time followed by a further period of 150 hours of Local Action for confidence building.

You commenced a 150 hour Local Supervising Authority Practice Programme in March 2013. At a final programme review meeting on 1 May 2013 it was agreed that you had successfully completed the programme.

**Decision on whether the registrant panel member should recuse herself:**

At the end of day one of this hearing, and upon the panel receiving information with regards to the witnesses due to be called by the NMC in this case, the registrant panel member, Ms Tindale, prepared a written statement dated 6 December 2016.

In this statement Ms Tindale confirmed that, between December 1999 and March 2013, she had worked at Heartlands and Solihull NHS Trust, which then became the Heart of England NHS Foundation Trust following a merger with a third hospital. She also confirmed that from 2008, she was seconded to the Department of Health. During this time she knew of Dr 1, Consultant Obstetrician and Gynaecologist for Heart of England NHS Foundation Trust, who was to be called as the expert witness for the NMC in this case. She confirmed that she knew of Dr 1 because of his appointment as one of the Heart of England NHS Trust’s Obstetric and Gynaecology Consultants but that she had not worked with him clinically as she moved into a management role from 2002.

Ms Tindale confirmed that she left the Heart of England NHS Trust in March 2013 and has had no further involvement with the Trust.
Ms Shah, on behalf of the NMC, raised no objections in relation to the panel proceeding with the hearing in its constituted form.

Ms Hewitt, on behalf of Mrs Marston, raised no objections in relation to the panel proceeding with the hearing in its constituted form. Whilst making clear that she only represents Mrs Marston, she pointed out that Mrs Mather had indicated prior to this hearing that she was content for it to proceed in her absence.

The panel heard and accepted the advice of the legal assessor. The legal assessor referred the panel to the case of *Porter V Magill* [2002] 2 A.C. 357 HL and to the appropriate test when considering bias:

“*the question is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased.*”

The panel as a whole first considered whether the registrant panel member should continue to hear this matter in light of the information as outlined above.

The panel took into account that Ms Tindale had professional knowledge of, but no working or social involvement with Dr 1. Further, she had left the Heart of England NHS Trust in March 2013, from which point onwards, she had no further involvement with that Trust. The panel considered that in such circumstances, there could be no possibility of actual or perceived bias.

The panel noted that whilst Mrs Mather’s views have not been sought on this matter, the panel had, at the outset of this hearing, already determined that it would proceed with this hearing in her absence. In any event, the panel had determined that a fair-minded and informed observer would conclude that there was no real possibility of bias should the panel continue in its current constitution.
The panel was therefore satisfied, in all the circumstances, that it would be appropriate for the panel, in its constituted form, to continue hearing this matter.

**Decision on the findings on facts and reasons:**

In reaching its decisions on the facts, the panel considered all of the oral and documentary evidence adduced in this case together with the submissions made by Ms Shah, on behalf of the NMC and Ms Hewitt, on your behalf.

The panel heard oral evidence from three witnesses called on behalf of the NMC:

- Service User A, mother of Baby A, to whom these charges relate.
- Dr 1, Consultant Obstetrician and Gynaecologist for the Heart of England NHS Foundation Trust. Dr 1 was instructed as an expert witness by the NMC.
- Ms 2, who at the relevant time, was employed as a Band 7 Senior Midwife and Labour Co-ordinator at County Hospital which is part of University Hospitals of North Midlands. This was previously Stafford Hospital, Mid Staffordshire NHS Trust. Ms 2 conducted the internal investigation in relation to your and Mrs Mather's involvement in this incident.

The panel considered Service User A to be a credible witness who was endeavouring to be open and honest in giving her recollection of factual events. Her evidence focused on the care provided to her and Baby A upon admission to the delivery suite on 23 December 2012 at 14:25 up until the birth of her baby at 01:06. Sadly, Baby A died on 27 December 2012 and the panel has recognised the devastating effect this has had on her and her family and the overwhelming sympathy to which they remain entitled. In assessing the reliability of her recollection, the panel has been struck by Service User A's ability to give her oral evidence objectively. It has however – and without any criticism of her – been aware that some aspects of her evidence, including parts of her witness statement, may have involved an honest interpretation of events coloured by
the traumatic nature of those events and the consequent emotion understandably and inevitably felt by her.

Dr 1 was an expert witness instructed by the NMC. The panel considered him to be a knowledgeable and impressive witness. It considered him to be credible and reliable and to have given a balanced account.

The panel considered Ms 2 to have been an overall credible witness who assisted the panel. The panel considered that she had no intention to mislead the panel but it could not overlook her evidence that she had worked with you for some time and that she continues to maintain a friendship with you. The panel drew no criticism as to the findings of the internal investigation such that they impacted its determination on facts but noted the potential for a loss of objectivity due to the professional and social relationship you shared. The panel found that there were some aspects of Ms 2’s evidence where she lacked clarity, such as her interpretation of the CTGs at the time of her investigation and then upon reviewing them in this hearing.

The panel considered you to be a credible witness and that you did your best to assist the panel. It acknowledged that any registrant giving evidence in the presence of a patient to whom the charges relate, and particularly given the circumstances of this case, would find this a difficult experience. The panel did not however consider this to impact upon the overall reliability of your evidence.

The panel heard and accepted the advice of the legal assessor.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

At the start of this hearing you admitted charges 1, 3, 4 and 5.
These were therefore announced as proved.

