Name of Registrant Nurse: Mrs Tuija Roussel

NMC PIN: 97Y0077C

Part(s) of the register: RM, Registered Midwife (21 May 1997)

Area of Registered Address: England

Type of Case: Misconduct

Panel Members: Alexander Coleman (Chair - Lay member)
James Peacock (Lay member)
Julie Tindale (Registrant member)

Legal Assessor: Ian Ashford-Thom

Panel Secretary: Vicki Watts

Mrs Roussel: Mrs Roussel was represented throughout the hearing by Ms Hamilton, Counsel instructed on behalf of the Royal College of Midwives (RCM). Mrs Roussel attended parts of the hearing in person and on 27 September 2017 Video link.

Nursing and Midwifery Council: Represented by Katherine Higgins, Counsel instructed by NMC Regulatory Legal Team

Facts proved by admission: 1.1.1, 1.1.2, 1.1.5, 1.5, 1.6 (in part relating to 1.1.1 and 1.1.2) 4.1.1, 4.1.2, 4.3, 5.1.1, 5.1.2
No case to answer: 1.1.3 and 5.4

Facts proved: 1.2.1, 1.2.2, 1.2.3, 1.3.1, 1.3.2, 1.3.3, 1.4, 2.3, 4.2.1, 4.2.2

Facts not proved 1.1.4, 5.2, remainder of charge 1.6

Fitness to practise: Impaired

Sanction: Striking Off Order

Interim Order: Interim Suspension Order – 18 Months
Charges as read:

That you, a registered midwife, whilst employed by the Health and Social Services Department of the States of Guernsey (“HSSD”) at the Princess Elizabeth Hospital, Guernsey (“the Hospital”):

1. In respect of the care delivered to Baby A and/or Patient A on 29 and 30 January 2014, when you were the midwifery ward coordinator:

   1.1 At or around 23:20 on 29 January 2014, commenced and/or oversaw the administration of Syntocinon to Patient A:

      1.1.1 When there was no valid written prescription;

          Proved by admission

      1.1.2 Without a medical review of Patient A;

          Proved by admission

      1.1.3 In the presence of mild fetal heart rate distress;

          No case to answer

      1.1.4 Which was commenced without appropriate patient consent and/or patient consultation;

          Not proved

      1.1.5 Which was not appropriately recorded with a signature

          Proved by admission
1.2 At or around 23.50 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

   1.2.1 When there was no valid written prescription; 
   Proved
   1.2.2 Without a medical review of Patient A; 
   Proved
   1.2.3 When the CTG had shown a “suspicious” trace; 
   Proved

1.3 At or around 00.10 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

   1.3.1 When there was no valid written prescription; 
   Proved
   1.3.2 Without a medical review of Patient A; 
   Proved
   1.3.3 When the CTG had shown a “suspicious” trace; 
   Proved

1.4 Did not seek a review of Patient A’s condition at or around 23:50 on 29 January 2014, Patient A having given a “suspicious” cardiotocograph (“CTG”) trace. 
Proved

1.5 Did not escalate, in a timely manner, the delay in the delivery of Baby A, in that you did not seek a review of Patient A’s condition until 00:55 on 30 January 2014, Patient A having entered the second stage of labour at the latest time of 21:45 on 29 January 2014. Proved by admission

1.6 Your actions as described at paragraphs 1.1 and/or 1.2 and/or 1.3 and/or 1.4 and/or 1.5 increased the risk of harm to Patient A and/or Baby A

   Proved in part in relation to 1.1.1 and 1.1.2
2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A. Proved

3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014. Proved

4. In respect of care delivered to Patient C on 29 November 2013:

4.1. At or around 04:10, allowed the administration of an infusion of Syntocinon:

4.1.1. When there was no valid prescription

   Proved by admission

4.1.2. Without a medical review of Patient C

   Proved by admission

4.2. At or around 05.00 and/ or 07.00 increased and/ or oversaw the increase to the rate of infusion of Syntocinon:

4.2.1. When there was no valid prescription;

   Proved

4.2.2. Without a medical review of Patient C

   Proved

4.3. At or around 07:15, Patient C having given a “suspicious” CTG trace whilst the administration of Syntocinon continued, did not seek a review of Patient C’s condition from a consultant obstetrician

   Proved by admission

5. Between approximately 2012 and 2014, as Local Supervisory Authority Contact Supervisor of Midwives and/or Band 6 ward coordinator:
5.1. Did not adequately challenge and/or participated in inappropriate working practices at the Hospital, namely:

5.1.1 Midwives accepting verbal orders for the use of Oxytocin;
   Proved by admission
5.1.2 Midwives seeking to avoid contact with obstetricians at night, when contact was required according to policy;
   Proved by admission

5.2 Did not escalate and/or seek to reform the difficulties in communication between midwives and obstetricians;
   Not proved

5.3 Did not question the validity of Patient Group Directives at the Hospital;
   Not proved

5.4 Did not ensure that there was a robust system to review concerns relating to midwifery practice at the Hospital
   No case to answer

AND in light of the above your fitness to practise is impaired by reason of your misconduct.
Mrs Roussel,

This was a multi-registrant hearing relating to you, Midwife A, and Midwife C.

Separate determinations were produced for each registrant.

Your response to the charges (10 January 2017)

Ms Hamilton informed the panel on your behalf that you admitted the following charges:
- Charge 1.1.1;
- Charge 1.1.2;
- Charge 1.1.5;
- Charge 1.5;
- Charge 1.6 (in part relating to 1.1.1 and 1.1.2);
- Charge 4.1.1;
- Charge 4.1.2;
- Charge 4.3;
- Charge 5.1.1; and
- Charge 5.1.2.

In accordance with Rule 24(5) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) (“the Rules”), the panel found proved the charges indicated above, by virtue of your admissions.

Decision and reasons on the admissibility of hearsay evidence

After the charges were read, Ms Hamilton on your behalf submitted that the sole evidence against you in support of charges 2 and 3 amounted to hearsay and that the panel should not permit such evidence to be admitted in evidence.

Ms Hamilton identified the evidence to which she was referring. Ms Hamilton told the panel that an NMC witness, Ms 1, a Local Supervising Authority for Midwives Midwifery Officer (LSAMO) for the South West Area for NHS England, had conducted a meeting
with Midwife A on 17th June 2014. She told the panel that it was alleged by Ms 1 in her witness statement, and in notes of a meeting with Midwife A on 17 June 2014 exhibited to that statement, that Midwife A had allegedly been informed by you that you had telephoned a Consultant Obstetrician at 23.20 on 29 January 2014 and obtained verbal authority from the Consultant to administer Syntocinon to Patient A. A written statement made by Midwife A to the same effect was exhibited to the witness statement of Ms 7, a LSAMO in Guernsey, who had carried out investigations in 2014.

Ms Hamilton submitted that this evidence is inadmissible. Initially, she submitted that the evidence does not satisfy the requirements of ‘relevance’ or ‘fairness’ under Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules). However, having taken instructions, she conceded that the evidence was relevant, but maintained that it would be unfair to admit it.

Ms Hamilton submitted the burden of proving the facts alleged against you rests with the NMC to the civil standard to the end of the NMC’s case. There is no burden upon the Registrant to disprove any fact asserted by the NMC. The NMC can only prove its case by adducing admissible evidence and fairness demands that the Registrant should be entitled to test that evidence through cross-examination of the maker of any statement used in evidence against the Registrant.

Ms Hamilton submitted that Midwife A has not given a statement in these proceedings and she cannot be called as a witness as she is a co-Registrant in this case. Therefore she is unavailable for cross-examination and the requirement for fairness would, if the evidence were admitted, be breached. There is no other evidence in support of charges 2 and 3, so that the hearsay evidence would be the sole and decisive evidence upon which the facts in charges 2 and 3 could be proved. Without the live evidence of Midwife A during the NMC’s case, the panel would not be able to decide if:

i. Midwife A is a credible witness; and
ii. The statements made by her were self-serving.
Ms Hamilton relied on the Criminal Justice Act 2003 in support of her submission that the evidence is inadmissible.

Ms Hamilton also referred the panel to the case of (J Bonhoeffer v GMC [2011] EWHC 1585 and NMC V E Ogbonna [2010] EWCA Civ 1216).

Ms Higgins on behalf of the Nursing and Midwifery Council opposed Ms Hamilton’s application.

She submitted that this case is very different from the above two cases, in which the Courts had held that the GMC and the NMC respectively had not taken sufficient steps to call the makers of the statements that had been admitted in the form of hearsay. Here, the NMC’s position was that there was never any question of Midwife A being called as a witness by the NMC, whether or not her case had been joined with your case.

Ms Higgins further submitted that the rules applicable in criminal cases do not apply in this jurisdiction.

Ms Higgins also submitted that there is further relevant evidence which the panel will hear from a live witness, Ms 3, who can be cross-examined. She will say that you made a verbal statement to her to the same effect as the statement made to Midwife A.

Ms Hamilton in response submitted that Ms 3’s evidence is wholly irrelevant to the allegations in charges 2 and 3.

The panel also heard submissions from Mr Elton on behalf of Midwife A and from Mr Collis on behalf of Midwife C.

The panel heard and accepted the advice of the legal assessor, including reference to Rule 31 which states;
“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 legal assessor also referred the panel to a number of cases including the cases of R (Bonhoeffer) v GMC Reference [2011] EWHC 1585 (Admin) and Ogbonna v NMC [2010] EWCA Civ 121.

With regard to fairness, the legal assessor referred the panel to the relevant considerations identified below as set out in the case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin):

“(1) whether the statements were the sole or decisive evidence in support of the relevant allegations,
(2) the nature and extent of the appellant's challenge to the contents of the statements,
3) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
(4) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;
(5) whether there was a good reason for the non-attendance of the witnesses;
(6) whether the Respondent had taken reasonable steps to secure their attendance, and;
(7) the fact that the Appellant did not have prior notice that the witness statements were to be read”.

The panel reminded itself of the legal assessor's advice in relation to Rule 31 which states that the panel may admit a statement of evidence, subject to the consideration of fairness and relevance, whether or not it would be admissible in civil proceedings. The panel noted that this is a wide ranging power and reflected the fact that the panel has a responsibility to investigate and decide upon issues relating to patient protection, as well as maintaining public confidence in and upholding proper standards within the profession.
The panel took into account the submissions made by Ms Hamilton and Ms Higgins. The panel was mindful of the competing interests of fairness to both parties.

The panel noted that prior to this hearing, in August 2015, a pre-hearing meeting took place, whereby the NMC made an application for the three cases to be joined. Ms Hamilton informed the panel that she had been present at that meeting and that she had made no objection to your case being joined with the cases of Midwife C and Midwife A. However, the panel also noted the NMC’s position that there would have been no question of the NMC calling Midwife A, who faced charges arising from the same events to which your charges had arisen, even if the cases had not been joined.

The panel did not accept Ms Hamilton’s submission that the Criminal Justice Act 2003 applied to these proceedings. However, as laid down in *Bonhoeffer*, the panel accepted that the absence of any such statutory safeguards in this jurisdiction governing the admissibility and treatment of hearsay is a relevant consideration, and the panel accordingly weighed this in the scales, together with the other factors referred to below, in reaching its decision.

The panel did not accept Ms Hamilton’s submission that the evidence in question was the sole or decisive evidence in support of charges 2 and 3. The panel considered that evidence from Ms 3 of a conversation to a similar effect to that referred to in charges 2 and 3 could potentially be of some relevance. However, the panel accepted that the hearsay evidence of Midwife A, if admitted, would be the central evidence in support of these charges, and that without this evidence the NMC would not be in a position to pursue them further.

The panel noted that charges 2 and 3 were simply, but firmly, denied by you.

The panel considered the seriousness of the charges and the impact which adverse findings might have on your career. The panel had no doubt that, if proved, the allegations of giving misleading information to Midwife A, and doing so dishonestly, could have very serious implications for your career.
However, in considering fairness to the NMC, the panel also took into account that the serious nature of the allegations in the charges was relevant to the NMC’s overarching objective to protect the public and uphold the public interest and the importance of ensuring that the allegations were addressed.

The panel considered whether there was good reason for the fact that the NMC could not call Midwife A as a witness. The panel accepted that it would not be possible for the NMC to call Midwife A as a witness. In the light of this conclusion, the panel accepted Ms Higgins’ submission that the facts of this case are very different to those in the cases of Ogbonna and Bonhoeffer. The key reason in those cases for the Courts’ conclusions that it had been unfair to admit statements in the form of hearsay did not apply to this case. In this case, there was nothing further that the NMC could reasonably have done to enable you by your counsel to test Midwife A’s statement by cross-examining her. Accordingly, the NMC could do no more than rely on the evidence of Midwife A in the form of hearsay in which it stood. In these circumstances, the panel did not accept that it would in principle be unfair to you to admit this evidence.

Furthermore, the panel was satisfied that it would be unfair to the NMC to exclude this evidence, which would thereby result in these serious allegations being unaddressed.

The panel accordingly concluded that the requirements of relevance and fairness were met, and decided to admit the evidence.
Decision and reasons on application under Rule 31 to hear evidence via Video Link (WebEx) (18 January 2017)

Ms Higgins made an application under Rule 31 of ‘The Nursing and Midwifery (Fitness to Practise) Rules Order of Council 2004’, “the Rules”, to allow Dr. 1 to give evidence by webex. She submitted that Dr. 1’s evidence is relevant to the charges and that it would be fair in the circumstances to hear his evidence in this way. Ms Higgins submitted that Dr. 1 was unable to attend the hearing in person due to his clinic commitments, she provided the panel with a schedule of Dr. 1’s work commitments which she submitted were booked some six weeks in advance. Ms Higgins told the panel that Dr. 1’s statement was not obtained by the NMC until 3 January 2017 and that he had not been given the usual six week notice in order to avail himself to attend the hearing in person.

Ms Hamilton, on your behalf, opposed the application, she submitted that live evidence is the best form of evidence. Ms Hamilton submitted that there is an issue of credibility regarding Dr. 1 as he was under investigation at the same time as other members of staff and that his evidence required close examination. Ms Hamilton submitted that although webex was one step up from that of telephone evidence, it was not the same as having a witness in the room. Ms Hamilton submitted that it was clear from Dr. 1’s rota that there were other consultants available at the hospital to cover for him in his absence.

Ms Hamilton submitted that in regards to charges 2 and 3, Dr. 1’s evidence was of pivotal importance as he was the obstetrician on duty at the time of the events and Ms Roussel was the Midwife Co-ordinator. She submitted that a phone call had been made earlier to him by Ms 3 and that Dr. 1 cannot remember who called him and now says in his statement that he does not remember receiving a telephone call. Ms Hamilton concluded that there has also been contact between your and Dr 1 as you have continued to work together since 2014 and that there were matters she would like to put to him in evidence.

The panel heard and accepted the legal assessor’s advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that
“subject only to the requirements of relevance and fairness” a panel may accept evidence in a range of forms and circumstances and whether or not it is admissible in civil proceedings.

The panel was satisfied that the evidence of Dr. 1 was relevant to the charges and considered whether it was fair to allow him to give evidence via webex. The panel accepted Ms Hamilton’s submission that the best practice would be for Dr. 1 to be present and give live evidence.

The panel noted that the general demeanour of witnesses giving evidence over the telephone or webex could not be tested fully through cross examination. It was mindful that it was the NMC’s responsibility to ensure that the witnesses it intends to rely upon are available to give live evidence at the proceedings so that they can be thoroughly examined. The NMC was aware that this was a contested case where the evidence was disputed, and required to be carefully scrutinised.

The panel considered that this case was a split hearing which was due to resume for a further two weeks from week commencing 6 February 2017. The panel determined it would therefore be appropriate for the NMC to make arrangements for Dr. 1 to attend this hearing in person on either week the week of the 6th or the 13th February 2017.

In all the circumstances, the panel considered that it would not be fair to allow Dr. 1 to give evidence via webex. Accordingly, the panel did not accept Ms Higgins application for Dr. 1 to give evidence by webex.
Further application to hear the evidence of Dr 1 via WebEx.
(19 January 2017)

Ms Higgins submitted that upon making enquiries with Dr. 1 regarding his availability to attend this hearing in person, on either the week of the 6th or 13th February 2017, she had been advised by Dr 1 that he is out of the country for both weeks on a pre-arranged holiday. In light of this information, Ms Higgins renewed her earlier application to hear the evidence of Dr. 1 by webex.

The panel bore in mind the three registrants interests as well as the public interest in determining whether it would be fair to hear Dr. 1’s evidence via WebEx.

The panel considered that the situation had changed significantly since yesterday and with it the issue of fairness.

The panel had regard to the details of Dr. 1’s pre-arranged commitments provided by way of an email, which was from his Legal Representative. The panel determined that given today was the only availability he had to provide his evidence, it therefore acceded to the NMC’s application to hear Dr. 1’s evidence by webex.

The panel determined that, the three registrants are all represented by experienced counsel who will have the opportunity to cross-examine this witness by webex.
The panel can take into account the fact that this witness gives evidence by webex when considering what weight to give to his evidence in due course.

Decision on Interim Order (upon adjournment):

Prior to adjourning this hearing at this stage, the panel is required to consider under Rule 32 (5) whether it is necessary to impose an interim order to cover the adjournment period.
The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in the registrant’s own interests. The panel may make an interim conditions of practice order or an interim suspension order for a maximum of 18 months.