The panel noted that in relation to charge 6, you admitted that your clinical assessment of the CTG is likely to have been a contributing factor towards the death of Service User A’s baby and/or to have been a factor which caused Service User A’s baby to lose a significant chance of survival. However, Ms Hewitt submitted that what cannot be known is the extent of that contributing factor. She submitted that your failings were not the sole cause of this outcome and that there were other contributing clinical factors which may have led to the same outcome in any event, including a low blood pH level and the umbilical cord being wrapped twice around the baby’s neck.

The panel therefore went on to consider the remaining charges, including charge 6, and made the following findings:

That you, a registered midwife, whilst employed by the Mid-Staffordshire NHS Trust, on the night shift covering 23 to 24 December 2012:

Charge 2:

2. Between 19:30 and 22:45 on 23 December 2012 did not offer and/or did not document that you offered Service User A the opportunity to use the toilet or a bedpan;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Service User A, Ms 2, your account and your entries in Service User A’s notes/partogram.

Service User A told the panel that at no point, between 19:30 and 22:45, was she offered by you the opportunity to use the toilet or a bedpan. It is her account that she attempted to use the toilet at 18:10 but had not passed urine. Service User A said that
whilst the notes do not reflect that she had not passed urine, she had informed the midwife on shift at that time of this.

Ms 2, in her evidence, stated that “the guidelines for ‘Care of Women in Labour and Intrapartum Fetal Monitoring in all Care Settings’ specifies that women should be encouraged to pass urine two hourly.”

It is your account that upon a quick reading of Service User A’s notes at handover, you saw that at 18:10 it was documented by the previous midwife on shift; “Service User A coping well. Up to toilet to PU [pass urine]”. You said that you therefore had assumed Service User A had passed urine prior to you coming on shift.

You said that the guidelines specify that it is best practice to offer the labouring woman the opportunity to pass urine two hourly but that this is only the case once she is in established labour.

It was your account that between 19:30 and 22:45, Service User A was not in established labour nor had her epidural become effective due to the anaesthetist being called to attend to an unrelated emergency and the epidural being discontinued prior to commencement at 20:50. You said that the guidelines would have required you to offer Service User A the opportunity to use the toilet/a bedpan two hours after the epidural had been administered but that, in any case, you were only required to ask Service User A if she needed the toilet or a bedpan once she was in established labour. It is your account that Service User A was not in established labour from 19:30 and that by the time she was in established labour, the two hour timeframe according to the guidelines had not yet elapsed by 22:45.

You accepted that you had not documented anywhere in Service User A’s notes, that you had offered her the opportunity to use the toilet or a bedpan. You had also completed a partogram (a chart summarising labour used to document observations once labour has been established), where you entered NPU (not passed urine) at
19:30, 20:30, 21:30, 22:30 and at 23:30 you entered ‘700ml voided’. You told the panel that it was your general practice to offer a service user the opportunity to use the toilet when you first attended to them. You said that you would have therefore first recorded NPU to indicate that Service User A had been offered the opportunity to use the toilet but did not do so. You also said that the subsequent entries of NPU would be to indicate that whilst you had not asked Service User A if she needed to use the toilet, she had not passed urine and had not been incontinent. You accepted that you could have written in detail in the progress notes regarding this information. You also accepted that the entry at 23:30 which stated ‘700ml voided’ did not make it clear that Service User A had passed urine via catheterisation on the partogram but you had documented this in the progress notes.

Ms 2, in her evidence, also stated that “Carol has documented ‘NPU’ which indicates that the woman had not passed urine, but it would have been better to document that a bedpan or toilet had been offered to the patient as well to evidence that the woman had been encouraged to pass urine. The woman’s bladder was not emptied for five hours when 700mls urine was obtained from catheterisation.”

The panel accepted Service User A’s account that she had attempted to use the toilet at 18:10 but had not been able to pass urine. The panel also took into account that during the relevant time, between 19:30 and 22:45, Service User A had been having 3 in 10 minute contractions. The panel therefore considered that whilst her epidural had not been commenced until 20:50 due to the anaesthetist being required to attend to another patient, Service User A had been in labour.

The panel therefore considered that the ‘Care of Women in Labour and Intrapartum Fetal Monitoring in all Care Settings’ guidelines would have been engaged at that time. According to these guidelines, you therefore had a duty to offer Service User A the opportunity to use the toilet or a bedpan two-hourly. Whilst you gave the panel evidence as to your normal practice to offer a labouring woman the opportunity to use the toilet/bedpan when first attending to her, you had not documented this in Service User
A’s notes. Further, you offered three separate explanations as to the definition of NPU, as documented by you in Service User A’s partogram. Namely, to indicate that the opportunity to use the toilet/a bedpan was offered to Service User A but declined and, that whilst you had not offered further opportunities, that Service User A had not passed urine, and that she had not been incontinent. The panel did not accept your evidence that recording ‘NPU’ was intended to have these three different meanings and therefore had no independent evidence before it to support your case that you had offered Service User A the opportunity to use the toilet or a bedpan.

The panel preferred Service User A’s evidence in this regard and accepted her account that she had not been offered the opportunity to use a toilet or bedpan by you.

The panel therefore found charge 2 proved.