Ms Higgins made no application for an interim order and Ms Hamilton, on your behalf made no contrary submissions.

The panel has decided not to impose an interim order.

This hearing will resume, on 17 July 2017.
Submissions on application of no case to answer 17 July 2017

Mrs Roussel,

The panel had the benefit of detailed written submissions from Ms Hamilton on your behalf (Exhibit 32) and a detailed written response from Ms Higgins on behalf of the NMC (Exhibit 33).

At the close of the NMC’s case Ms Hamilton made an application under Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (as amended) (‘the Rules’). She submitted that there was no case to answer in respect of charges 1.1.3, 2, 3, 5.2, 5.3 and 5.4.

Rule 24(7) states:

24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council’s case, and—

(i) either upon the application of the registrant, or

(ii) of its own volition,

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

Charge 1

1. In respect of the care delivered to Baby A and/or Patient A on 29 and 30 January 2014, when you were the midwifery ward coordinator:

1.1 At or around 23:20 on 29 January 2014, commenced and/or oversaw the administration of Syntocinon to Patient A:

1.1.3 In the presence of mild fetal heart rate distress;
Ms Hamilton submitted that no witness has defined mild fetal distress. She submitted that at 22:25 hours on 29th January 2014, you categorised the CTG as having one non-reassuring feature and noted on the CTG sticker that further decelerations should be observed closely. Ms Hamilton submitted that one deceleration denotes a suspicious trace but this, per se, does not equate to a diagnosis of fetal distress. On 19th January 2014, Dr. 1 agreed that at 23:20, with regard to the trace alone, the picture would not warrant escalation. Ms Hamilton submitted that Dr. 2 examined the trace (on 1st February 2014) and found that the trace showed good variability throughout with intermittent variable decelerations with good recovery.

Ms Hamilton submitted that there is no evidence of fetal distress at 23:20, and that the charge should be dismissed.

Charges 2 and 3

2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a Consultant Obstetrician to support the subsequent administration of Syntocinon to Patient A.

3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014.

Ms Hamilton submitted that Charges 2 and 3 arise from a series of conversations between you, Midwife A and Ms 3. Ms Hamilton submitted that you have admitted from the outset that you failed to contact Dr 1 when you and Midwife C commenced Syntocinon.

Ms Hamilton submitted that there is no dispute that you informed Midwife A that you had spoken to the Consultant about another patient earlier in the evening and had during the course of the conversation, mentioned Patient A, but you failed to make a second call. Ms Hamilton submitted that there is no dispute that you said to Ms 3, during a heated
conversation about Patient A, that you had not called Dr 1 when you commenced the Syntocinon.

Ms Hamilton submitted that confusion has arisen following the subsequent emails between Midwife A and Ms 3 on 1st May 2014 and that this was what led to a conclusion that you had “covered up” in some way. Ms Hamilton submitted that neither Midwife A nor Ms 3 spoke to you about whether or not you had spoken to Dr 1 at the commencement of the Syntocinon or at all.

Ms Hamilton submitted that the evidence before the Panel arises from the hearsay evidence of Midwife A and the live evidence of Ms 3. Ms Hamilton submitted that the evidence from both sources is inherently unreliable and should be approached with caution. Ms Hamilton submitted that where there is an allegation of dishonesty, the Panel should approach any allegation made by a co-Registrant with the utmost caution, she reminded the panel of the argument on that point concerning hearsay. She submitted that the Panel should extend caution where the source of information arises from staff who are under investigation, namely Ms 4 and Dr 1. Ms Hamilton submitted that Ms 3 was also concerned about her own position in Guernsey.

Ms Hamilton submitted that the Panel must examine the chain of communication that led to Midwife A’s conclusion in her statement that:

“I was shocked at what had happened while I was on leave and on discussion with HK realised that TR had not been honest with me at the outset; she had informed me that she had contacted the on call obstetrician CJ regarding the ordering of Syntocinon, when in fact this was not the case.”

Ms Hamilton submitted that it was not altogether clear who led Midwife A to believe that you had not been honest with her. She submitted that no one in the chain returned to you to clarify with you, even in the light of Ms 3’s enquiry with the switchboard, as to when you had spoken to Dr 1 and what they had said to each other. Ms Hamilton submitted that there appeared to have been a conclusion drawn without further enquiry or an opportunity for you to provide details of the earlier call.
Ms Hamilton submitted that Ms 3 is a witness whose evidence in relation to you stands or falls depending upon the Panel's assessment of her credibility. Ms Hamilton submitted that Ms 3 is not an honest witness and that she nursed a grudge against you because of your position as a SoM. Ms Hamilton submitted that Ms 3 held the view that you had the benefit of time off to fulfil your role as SoM and that she expressed a view to Midwife A that the case of Patient A had been "covered up" because you were a SoM.

Ms Hamilton submitted that you were a highly regarded midwife on Loveridge Ward who had had no practice concerns prior to the incident of Patient A. In the referral made to the NMC on 22nd October 2014 by Ms 3, it is submitted that she made unsubstantiated allegations against you. Ms Hamilton submitted that in the body of the referral form, the information provided by Ms 3 is misleading: the trace was not classified as pathological; there was no mystery surrounding the blood gases – the results were normal; you did not fail to turn off the Syntocinon when relieving for breaks as the infusion did not commence until after Midwife C's break; you did not fail to guide Midwife C; you and she made a joint decision to commence the Syntocinon.

Ms Hamilton submitted that during cross examination, Ms 3 was asked to look at the referral she made to the NMC and denied any knowledge of the form and suggested that someone else must have completed it. Ms Hamilton submitted that Ms 3 attended the NMC to give evidence concerning you and that she could not have forgotten that she had made a referral. Ms Hamilton reminded the panel that after a break in the proceedings, Ms 3 was asked to look at a number of emails to the NMC and only then accepted that she had referred you to the NMC. Ms Hamilton submitted that Ms 3's initial answers were dishonest and designed to distance her from that referral, in the eyes of the Panel.

Ms Hamilton submitted that it is your case that the referral from Ms 3 was motivated by her personal ill feeling towards you. She submitted that Ms 3 appears to have misled Midwife A in that she failed to notify her that there had been a call to Dr 1 at 21:45 and the fact that Dr 1 claimed not to remember an additional call. It is submitted that, if Midwife A had been provided with a full picture from Ms 3 and, in particular, the
additional call to the Consultant, she would not have concluded that Mrs. Roussel had misled her.

**Charge 5**

5. Between approximately 2012 and 2014, as Local Supervisory Authority Contact Supervisor of Midwives and/or Band 6 ward coordinator:

   5.1 Did not adequately challenge and/or participated in inappropriate working practices at the Hospital, namely:

   5.2 Did not escalate and/or seek to reform the difficulties in communication between midwives and obstetricians;

   5.3 Did not question the validity of Patient Group Directives at the Hospital;

   5.4 Did not ensure that there was a robust system to review concerns relating to midwifery practice at the Hospital

Ms Hamilton submitted that with regard to the communication between midwives and consultants, the NMC had called inconsistent evidence about whether or not there were communication difficulties. Ms Hamilton submitted that Ms 7 reported anecdotally that the Consultants valued the midwives who did not disturb them with telephone calls. Ms 1 also reported a culture dominated by the Consultants but Dr 1 and Ms 3 gave evidence that the consultants were always approachable and could be contacted night and day. Ms Hamilton submitted that you were under no duty to reform difficulties in communication unless you were aware of problems and that not all members of staff recognised a picture of poor communication.

Ms Hamilton submitted that administration of drugs under Patient Group Directives (PGDs) was in widespread use and the midwives practised with the genuine belief that the PGDs had been ratified. This was confirmed by Ms 5 in her evidence. Ms 7 in evidence said that the Head of Midwifery told her that a signature sheet for the PGDs was held in her office. This could not be found but the midwives had acted under the
guidance of the Head of Midwifery. Ms Hamilton submitted that you had no reason to believe (and therefore no duty) to challenge the validity of PGDs.

Ms Hamilton submitted that the NMC have not called any evidence to show that, as a Band 6 Ward Coordinator and a Supervisor of Midwives, you were under a duty to ensure that there was a robust system to review concerns relating to midwifery practice. She submitted that as a Band 6 Coordinator, you had a duty to ensure safe working within your team at ward level. As a SoM, you were concerned with promoting safe and appropriate practice in the delivery of midwifery care. Ms Hamilton submitted that the management structure at the Hospital led by the Head of Midwifery supported by a tier of managers (Band 7 and above) who ranked above the Band 6 Ward Midwives.

Ms Hamilton submitted that in her evidence, Ms 5 confirmed that you would not have been in a position, in any event, to implement a robust review system. Ms 5 had not been able to effect change from her Band 7 Risk Management Role from 2008 until 2011.

Ms Hamilton concluded by submitting that, in all the circumstances, there is insufficient evidence to proceed with charges 1.1.3, 2, 3, 5.2, 5.3 and 5.4.
NMC Response

In relation to charge 1.1.3, Ms Higgins submitted that the NMC accept that the evidence of Dr 1 that he did not consider the trace required escalation at 23:20. His evidence regarding the trace was that it became suspicious and required escalating at 23:50 on 29 January 2014. As a consultant obstetrician considering the CTG trace under oath, the NMC accepts this opinion and does not seek to challenge Ms Hamilton’s submission in respect of this charge.

Charge 2 & 3

2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 2320 on 29 January from a consultant obstetrician to support the subsequent administration on Syntocinon to Patient A.

3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014.

Ms Higgins submitted that the evidence relied upon by the NMC includes the live evidence of Ms 3, Dr. 1 (via webex) and the transcript of interviews relevant to Midwife A and you.

Ms Higgins submitted that Ms 3 gave evidence over two days and that she was forthright and honest in her recollection of the morning and days after the birth and subsequent death of Baby A and the months thereafter. It was clearly a period of time that she found distressing and difficult to cope with. Ms Higgins submitted that Ms 3’s evidence as to her concern from the outset, on the morning of 30 January, was clear. She was not happy with the standard of midwifery and challenged it as best as she knew how ultimately leading her to make a referral to the LSA. She explained that central to her concerns was the use of Syntocinon in the second stage of labour without the involvement of an obstetrician. She added that in light of her concerns she
challenged you as to the lack of consultant intervention and indeed looked into the calls made to the consultant that night.

Ms Higgins submitted that in Ms 3’s interview with HSSD and the LSA on 10 June 2014 she described a conversation between herself and you “..I said what did Carl say when you rang him and you described this picture, and she didn’t really answer me in terms of what he said, but she said it was to start Syntocinin, and I said there is nothing documented about your conversation and she said no but she had, but she did keep saying she had called him and then she got really angry with me for discussing this so I just put my hand very gently, look I said I really don’t want to upset you, I said I just want to get to the bottom because I can’t understand why he didn’t come in. And then we sat there all of a sudden it was so unexpected it was the last thing I expected her to say, she just said I didn’t call him. I know I was really shocked and so I waited and she said I didn’t call him. I said Tuija that’s, I think my words were, you know that’s wrong don’t you and she said yes I know and we were quite quiet and I said you will never do that again will you and she said no I won’t.”

In evidence, Ms 3 reiterated and described this conversation with you in her live evidence. Ms Higgins submitted that she remained consistent and that her evidence is wholly reliable and provides evidence of an admission by you to her when pushed that despite saying she initially spoke to Dr 1 regarding Syntocinin she had not in fact spoken to him regarding Patient A and Syntocinin.

Ms Higgins submitted that Ms 3 has no motive to fabricate such a conversation, she submitted that it was clear from Ms 3’s evidence that she found her time in Guernsey difficult and the circumstances around the death and investigation into the death of Baby A extremely challenging. Ms Higgins submitted that the panel will no doubt have in mind that she became a whistleblower in an environment in which Ms 5 stated was extremely difficult to challenge. Ms Higgins submitted that Ms 3 sought no personal gain from such action, rather her actions made her life considerably more uncomfortable and difficult. Ms Higgins submitted that Ms 3 was clear that she had no personal feelings of animosity towards you and furthermore at no stage felt under investigation by either the LSA or HSSD. Ms Higgins submitted that Ms 3 had no motivation to lie to the panel.
Ms Higgins submitted that Dr 1 was forthright. He was clear, that he has no recollection of receiving a call regarding Patient A on the night of the 29/30 January prior to being called at 0055 to attend. His evidence confirmed and reiterated his position at the SUI and his statement made on the 4 June 2014 “I was not informed that Patient A had been started on a Syntocinon infusion at 2320.” He was honest in his recollection, or lack thereof regarding earlier calls; he cannot remember the exact nature or quantity of calls. What he can remember is that he did not receive a call regarding Patient A and further that at no stage was he asked if Syntocinon could be administered. He further stated that he was unaware that the midwives would take it upon themselves to administer Syntocinon in the second stage of labour and was clear that he viewed such practice to be unacceptable and clearly against the practice set out in the policy authored by him ‘The Use of Oxytocin in Labour’. Ms Higgins submitted that considering the evidence of Dr 1 it is highly unlikely that he would have given a verbal order for Syntocinon to be administered to Patient A in the second stage of labour. She submitted that Dr 1 provides cogent evidence that you did not call him regarding Patient A receiving Syntocinon. Ms Higgins submitted that the evidence of Dr 1 is supported by the evidence of Ms 3 regarding her conversation with you.

Ms Higgins submitted that Midwife A was interviewed by HSSD and the LSA on 17 June 2014. She submitted that Midwife A, in describing her actions on the morning of 30 January, stated as follows: “… it didn’t look like the Syntocinon had been ordered by the obstetrician… there was not record of it… so that’s what I went away with in my mind that I need to clarify this so when I got back around the office I had a quick look… you know I was looking at the notes looking for what wasn’t there rather than was, saw that it wasn’t there, phoned the midwife at home to clarify and she told me that she’d spoken to the obstetrician and it had been ordered and she hadn’t documented it. Again this is a senior midwife, supervisor of midwives, I had no reason to doubt what she was telling me, she was happy with the care she’d given…” Further, when Midwife A is asked by Ms 1 “Why did you think this was a good idea to phone her at home and not wait for her to…” to which Midwife A answered “Because I felt that to me at the time that was quite an important factor because if she …for me to ascertain because if she hadn’t ordered it…if she hadn’t spoken to anyone and had it ordered then that was a big issue and to
my mind you know that was really sort of.. in retrospect that was the game change for me because if she’d told me the truth then it would have immediately sparked … that would have immediately instigated a supervisory investigation because she’d gone against her rules.” Further Ms 1 asks “Do you think she was aware of the significance of what you were asking” to which Midwife A replied “Yes”.

Miss Higgins submitted that Midwife A was categorical in her formal interview to HSSD and LSA that she had specifically called you to discuss the authorisation for Syntocinon. She wanted to ensure the Syntocinon, as with custom practice, had been authorised by a verbal order and on satisfactory receipt of such information her primary concern became one of record keeping. This is reflected in the LSA Investigation Decision Tool and in her statement made 13 June 2014.

Ms Higgins submitted that it seems clear on the evidence, that Midwife A was focused on the issue of the Syntocinon when calling you and as such it is inconceivable that the conversation between Midwife A and you did not include a direct question regarding the Syntocinon and whether a consultant had given a verbal order. Midwife A was clear in her interview that you stated that a verbal order had been given and as such Midwife A, in light of the condoned culture at the time, viewed the only problem to be one of record keeping.

Ms Higgins submitted that prior to Midwife A’s interview she completed a statement setting out that between 1020 and 1050 on the morning of 30 January she phoned you and was informed by you that prior to the administration of Syntocinon, she spoke to Dr 1 about another patient and at that time she also referred to Patient A and Syntocinon. Her statement documents that she asked you to add a retrospective note to reflect the conversation. Midwife A’s statement goes on to describe Sunday 2 February when she was on duty. She describes a conversation with you in which she again reminded you to write the retrospective entry. No entry was made. The NMC rely upon the medical notes of patient A which make no mention of a call or conversation with Dr Carl Jensen regarding the commencement of Syntocinon at 2320.
Ms Higgins submitted that you were interviewed by HSSD and the LSA on 10 June 2014 you admitted that regarding the administration of Syntocinon at 2320 “I failed to inform obstetrician when Syntocinon was considered and started.” Ms Higgins submitted that you was categorical; you did not phone the consultant when Syntocinon was either considered or started. She further reiterates the position by stating at “he arrived ten past one. At this time when I writing the CTG I simply cannot remember if I informed him about the Syntocinon when I phoned him or when he arrived”. Ms Higgins submitted that the phone call referred to is the 1255 phone call, thereby emphasising that the first time you told the consultant about the Syntocinon was either during the 1255 phone call or when he arrived. At page 221 you stated when discussing Dr 1 “it was after delivery after baby was transferred that the conversation started I apologised to him, I’m sorry I did not inform you about the Syntocinon, kicking myself big time kicking myself ever since.” Ms Higgins submitted that such statements provide clear evidence and intend acceptance that you did not speak to Dr 1 regarding the Syntocinon prior to its administration.