**Charge 6:**

6. *By your conduct at charges 4 and/or 5, contributed towards the death of Service User A’s baby and/or caused Service User A’s baby to lose a significant chance of survival;*

**This charge is found proved.**

In reaching this decision, the panel had to consider whether by misclassifying the CTG as suspicious when it ought to have been pathological and failing to report your assessment to the Registrar on duty at or around 23:30 on 23 December 2012 (charge 4) and by failing to recognise that the CTG was pathological and failing to report your assessment that the CTG was suspicious to the Registrar on duty from 00:00 – 01:06 (charge 5), you had contributed towards the death of Service User A’s baby and/or caused Service User A’s baby to lose a significant chance of survival.

The panel considered that, upon the particular facts of this case, there was little if any difference between the two limbs of the charge, namely, contributing towards the death
of Service User A’s baby and causing Service User A’s baby to lose a significant chance of survival.

The panel noted that in response to this charge, at the outset of this hearing, you admitted that your clinical assessment of the CTG is likely to have been a contributing factor towards the death of Service User A’s baby/caused Service User A’s baby to lose a significant chance of survival. But you stated that the extent of this contributing factor cannot be known nor were your failings the sole cause of this outcome and that there were other contributing clinical factors which may have led to the same outcome in any event.

The panel took into account the evidence of Dr 1. Dr 1 stated that upon his interpretation of the CTG trace, it was clearly ‘pathological’ from 23:30 onwards.

Dr 1’s evidence was that the CTG trace had become ‘pathological’ some time before this. However, the wording of the charge was such that the panel did not need to consider when in fact the trace had first become ‘pathological’.

In his report he stated:

“…on balance, a category 1 Caesarean Section would have been called for. Hence, delivery would have been expected to take place, by approximately 23:40, on the 23rd of December 2012, or approximately an hour and 26 minutes earlier. On balance the baby would have been born in a much better condition, would have required immediate neonatal support and admission to the neonatal unit, but would have survived.”

He went on to state:

“On balance, if medical review was requested at 23:30 hours (5.2.3), a clinical examination would have been repeated. Service User A would have been encouraged to start pushing during an internal obstetric assessment, so that descent with maternal
expulsive efforts could be assessed. Given that the baby’s size was within normal, and in fact proved to be less than average (see 6.2) and also that the vertex became visible (4.5.5) only 14 minutes after active pushing was commenced (4.5.2.), the reasonable obstetrician, faced with continuing CTG abnormality and taking into account that a working epidural was in place, would have attempted and would have been on balance successful in performing an instrumental delivery in the room. Such delivery would have been achieved with appropriate support by other members of staff, within about 20 minutes from when requested to review, or at about 23:55, or about one hour and 10 minutes before the baby was actually delivered. Neonatal support would have been necessary for days; however on balance the baby would have survived…

…by not prompting an earlier intervention to deliver the baby, CTG misinterpretations materially contributed to the neonatal outcome in this case.”

The panel took into account that even where the CTG trace was misclassified by you as suspicious at or around 23:30 on 23 December 2012 and from 00:00 until Service User A gave birth at 01:06, you would have had a duty to report this to the Registrar on duty.

The panel therefore considered that it was a significant failing to have not reported your assessment of the CTG to the Registrar on duty, even in the circumstances where you had misclassified the CTG as suspicious rather than pathological, as you would have been duty bound to do so.

The panel accepted the evidence of Dr 1 that had you reported your assessment to the Registrar, this would have provided the opportunity for earlier medical intervention and that failing to do so was so significant that it contributed towards the death of Service User A’s baby/caused him to lose a significant chance of survival.

The panel considered Dr 1’s expert opinion as to the potential for Baby A being left with any long term physical or mental disability to be a factor it did not take into account in its
consideration on facts, given that the charge relates to the chances of Baby A’s survival and not the impact upon his health following his birth.

The panel therefore found that by your failings, as set out in charges 4 and 5, you had contributed towards the death of Service User A’s baby and caused Service User A’s baby to lose a significant chance of survival.

**Charge 7:**

7. *Between 00:50 and 01:00 on 24 December 2012 did not auscultate the fetal heart rate for a full minute;*

**This charge is found not proved.**

In reaching this decision, the panel took into account the evidence of Service User A and your evidence.

Service User A told the panel that both you and Mrs Mather were stood at the foot of the bed trying to angle the fetal heart transducer in different directions just above her pubic arch in order to get a reading of the fetal heart rate. It was Service User A’s account that this was done only twice despite recordings being documented at 00:50, 00:55 and 01:00. Service User A said that Mrs Mather was looking at her fob watch while doing this, but that neither did you nor Mrs Mather look at the fob watch or a clock for longer than 10 seconds. Service User A said that she was certain in her recollection because she recalled them pushing the transducer above her pubic bone which hurt her for a matter of seconds while they were auscultating.

You told the panel that you had auscultated for a full minute on each of the three occasions you had documented. You said that you were auscultating the fetal heart rate every 5 minutes or so. You said that whilst you were angling the transducer, Mrs Mather was using her fob watch to indicate the start and finish time of the full minute.
You said that at 00:50, the Registrar had come to speak to Mrs Mather. You said that you were not sure what this discussion was about but that you were reassured that the care you were providing to Service User A had been an appropriate plan of care given that neither the Registrar nor Mrs Mather raised any concerns with you at that time. The panel however noted that you did not document the Registrar attending at this time, nor did Mrs Mather, in her account at the internal investigation state this.

You also gave an account that you had used the digital clock on the wall, waited for the minute to turn, and then measured one minute while you auscultated the fetal heart rate. You said that you were certain that you auscultated the fetal heart rate for a full minute, three times, as documented. You said that although you had relied on Mrs Mather to indicate when a minute had elapsed, whilst you counted out loud the beats per minute, you had no reason to believe that Mrs Mather would not be counting for a full minute.