Ms Higgins submitted that the allegation that you did not discuss Syntocinon with Dr 1 prior to its administration is supported by your comments regarding the customs and practices present at the time:

\[\text{TR} \quad \text{“yes is about custom and practice. About around the Syntocinon that over the years the midwives do start a patient on Syntocinon for low risk mums, middle of the night for patients when it is deemed to be required.”} \]

\[\text{KP} \quad \text{“without discussion with the obstetricians”} \]

\[\text{TR} \quad \text{“yes”} \]

Ms Higgins submitted that several times throughout the interview it is put to you that you administer Syntocinon to patients without calling a consultant. At no stage did you challenge this.

\[\text{MP} \quad \text{“Can I ask you because I’m just trying to understand the background, so you put up Syntocinon up without you know making the phone call for the verbal order, how do you become comfortable with that practice or may be}\]
not comfortable but that’s become your practice and I’m just trying to understand how you got to that, because you are not speaking, your not doing the phone call or discussion”

TR “Over the years I can’t pin point any any certain time…the Syntocinon is used without discussion with obstetrician, why I have done that I believe I along with other people doing it as well.”

Ms Higgins submitted that you went on however to state and accept that administering Synoticnon in the second stage is considered differently:

DP “Tuija can I just ask you, you’ve spoken that you were sorry you didn’t tell him about it, but the practice is that people don’t make these phone calls isn’t it.

TR “Yes but that was mum in second stage.”

MP “…so second stage is different?”

TR “Midwives shouldn’t start it anyway by second stage Syntocinon should be used in consultation I know that.”

Ms Higgins submitted that Ms 3 spoke to the hospital switchboard regarding phone calls made from the Loveridge Ward to Dr 1. Her evidence is that two calls were made. The later call at 0055 is not disputed and it is agreed that this was the call for Dr 1 to attend Patient A. The timing of the first call is less clear. In Ms 3’s interview she stated 2145 but in her witness statement and reiterated in evidence she was firm in the belief that it was earlier, around 2115. Ms Higgins submitted that the timing of the call is so far prior to the eventual administration of Syntocinon, with a wholly different medical picture, that even if Patient A had be discussed (which the NMC says the evidence suggests not) no meaningful discussion regarding the administration of Syntocinon, in the second stage, could have possibly been had.

Ms Higgins concluded that based on the evidence of Ms 3, Dr 1 and the interview transcripts of Midwife A and you that no phone call was made to Dr 1 regarding Patient A and Syntocinon prior to its administration. And that it appears clear that while it was accepted custom and practice for low risk women to be administered
Syntocinon in the first stage of labour without a verbal order it was not the accepted practice to administer it in the second stage. As such, she submitted that it is more likely than not that you dishonestly informed Midwife A that you had spoken to Dr 1.

Ms Higgins submitted that based on the evidence, as set out above, there is undoubtedly sufficient evidence that there is a case to answer on both allegations 2 and 3. There are a variety of sources of evidence relied upon, both directly through prosecution witnesses and further corroborated by the accounts of Midwife A and you. The evidence put forward by the NMC cannot, when considered in the whole, be described as tenuous in character.

Charge 5

5. Between approximately 2012 and 2014 as Local Supervisory Authority Contact for Supervisor of Midwives and/or Band 6 ward coordinator:

5.2 Did not escalate and/or seek to reform difficulties in communications between midwives and obstetricians:

Ms Higgins submitted It was important to focus on the wording of the charge. To escalate or seek to reform being an and/or. The evidence on the communication difficulties has been set out by a variety of witnesses including primarily by those investigating the Loveridge Ward who interviewed midwives. The LSA were clear in their conclusions that communications were challenging. Ms Higgins submitted that Dr 1 refuted the suggestion that he could be difficult but accepted that there was one particular consultant who could be difficult. Ms 3 gave evidence that she felt she could communicate well with the consultants. Ms Higgins submitted it was important to note that she was a senior midwife, the ward manager. Furthermore it came clear in the evidence that she did not work at nights.

Ms Higgins submitted that importantly you in your own interview on 10 June 2014 discussed the difficulties. There is direct evidence that you were fully aware such difficulties existed and were felt by staff at night. One of your reasons for the administration of Syntocinon without a verbal order and without an obstetrics review
was because communication was bad. Ms Higgins submitted that of relevance, you admitted Charge 5.1.2, namely that you did not adequately challenge and or participate in inappropriate working practices at the hospital namely: midwives seeking to avoid contact with obstetricians at night, when contact was required according to policy.

Ms Higgins submitted that the next question therefore is whether in your position as a Band 6 coordinator and/or a SOM you had a duty to escalate and/or seek to reform the difficulties. Ms Higgins submitted that the NMC rely upon your job description as a Band 6 Co-ordinator. She submitted it was important to note that your job description includes; ensuring clear systems of communication; to act as a professional role model for junior staff, to manage conflict and to communicate clearly with the multidisciplinary team. Throughout the job description the multi-disciplinary nature of the ward is emphasised as to is the expectation of working appropriately within such an environment. Further, Ms Higgins submitted that your role, as the most senior midwife on duty at night, it is axiomatic that she had a duty and responsibility to escalate any concerns she had.

Ms Higgins submitted that as a SOM you had a further duty. Ms 1, Ms Patterson and Ms 7 provided evidence as to the expectations on SoMs. The role of a SOM is to ensure and promote safe and appropriate practice. As a SoM you had a duty to escalate and act upon fundamental failures.

Ms Higgins submitted that based on the evidence, as set out above, there is undoubtedly sufficient evidence that there is a case to answer. There are a variety of sources of evidence relied upon, both directly through prosecution witnesses and further corroborated by the account of your interview. She concluded that the evidence put forward by the NMC cannot, when considered in the whole, be described as tenuous in character.

5.4 Did not question the validity of Patient Group Directives at the Hospital

Ms Higgins submitted that in addressing this charge, the NMC must first prove that the PGD’s were not validated. She submitted that the evidence on this issue had been clearly put forward and indeed not challenged by you. She submitted that it appeared that you accept that the PGD’s were not validated. Ms Higgins submitted that the
question therefore remains as to what responsibility you had. Ms Higgins submitted that the charge pitches the responsibility as a low one, ‘did not question’. Ms Higgins submitted that the NMC do not say that it was the responsibility of you to ensure they were validated but merely to question.

Ms Higgins submitted that within the job description it is expected that you should ‘ensure team members are aware of organisational objectives, policies and procedures and the implications they have on their practice.’ Miss Higgins submitted that a requirement to understand policies and practices and to educate other team members clearly implies that you should be fully au fait with such documents. It is submitted that on both the job description as a Band 6 co-ordinator and as a SoM you should have actively questioned the validity of such documents upon which you relied on. Ms Higgins submitted that based on the evidence, as set out above, there is sufficient evidence that there is a case to answer.

5.4 Did not ensure that there was a robust system to review concerns relating to midwifery practice at the hospital

Ms Higgins submitted that the NMC do not seek to challenge the submissions of Ms Hamilton regarding this charge. She submitted that the NMC acknowledges that the wording of the charge puts a high burden on you ‘to ensure’. Ms Higgins submitted that the NMC accepts the evidence of Ms 5 that you would not, as a Band 6 midwife, be in a position to ensure there was a robust system of review.

The panel heard and accepted the advice of the legal assessor. He referred the panel to Rule 24(7) of the Rules. He also referred the panel to the case of R. v Galbraith [1981] 1 W.L.R. 1039, which sets out the test to be applied in considering whether or not there is a case to answer.
Panel’s decision and reasons on application of no case to answer on charges 1.1.3 and 5.4:

The panel accepted the concessions made by Ms Higgins in respect of charges 1.1.3 and 5.4 which they adopted and determined that there is no case for you to answer in respect of charges 1.1.3 and 5.4.

The panel’s task at this stage is not to make factual findings in relation to the evidence but rather to assess whether there is ‘sufficient evidence’ in terms of the Galbraith test. Accordingly, in respect of those charges where the panel has found that there is “sufficient evidence”, the panel wishes to stress that it does not determine until a later stage the view it takes of that evidence and whether or not the NMC has proved these charges upon the civil standard of proof.

The panel has made the following determinations in respect of the remaining contested charges: -

The Panel decision and reasons on application of no case to answer on charges 2, 3, 5.2 and 5.3

Charges 2 & 3

2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 2320 on 29 January from a consultant obstetrician to support the subsequent administration on Syntocinon to Patient A.
3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014.

In reaching its decision, the panel has made an assessment of all the evidence that had been presented to it at this stage.

The panel considered that there is sufficient evidence before it to support charges 2 and 3 at this stage and as such it was not prepared to accede to an application of no case to answer.
In the circumstances, the panel finds there is a case for you to answer in respect of charge 2 and 3

Charge 5.2

5. Between approximately 2012 and 2014 as Local Supervisory Authority Contact for Supervisor of Midwives and/or Band 6 ward coordinator:

5.2 Did not escalate and/or seek to reform difficulties in communications between midwives and obstetricians:

The panel considered that there is sufficient evidence before it to support charge 5.2 at this stage and as such it was not prepared to accede to an application of no case to answer.

In the circumstances, the panel finds there is a case for you to answer in respect of charge 5.2.

Charge 5.3

5. Between approximately 2012 and 2014 as Local Supervisory Authority Contact for Supervisor of Midwives and/or Band 6 ward coordinator:
5.3  *Did not question the validity of Patient Group Directives at the Hospital*

The panel considered that there is sufficient evidence before it to support charge 5.3 at this stage and as such it was not prepared to accede to an application of no case to answer.

In the circumstances, the panel finds there is a case for you to answer in respect of charge 5.3.

*(Midwife B – Mrs Roussel)*

**Background presented by the NMC**

This case concerns three registrants, all registered midwives and all employed by the Health and Social Services Department (HSSD) of Guernsey at the Princess Elizabeth Hospital (the Hospital) on the Maternity Suite known as the Loveridge Ward (the Ward).

The Hospital is situated within the Bailiwick of Guernsey, which is a Crown Dependency. As such, it is governed by a directly elected legislature independent of the United Kingdom. However, the NMC has jurisdiction as a regulator of nurses and midwives practising in Guernsey.

The Ward itself contains a 12 bed antenatal/postnatal ward, 4 delivery rooms, a 2 bed transitional care unit and a 3 bed neonatal unit.
Midwives on the Ward were allocated to provide one to one care for a woman before, during and after labour. The nature of the one to one care system involved a midwife taking on responsibility for both the care personally delivered and the management of the patient’s condition. The midwife’s role therefore included the need to escalate the condition of the patient allocated to her to a Consultant Obstetrician as required, in order to ensure that any abnormalities in the patient’s condition were dealt with in a timely and appropriate manner.

The structure in place at the Hospital was such that it did not have junior or middle grade doctors working within the Maternity Service. Therefore when a midwife referred a patient for medical intervention this was directly to one of four Consultant Obstetricians.

A shift coordinator [a Midwife] would also be on the ward, not allocated to individual patients, their purpose was to allocate tasks and also to act in a supporting and advisory role for the midwives present.

36 midwives in total were employed at the Hospital who, at the relevant time, were supervised in their practice by four locally based Supervisor of Midwives (“SoM”). Both you and Midwife A were SoMs.

In May 2014, Ms 3, a midwife on the Ward, started to contact the Local Supervising Authority for Midwives (“LSA”) in order to register her concerns regarding midwifery practices. The LSA is the statutory body responsible for the supervision of all midwives practising within its boundaries. It is responsible for ensuring that the Midwifery Rules and Standards and the NMC code are met.

Ms 3 raised concerns as a result of a neonatal death in January 2014 of Baby A. Ms 3 was concerned as to deficiencies in the care provided on the night shift of 29 – 30 January 2014 by the midwifery team during Patient A’s labour. Ms 3’s concerns related in particular to what she considered amounted to inadequate management of the cardiotocograph (“CTG”) trace obtained during fetal heart monitoring, and the unauthorised use of medication, specifically syntocinon. Ms 3 was further concerned by
what she considered were inadequacies in the subsequent investigation by the Hospital into this neonatal death.

Ms 3’s concerns regarding the management of the CTG trace related to alleged failure on the part of the midwives to identify characteristics of the CTG trace in order to correctly classify it as normal, suspicious or pathological. Ms 3 was further concerned that, where signs giving rise to abnormal classifications of the CTG had been present and recognised as such by the midwives, this had not been escalated to a Consultant Obstetrician. Midwives were therefore acting outside the scope of their practice by continuing to lead the decision making in respect of patient care.

Syntocinon is a synthetic form of the naturally occurring hormone oxytocin. It is a drug used to augment labour by making contractions both stronger and more regular. Syntocinon is a form of medication which can only be administered after a written prescription has been given by a suitably qualified medical practitioner, i.e. in the case of this hospital, a Consultant Obstetrician. There are specific risks associated with the administration of Syntocinon which differ according to the stages of labour, but become more acute when stage 2 of labour has been reached, and there was a clear requirement for an Obstetrician to attend and review a patient to make a clinical decision as to whether Syntocinon should be administered before this was done.

There were a number of HSSD guidelines in place at the Hospital at the relevant time, including “Clinical Guideline for Fetal Monitoring During Intrapartum Period” setting out how to categorise a fetal heart rate trace from a CTG and the consequential actions to be taken. Of particular relevance is that part of the policy which sets out that if a CTG trace presents as suspicious and the patient is receiving Syntocinon the patient should be reviewed by an Obstetrician. In addition, there were national guidelines which applied in the NHS’s National Institute for Health and Clinical Excellence’s guideline on intrapartum care (“the NICE Guidelines”).

Ms 3 raised further concerns regarding the use of Syntocinon by midwives without written prescriptions or, in some cases, any authorisation from a Consultant Obstetrician. The culture was such that Syntocinon would be routinely administered to a patient, and its rate increased, by a midwife acting on a verbal order over the telephone by a
Consultant Obstetrician. Further concerns were raised that syntocinon was being administered in the absence of any form of Consultant Obstetrician involvement at all.

Following the concerns raised by Ms 3, the LSA Midwifery Officer (“LSAMO”), Ms 1, ordered an initial audit of patient records to take place on 2 June 2014. The audit, containing a sample group of ten records, was completed by a SoM named Ms 14. Ms 14, discovered evidence to support the concerns being raised by Ms 3, particularly in respect of the unauthorised use of Syntocinon.

Over the course of August 2014, the LSA continued its investigation into midwifery services at the Hospital. Two significant audits took place during this month. The audit process revealed a significant culture that had developed whereby midwives would act outside the scope of their practice. As well as issues concerning the use of Syntocinon, which were considered to be widespread, a culture was discovered whereby communications between Consultant Obstetricians and midwives were discouraged or avoided because of their difficult nature. Midwives were considered to be better at their roles if they delivered care without troubling a Consultant Obstetrician, an attitude particularly prevalent during the course of the night shift. Risk management was assessed by the LSA as inadequate on the basis that substandard midwifery care was not identified and was therefore neither challenged, reviewed nor remediated.

Following the LSA audit a number of individual cases were identified where the standard of care was such that they were considered to require a LSA SoM led investigation, so that individual conduct could be considered in greater detail. These investigations were led by LSAMO Shirley Smith. The outcome was that a number of Local Action Plans and LSA Practice programmes were imposed on individual midwives to attempt to remediate the wide ranging concerns.

In view of the substantial concerns identified, the NMC commissioned a Management Consultancy to conduct a LSA extraordinary review. The review was designed to focus specifically on the issue as to whether or not adequate supervision of midwives was taking place at the Hospital.

The review was conducted by a team of LSA midwives between 1 and 3 October 2014. Over the course of the review, the team uncovered significant difficulties in the
supervision of midwives. There was significant criticism of the risk management structure, for example they concluded that the Obstetrics and Gynaecological Clinical Governance Committee meetings were failing to achieve their purpose, which was to examine adverse incidents with sufficient scrutiny to allow best practice to be identified and maintained, and inadequate practice to be managed and changed.

The review team encountered a description of the culture at the Hospital known as the “Guernsey Way”. This epithet was used by members of staff at the Hospital to justify sub-standard midwifery practices in particular and maternity care in general that were not compliant with the NMC Code of Conduct Rules and Guidance and National Guidelines. There was widespread acknowledgement of the use of verbal orders for the use of Syntocinon and a lack of escalation by midwives to Consultant Obstetricians. There was an acknowledgement by members of staff, including midwives, of a system of care falling outside the midwifery scope of practice that was not only allowed to continue unchallenged, but actively participated in and therefore perpetuated.

As a result both the LSA and HSSD started investigations. In June 2014 the LSA investigation into the care given to Baby A took place. This was led by Ms 8 and ran in conjunction to the HSSD’s investigation run by Ms 7 and Ms 11. You were interviewed by Ms 1 on behalf of the LSA with Ms 7 and Ms 11 present.

During the course of the Baby A investigations concerns were raised that similar failures had occurred in the care of Baby B, delivered on 1 September 2012. Baby B had also died. At the time, Midwife A had conducted a review of the case and concluded that the midwifery care had been of an acceptable standard. As a result of the subsequent that arose during Baby A’s investigation, Ms 5, a Band 6 Midwife, was asked to review Baby B’s case. She provided a report of her findings dated 20 June 2014 on a recognised format designed for analysing such incidents. In addition, an investigation into the death of Baby B was carried out on behalf of HSSD by Mr 12 an ENT consultant and Ms 11, the Head of Governance Support and Compliance between October 2014 – February 2015.

LSA investigations were conducted into the care provided by and conduct of you and Midwife C in relation to Patient C on 29 November 2013 and for Midwife C in relation to
Patient B on 13 March 2014. The SoM conducting the review was Ms 9. She raised similar concerns on the failure of the part on the midwife to escalate concerns.
Determination on facts

Mrs Roussel,

In reaching its determination on facts, the panel had regard to all the evidence adduced, including the oral evidence and the exhibited documents. It was provided with detailed written submissions from Ms Higgins on behalf of the NMC and Ms Hamilton on your behalf.