Your account was that the recordings taken could not have been taken from a ten second reading and multiplied up. However, the panel had not heard any independent evidence to suggest that this was not feasible.

The panel also took into account that Service User A, as a midwife herself, would have been well aware of the procedure of auscultating the fetal heart rate. The panel was in no doubt that Service User A genuinely believed her recollection was accurate. However, given that she was in the very final stage of labour, and in the particular circumstances of this case, the panel could not overlook the real risk of an honest misinterpretation of events as to the time that had elapsed whilst the fetal heart rate was auscultated.

The panel also had before it the witness statement of Mrs Mathers, in which she stated “I did auscultate the fetal heart and I did inspect my watch to monitor duration whilst doing so. This is so far as I recall, but without the benefit of any specific means to recall
exactly how long I did so. It was not necessary to stop all other activity and count sixty seconds on my fob watch to perform this function. It is sufficient to mentally note when a count begins and return to the clock (fob watch) within the minute to determine how much time has passed since the commencement of the procedure.”

The panel therefore was presented with a stark conflict of evidence in relation to this charge which it had to resolve. In the absence of any independent evidence, the panel considered that the documentary evidence before it at 00:50, 00:55 and 01:00 provided some support for your account. On the balance of probabilities, the panel considered that this charge could not safely be found proved.

The panel therefore found charge 7 not proved.

Panel's decision and reasons on an application to admit Ms 3’s witness statement into evidence:

Following handing down its decision on the facts, the panel heard an application made by Ms Shah, to admit the witness statement of Ms 3, mother of Service User A, into evidence.

Ms Shah submitted that the witness statement outlined the wider impact of both Mrs Marston and Mrs Mather’s actions upon Service User A and her family. Ms Shah submitted that Ms 3’s evidence was relevant to the panel’s consideration of the seriousness of charge 6 for Mrs Marston and charge 2 for Mrs Mather.

Ms Hewitt opposed this application. She submitted that whilst taking into account the undeniable impact of these events upon Service User A and her family, Ms 3’s witness statement would not assist the panel in its very clear function when determining misconduct and current impairment. She submitted that the scope of evidence that the panel can admit at the stages of misconduct and impairment are clearly defined and
that Ms 3’s witness statement did not address any of the issues upon which the panel is yet to determine at this stage. She invited the panel to refuse the application.

The panel heard and accepted the legal assessor’s advice.

Rule 31(1) of the Rules states that:

“Upon receiving the advice of the legal assessor and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings.”

The panel was provided with a redacted version of Ms 3’s witness statement.

Having read Ms 3’s witness statement, the panel considered that whilst outlining the inevitably profound impact upon Service User A and her family, it did not provide any information above and beyond the evidence it already had before it.

The panel concluded that it would not be relevant to admit Ms 3’s witness statement into evidence. The panel determined Ms 3’s witness statement would not be relevant to the issues it had yet to consider at the misconduct and impairment stage.

The panel considered that to admit a witness statement which could be described as akin to a ‘victim impact’ statement in criminal proceedings at the misconduct and impairment stage could be perceived as unfair. It also considered, therefore, that it would not be fair to admit it into evidence.

The panel therefore decided to refuse the application and considered it would be neither fair nor relevant to admit Ms 3’s witness statement into evidence and that it would not call her as a witness in this case at the misconduct and impairment stage.
Decision and reasons on interim order upon adjournment:

As this case is unable to conclude in the time allocated, the panel has to now consider the matter of an interim order under Rule 32(5), which states:

32. (5) Save where the proceedings relate to the consideration of an interim order, before adjourning the proceedings, the Practice Committee shall consider whether or not to make an interim order and shall—

(a) invite representations from the parties (where present) on this issue;

(b) deliberate in private;

(c) announce its decision in the presence of the parties (where present);

(d) give reasons for its decision; and

(e) notify the registrant of its decision in accordance with article 31(14) of the Order.

The panel heard the submissions of Ms Shah who submitted that no matters arise in relation to an interim order. The panel heard the submissions of Ms Hewitt, on your behalf.

The panel heard and accepted the advice of the legal assessor.

The panel is aware that in accordance with Article 31 of the Nursing and Midwifery Order 2001 it may make an interim order for up to 18 months on any one of three grounds, namely, if it is satisfied that such an order is necessary for the protection of the public, is otherwise in the public interest or in your own interests.
You are not currently subject to an interim order nor have you been. The panel is aware that you have voluntarily taken yourself out of practice as a midwife. The panel took into account that you had been subject to and successfully completed 150 hours of a Local Supervising Authority Practice Programme and a further period of 150 hours of Local Action. It also had before it a reference from your current employer who confirmed that no concerns have been raised with your clinical practice.

In the panel’s view, there are no different circumstances today that should affect the requirement for an interim order.

The panel therefore concluded that an interim order was not, at this stage, necessary to protect the public, nor was an order otherwise in the public interest, nor in your own interests.

The panel therefore made no interim order.

This hearing is to resume from 27 – 31 March 2017.
This hearing resumed on 27 March 2017.

**Submissions on misconduct and impairment:**

Having announced its findings on the facts, the panel then moved on to consider firstly, whether the facts found proved amount to misconduct and, if so, secondly whether your fitness to practise is currently impaired. The NMC has defined fitness to practise as a registrant’s suitability to remain on the register unrestricted.