The panel accepted the advice of the legal assessor who referred to the case law regarding dishonesty (charge 3), namely *R v Ghosh [1982] EWCA Crim 2; Hussein v General Medical Council [2014] EWCA Civ 2246*. The legal assessor referred the panel to the two part test as set out in the case of *Ghosh*. The first part being an objective test; whether according to the ordinary standards of reasonable and honest people what was done by the registrant was dishonest. If it was dishonest by those standards then secondly, the subjective test, namely, whether a registrant must have known that what he/she was doing was, by those standards, dishonest.

The burden of proof rests entirely upon the NMC. You do not have to prove or disprove anything. The standard of proof is the civil standard, namely the balance of probabilities. This means that, for a fact to be found proved, the NMC must satisfy the panel that what is alleged to have happened is more likely than not to have occurred.

The panel heard evidence on behalf of the NMC from the following witnesses who held the positions (as listed below) at the relevant time:

- Ms 1 - Local Supervising Midwifery Officer (LSAMO);
- Ms 2 - Lead Reviewer of the NMC instructed by the Local Supervising Authority (LSA);
- Ms 5 - Current Head of Midwifery HSSD;
- Ms 6 - LSAMO;
- Ms 7 - Service Manager for Child Services at HSSD;
- Ms 8 - LSA Midwife;
• Ms 9 - LSA Midwife
• Ms 10 - Academic Lead at HSSD;
• Ms 11 - Head of Quality Improvement at HSSD;
• Ms 13 - Band 7 Midwife, Ward Manager; and
• Ms 14 - Community Midwife Manager at Jersey General Hospital.

The panel considered that the above mentioned NMC witnesses generally were credible and reliable and gave their evidence in a fair, clear and helpful manner and sought to assist the panel.

Patient A and Person A.
The panel heard evidence from Patient A and her husband Person A via video link (Webex) from Singapore. The panel considered that they gave evidence about events that were obviously very difficult for them to revisit and which the panel fully acknowledge was a traumatic time for them. The panel found that that they were reflective, dignified and composed when talking about what was clearly a very stressful time in their lives. The panel found that they were being sincere in their efforts to assist the panel and that they gave their evidence to the best of their recollections and perceptions. To the extent to which the panel found that there were gaps in their recollections, this was entirely understandable.

Ms 3: Band 7 Midwife and Ward Manager of Loveridge Ward.
On 6 May 2014, Ms 3 came forward as a whistle-blower. She contacted the LSA in order to register concerns she had about the case of Baby A. Ms 3 alleged that there had been deficiencies in the midwifery care provided in this case during the night shift of 29-30 January 2014. Also that there had been a subsequent failure by the Hospital to investigate the case adequately. Ms 3 was particularly critical of what she felt was inadequate management of the cardiotocograph (“CTG”) trace during the fetal heart rate monitoring, and the unauthorised use of Syntocinon. The panel found Ms 3 to be a candid and credible witness who demonstrated sound knowledge of midwifery practice.

The panel appreciated how difficult it must have been for Ms 3 to come forward as a whistle-blower and to give evidence which was critical of the practices of midwives who
had been her colleagues. The panel noted that in her evidence Ms 3 acknowledged where her recollection had been affected by the passage of time. The panel also noted that Ms 3’s evidence had been consistent over the course of time. The panel did not accept the proposition put to her by Miss Hamilton that she had been motivated by ill-will towards Midwife B. Nor did the panel accept that Ms 3’s credibility as a witness had been undermined by her initial inability to recollect that she had made her own referral (in addition to an NMC referral) of Midwife B to the NMC or to recognise immediately her authorship of the document involved. The panel accepted that this was attributable to a genuine lapse in recollection owing to the passage of time.

**Dr. 1: Consultant Obstetrician and Gynaecologist.**

Dr. 1 gave his evidence by video link from Guernsey as he was unable to attend the hearing in person. The panel considered that Dr. 1’s evidence was vague at times and that there appeared to be gaps in his recollection of events. The panel considered that Dr. 1 in his evidence tended at times to be defensive. He also tended to understate the extent of his knowledge at the time of the reluctance of midwives to escalate cases to the Obstetricians during night shifts, or, of the prevalence of the practice of midwives on night shifts administering Syntocinon on their own initiative without following proper procedures. Overall, at times, the panel found certain aspects of Dr. 1’s evidence unconvincing.

The panel also considered your oral evidence and noted that at times during your testimony you were candid and appeared to realise how far your practice had deviated from acceptable practice which was made apparent to you when you completed an LSA supervised practice programme.

At the commencement of this hearing in January 2017, Ms Hamilton informed the panel on your behalf that you admitted the following charges:

- Charge 1.1.1;
- Charge 1.1.2;
- Charge 1.1.5;
- Charge 1.5;
- Charge 1.6 (in part relating to 1.1.1 and 1.1.2);
Accordingly, the panel found charges 1.1.1, 1.1.2, 1.1.5, 1.5, 1.6 (in part relating to 1.1.1 and 1.1.2), 4.1.1, 4.1.2, 4.3, 5.1.1, 5.1.2, the panel found these charges proved by way of your admission.

On 17 July 2017, the panel determined that there was no case for you to answer in respect of charge 1.1.3.

The panel went on to consider the remaining charges and made the following findings of facts.

**Charge 1**

That you, a registered midwife, whilst employed by the Health and Social Services Department of the States of Guernsey ("HSSD") at the Princess Elizabeth Hospital, Guernsey ("the Hospital"):

1. In respect of the care delivered to Baby A and/or Patient A on 29 and 30 January 2014, when you were the midwifery ward coordinator:

   1.1 At or around 23:20 on 29 January 2014, commenced and/or oversaw the administration of Syntocinon to Patient A:

      1.1.1 When there was no valid written prescription; **Admitted and found proved**
      1.1.2 Without a medical review of Patient A; **Admitted and found proved**
      1.1.3 In the presence of mild fetal heart rate distress; **No case to answer**
1.1.4 Which was commenced without appropriate patient consent and/or patient consultation;

**Not proved**

1.1.5 Which was not appropriately recorded with a signature

**Admitted and found proved**
Charge 1.1.4

In determining this charge, the panel considered your evidence, the evidence of Patient A and Person A, the evidence of Midwife C and the relevant documentary evidence. It is accepted by you and Midwife C that she was taking the lead in caring for Patient A and that you were overseeing this in your role as Midwife Coordinator.

It is clear from Patient A’s notes, and you accept, that neither you nor Midwife C made any documentary record of any consent or consultation with Patient A with regard to administering Syntocinon. It is equally clear, and you also accept, that you were under a duty to make such a record, if such consent or consultation occurred.

Midwife C told the panel in her oral evidence that, prior to its administration, she explained what was proposed and obtained informed consent from Patient A for administering Syntocinon. The panel noted that Midwife C has been consistent in asserting that she obtained such consent during her interviews in the subsequent investigations. The panel also found her oral account of the procedure that she followed as a matter of custom and practice convincing.

The panel noted that Midwife C is softly spoken and that English is not her first language. The panel had no difficulty in accepting that this may have been one of the factors which accounts for a lack of a clear recollection on the part of Patient A and Person A of a discussion regarding the administration of Syntocinon.

Midwife C’s account that informed consent was obtained was supported by your evidence to the panel. You told the panel that you had also been involved in the discussion. You told the panel that when it was explained that Patient A’s contractions were not strong enough and her consent was sought regarding the administration of Syntocinon, you understood that she gave consent by saying, “whatever is needed – whatever you feel safe”.

The panel noted that Patient A and Person A’s accounts in respect of this allegation have varied. During her telephone interview with Ms 8 as part of the LSA interview, on 26 June 2014, Patient A said, “I don’t recall having a specific conversation about the Syntocinon drip. I had the drip equipment in my hand for the antibiotics for GBS [Group
B Streptococcus]. I assume Syntocinon was delivered through the same drip. As I recall there wasn't any formal discussion regarding my labour…We were told not asked, no consent was sought.”

During the interview with the Police on 30 July 2015 as part of their investigation, Patient A, in contrast to the above, stated, “I understand from various reports that the midwives say that our consent was obtained from us for the use of Syntocinon. I categorically deny this.”

Patient A and Person A gave evidence to this panel on 19 January 2017 and during their evidence, when asked about this charge by Mr Collis behalf of Midwife C and in particular about the telephone conversation with Maria Patterson, Person A stated the following:

Q – Ms 8 has documented what your wife said about Syntocinon in the course of that telephone conference in June 2014, can you recall at all how the issue of whether or not consent had been given was raised by Ms Patterson?

A – I'm sorry I do not remember. No, I'm sorry I do not remember.

Patient A was asked the following questions in relation to this charge during her evidence on 19 January 2017:

Q – Am I right then in thinking that you don’t have any independent recollection of the two midwives, Midwife B and Midwife C administering a medication to you at twenty past 11 that night?

A – No. I don't recall

Q – Would you accept Patient A, it’s possible that if you can’t recall the medication being set up and administered, it’s possible that you also can’t recall a conversation between yourself and the midwives about the medication.

A – My husband would have been involved in that conversation, It would have been a longer conversation, I believe than the brief conversation that we had in the room.
The panel considered that the variance in Patient A and Person A’s answers regarding what was discussed with them is entirely understandable given all that they had gone through and how traumatic events had been for them.

The panel is satisfied that you have been consistent in the documentary evidence and your oral evidence in relation to this charge and that you have always maintained that consent was obtained from Patient A and Person A before administering Syntocinon.

The evidence showed that the process involved in setting up and commencing the administration of Syntocinon would not simply have involved connecting another bag to an existing line. It involved a process which would have taken a significant period of time, including setting up a new piece of equipment, a pump, which emitted audible noises. The panel accepted that it is inherently implausible that this process would have been carried out without any explanation on either your part or the part of Midwife C as to what was going on. The panel further noted that, given how involved the parents were in every facet of the planning and decision making in respect of the birth, it is highly unlikely that, had no explanation been offered to Patient A or Person A, this process would not have been completed without either of them asking Midwife C or you what you were doing.

The panel was not satisfied that the NMC had discharged the burden of proving on the balance of probabilities that you commenced Syntocinon without appropriate patient consent and/or patient consultation. Accordingly, charge 1.1.4 is not proved.

Charge 1.2

1.2 At or around 23.50 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

1.2.1 When there was no valid written prescription;

PROVED

1.2.2 Without a medical review of Patient A;

PROVED
1.2.3 When the CTG had shown a “suspicious” trace; 

PROVED

In determining this charge, the panel first had regard to The Use of Oxytocin in Labour 
(issued in January 2011), the policy states:
(exhibit 7 Page 839)

Appendix 1: Regimen for oxytocin infusion (induction and augmentation)

• The maximum licensed dose is 20 milliunits per and if contractions are established after TOTAL of 5 iu (5 hours and suggested regimen) the induction should be stopped. The case must be discussed with the consultant on call
• 4 international units (iu) oxytocin to be made up to 100mls with 5% sodium chloride (normal saline). Infusions must be checked by two midwives and given via an alris pump
• Each infusion must be used within 12 hours
• A new infusion must be set up if continued treatment is required beyond 12 hours
• Please ensure that the DOSE is recorded on the partogram rather than the rate of the infusion
• Care should be taken with the administration of other intravenous fluids, which do not need to be routinely used.

The panel had regard to your answers given during cross examination by Miss Higgins as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.
The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother's and baby's needs are met and that significant others are supported.

The panel had regard to the statement of evidence of Ms 8 and in which she states:

*I identified further concerns in the care delivered to Patient A and Baby A at 23:50 when significant decelerations accelerations in the fetal heart rate were noted within the CTG trace. There were therefore visible signs of fetal distress being demonstrated at 23:50 within the context of the use of syntocinon. This constituted another opportunity for Midwife C and Midwife B to seek the intervention of a consultant obstetrician…*

The panel considered that it had become custom and practice not to call the on call obstetrician following a suspicious CTG trace. This was accepted by you during the joint HSSD and LSA interview on 10 June 2014 and in which you said “it’s about suspicious CTG calling obstetrician but we don’t call obstetrician for first or second CTG not unless it’s getting severe CTG because they wouldn’t do anything”.

The panel considered that Patient A was the only woman in labour on the night of 29 January 2014 and accept that Midwife C was the junior less experienced, midwife on shift with you. You were fully aware of the regime for increasing Syntocinon. Further, you noticed that the CTG was suspicious before the Syntocinon was commenced, and recorded this on the Fetal Heart Auscultated With Pinnard Sticker.

The panel also had regard to the statement of Ms 8 dated 15 December 2015 in which she states:
“From my consideration of the patient’s records and the decision making tool guidance, I considered there to be the need for a full LSA investigation. I was concerned that the evidence suggested that a suspicious CTG trace had not been escalated to a consultant obstetrician, that Syntocinon appeared to have been used without appropriate authorisation and that Syntocinon had continued to be used despite deterioration in the CTG trace. There appeared to be early signs that the midwives concerned had acted outside the scope of their practice and therefore here were serious concerns in respect of the level of midwifery care provided”.

“I further noted that a National Guideline Decision Making Tool had been completed on 31 January 2014 by Midwife A. I noted that Midwife A also held the statutory position of SoM. Midwife A’s opinion in respect of the Patient A case was that a full LSA investigation was not required as, other than minor recording errors, there were no difficulties with midwifery practice”.

“I completely disagree with Midwife A’s assessment of the situation, as demonstrated by the fact that I quickly concluded that a full LSA investigation was definitely required. In my opinion, the concerns I have identified with the care given to Baby A on 29 and 30 January 2014 by Midwives B and C are fundamental concerns that any qualified midwife should be able to note. They are therefore ones that Midwife A, as a Risk Management Midwife and a SoM, may be reasonably expected to realise as well, from reading the patients records, as I did”.

“Although it is possible for Syntocinon to be used where a CTG trace has been classified as suspicious, this would not be a decision that a midwife would be qualified to make. Syntocinon has the effect of augmenting contractions in order to make them stronger and more frequent. As such, there can be an association between the use of Syntocinon and acceleration or decelerations in the fetal heart rate. Therefore, the use of Syntocinon in the context of a fetus that is already demonstrating some signs of suspicious CTG actively would need to be closely supervised and conducted under the direct instruction of a consultant obstetrician.”
The panel considered the notes of your Disciplinary hearing on 7 January 2015 during which the following was presented on your behalf by your representative attending the meeting with you from the Royal College of Midwives (RCM).

“[Midwife B] stated in her interview that “we don’t call the Obstetrician for first or second suspicious CTG, not unless it’s getting severe CTG because they wouldn’t do anything”.

“…This reflects the custom and practice within the unit and the difficulties midwives faced getting support at night. Midwife B stated at interview that if she rang the Obstetricians every time she marked a CTG as suspicions “well they would be marching to the Head of Midwifery obviously in the morning.”

The panel had sight of Patient A/Baby A’s Clinical Social Care Notes which contained the “Fetal Heart Auscultated With Pinnard Sticker”. The sticker was signed by you at 22:25 at which time you had conducted a fresh eyes review. The panel noted that the sticker clearly details that the CTG was suspicious as you had circled the box that said “Suspicious CTG” (one non reassuring feature).

The panel noted that during your oral evidence at this hearing, you accepted the decision to commence Syntocinon was made jointly with you and Midwife C and that you were aware this should not have been given without a prescription. You accepted that the Syntocinon was increased and that at both times there was no valid prescription and no medical review in place. Midwife C’s evidence to the panel was that you were “in and out of the room” whilst the Syntocinon was being administered although she acknowledged that this was not recorded in the Patient A’s notes.

The panel accepted the evidence of Midwife C that you were in and out the room and that you were fully aware that the Syntocinon was being increased. You failed to seek a review of Patient A despite the suspicious CTG. Having regard to the HSSD Policy for the use of oxytocin in labour, of which you were clearly aware, sets out the regime for increasing the Syntocinon which is to double the dose at set times.
The panel concluded that as the coordinator of the shift, you were the most senior midwife on the Ward that night. You were responsible for overseeing the continued increase in Syntocinon as the shift coordinator. You have acknowledged that Midwife C was a less experienced midwife whom you felt required greater support. The panel has determined, based on all the evidence before it, at or around 23.50 on 29 January 2014 you oversaw the increase to the rate at which Syntocinon was administered when the CTG had shown a suspicious trace with no prescription and no medical review in place. **Accordingly, charge 1.2 is proved in its entirety.**

**Charge 1.3**

1.3 At or around 00.10 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

1.3.1 When there was no valid written prescription;  
**PROVED**  
1.3.2 Without a medical review of Patient A;  
**PROVED**  
1.3.3 When the CTG had shown a “suspicious” trace;  
**PROVED**

The panel had regard to the HSSD Policy for The Use of Oxytocin In Labour (issued in January 2011).

The panel also had regard to your answers given during cross examination by Miss Higgins as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?  
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.
In considering the Regimen for oxytocin infusion (induction and augmentation) in this policy, the panel determined that you were fully aware that the Syntocinon is increased as per this regimen. Patient A’s notes detail that you were present in the room 16 minutes after the Syntocinon was commenced.