At the outset of this hearing, you provided the panel with a bundle of documentation which included your witness statement and the witness statements of the Deputy Head of Midwifery and the Local Supervisory Authority Midwifery Officer. This bundle also contained a number of testimonials and documents relating to the Local Supervising Authority Practice Programme (LSAPP) you had undertaken and completed following this incident.

You also gave evidence at this stage.

You outlined to the panel your practice as a nurse since the time of this incident. You told the panel that following this incident, you undertook the LSAPP and practised as a midwife for some seven months following the successful completion of the programme. You said that although the LSAPP gave you the tools to practise as a midwife effectively, your feelings towards midwifery practice on a personal level led you to take the decision that you no longer wanted to practise as a midwife.

Since that time, you have practised as an IV medications nurse in a community setting. You said that there have been no concerns raised about your nursing practice and that no concerns had been raised with your midwifery practice prior to and in the seven months following the successful completion of the LSAPP. You said that you have no intention of ever returning to midwifery practice and would like to continue your work as
an IV nurse. You told the panel that your current employer is fully aware of these proceedings.

You said that you are very remorseful and described feelings of guilt and shame that will remain with you forever. You said that you accept that this is nothing in comparison to what the family have to live with and that if you could go back and change what happened you would. You said that you accept responsibility for your actions and are very remorseful for the impact of your actions on Service User A and her family.

You said that since the time of the incident, you had completed your LSAPP and feel that you have done everything that was asked of you. You outlined to the panel your personal circumstances at the time of the incident and that the Trust had offered you a deferment of your LSAPP. You said that you felt it would not have been fair to Service User A and her family to have deferred the programme and took the decision to undertake the programme at that time. You said that since deciding that you no longer wished to practise as a midwife, you have been able to carry over some learning from the LSAPP to your current nursing role.

You said that in your current nursing role, you visit patients with IV lines, in their homes to provide nursing care. You said that this role has no aspects of midwifery practice. You said that it is a ‘more prescriptive role’. You told the panel that you are subject to three to six monthly observations/assessments of your practice and that no concerns have been raised with your practice. You said that you are enjoying nursing practice and would like to continue within this role.

In her submissions, Ms Dosoruth referred the panel to the case of Roylance v GMC (no. 2) [2000] 1 AC 311 which defines misconduct as “a word of general effect involving some act or omission which falls short of what would be proper in the circumstances”. In this regard and in relation to each of the charges, she outlined the relevant parts that, in her submission, breached the Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives 2008 (‘the Code’). She also referred the panel to the relevant
parts that, in her submission, breached the Midwives rules and standards (‘the Midwives Rules’). Given the nature of the issues found proved Ms Dosoruth submitted that, taken individually and collectively, these amounted to acts and omissions falling short of what would be proper in the circumstances such that they amounted to misconduct.

Ms Dosoruth then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She referred the panel to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). In considering the issue of impairment, she submitted that the first three limbs of the Grant test are engaged in this case.

Ms Dosoruth submitted, with reference to those questions, that your actions indicate that your fitness to practise is impaired on the basis that you had, in the past, acted in a way liable to put patients at unwarranted risk of harm. She further submitted that your actions brought the profession into disrepute and constituted serious breaches of fundamental tenets of the midwifery profession.

When considering the question of future risk, she submitted that in your evidence you had demonstrated some insight and remorse and outlined to the panel the steps you had taken to remediate your practice. However, she submitted that there is not sufficient evidence to suggest that you have fully remediated your failings.

Ms Dosoruth therefore submitted that the panel should find that your fitness to practise is currently impaired. Additionally, she submitted that in the light of the facts found proved, the reputation of the profession and the regulator would be undermined if a finding of impairment were not made.

Ms Hewitt submitted that you accept that your actions are examples of deficient professional performance capable of amounting to misconduct.
Ms Hewitt submitted that should the panel find that your failings amount to misconduct, it is her submission that your failings should not lead to a finding of current impairment. Ms Hewitt submitted that there is no evidence of any concerns in relation to your midwifery practice prior to the time of the incident or in the seven months following the successful completion of your LSAPP, nor is there evidence of any concerns in relation to your nursing practice. She submitted that you have expressed significant remorse for your actions and addressed your shortcomings by way of complying fully with your LSAPP. She also submitted that you had fully engaged with the Trust’s investigation and have also engaged fully with these proceedings. She submitted that the concerns with your practice arose in your midwifery practice, and that you have assured the panel that you do not intend to ever return to midwifery. She said that your actions can be classified as a single clinical mistake that was borne out of human error. She therefore submitted that you are not likely to repeat these shortcomings and that you have remedied them by way of your training and self-reflection.

The panel accepted the advice of the legal assessor who advised the panel that it should adopt a two stage process in its considerations. Firstly, the panel must decide whether the facts found proved amount to misconduct. If the panel finds that the facts found proved do amount to misconduct, the panel must then go on to decide whether your fitness to practise is currently impaired.

**Decision on misconduct:**

The panel then went on to consider whether the facts found proved amount to misconduct. The panel is aware that this is a matter entirely for the panel to determine exercising its own independent judgement with no burden or standard of proof.

When determining whether the facts found proved amount to misconduct the panel had regard to the Code.
The panel determined that your actions fell substantially short of the standards expected of a registered midwife, and that your actions breached the Code as follows:

**Preamble:**

*The people in your care must be able to trust you with their health and wellbeing. To justify that trust, you must:

- provide a high standard of practice and care at all times*

**Paragraphs:**

28. *You must make a referral to another practitioner when it is in the best interests of someone in your care.*

42. *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*

61. *You must uphold the reputation of your profession at all times.*

The panel also considered your actions to have breached the following sections of the Midwives Rules:

**Rule 6**

**Responsibility and sphere of practice**

3 *In an emergency, or where a deviation from the norm which is outside her current sphere of practice becomes apparent in a woman or baby during the antenatal, intranatal or postnatal periods, a practising midwife shall call such qualified health*
professional as may reasonably be expected to have the necessary skills and experience to assist her in the provision of care.

**Standard**

4 A midwife:

b) must make sure the needs of the woman or baby are the primary focus of her practice

h) is responsible for familiarising herself with her employer’s policies.

**Guidance**

5 The Federation of International Gynaecologists and Obstetricians (FIGO), and the World Health Organisation’s (WHO) definition of the activities of a midwife determine your sphere of practice (see page 43). The conditions in which you may practise vary widely, whether in the home, in hospital or elsewhere. Your practice should be based on the best available current evidence. You are accountable for your own practice and you cannot have that accountability taken from you by another registered practitioner, nor can you give that accountability to another registered practitioner.

The panel recognised that breaches of the Code do not automatically result in a finding of misconduct. The panel considered all the circumstances and whether the facts found proved were sufficiently serious to constitute misconduct in a regulatory context.

The panel concluded that your actions in this regard fell far short of the conduct and standards expected of a registered midwife and that this was serious enough to amount to misconduct.

The panel considered that in misclassifying the CTG as suspicious when it ought to have been classified as pathological and also failing to report your assessment of the CTG as suspicious to the Registrar on duty, amounted to significant departures from the standards expected of a registered midwife, such that it contributed to Baby A’s death/caused Baby A to lose a significant chance of survival.
The panel considered that as the named midwife providing care to Service User A during her labour, it was your responsibility to escalate to a Registrar, even in the circumstances where you had misclassified the CTG as suspicious. The panel considered that this would have been all the more evident to you given the irregularities being shown on the CTG and that the fetal heart rate monitor alarm was silenced on nine occasions. The panel accepted the evidence of Dr 1 that had you reported your assessment to the Registrar, this would have provided the opportunity for earlier medical intervention and that failing to do so was so significant that it contributed towards the death of Service User A’s baby/caused him to lose a significant chance of survival.

The panel therefore concluded that your actions in this regard amounted to a significant departure from the standards expected of a registered midwife and that this was serious so as to amount to misconduct.

The panel considered the charges that you had did not document not having administered Ranitidine to Service User A, did not document offering Service User A the opportunity to use the toilet or a bedpan and did not record the hourly assessment sticks of Service User A’s CTG at 22:30 and 00:30. The panel considered that taking into account the wider context of your actions during this shift, these charges, taken cumulatively with the other charges in this case, demonstrated a substantial falling short of the conduct and standards expected of a registered midwife and were therefore serious enough to amount to misconduct.

The panel considered that ensuring that you documented your actions and most importantly, in classifying the CTG correctly or, at a minimum, escalating to the Registrar were crucial in the circumstances and in failing to do so, had a catastrophic impact on Baby A’s chances of survival, Service User A and her family.
The panel therefore concluded that your actions were serious so as to amount to misconduct.

**Decision on impairment:**

The panel then went on to consider, on the basis of the misconduct found, whether your fitness to practise is currently impaired.

In this regard, the panel considered the judgement of Mrs Justice Cox in the case of CHRE and NMC and Grant [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said;

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

Mrs Justice Cox went on to say in Paragraph 76:

76. *I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor’s fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.*
“Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. …

The panel first considered the issue of past impairment. It asked itself whether the serious misconduct in question had breached one or more fundamental tenets of the profession to an extent that would bring the profession into disrepute. It had careful regard to the facts found proved and the matters set out above and concluded that your misconduct had in the past:

- Put Service User A and Baby A at unwarranted risk of harm and caused Baby A actual harm with the most catastrophic of results;
- Brought the profession into disrepute; and
- Breached fundamental tenets of the midwifery profession.

For these reasons, the panel had no doubt that at the time these events occurred your fitness to practise had been impaired by reason of your misconduct.
The panel next considered whether your fitness to practise is currently impaired and whether you are liable to repeat your misconduct. The panel had careful regard to the issues of insight and remediation.

The panel took into account that since the time of this incident you had agreed to undertake a LSAPP and successfully completed the programme. The panel heard evidence from you as to the feelings of guilt, shame and remorse that you carry with you and will continue to do so for the rest of your life. You accepted that your feelings towards what happened pale in comparison to what Service User A and her family have to go through and you apologised to her and her family. The panel accepted your remorse as genuine.

Your mentors and supervisors agreed that you had fully complied with and completed your LSAPP and Local Action Plan and were satisfied with the work you had completed and the learning that had been demonstrated. The panel accepted your willingness to comply with the LSAPP and successfully completing it as well as your reflection and insight into the impact of your actions as evidence that you have fully remediated your practice. Further, you have shown genuine and focused reflection as to your midwifery practice and your decision subsequent to completing the LSAPP and returning to midwifery practice that you no longer wished to practise as a midwife. The panel determined that the risk of repetition in this case was minimal.

The panel determined that given your full insight into your actions and the devastating impact they have had, your compliance with and successful completion of the LSAPP and the learning undertaken by you, you have demonstrated full remediation for your actions such that the panel considered that a finding of impairment was not required on public protection grounds.