The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

The panel had regard to the Minutes of the Disciplinary Hearing dated 7 January 2015 during which, the following was submitted on your behalf by your RCM representative:

“[Midwife B] acknowledged that she should have turned the Syntocinon infusion off once she realised the CTG was deteriorating. She admits that she lost sight of this in her desire to facilitate the woman’s choice and strong desire to have a normal delivery”.

The panel accepted the evidence of Midwife C that you were in and out of the room and determined that as the Midwife Coordinator you had an overall responsibility for the oversight of care and increasing the rate of Syntocinon when there was no valid prescription, without a medical review of Patient A and when the CTG had shown a suspicious trace. **Accordingly, charge 1.3 is proved in its entirety.**

**Charge 1.4**
1.4 Did not seek a review of Patient A’s condition at or around 23:50 on 29 January 2014, Patient A having given a “suspicious” cardiotocograph (“CTG”) trace.

PROVED

The panel had regard to the statement of Ms 8 in which she states:

“I identified further concerns in the care delivered to Patient A and Baby A at 23:50 when significant decelerations and accelerations in the fetal heart rate were noted within the CTG trace. There were therefore visible signs of fetal distress being demonstrated at 23:50 within the context of the use of Syntocinon. This constituted another opportunity for Midwife B and C to seek the intervention of a consultant obstetrician. Unfortunately, there is no evidence at this point that such a referral too place and the use of Syntocinon continued.”

The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

During your interview on 10 June 2014 with Ms 14, you stated the following:

TR: It’s about suspicious CTG calling obstetrician but we don't call obstetrician for first or second suspicious CTG unless it's getting severe CTG because they wouldn’t do anything

The panel determined that as the Midwife coordinator, your overarching responsibility was to ensure that Patient A’s condition was under constant review particularly as the
CTG trace had been noted as being “suspicious”. However, despite this you failed to call for an obstetrician to review Patient A at or around 23:50 on 29 January 2014 which was conceded by you in your interview with Ms 14. Accordingly, charge 1.4 is proved.

Charge 1.5

1.5 Did not escalate, in a timely manner, the delay in the delivery of Baby A, in that you did not seek a review of Patient A’s condition until 00:55 on 30 January 2014, Patient A having entered the second stage of labour at the latest time of 21:45 on 29 January 2014. Admitted and found proved

Charge 1.6

1.6 Your actions as described at paragraphs 1.1 and/or 1.2 and/or 1.3 and/or 1.4 and/or 1.5 increased the risk of harm to Patient A and/or Baby A.

Admitted and found proved in part as to 1.1.1 and 1.1.2

PROVED in relation to 1.1.2, and 1.1.4

Not Proved 1.1.5

In approaching the numbering of this charge, the panel have adopted the approach set out by Miss Hamilton in her submissions.

You have admitted that your actions described at charges 1.1.1 and 1.1.2 increased the risk of harm to Patient A and/or Baby A. The panel has to therefore determine whether your actions as described at 1.2, 1.3, 1.4 and/or 1.5 increased the risk of harm to Patient A and/or Baby A.

In reaching its decision, the panel had regard to the evidence of Midwife C who has consistently asserted that you were “in and out of the room” during the night of 29/30 January 2014. You accept that the administration of Syntocinon to Patient A was a joint decision between you and Midwife C and that you were aware this did not follow
national guidelines. The panel have drawn this inference from your answer under cross examination to a question from Miss Higgins as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.

The panel had regard to the statement of evidence of Ms 8 and in which she states:

I identified further concerns in the care delivered to Patient A and Baby A at 23:50 when significant decelerations accelerations in the fetal heart rate were noted within the CTG trace. There were therefore visible signs of fetal distress being demonstrated at 23:50 within the context of the use of Syntocinon. This constituted another opportunity for Midwife C and Midwife B to seek the intervention of a consultant obstetrician...

The panel considered that it had become custom and practice not to call the on call obstetrician following a suspicious CTG trace. This was accepted by you during your joint LSA HSSD interview on 10 June 2014 and in which you said “it’s about suspicious CTG calling obstetrician but we don’t call obstetrician for first or second CTG not unless it’s getting severe CTG because they wouldn’t do anything”. The panel considered that Patient A was the only woman in labour on the night of 29 January 2014 and accept that Midwife C was the junior less experienced midwife on shift with you. You were aware of the regime for increasing Syntocinon. Further, you noticed at 22:25 that the CTG was suspicious before the Syntocinon was commenced.

The panel also had regard to the minutes of the disciplinary meeting on 7 January 2015 when it was submitted on your behalf that you acknowledged you should have turned the Syntocinon infusion off once you realised the CTG was deteriorating. It was further submitted on your behalf at that meeting “that you had lost sight of this in your desire to facilitate the woman’s choice and strong desire to have a normal delivery”.
The panel consider however that it is too remote to any risk of harm not to have a signature in the notes at that time.

Having regard to all the evidence adduced in respect of this charge, the panel determined that your actions at charges 1.2, 1.3 and 1.4 increased the risk of harm to Patient and Baby A. Accordingly, charge 1.6 is proved in relation to charges 1.1.2, and 1.1.4. Not proved in relation to charge 1.1.5.

**Charge 2**

2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A.

PROVED

In determining this charge, the panel first had regard to the time line of events during the night of 28/29 January 2014 as follows:

- **21.35** Full dilatation “second stage” epidural just cited (exhibit 9 page 265) normal CTG some pressure to push expecting things to progress 3 to 4 in 10 contractions.
- **21:15/21:45** Telephone call to Dr. 1 from Loveridge Ward – *(evidence of Ms 3)*
  - **22:25** “Fresh eyes” review carried out by Midwife B at which time the CTG is noted as being “suspicious”, contractions were 3 – 4 in 10 and were documented as “strong”.
- **23:00** Midwife C had a 15 minute Midwife B assessed Patient A and notes “weak contractions” fully dilated since **21:35** CTG at this stage had been “suspicious” for an hour.
- **23:15** Syntocinon was discussed between Midwife B and C, Syntocinon was commenced 5 minutes later at 23:20, both Midwife B and C checked the drug, put it into the bag of fluid and giving set and attached it to the machine to commence the infusion.
23:30  “Blood stain liquor” the plan was “to start active pushing”
00:10  Suspicious CTG trace
00:26  “Pushing well variable decelerations” (abnormal heart trace) “changed Patient A’s position”
00:50  CTG Suspicious
00:55  Fully dilated for 3 hours and 20 minutes, no descent (of the presenting part) after 1.5 hours of pushing CTG suspicious Dr. 1 informed to review Patient A due to delay in 2nd stage
01:10  Dr. 1 arrived
01:24  Baby A delivered.

Midwife A was informed of the death of Baby A by Ms 3 on 30 January 2014 at 16:00. Ms 3 telephoned Midwife A at home as she was the on call SoM on that date. In her statement of evidence provided for Ms 1 dated 13 June 2014, Midwife A states the following.

**Thursday 30/1/14 Approx 16:00**
“I was contacted at home as the on call Supervisor Of Midwives (SOM) by Ward Manager Ms 3 who informed me that a baby who had been born earlier that day had died in NICU at 15.30. She informed me that she had spoken to the Ms 4 Head Of Midwifery (HOM) who had given her guidance on what to do, i.e. secure and photocopy the notes and support staff involved. I asked her if there were any midwifery issues or concerns regarding the care given, she informed me there were ‘no worries’ regarding midwifery care as everything was being dealt with. I informed her I would be on the maternity unit the following day and would come and speak with her”

**Friday 31/1/14 09:00**
“I accessed the safeguard incident reporting system and viewed the form that had been entered by Ms 3, the category for submission was ‘Apgars <6 @ 5 minutes’. Ms 3 had entered some information into the local manager part of the form, there were no midwifery issues raised at this time. I had collected the notes from the ward to start reviewing them; I browsed the labour part to ascertain if there was any documentation regarding the ordering of Syntocinon, but could not find any, I therefore phoned Midwife
B at home to ask her. She informed me that she had spoken with the on call Obstetrician Dr 1 about another patient on the ward and had asked him if she could start the Syntocinon, to which he agreed. I told Midwife B that this was not reflected in the notes and she should have documented this conversation in the woman’s notes and used an SBAR sticker. She said she hadn’t used SBAR as she had phoned Dr 1 about another patient. She said she would make this retrospective addition to the notes when she was next on duty (2nd February), she said she was happy with the care she had given. As I was also working on Sunday, I said we would meet up and discuss it further.”

The panel also had regard to the joint LSA and HSSD interview with Ms 3 on 10 June 2014 conducted by Ms 8 during which she gave the following answers:

AT: …So I asked Midwife B if she had a quick word with me in the office and she came in and we sat down. I said Midwife B do you mind if I ask you about this, look at this CTG and I did say, I did say, she said no she wasn’t contracting you weren’t there, I said fair enough I said yes because I wasn’t there and I was feeling it, but I said it looks to me and how its documented the progress that she was really contracting well.

I don’t think she was, I know very well when people need Syntocinon. So I said well can you tell me, I said what did Dr. 1 say when you rang him and you described the picture, and she didn’t really answer me in terms of what he said, but she said it was to start Syntocinon, and I said there is nothing documented about your conversation and she said no but she had, but she did keep saying she had called him and then she got really angry with me for discussing this so I just put my hand very gently, look I said I really don’t want to upset you, I said I just want to get to the bottom because I can’t understand why he didn’t come in, I just don’t understand why he didn’t come in. And then we sat there and all of a sudden it was so unexpected it was the last thing I expected her to say, she just said I didn’t call him. I know I was really shocked and so I waited and she said I didn’t call him. I said Midwife B that’s, I think my words were, you know that’s wrong don’t you and she said yes I know and we were quite quiet and I said you will never do that again will you and she said no I won’t. And we were okay and then she left but it was just like a moment where she sat very and she said this so.
The panel had regard to the evidence of Ms 3 during this hearing and considered the submissions on your behalf which refer to Ms 3 having a “grudge against you”. The panel note in the written submissions on your behalf reference is made to a complaint about you of a similar nature as set out in a form completed by Ms 3 to the NMC. The panel had regard to transcript of Ms Hamilton’s cross examination of Ms 3 on this point, the panel also took into account your evidence. The panel accepted Ms 3’s evidence that she did not harbour any “ill will” towards you. The panel does not accept that any perception on your part that this was the case was well founded.

The panel further considered the submissions on your behalf that Ms 3 denied making a referral to the NMC against you. The panel did not consider because she was initially unable to recall making the referral, diluted her credibility as a witness. The panel considered that Ms 3 has been consistent in her assertions regarding what you said to her regarding your telephone call to Dr. 1 throughout the LSA investigations and her oral evidence to this panel. Further, the panel considered that Ms 3’s testimony is supported by the concessions made by you during the Disciplinary Hearing on 7 January 2015 and in which you stated:

TR: said she did not refute that she started the Syntocinon with no verbal order. There was a culture around this and definitely given to aid care to the mums.

The panel considered the statement of Dr 1 dated 3 January 2017 and in which he stated:

2. In relation to Patient A:

a. In 2014 there were four consultant obstetrician/gynaecologists and we worked an on-call rota which meant that one weekend in four (08:00hrs Friday – 17:00hrs Monday) we were on call, together with a night on call during the week, as well as covering Labour Ward on weekdays. We were on-call from home and were called in, when required, normally by the midwives. The A&E department,
Princess Elizabeth Hospital (PEH) Ward staff or GPs could also call us if required. If the midwife wished to contact us they would ask the switchboard operator to contact us by telephone using either our mobile phone or our landline.

b. I was on call the night of the 29/30 January. There was no other Obstetrician on call that evening.

c. At about 00:55 hrs on 30th January 2014 I was at home in bed when I received a telephone call from the midwife. She explained to me that she had a patient in labour who had been receiving midwifery led care throughout her pregnancy. There had been no descent of the presenting part and the CTG was suspicious. This was the first telephone call I had received and I was not informed about the use of Syntocinon.

d. I recall being called by Midwife B at 00:55 on the 30th January 2014. I cannot recall the timings of other calls during the 29./30 January 2014.

e. I do not recall at any stage being contacted about the use of Syntocinion in this patient. At the time of labour and delivery I was not aware that Syntocinon had been used, and according to out [sic] local policy, I should have been contacted before it was administered to this patient.

The panel also had regard to answers given by Dr. 1 during this hearing in answers to questions put to him by Miss Higgins.

Q. …we see that you were on call that night, correct?
A. That’s correct

Q. And you say at bullet point C, ‘at about 00:55 hours on 30 January I was at home in bed when I received a telephone call from the midwife, she explained to me that she had her patient in labour who had been receiving midwifery-led care throughout her pregnancy, there had been no descent of the presenting part and the CTG was suspicious, this was the first telephone call I had received and I was not informed about the use of Syntocinon’
A. Yes, that’s correct.
Q. And then the next bullet point, you say ‘I recall being called by Midwife B at 00:55 on 30 January, I cannot recall the timings of other calls during 29 and 30 January 2014’

Do you recall any calls earlier that evening?

A. No I can’t recall at all.

Q. Okay, are you able to say whether ---is your recollection that there weren’t any calls or in your recollection you just don’t know.

A. I just don’t know.

Q. Okay. Do you recall any previous phone call regarding Patient A?

A. No, I don’t recall any previous conversations.

Q. Now, when were you first aware Syntocinon had been used?

A. I cannot recall when I was told the Syntocinon --- but it was definitely not before the delivery or soon after.

Q. Okay, And we see that in your statement made on 4 June, if we can go to that, within the first paragraph you say ‘I was not informed that Patient A had been started on Syntocinon infusion at 23:20’ Correct?

In the notes of the joint LSA and HSSD interview conducted by Ms 8 on 10 June 2014, you stated the following:

TR: He knew that night because, because when he came in or when I asked him to come in I can’t remember which point, was it the phone call when I asked him to come in or on his arrival but I told him when he was on the ward and obviously he saw Syntocinon up because he knew about it and afterwards, it was after delivery after baby was transferred that the conversation started I apologised to him, I’m so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since.

The panel note that you accept that Midwife A telephoned you at home on the morning of 31 January 2014 and that you do not dispute the content of that conversation. The panel further note that whilst you were asked by Midwife A on two occasions to make retrospective entries into Patient A’s notes you did not do so and informed the panel in evidence that you did not do so because you were too busy. The panel had regard to
the answers you gave to questions put to you by Miss Higgins during this hearing when you stated the following:

Q. It is right, is it not, that Midwife A told you on two occasions to fill out an SBAR sticker retrospectively – correct?
A. Yes.
Q. In order to show that a telephone call had taken place, because that is what she thought – correct?
A. Yes that is correct.
Q. She asked you to do it in the phone call the day after – correct?
A. Yes she did.
Q. The she told you again, she reminded you I think it was on 2 February when you were working on the ward – correct?
A. Yes that is correct.
Q. You never did that, did you?
A. I did not and that is because the shift on that Sunday – well, going to the first phone call, I did not return to work after the incident until my next shift and that day was really, really busy and I did not have time to go back to my previous patient notes and I failed to return that. I am really, really sorry about that, my record-keeping is a very poor standard.

The panel note that Ms 3 states that she checked the telephone records from the Loveridge Ward to Dr 1. The telephone call on 30 January 2014 at 00:55 is not contested. The panel note that Ms 3 is inconsistent in the timing of an earlier call having been made to Dr. 1. In her NMC statement of evidence and in her oral evidence, Ms 3 indicated that the time was 21:15. By contrast in an earlier statement she put the time at 21:45.

However, when considering the timeline of events, the panel bore in mind that even if the correct time was the later time of 21:45, Patient A had just had an epidural and there was nothing to suppose at that time there were any problems. Patient A was contracting well, the CTG was normal and the expectation was that Patient A would progress to a vaginal delivery. The panel determined that there would have been no
reason during the telephone call at either time for you to request a verbal order for Syntocinon augmentation.

In light of the evidence, the panel determined that the conversation that took place either at 21:15 or 21:45 between you and Dr 1 could not have in consequence have been to discuss the administration of Syntocinon to Patient A.

Further, the panel considered the answers you gave during your interview with the HSSD and LSA on 10 June 2014 in which you stated, you told Dr 1 after the delivery of Baby A when he attended “I apologised to him, I'm so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since”. The panel considered that this statement given at this interview supports the fact that you did not obtain a verbal order from Dr.1 during your telephone call to him regarding another patient at either 21:15 or 21:45. Further, Dr. 1 cannot recall any conversation regarding Patient A and Syntocinon until after the birth of Baby A.

The panel is satisfied, on the balance of probabilities having regard to all of the information before it, that on 31 January 2014 and/or 2 February 2014, you gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A when you had not. **Accordingly charge 2 is proved.**
Charge 3

3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014

PROVED

The allegation of dishonesty made against you is that you gave incorrect information to Midwife A, in that you stated you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A when you had not.

As already noted above in charge 2, you accept that Midwife A telephoned you at home on 31 January 2014 and met with you again on your next working shift.

In reaching its decision, the panel took into account the evidence from Ms 3, who the panel considered was a reliable and credible witness, Ms 3’s documentary evidence was supported by her oral evidence given to this panel as well as her consistent accounts given at the various times during the investigation.

Further, the panel considered that Ms 3’s testimony is supported by the concessions made by you in the notes of the Disciplinary Hearing on 7 January 2015.

TR: Said she did not refute that she started the Syntocinon with no verbal order. There was a culture around this and definitely given to aid care to the mums.

The panel also considered the answers you gave during the joint interview with the LSA and HSSD on 10 June 2014 in which you stated:

“I apologised to him [Dr. 1], I’m so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since.”
In considering this charge in relation to dishonesty the panel, as well as considering the evidence before it, also considered the two stage test as set out in *Ghosh*. As advised by the legal assessor, the panel first considered the objective test and whether, on the balance of probabilities, your actions would be deemed to be dishonest by the ordinary standards of reasonable and honest people. If the panel found that you had acted dishonestly by these standards, then it would move on to consider whether, on the balance of probabilities, you realised that your actions were, by those standards, dishonest.

Applying the first element of the test the panel considered whether or not your actions as set out in charge 2 were dishonest. The panel considered that any reasonable and honest person would consider that a midwife providing inaccurate and misleading information to a senior colleague regarding such a serious incident to be dishonest.

Applying the second element of the test, the panel is required to consider whether you realised that what you were doing was by the standards of reasonable and honest people, dishonest. The panel rejected your assertion that the conversation you had with Ms 3 did not involve a discussion regarding the earlier part of the evening of 29 January 2014 when you had telephoned Dr 1 to discuss another patient and assert that during this telephone call obtained a verbal order to start Syntocinon on Patient A when it was required. The panel determined this was a wholly implausible explanation given that at the time of the first phone call either at 21:15, or at the latest, 21:45 to Dr. 1, Patient A had just had an epidural and her labour at that time appeared to be progressing well.

The panel determined that you must have realised that the incorrect information provided by you to Midwife A was dishonest. The panel considered that the incorrect information you provided to Midwife A was self-serving, in the sense that you implicitly asserted you had had obtained a verbal order when you had not to administer Syntocinon during a telephone call to Dr.1 about another patient.

Further, the panel note that despite being asked on two separate occasions by Midwife A, who was senior to you to retrospectively document the verbal order, you did not do so. The inference the panel have drawn from you failing to do this is that you knew what
you were doing was dishonest but by reducing the incorrect information to writing was a step too far.

The panel concluded that your behaviour in relation to this charge was deliberate and is satisfied on the balance of probabilities that your conduct was dishonest, in that you intended to mislead the Risk Management Midwife as to the correct facts of the care given to Patient A /Baby A on 29 and 30 January 2014. **Accordingly, charge 3 is proved.**
Charge 4

4. In respect of care delivered to Patient C on 29 November 2013:

5.3. At or around 04:10, allowed the administration of an infusion of Syntocinon:

    4.1.3. When there was no valid prescription
    Admitted and found proved
    4.1.4. Without a medical review of Patient C
    Admitted and found proved

Charge 4.2

5.4. At or around 05.00 and/or 07.00 increased and/or oversaw the increase to the rate of infusion of Syntocinon:

    4.2.3. When there was no valid prescription;
    PROVED
    4.2.4. Without a medical review of Patient C
    PROVED

The panel had regard to the HSSD Policy for The Use of Oxytocin in Labour.

The panel also had regard to the answers you gave to Miss Higgins at this hearing under cross examination as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.
The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. **To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.**

5. **To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.**

It is submitted on your behalf that you were not in the room at the precise times of the increases in Syntocinon and that you cannot therefore be held responsible for the increases. It is accepted by you as per charge 4.1 that there was no valid prescription for Patient C and that a medical review was not carried out.

The panel determined that you would have been aware that once Syntocinon was commenced, it is increased as per the regime contained in the above mentioned policy. The panel rejects your submission in that you were not in the room at the precise times of the increases in Syntocinon. The panel determined that as Midwife co-ordinator on the shift on 29 November 2013, you had an overarching responsibility for the oversight of the care delivered to patients during the shift you were coordinating. **Accordingly, charge 4.2 is proved in its entirety.**

**Charge 4.3**

5.5. At or around 07:15, Patient C having given a “suspicious” CTG trace whilst the administration of Syntocinon continued, did not seek a review of Patient C’s condition from a consultant obstetrician

**Admitted and found proved**

**Charge 5**
6. Between approximately 2012 and 2014, as Local Supervisory Authority Contact Supervisor of Midwives and/or Band 6 ward coordinator:

6.1. Did not adequately challenge and/or participated in inappropriate working practices at the Hospital, namely:

5.4.1 Midwives accepting verbal orders for the use of Oxytocin;

Admitted and found proved

5.4.2 Midwives seeking to avoid contact with obstetricians at night, when contact was required according to policy;

Admitted and found proved

Charge 5.2

5.5 Did not escalate and/or seek to reform the difficulties in communication between midwives and obstetricians;

PROVED

In determining this charge, the panel had regard to the report of Ms 7 and Ms 11 dated 14 August 2014 in which the following information was obtained from you and Midwife C regarding the culture and working practices within the maternity unit.

Culture and Working Practices within the Maternity Unit:

Midwife B reported in interview that there was a culture of midwives not calling obstetricians in at night and midwives taking on more responsibility because of this. She reports that if the obstetricians feel they have been called out unnecessarily then they will complain to Ms 4 about it. Ms 4 refutes this, saying in the past there was one obstetrician who did make it difficult for midwives to contact him, but he has retired now and she has not had any concerns expressed to her in the past two years. Midwife C states in interview it is not as easy to call a doctor in from home as it is when they are based in the hospital. Midwife B was obviously influenced by the fact the midwives have to call a doctor from home, hence commencing the syntocinon without prescription.
The panel heard oral evidence from Ms 5 who had been a senior midwife at the Hospital before taking over as Acting Head of Midwifery in September 2014. In answers to questions from the panel regarding communication difficulties between midwives and obstetricians, Ms 5 stated the following:

Q: *There were difficulties in communication between the midwives and consultants, how easy was that to challenge?*

A: *It varied. It varied between each consultant so they each had—it was very difficult to challenge because you didn’t know which response, what type of response you would get, but generally if there as a midwife challenging an obstetrician the obstetrician although knowing there was perhaps an issue for example obstetric practice, they would still support each other and they would not support the midwives. Certainly, if you were challenging an obstetrician about their own practice, that was extremely difficult and I attempted to do that a few times.*

The panel considered that under the NMC Code of Conduct, you had a duty to challenge bad practice even if it was uncomfortable for you to do so. The panel determined that where a working culture is so entrenched and unsafe, it in no way negates your professional duties under the NMC Code of Conduct to challenge it. The panel concluded that you had opportunities to discuss the difficulties in communication between midwives and obstetricians and you failed to do so.

The panel considered that you had a unique opportunity amongst the Band 6 Coordinator in that you were also a SoM and as a SoM you also had a unique opportunity amongst the other SoMs as contact supervisor, as you were regularly travelling to the LSAMO Meetings in Taunton. In attending at these meetings would have undoubtedly provided you with many opportunities to address the problems Guernsey midwives were facing and to discuss, take advice from other experienced and senior midwives.

The panel had particular regard to the answers you gave during this hearing, when questioned by Ms Hamilton and in which you stated:
Q. What was the purpose of you going over to the meetings in Taunton?

A. It was to tighten up the supervisors' communication teamwork and update about things around supervision and bring back the feedback then to the own units.

Q. How did you feed back the information that you gained from going over to Taunton and taking part as a contact SOM?

A. It was listed on our supervisor meeting agenda, the feedback from the previous meeting.

Q. How would midwives that were not supervisors, so other Band 6s, how would they know what was going on?

A. Well, we had supervisory board on a ward where we put notes and notification about supervision changes and new guidelines, the national guidelines.

Q. If you wanted to make any changes, was it easy?

A. No.

Q. How was the prospect of change met?

A. I felt that...at the meetings sometimes I got the comment that: "Well, we don't have to do everything that comes back from Taunton, we don't have to change everything what is said there."

The panel concluded that when faced with the resistant attitude on Guernsey, that Guernsey midwives did “not have to do everything that comes back from Taunton, we don’t have to change everything what is said there”. As a SoM and as a Band 6 Midwife Coordinator, you had an unequivocal duty under the NMC Code of Conduct to raise these concerns with the LSAMO in Taunton for further advice and guidance. Accordingly charge 5.2 is proved.

Charge 5.3

5.6 Did not question the validity of Patient Group Directives at the Hospital;

NOT PROVED
In determining this charge, the panel considered your role as a SoM and as a Band 6 Midwife Coordinator. Whilst the panel accept that under the Midwives Rules and Standards and the NMC Guidance on Administration of Medication, midwives must ensure that all medicines are administered safely. In this case however, the panel did not have before it the PGDs at issue as the panel were told that they had all disappeared.

Further, there is no evidence before the panel that you were part of the appropriate committee responsible for reviewing the PGD’s. In the circumstances, the panel consider that the MNC has not discharged the burden of proof. Accordingly, charge 5.3 is not proved

Charge 5.4

5.7 Did not ensure that there was a robust system to review concerns relating to midwifery practice at the Hospital

PROVED

In determining this charge, the panel had regard to your Job Description and noted the following requirements and responsibilities contained therein.

*Midwife Coordinator Band 6 - Job Description*

**Clinical Responsibilities**

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.
4. To initiate risk assessment processes to determine risks to the health and will being of mothers and babies with complex care needs, taking relevant action to minimise the risks.
8. To independently liaise and communicate effectively with all members of the multidisciplinary team and other agencies involved in the care of mother and babies.
**Leadership**

1. To co-ordinate a team of staff, ensuring that clear systems of communication are developed within the team and any work related issues raised by the team are addressed.
2. To ensure team members are aware of organisational objectives, policies and procedures and the implication they have for their practice.
3. To act as a professional role model for junior staff, promoting high standards of practice and strong professional values.

**Communication**

4. To act as an advocate for mothers, babies, significant others and more junior staff members
5. To ensure written communication complies with organisational and professional standards.

**Audit/Information Technology/Research Activity**

1. In conjunction with the audit department, initiate and undertake clinical audits to monitor and maintain standards of practice.
2. To actively promote evidence based practice in own and the practice of other members of staff involved in the care of mothers and babies.

**Job Summary**

The post holder will practice safely adhering to the HSSD policies, national guidelines and to the midwives rules and standards, accessing a supervisor of midwives when required.

The panel also had regard to the role of a SoM as set out at Rule 11 in the guidance of the Midwives Rules and Standards which states the role is the SoM is to protect the
public by empowering midwives…to practice safely and effectively supervisors are accountable to the LSA for all supervisory activities

The panel determined it was explicit from your job description that as a Band 6 Midwife Co-ordinator, SoM and LSA Contact SoM you had a duty to ensure that there was a robust system in place to review concerns relating to midwifery practice. Further, as a SoM, you had a responsibility to be a role model and to ensure safe practice. The panel considered that you attended supervisory meetings whereby any concerns could and should have been discussed so as appropriate actions could be taken to ensure systems were in place to review any concerns relating to midwifery practice.

The panel had regard to the answers you gave to Miss Hamilton regarding your attendance at LSA meetings in Taunton whereby you stated:

Q. What was the purpose of you going over to the meetings in Taunton?
A. It was to tighten up the supervisors' communication teamwork and update about things around supervision and bring back the feedback then to the own units.

Q. How did you feed back the information that you gained from going over to Taunton and taking part as a contact SOM?
A. It was listed on our supervisor meeting agenda, the feedback from the previous meeting.

Q. How would midwives that were not supervisors, so other Band 6s, how would they know what was going on?
A. Well, we had supervisory board on a ward where we put notes and notification about supervision changes and new guidelines, the national guidelines.

Q. If you wanted to make any changes, was it easy?
A. No.

Q. How was the prospect of change met?
A. I felt that...at the meetings sometimes I got the comment that: "Well, we don't have to do everything that comes back from Taunton, we don't have to change everything what is said there."
When meeting this resistance, you failed to go back to the LSAMO in Taunton for advice and guidance.

The panel concluded that by your failure to adhere to your job description as a Band 6 Midwife Coordinator and as a SoM and as a Local Supervisory Authority Contact Supervisor of Midwives you did not ensure that there was a robust system to review concerns relating to midwifery practice at the Hospital. Accordingly, charge 5.4 is proved.

Revised determination on facts – 22 September 2017

This determination dated 21 September 2017 is a revised version of the draft determination handed down to the parties on 20 September 2017. The reasons for this are set out in the Addendum at the end of this determination on facts.

Background presented by the NMC

This case concerns three registrants, all registered midwives and all employed by the Health and Social Services Department (HSSD) of Guernsey at the Princess Elizabeth Hospital (the Hospital) on the Maternity Suite known as the Loveridge Ward (the Ward).

The Hospital is situated within the Bailiwick of Guernsey, which is a Crown Dependency. As such, it is governed by a directly elected legislature independent of the United Kingdom. However, the NMC has jurisdiction as a regulator of nurses and midwives practising in Guernsey.

The Ward itself contains a 12 bed antenatal/postnatal ward, 4 delivery rooms, a 2 bed transitional care unit and a 3 bed neonatal unit.

Midwives on the Ward were allocated to provide one to one care for a woman before, during and after labour. The nature of the one to one care system involved a midwife taking on responsibility for both the care personally delivered and the management of the patient’s condition. The midwife’s role therefore included the need to escalate the
condition of the patient allocated to her to a Consultant Obstetrician as required, in order to ensure that any abnormalities in the patient’s condition were dealt with in a timely and appropriate manner.

The structure in place at the Hospital was such that it did not have junior or middle grade doctors working within the Maternity Service. Therefore when a midwife referred a patient for medical intervention this was directly to one of four Consultant Obstetricians.

A shift coordinator [a Midwife] would also be on the ward, not allocated to individual patients, their purpose was to allocate tasks and also to act in a supporting and advisory role for the midwives present.

36 midwives in total were employed at the Hospital who, at the relevant time, were supervised in their practice by four locally based Supervisor of Midwives (“SoM”). Both you and Midwife A were SoMs.

In May 2014, Ms 3, a midwife on the Ward, started to contact the Local Supervising Authority for Midwives (“LSA”) in order to register her concerns regarding midwifery practices. The LSA is the statutory body responsible for the supervision of all midwives practising within its boundaries. It is responsible for ensuring that the Midwifery Rules and Standards and the NMC code are met.

Ms 3 raised concerns as a result of a neonatal death in January 2014 of Baby A. Ms 3 was concerned as to deficiencies in the care provided on the night shift of 29 – 30 January 2014 by the midwifery team during Patient A’s labour. Ms 3’s concerns related in particular to what she considered amounted to inadequate management of the cardiotocograph (“CTG”) trace obtained during fetal heart monitoring, and the unauthorised use of medication, specifically Syntocinon. Ms 3 was further concerned by what she considered were inadequacies in the subsequent investigation by the Hospital into this neonatal death.

Ms 3’s concerns regarding the management of the CTG trace related to alleged failure on the part of the midwives to identify characteristics of the CTG trace in order to
correctly classify it as normal, suspicious or pathological. Ms 3 was further concerned that, where signs giving rise to abnormal classifications of the CTG had been present and recognised as such by the midwives, this had not been escalated to a Consultant Obstetrician. Midwives were therefore acting outside the scope of their practice by continuing to lead the decision making in respect of patient care.

Syntocinon is a synthetic form of the naturally occurring hormone oxytocin. It is a drug used to augment labour by making contractions both stronger and more regular. Syntocinon is a form of medication which can only be administered after a written prescription has been given by a suitably qualified medical practitioner, i.e. in the case of this hospital, a Consultant Obstetrician. There are specific risks associated with the administration of Syntocinon which differ according to the stages of labour, but become more acute when stage 2 of labour has been reached, and there was a clear requirement for an Obstetrician to attend and review a patient to make a clinical decision as to whether Syntocinon should be administered before this was done.

There were a number of HSSD guidelines in place at the Hospital at the relevant time, including “Clinical Guideline for Fetal Monitoring During Intrapartum Period” setting out how to categorise a fetal heart rate trace from a CTG and the consequential actions to be taken. Of particular relevance is that part of the policy which sets out that if a CTG trace presents as suspicious and the patient is receiving Syntocinon the patient should be reviewed by an Obstetrician. In addition, there were national guidelines which applied in the NHS’s National Institute for Health and Clinical Excellence’s guideline on intrapartum care (“the NICE Guidelines”).

Ms 3 raised further concerns regarding the use of Syntocinon by midwives without written prescriptions or, in some cases, any authorisation from a Consultant Obstetrician. The culture was such that Syntocinon would be routinely administered to a patient, and its rate increased, by a midwife acting on a verbal order over the telephone by a Consultant Obstetrician. Further concerns were raised that syntocinon was being administered in the absence of any form of Consultant Obstetrician involvement at all.

Following the concerns raised by Ms 3, the LSA Midwifery Officer (“LSAMO”), Ms 1, ordered an initial audit of patient records to take place on 2 June 2014. The audit,
containing a sample group of ten records, was completed by a SoM named Ms 14. Ms 14, discovered evidence to support the concerns being raised by Ms 3, particularly in respect of the unauthorised use of Syntocinon.

Over the course of August 2014, the LSA continued its investigation into midwifery services at the Hospital. Two significant audits took place during this month. The audit process revealed a significant culture that had developed whereby midwives would act outside the scope of their practice. As well as issues concerning the use of Syntocinon, which were considered to be widespread, a culture was discovered whereby communications between Consultant Obstetricians and midwives were discouraged or avoided because of their difficult nature. Midwives were considered to be better at their roles if they delivered care without troubling a Consultant Obstetrician, an attitude particularly prevalent during the course of the night shift. Risk management was assessed by the LSA as inadequate on the basis that substandard midwifery care was not identified and was therefore neither challenged, reviewed nor remediated.