Baby A sadly passed away and your actions directly contributed to his death and/or caused him to lose a significant chance of survival.

The panel carefully considered the critically important public interest issues to which it must also have regard. Those issues include the collective need to maintain confidence
in the profession as well as declaring and upholding the proper standards of conduct
and behaviour which the public have a right to expect. The panel reminded itself that the
consequences of your professional failings were of the most serious nature and had the
worst possible outcome for Baby A and an enduring impact on Service User A and her
family.

The panel was satisfied that it was necessary and proportionate to make a finding that
your fitness to practise is currently impaired in order to address the wider public interest.
The panel considered that public confidence in the midwifery profession and in the NMC
as its regulator would be undermined if a finding of impairment were not made.

Accordingly, the panel has concluded that your fitness to practise is currently impaired
by reason of your misconduct on public interest grounds alone.
**Determination on sanction**

In reaching its decision on sanction, the panel considered all the evidence before it, together with the submissions made by Ms Dosoruth and Ms Hewitt.

The panel heard and accepted the advice of the legal assessor.

The panel has applied the principles of fairness, reasonableness and proportionality, weighing the public interest with your own interests and taking into account any mitigating and aggravating factors in the case. The public interest includes the protection of members of the public including patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour within the profession. The panel has taken account of the NMC’s ‘Indicative sanctions guidance to panels’ (‘ISG’), bearing in mind that the decision on sanction is one for its own independent judgement.

The panel recognises that the purpose of sanction is not to punish, although any sanction may have a punitive effect.

The panel bore in mind that it had made a finding of impairment on public interest grounds alone. Given that you have a dual registration as a nurse and midwife, any decision to impose a sanction would apply to both your nursing and midwifery practice. In considering the principles of fairness, reasonableness and proportionality, the panel bore in mind your stated intention that you would never return to midwifery practice. The panel had before it positive testimonials and references attesting to your good practice as a nurse. Further, the panel had no evidence of any concerns in relation to your midwifery practice prior to the incident, nor in the seven months of your midwifery practice following your successful completion of the LSAPP programme. The panel also took into account that it considered you to have fully remediated your misconduct and to have expressed significant remorse and insight into your failings.
The panel then considered the mitigating and aggravating features in this case.

As regards aggravating features, the panel considered the following:

- Your actions had the most serious of consequences for Baby A, Service User A, her husband and her family.
- You were an experienced midwife.

As regards mitigating features, the panel considered the following:

- You have been open and honest about the incident and taken responsibility for your actions at the Trust’s investigatory stage as well as during these proceedings.
- You made early admissions to a number of the charges in this case.
- There is no evidence of any concerns in relation to your midwifery practice prior to the incident or in the seven months following the successful completion of the LSAPP in which you practised as a midwife before moving to nursing practice.
- You have provided positive references, and the most up to date reference from your current manager spoke highly of you as a nurse.
- There is minimal risk of repetition of the misconduct found.
- You have expressed genuine remorse and have apologised for your actions.
- You have reflected and demonstrated significant insight, including your decision never to return to midwifery practice.
- You have never previously been brought before the NMC.
- You have engaged fully with the NMC proceedings.

The panel went on to consider the appropriate sanction.

The panel was in no doubt that your conduct had fallen far below the standards expected of a registered midwife. As such, it was the panel’s duty to declare and uphold proper standards of conduct, so as to maintain public confidence in the profession.
The panel had before it a reference dated 5 October 2016 from a Supervisor of Midwives who had worked with you prior to the time of the incident and provided you with support during your LSAPP following the incident. It had particular regard to the following:

“In my clinical role as a labour ward shift co-ordinator I worked with Carol on a regular basis. This gave me the opportunity to observe Carol’s skills within the clinical area. Carol was an extremely competent, hard working, compassionate and caring midwife. The care that she provided to the women in her care and their families was exemplary. Carol set her standards high and was an excellent role model and mentor to student midwives and junior colleagues and as a senior midwife she provided integral support for the labour ward co-ordinator.

I supported Carol in my role of supervisor of midwives following the incident that has been referred to the NMC, throughout the investigatory process and during her local supervisory practice programme. Carol showed true compassion and remorse throughout the process. Her commitment and high standards shown throughout the programme was reflected in the outcome demonstrated by her portfolio of evidence and academic essay. I feel that Carol truly reflected upon the incident and showed clearly how she had learnt as a result of the programme of which I could not commend her highly enough.”

The panel considered your undertaking and successful completion of the LSAPP in the manner described to demonstrate insight into your failings and your commitment to remediating your failings. The panel accepted your evidence as genuine when you said that in the seven months following the completion of the LSAPP when you returned to midwifery practice, you felt that although you had been given the tools to practice to a high standard as a midwife, you felt that you could not find that part of you that ‘made you a midwife’. You said that you have always thought that if you are unable to be fully committed to midwifery practice and able to give it your all, you should not practise as a
midwife. The panel considered your decision to remove yourself from midwifery practice to be demonstrative of your insight into your own practice and accepted your stated intention to never return to midwifery practice as genuine.

The panel then looked to your current practice as an IV therapies nurse and in that regard had a reference dated 11 October 2016 from your current Line Manager, a Nursing Services Manager for Bupa Home Healthcare in the Midlands Region. It had particular regard to the following:

“In May 2016 I became Carol’s Line Manager, from our initial meeting Carol has been open and honest about what was happening with the NMC.