Following the LSA audit a number of individual cases were identified where the standard of care was such that they were considered to require a LSA SoM led investigation, so that individual conduct could be considered in greater detail. These investigations were led by LSAMO Shirley Smith. The outcome was that a number of Local Action Plans and LSA Practice programmes were imposed on individual midwives to attempt to remediate the wide ranging concerns.

In view of the substantial concerns identified, the NMC commissioned a Management Consultancy to conduct a LSA extraordinary review. The review was designed to focus specifically on the issue as to whether or not adequate supervision of midwives was taking place at the Hospital.

The review was conducted by a team of LSA midwives between 1 and 3 October 2014. Over the course of the review, the team uncovered significant difficulties in the supervision of midwives. There was significant criticism of the risk management structure, for example they concluded that the Obstetrics and Gynaecological Clinical Governance Committee meetings were failing to achieve their purpose, which was to examine adverse incidents with sufficient scrutiny to allow best practice to be identified and maintained, and inadequate practice to be managed and changed.
The review team encountered a description of the culture at the Hospital known as the “Guernsey Way”. This epithet was used by members of staff at the Hospital to justify sub-standard midwifery practices in particular and maternity care in general that were not compliant with the NMC Code of Conduct Rules and Guidance and National Guidelines. There was widespread acknowledgement of the use of verbal orders for the use of Syntocinon and a lack of escalation by midwives to Consultant Obstetricians. There was an acknowledgement by members of staff, including midwives, of a system of care falling outside the midwifery scope of practice that was not only allowed to continue unchallenged, but actively participated in and therefore perpetuated.

As a result both the LSA and HSSD started investigations. In June 2014 the LSA investigation into the care given to Baby A took place. This was led by Ms 8 and ran in conjunction to the HSSD’s investigation run by Ms 7 and Ms 11. You were interviewed by Ms 1 on behalf of the LSA with Ms 7 and Ms 11 present.

During the course of the Baby A investigations concerns were raised that similar failures had occurred in the care of Baby B, delivered on 1 September 2012. Baby B had also died. At the time, Midwife A had conducted a review of the case and concluded that the midwifery care had been of an acceptable standard. As a result of the subsequent that arose during Baby A’s investigation, Ms 5, a Band 6 Midwife, was asked to review Baby B’s case. She provided a report of her findings dated 20 June 2014 on a recognised format designed for analysing such incidents. In addition, an investigation into the death of Baby B was carried out on behalf of HSSD by Mr 12 an ENT consultant and Ms 11, the Head of Governance Support and Compliance between October 2014 – February 2015.

LSA investigations were conducted into the care provided by and conduct of you and Midwife C in relation to Patient C on 29 November 2013 and for Midwife C in relation to Patient B on 13 March 2014. The SoM conducting the review was Ms 9. She raised similar concerns on the failure of the part on the midwife to escalate concerns.

**Determination on facts**
Mrs Roussel,

In reaching its determination on facts, the panel had regard to all the evidence adduced, including the oral evidence and the exhibited documents. It was provided with detailed written submissions from Ms Higgins on behalf of the NMC and Ms Hamilton on your behalf.

The panel accepted the advice of the legal assessor who referred to the case law regarding dishonesty (charge 3), namely *R v Ghosh [1982] EWCA Crim 2; Hussein v General Medical Council [2014] EWCA Civ 2246*. The legal assessor referred the panel to the two part test as set out in the case of *Ghosh*. The first part being an objective test; whether according to the ordinary standards of reasonable and honest people what was done by the registrant was dishonest. If it was dishonest by those standards then secondly, the subjective test, namely, whether a registrant must have known that what he/she was doing was, by those standards, dishonest.

The burden of proof rests entirely upon the NMC. You do not have to prove or disprove anything. The standard of proof is the civil standard, namely the balance of probabilities. This means that, for a fact to be found proved, the NMC must satisfy the panel that what is alleged to have happened is more likely than not to have occurred.

The panel heard evidence on behalf of the NMC from the following witnesses who held the positions (as listed below) at the relevant time:

- Ms 1 - Local Supervising Midwifery Officer (LSAMO);
- Ms 2 - Lead Reviewer of the NMC instructed by the Local Supervising Authority (LSA);
- Ms 5 - Current Head of Midwifery HSSD;
- Ms 6 - LSAMO;
- Ms 7 - Service Manager for Child Services at HSSD;
- Ms 8 - LSA Midwife;
- Ms 9 - LSA Midwife
- Ms 10 - Academic Lead at HSSD;
• Ms 11 - Head of Quality Improvement at HSSD;
• Ms 13 - Band 7 Midwife, Ward Manager; and
• Ms 14 - Community Midwife Manager at Jersey General Hospital.

The panel considered that the above mentioned NMC witnesses generally were credible and reliable and gave their evidence in a fair, clear and helpful manner and sought to assist the panel.

**Patient A and Person A.**

The panel heard evidence from Patient A and her husband Person A via video link (Webex) from Singapore. The panel considered that they gave evidence about events that were obviously very difficult for them to revisit and which the panel fully acknowledge was a traumatic time for them. The panel found that that they were reflective, dignified and composed when talking about what was clearly a very stressful time in their lives. The panel found that they were being sincere in their efforts to assist the panel and that they gave their evidence to the best of their recollections and perceptions. To the extent to which the panel found that there were gaps in their recollections, this was entirely understandable.

**Ms 3: Band 7 Midwife and Ward Manager of Loveridge Ward.**

On 6 May 2014, Ms 3 came forward as a whistle-blower. She contacted the LSA in order to register concerns she had about the case of Baby A. Ms 3 alleged that there had been deficiencies in the midwifery care provided in this case during the night shift of 29-30 January 2014. Also that there had been a subsequent failure by the Hospital to investigate the case adequately. Ms 3 was particularly critical of what she felt was inadequate management of the cardiotocograph (“CTG”) trace during the fetal heart rate monitoring, and the unauthorised use of Syntocinon. The panel found Ms 3 to be a candid and credible witness who demonstrated sound knowledge of midwifery practice.

The panel appreciated how difficult it must have been for Ms 3 to come forward as a whistle-blower and to give evidence which was critical of the practices of midwives who had been her colleagues. The panel noted that in her evidence Ms 3 acknowledged where her recollection had been affected by the passage of time. The panel also noted
that Ms 3’s evidence had been consistent over the course of time. The panel did not accept the proposition put to her by Miss Hamilton that she had been motivated by ill-will towards Midwife B. Nor did the panel accept that Ms 3’s credibility as a witness had been undermined by her initial inability to recollect that she had made her own referral (in addition to an NMC referral) of Midwife B to the NMC or to recognise immediately her authorship of the document involved. The panel accepted that this was attributable to a genuine lapse in recollection owing to the passage of time.

**Dr. 1: Consultant Obstetrician and Gynaecologist.**

Dr. 1 gave his evidence by video link from Guernsey as he was unable to attend the hearing in person. The panel considered that Dr. 1’s evidence was vague at times and that there appeared to be gaps in his recollection of events. The panel considered that Dr. 1 in his evidence tended at times to be defensive. He also tended to understate the extent of his knowledge at the time of the reluctance of midwives to escalate cases to the Obstetricians during night shifts, or, of the prevalence of the practice of midwives on night shifts administering Syntocinon on their own initiative without following proper procedures. Overall, at times, the panel found certain aspects of Dr. 1’s evidence unconvincing.

The panel also considered your oral evidence and noted that at times during your testimony you were candid and appeared to realise how far your practice had deviated from acceptable practice which was made apparent to you when you completed an LSA supervised practice programme.

At the commencement of this hearing in January 2017, Ms Hamilton informed the panel on your behalf that you admitted the following charges:

- Charge 1.1.1;
- Charge 1.1.2;
- Charge 1.1.5;
- Charge 1.5;
- Charge 1.6 *(in part relating to 1.1.1 and 1.1.2)*;
- Charge 4.1.1;
- Charge 4.1.2;
• Charge 4.3;
• Charge 5.1.1; and
• Charge 5.1.2.

Accordingly, the panel found charges 1.1.1, 1.1.2, 1.1.5, 1.5, 1.6 (in part relating to 1.1.1 and 1.1.2), 4.1.1, 4.1.2, 4.3, 5.1.1, 5.1.2, the panel found these charges proved by way of your admission.

On 17 July 2017, the panel determined that there was no case for you to answer in respect of charge 1.1.3.

The panel went on to consider the remaining charges and made the following findings of facts.

Charge 1

That you, a registered midwife, whilst employed by the Health and Social Services Department of the States of Guernsey (“HSSD”) at the Princess Elizabeth Hospital, Guernsey (“the Hospital”):

1. In respect of the care delivered to Baby A and/or Patient A on 29 and 30 January 2014, when you were the midwifery ward coordinator:

   1.1 At or around 23:20 on 29 January 2014, commenced and/or oversaw the administration of Syntocinon to Patient A:

      1.1.1 When there was no valid written prescription;

      **Admitted and found proved**

      1.1.2 Without a medical review of Patient A;

      **Admitted and found proved**

      1.1.3 In the presence of mild fetal heart rate distress;
No case to answer

1.1.4 Which was commenced without appropriate patient consent and/or patient consultation;

Not proved

1.1.5 Which was not appropriately recorded with a signature

Admitted and found proved

Charge 1.1.4

In determining this charge, the panel considered your evidence, the evidence of Patient A and Person A, the evidence of Midwife C and the relevant documentary evidence. It is accepted by you and Midwife C that she was taking the lead in caring for Patient A and that you were overseeing this in your role as Midwife Coordinator.

It is clear from Patient A’s notes, and you accept, that neither you nor Midwife C made any documentary record of any consent or consultation with Patient A with regard to administering Syntocinon. It is equally clear, and you also accept, that you were under a duty to make such a record, if such consent or consultation occurred.

Midwife C told the panel in her oral evidence that, prior to its administration, she explained what was proposed and obtained informed consent from Patient A for administering Syntocinon. The panel noted that Midwife C has been consistent in asserting that she obtained such consent during her interviews in the subsequent investigations. The panel also found her oral account of the procedure that she followed as a matter of custom and practice convincing.

The panel noted that Midwife C is softly spoken and that English is not her first language. The panel had no difficulty in accepting that this may have been one of the factors which accounts for a lack of a clear recollection on the part of Patient A and Person A of a discussion regarding the administration of Syntocinon.

Midwife C’s account that informed consent was obtained was supported by your evidence to the panel. You told the panel that you had also been involved in the discussion. You told the panel that when it was explained that Patient A’s contractions were not strong enough and her consent was sought regarding the administration of Syntocinon, you understood that she gave consent by saying, “whatever is needed – whatever you feel safe”.

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The panel noted that Patient A and Person A’s accounts in respect of this allegation have varied. During her telephone interview with Ms 8 as part of the LSA interview, on 26 June 2014, Patient A said, “I don’t recall having a specific conversation about the Syntocinon drip. I had the drip equipment in my hand for the antibiotics for GBS [Group B Streptococcus]. I assume Syntocinon was delivered through the same drip. As I recall there wasn’t any formal discussion regarding my labour…We were told not asked, no consent was sought.”

During the interview with the Police on 30 July 2015 as part of their investigation, Patient A, in contrast to the above, stated, “I understand from various reports that the midwives say that our consent was obtained from us for the use of Syntocinon. I categorically deny this.”

Patient A and Person A gave evidence to this panel on 19 January 2017 and during their evidence, when asked about this charge by Mr Collis behalf of Midwife C and in particular about the telephone conversation with Maria Patterson, Person A stated the following:

Q – Ms 8 has documented what your wife said about Syntocinon in the course of that telephone conference in June 2014, can you recall at all how the issue of whether or not consent had been given was raised by Ms Patterson?

A – I’m sorry I do not remember. No, I’m sorry I do not remember.

Patient A was asked the following questions in relation to this charge during her evidence on 19 January 2017:

Q – Am I right then in thinking that you don’t have any independent recollection of the two midwives, Midwife B and Midwife C administering a medication to you at twenty past 11 that night?

A – No. I don’t recall

Q – Would you accept Patient A, it’s possible that if you can’t recall the medication being set up and administered, it’s possible that you also can’t recall a conversation between yourself and the midwives about the medication.
A – *My husband would have been involved in that conversation, It would have been a longer conversation, I believe than the brief conversation that we had in the room.*

The panel considered that the variance in Patient A and Person A’s answers regarding what was discussed with them is entirely understandable given all that they had gone through and how traumatic events had been for them.

The panel is satisfied that you have been consistent in the documentary evidence and your oral evidence in relation to this charge and that you have always maintained that consent was obtained from Patient A and Person A before administering Syntocinon.

The evidence showed that the process involved in setting up and commencing the administration of Syntocinon would not simply have involved connecting another bag to an existing line. It involved a process which would have taken a significant period of time, including setting up a new piece of equipment, a pump, which emitted audible noises. The panel accepted that it is inherently implausible that this process would have been carried out without any explanation on either your part or the part of Midwife C as to what was going on. The panel further noted that, given how involved the parents were in every facet of the planning and decision making in respect of the birth, it is highly unlikely that, had no explanation been offered to Patient A or Person A, this process would not have been completed without either of them asking Midwife C or you what you were doing.

The panel was not satisfied that the NMC had discharged the burden of proving on the balance of probabilities that you commenced Syntocinon without appropriate patient consent and/or patient consultation. **Accordingly, charge 1.1.4 is not proved.**

**Charge 1.2**

1.2 At or around 23.50 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

1.2.1 When there was no valid written prescription; **PROVED**
1.2.2 Without a medical review of Patient A;

    PROVED

1.2.3 When the CTG had shown a “suspicious” trace;

    PROVED

In determining this charge, the panel first had regard to The Use of Oxytocin in Labour
(exissued in January 2011), the policy states:

(exhibit 7 Page 839)

Appendix 1: Regimen for oxytocin infusion (induction and augmentation)

- The maximum licensed dose is 20 milliunits per and if contractions are
  established after TOTAL of 5 iu (5 hours and suggested regimen) the induction
  should be stopped. The case must be discussed with the consultant on call
- 4 international units (iu) oxytocin to be made up to 100mls with 5% sodium
  chloride (normal saline). Infusions must be checked by two midwives and given
  via an alris pump
- Each infusion must be used within 12 hours
- A new infusion must be set up if continued treatment is required beyond 12 hours
- Please ensure that the DOSE is recorded on the partogram rather than the rate
  of the infusion
- Care should be taken with the administration of other intravenous fluids, which do
  not need to be routinely used.

The panel had regard to your answers given during cross examination by Miss Higgins
as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or
escalation to an obstetrician, you did not do it because you felt this would make the
obstetricians unhappy?

A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I
    did not do what I was supposed to do according to those policies.
The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

The panel had regard to the statement of evidence of Ms 8 and in which she states:

I identified further concerns in the care delivered to Patient A and Baby A at 23:50 when significant decelerations accelerations in the fetal heart rate were noted within the CTG trace. There were therefore visible signs of fetal distress being demonstrated at 23:50 within the context of the use of syntocinon. This constituted another opportunity for Midwife C and Midwife B to seek the intervention of a consultant obstetrician…

The panel considered that it had become custom and practice not to call the on call obstetrician following a suspicious CTG trace. This was accepted by you during the joint HSSD and LSA interview on 10 June 2014 and in which you said “it’s about suspicious CTG calling obstetrician but we don’t call obstetrician for first or second CTG not unless it’s getting severe CTG because they wouldn’t do anything”.

The panel considered that Patient A was the only woman in labour on the night of 29 January 2014 and accept that Midwife C was the junior less experienced, midwife on shift with you. You were fully aware of the regime for increasing Syntocinon. Further, you noticed that the CTG was suspicious before the Syntocinon was commenced, and recorded this on the Fetal Heart Auscultated With Pinnard Sticker.

The panel also had regard to the statement of Ms 8 dated 15 December 2015 in which she states:
“From my consideration of the patient’s records and the decision making tool guidance, I considered there to be the need for a full LSA investigation. I was concerned that the evidence suggested that a suspicious CTG trace had not been escalated to a consultant obstetrician, that Syntocinon appeared to have been used without appropriate authorisation and that Syntocinon had continued to be used despite deterioration in the CTG trace. There appeared to be early signs that the midwives concerned had acted outside the scope of their practice and therefore here were serious concerns in respect of the level of midwifery care provided”.

“I further noted that a National Guideline Decision Making Tool had been completed on 31 January 2014 by Midwife A. I noted that Midwife A also held the statutory position of SoM. Midwife A’s opinion in respect of the Patient A case was that a full LSA investigation was not required as, other than minor recording errors, there were no difficulties with midwifery practice”.

“I completely disagree with Midwife A’s assessment of the situation, as demonstrated by the fact that I quickly concluded that a full LSA investigation was definitely required. In my opinion, the concerns I have identified with the care given to Baby A on 29 and 30 January 2014 by Midwives B and C are fundamental concerns that any qualified midwife should be able to note. They are therefore ones that Midwife A, as a Risk Management Midwife and a SoM, may be reasonably expected to realise as well, from reading the patients records, as I did”.