My experience with Carol has been a very positive member of the team [sic], she is a very conscientious and flexible Nurse and willingly assists her colleagues when help is needed. Due to the nature of our Homecare Nurse roles, our team members need to manage their time effectively and deal with the daily challenges and situations that can arise, Carol is excellent in this role and communicates with her colleagues and patients well. Carol also acts as a key link between Bupa Home Healthcare and one of the major Trusts that we work with. Carol regularly assists in covering sickness when additional patient visits need accommodating and this is due to Carol’s dedication as a Nurse and her commitment to our patients. Carol is also regularly “on call” for the patients throughout the Midlands and South West.

As Carol’s Line Manager for the past 6 months I have had no concerns regarding her clinical practice and class her as an exceptional member of the Midlands IV Therapy Team, she is a pleasure to work with and is well respected by her peers.”

The panel first considered whether to take no further action.

The panel paid careful consideration to the mitigating features in your case. It noted that since the incident you have moved to practise within the nursing field and that there
have been no concerns raised regarding your conduct or practice. You do not wish to return to midwifery practice. It also noted all the positive references and testimonials you have provided. You have expressed genuine remorse and have reflected on your actions. The panel was therefore satisfied that the risk of repetition is minimal.

However, the panel concluded that because of the seriousness of the case, taking no further action would not satisfy the public interest considerations in this case.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the ISG, which states that a caution order may be appropriate where ‘the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.’

Whilst the panel did not consider the consequences of the charges found proved to be at the ‘lower end of the spectrum of impaired fitness to practise’, the panel bore in mind that ‘each case is different and should be decided on its own particular facts’.

The panel had regard to the case of Raschid and Fatnani v GMC [2007] 1 WLR 1460 where the Court of Appeal made it plain that the functions of a fitness to practise panel are quite different from those of “a court imposing retributive punishment” since “the panel…is centrally concerned with the reputation or standing of the profession rather than the punishment of the [registrant].” Accordingly, the panel bore in mind that the purpose of sanctions is not punitive, and its role was to protect the public interest.

The panel has been told that there have been no adverse findings in relation to your conduct or practice either before or after this incident.

The panel considered you to have fully remediated and to have demonstrated significant insight and remorse into your actions. The panel had already determined that the risk of repetition in this case is minimal.

In this regard, the panel had regard to paragraph 62 of the ISG:
When fitness to practise is impaired by reason of misconduct and a panel is minded to impose a caution order, it should consider whether such an order provides adequate public protection, bearing in mind that it does not restrict the nurse or midwife’s practice rights. It might be appropriate where the nurse or midwife’s history is such that the panel is confident that there is no risk to the public or to patients which requires the nurse or midwife’s practice rights to be restricted.

The panel took into account the seriousness of the facts found proved in this case. However, it accepted that this serious incident took place during a single shift in an otherwise exemplary and long-standing midwifery career and that you have since removed yourself from midwifery practice. Before doing so, you fully complied with and successfully completed your LSAPP and the panel had determined that you had fully remediated your actions. You are currently practising as a nurse and the panel accepted your evidence that you would want to continue within the nursing field of practice.

The panel took into account that there were no deep-seated attitudinal issues. To the contrary, the panel considered you to have demonstrated a significant level of insight and remorse for your actions. Whilst you accepted that the guilt and remorse you feel do not compare to what Service User A and her family must feel the panel accepted your evidence that this is an incident that will remain with you forever.

Taking into account all of the particular facts of this case, the panel has concluded that a caution order is the most appropriate and proportionate sanction.

The panel was satisfied that the sanction of a caution order would maintain public confidence in the nursing and midwifery profession and the regulator. It would uphold the proper professional standards expected of a registered midwife. It was satisfied that a member of the public in full possession of the facts of the case would understand the reasons for imposing the sanction of a caution order in your case. The panel also took into account the public interest in retaining a highly valued nurse in practice. It therefore concluded that a caution order is the most appropriate and proportionate sanction,
balancing the public interest with your interests.

The panel noted your personal and financial circumstances but was mindful that such circumstances can only be given limited weight in those cases where a sanction is required to protect the public interest.

The panel considered whether it would be appropriate and proportionate to impose a more restrictive sanction and considered a conditions of practice order. The panel was satisfied that there were no outstanding areas of concern in relation to your clinical practice that required re-training. The panel therefore found that there would be no useful purpose served in imposing a conditions of practice order, nor would it be appropriate or proportionate in these circumstances.

The panel went on to consider the next available sanction of suspension. The panel was mindful that a period of suspension would also sufficiently serve the public interest considerations in this case. However, the panel took into account the mitigating features in your case and the fact that this was a serious incident occurring on a single shift in an otherwise exemplary career. The panel determined, accepting your full remediation and insight in relation to your midwifery practice and the minimal risk of repetition, that the public interest could be addressed by the imposition of a caution order. The panel considered that a suspension order would be disproportionate and unduly punitive and would also deprive the public of the services of a good nurse.

The panel next considered the appropriate length of time for the caution order. The panel concluded that nothing less than the maximum period of five years would be proportionate or would protect the wider public interest.

During this period any prospective employer or member of the public will be on notice that your fitness to practise has been found to be impaired and that a caution order has been imposed. Any prospective employer could make enquiries as to the circumstances of the making of the caution order and this will put the employer on notice of the public interest concerns that have been identified.

At the end of this period the note on your entry in the Register will be removed.
That concludes this determination.

This decision will be confirmed to you in writing.