“Although it is possible for Syntocinon to be used where a CTG trace has been classified as suspicious, this would not be a decision that a midwife would be qualified to make. Syntocinon has the effect of augmenting contractions in order to make them stronger and more frequent. As such, there can be an association between the use of Syntocinon and acceleration or decelerations in the fetal heart rate. Therefore, the use of Syntocinon in the context of a fetus that is already demonstrating some signs of suspicious CTG actively would need to be closely supervised and conducted under the direct instruction of a consultant obstetrician.”
The panel considered the notes of your Disciplinary hearing on 7 January 2015 during which the following was presented on your behalf by your representative attending the meeting with you from the Royal College of Midwives (RCM).

“[Midwife B] stated in her interview that “we don’t call the Obstetrician for first or second suspicious CTG, not unless it’s getting severe CTG because they wouldn’t do anything”.

“…This reflects the custom and practice within the unit and the difficulties midwives faced getting support at night. Midwife B stated at interview that if she rang the Obstetricians every time she marked a CTG as suspicious “well they would be marching to the Head of Midwifery obviously in the morning.”

The panel had sight of Patient A/Baby A’s Clinical Social Care Notes which contained the “Fetal Heart Auscultated With Pinnard Sticker”. The sticker was signed by you at 22:25 at which time you had conducted a fresh eyes review. The panel noted that the sticker clearly details that the CTG was suspicious as you had circled the box that said “Suspicious CTG” (one non reassuring feature).

The panel noted that during your oral evidence at this hearing, you accepted the decision to commence Syntocinon was made jointly with you and Midwife C and that you were aware this should not have been given without a prescription. You accepted that the Syntocinon was increased and that at both times there was no valid prescription and no medical review in place. Midwife C’s evidence to the panel was that you were “in and out of the room” whilst the Syntocinon was being administered although she acknowledged that this was not recorded in the Patient A’s notes.

The panel accepted the evidence of Midwife C that you were in and out the room and that you were fully aware that the Syntocinon was being increased. You failed to seek a review of Patient A despite the suspicious CTG. Having regard to the HSSD Policy for the use of oxytocin in labour, of which you were clearly aware, sets out the regime for increasing the Syntocinon which is to double the dose at set times.
The panel concluded that as the coordinator of the shift, you were the most senior midwife on the Ward that night. You were responsible for overseeing the continued increase in Syntocinon as the shift coordinator. You have acknowledged that Midwife C was a less experienced midwife whom you felt required greater support. The panel has determined, based on all the evidence before it, at or around 23.50 on 29 January 2014 you oversaw the increase to the rate at which Syntocinon was administered when the CTG had shown a suspicious trace with no prescription and no medical review in place. 

**Accordingly, charge 1.2 is proved in its entirety.**

**Charge 1.3**

1.3 At or around 00.10 on 29 January 2014 increased and/or oversaw the increase to the rate at which Syntocinon was administered:

1.3.1 When there was no valid written prescription;  
**PROVED**

1.3.2 Without a medical review of Patient A;  
**PROVED**

1.3.3 When the CTG had shown a “suspicious” trace;  
**PROVED**

The panel had regard to the HSSD Policy for The Use of Oxytocin In Labour (issued in January 2011).

The panel also had regard to your answers given during cross examination by Miss Higgins as follows:

Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?  
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.
In considering the Regimen for oxytocin infusion (induction and augmentation) in this policy, the panel determined that you were fully aware that the Syntocinon is increased as per this regimen. Patient A’s notes detail that you were present in the room 16 minutes after the Syntocinon was commenced.

The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

The panel had regard to the Minutes of the Disciplinary Hearing dated 7 January 2015 during which, the following was submitted on your behalf by your RCM representative:

“[Midwife B] acknowledged that she should have turned the Syntocinon infusion off once she realised the CTG was deteriorating. She admits that she lost sight of this in her desire to facilitate the woman’s choice and strong desire to have a normal delivery”.

The panel accepted the evidence of Midwife C that you were in and out of the room and determined that as the Midwife Coordinator you had an overall responsibility for the oversight of care and increasing the rate of Syntocinon when there was no valid prescription, without a medical review of Patient A and when the CTG had shown a suspicious trace. Accordingly, charge 1.3 is proved in its entirety.

**Charge 1.4**

1.4 Did not seek a review of Patient A’s condition at or around 23:50 on 29 January 2014, Patient A having given a “suspicious” cardiotocograph (“CTG”) trace.
The panel had regard to the statement of Ms 8 in which she states:

“I identified further concerns in the care delivered to Patient A and Baby A at 23:50 when significant decelerations and accelerations in the fetal heart rate were noted within the CTG trace. There were therefore visible signs of fetal distress being demonstrated at 23:50 within the context of the use of Syntocinon. This constituted another opportunity for Midwife B and C to seek the intervention of a consultant obstetrician. Unfortunately, there is no evidence at this point that such a referral too place and the use of Syntocinon continued.”

The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

During your interview on 10 June 2014 with Ms 14, you stated the following:

TR: It’s about suspicious CTG calling obstetrician but we don’t call obstetrician for first or second suspicious CTG unless it’s getting severe CTG because they wouldn’t do anything

The panel determined that as the Midwife coordinator, your overarching responsibility was to ensure that Patient A’s condition was under constant review particularly as the CTG trace had been noted as being “suspicious”. However, despite this you failed to call for an obstetrician to review Patient A at or around 23:50 on 29 January 2014 which
was conceded by you in your interview with Ms 14. Accordingly, charge 1.4 is proved.

Charge 1.5

1.5 Did not escalate, in a timely manner, the delay in the delivery of Baby A, in that you did not seek a review of Patient A’s condition until 00:55 on 30 January 2014, Patient A having entered the second stage of labour at the latest time of 21:45 on 29 January 2014. Admitted and found proved

Charge 1.6

1.6 Your actions as described at paragraphs 1.1 and/or 1.2 and/or 1.3 and/or 1.4 and/or 1.5 increased the risk of harm to Patient A and/or Baby A.

Admitted and found proved in part as to 1.1.1 and 1.1.2

(Remainder of Charge 1.6 NOT PROVED)

Charge 2

2. On 31 January 2014 and/or 2 February 2014, gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A.

PROVED

In determining this charge, the panel first had regard to the time line of events during the night of 28/29 January 2014 as follows:

21:35 Full dilatation “second stage” epidural just cited (exhibit 9 page 265) normal CTG some pressure to push expecting things to progress 3 to 4 in 10 contractions.

21:15/21:45 Telephone call to Dr. 1 from Loveridge Ward – (evidence of Ms 3)
22:25  “Fresh eyes” review carried out by Midwife B at which time the CTG is noted as being “suspicious”, contractions were 3 – 4 in 10 and were documented as “strong”.

23:00  Midwife C had a 15 minute Midwife B assessed Patient A and notes “weak contractions” fully dilated since 21:35 CTG at this stage had been “suspicious” for an hour.

23:15  Syntocinon was discussed between Midwife B and C, Syntocinon was commenced 5 minutes later at 23:20, both Midwife B and C checked the drug, put it into the bag of fluid and giving set and attached it to the machine to commence the infusion.

23:30  “Blood stain liquor” the plan was “to start active pushing”

00:10  Suspicious CTG trace

00:26  “Pushing well variable decelerations” (abnormal heart trace) “changed Patient A’s position”

00:50  CTG Suspicious

00:55  Fully dilated for 3 hours and 20 minutes, no descent (of the presenting part) after 1.5 hours of pushing CTG suspicious Dr. 1 informed to review Patient A due to delay in 2nd stage

01:10  Dr. 1 arrived

01:24  Baby A delivered.

Midwife A was informed of the death of Baby A by Ms 3 on 30 January 2014 at 16:00. Ms 3 telephoned Midwife A at home as she was the on call SoM on that date. In her statement of evidence provided for Ms 1 dated 13 June 2014, Midwife A states the following.

Thursday 30/1/14 Approx 16:00
“I was contacted at home as the on call Supervisor Of Midwives (SOM) by Ward Manager Ms 3 who informed me that a baby who had been born earlier that day had died in NICU at 15.30. She informed me that she had spoken to the Ms 4 Head Of Midwifery (HOM) who had given her guidance on what to do, i.e. secure and photocopy the notes and support staff involved. I asked her if there were any midwifery issues or concerns regarding the care given, she informed me there were ‘no worries’ regarding
midwifery care as everything was being dealt with. I informed her I would be on the
maternity unit the following day and would come and speak with her”

Friday 31/1/14 09:00
“I accessed the safeguard incident reporting system and viewed the form that had been
entered by Ms 3, the category for submission was ‘Apgars <6 @ 5 minutes’. Ms 3 had
entered some information into the local manager part of the form, there were no
midwifery issues raised at this time. I had collected the notes from the ward to start
reviewing them; I browsed the labour part to ascertain if there was any documentation
regarding the ordering of Syntocinon, but could not find any, I therefore phoned Midwife
B at home to ask her. She informed me that she had spoken with the on call
Obstetrician Dr 1 about another patient on the ward and had asked him if she could
start the Syntocinon, to which he agreed. I told Midwife B that this was not reflected in
the notes and she should have documented this conversation in the woman’s notes and
used an SBAR sticker. She said she hadn’t used SBAR as she had phoned Dr 1 about
another patient. She said she would make this retrospective addition to the notes when
she was next on duty (2nd February), she said she was happy with the care she had
given. As I was also working on Sunday, I said we would meet up and discuss it
further.”

The panel also had regard to the joint LSA and HSSD interview with Ms 3 on 10 June
2014 conducted by Ms 8 during which she gave the following answers:

AT: …So I asked Midwife B if she had a quick word with me in the office and she came
in and we sat down. I said Midwife B do you mind if I ask you about this, look at this
CTG and I did say, I did say, she said no she wasn’t contracting you weren’t there, I
said fair enough I said yes because I wasn’t there and I was feeling it, but I said it looks
to me and how its documented the progress that she was really contracting well.

I don’t think she was, I know very well when people need Syntocinon. So I said well can
you tell me, I said what did Dr. 1 say when you rang him and you described the picture,
and she didn’t really answer me in terms of what he said, but she said it was to start
Syntocinon, and I said there is nothing documented about your conversation and she
said no but she had, but she did keep saying she had called him and then she got really angry with me for discussing this so I just put my hand very gently, look I said I really don’t want to upset you, I said I just want to get to the bottom because I can’t understand why he didn’t come in, I just don’t understand why he didn’t come in. And then we sat there and all of a sudden it was so unexpected it was the last thing I expected her to say, she just said I didn’t call him. I know I was really shocked and so I waited and she said I didn’t call him. I said Midwife B that’s, I think my words were, you know that’s wrong don’t you and she said yes I know and we were quite quiet and I said you will never do that again will you and she said no I won’t. And we were okay and then she left but it was just like a moment where she sat very and she said this so.

The panel had regard to the evidence of Ms 3 during this hearing and considered the submissions on your behalf which refer to Ms 3 having a “grudge against you”. The panel note in the written submissions on your behalf reference is made to a complaint about you of a similar nature as set out in a form completed by Ms 3 to the NMC. The panel had regard to transcript of Ms Hamilton’s cross examination of Ms 3 on this point, the panel also took into account your evidence. The panel accepted Ms 3’s evidence that she did not harbour any “ill will” towards you. The panel does not accept that any perception on your part that this was the case was well founded.

The panel further considered the submissions on your behalf that Ms 3 denied making a referral to the NMC against you. The panel did not consider because she was initially unable to recall making the referral, diluted her credibility as a witness. The panel considered that Ms 3 has been consistent in her assertions regarding what you said to her regarding your telephone call to Dr. 1 throughout the LSA investigations and her oral evidence to this panel. Further, the panel considered that Ms 3’s testimony is supported by the concessions made by you during the Disciplinary Hearing on 7 January 2015 and in which you stated:

TR: said she did not refute that she started the Syntocinon with no verbal order. There was a culture around this and definitely given to aid care to the mums.
The panel considered the statement of Dr 1 dated 3 January 2017 and in which he stated:

2. In relation to Patient A:

   a. In 2014 there were four consultant obstetrician/gynaecologists and we worked an on-call rota which meant that one weekend in four (08:00hrs Friday – 17:00hrs Monday) we were on call, together with a night on call during the week, as well as covering Labour Ward on weekdays. We were on-call from home and were called in, when required, normally by the midwives. The A&E department, Princess Elizabeth Hospital (PEH) Ward staff or GPs could also call us if required. If the midwife wished to contact us they would ask the switchboard operator to contact us by telephone using either our mobile phone or our landline.

   b. I was on call the night of the 29/30 January. There was no other Obstetrician on call that evening.

   c. At about 00:55 hrs on 30th January 2014 I was at home in bed when I received a telephone call from the midwife. She explained to me that she had a patient in labour who had been receiving midwifery led care throughout her pregnancy. There had been no descent of the presenting part and the CTG was suspicious. This was the first telephone call I had received and I was not informed about the use of Syntocinon.

   d. I recall being called by Midwife B at 00:55 on the 30th January 2014. I cannot recall the timings of other calls during the 29./30 January 2014.

   e. I do not recall at any stage being contacted about the use of Syntocinon in this patient. At the time of labour and delivery I was not aware that Syntocinon had been used, and according to our [sic] local policy, I should have been contacted before it was administered to this patient.

The panel also had regard to answers given by Dr. 1 during this hearing in answers to questions put to him by Miss Higgins.

   Q. …we see that you were on call that night, correct?
A. That’s correct

Q. And you say at bullet point C, ‘at about 00:55 hours on 30 January I was at home in bed when I received a telephone call from the midwife, she explained to me that she had her patient in labour who had been receiving midwifery-led care throughout her pregnancy, there had been no descent of the presenting part and the CTG was suspicious, this was the first telephone call I had received and I was not informed about the use of Syntocinon’

A. Yes, that’s correct.

Q. And then the next bullet point, you say ‘I recall being called by Midwife B at 00:55 on 30 January, I cannot recall the timings of other calls during 29 and 30 January 2014’

Do you recall any calls earlier that evening?

A. No I can’t recall at all.

Q. Okay, are you able to say whether ---is your recollection that there weren’t any calls or in your recollection you just don’t know.

A. I just don’t know.

Q. Okay. Do you recall any previous phone call regarding Patient A?

A. No, I don’t recall any previous conversations.

Q. Now, when were you first aware Syntocinon had been used?

A. I cannot recall when I was told the Syntocinon --- but it was definitely not before the delivery or soon after.

Q. Okay, And we see that in your statement made on 4 June, if we can go to that, within the first paragraph you say ‘I was not informed that Patient A had been started on Syntocinon infusion at 23:20’ Correct?

In the notes of the joint LSA and HSSD interview conducted by Ms 8 on 10 June 2014, you stated the following:

TR: He knew that night because, because when he came in or when I asked him to come in I can’t remember which point, was it the phone call when I asked him to come in or on his arrival but I told him when he was on the ward and obviously he saw Syntocinon up because he knew about it and afterwards, it was after delivery after baby
was transferred that the conversation started I apologised to him, I'm so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since.

The panel note that you accept that Midwife A telephoned you at home on the morning of 31 January 2014 and that you do not dispute the content of that conversation. The panel further note that whilst you were asked by Midwife A on two occasions to make retrospective entries into Patient A’s notes you did not do so and informed the panel in evidence that you did not do so because you were too busy. The panel had regard to the answers you gave to questions put to you by Miss Higgins during this hearing when you stated the following:

Q. It is right, is it not, that Midwife A told you on two occasions to fill out an SBAR sticker retrospectively – correct ?
A. Yes.
Q. In order to show that a telephone call had taken place, because that is what she thought – correct?
A. Yes that is correct.
Q. She asked you to do it in the phone call the day after – correct?
A. Yes she did.
Q. The she told you again, she reminded you I think it was on 2 February when you were working on the ward – correct?
A. Yes that is correct.
Q. You never did that, did you?
A. I did not and that is because the shift on that Sunday – well, going to the first phone call, I did not return to work after the incident until my next shift and that day was really, really busy and I did not have time to go back to my previous patient notes and I failed to return that. I am really, really sorry about that, my record-keeping is a very poor standard.

The panel note that Ms 3 states that she checked the telephone records from the Loveridge Ward to Dr 1. The telephone call on 30 January 2014 at 00:55 is not contested. The panel note that Ms 3 is inconsistent in the timing of an earlier call having been made to Dr. 1. In her NMC statement of evidence and in her oral evidence, Ms 3
indicated that the time was 21:15. By contrast in an earlier statement she put the time at 21:45.

However, when considering the timeline of events, the panel bore in mind that even if the correct time was the later time of 21:45, Patient A had just had an epidural and there was nothing to suppose at that time there were any problems. Patient A was contracting well, the CTG was normal and the expectation was that Patient A would progress to a vaginal delivery. The panel determined that there would have been no reason during the telephone call at either time for you to request a verbal order for Syntocinon augmentation.

In light of the evidence, the panel determined that the conversation that took place either at 21:15 or 21:45 between you and Dr 1 could not have in consequence have been to discuss the administration of Syntocinon to Patient A.

Further, the panel considered the answers you gave during your interview with the HSSD and LSA on 10 June 2014 in which you stated, you told Dr 1 after the delivery of Baby A when he attended “I apologised to him, I'm so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since”. The panel considered that this statement given at this interview supports the fact that you did not obtain a verbal order from Dr.1 during your telephone call to him regarding another patient at either 21:15 or 21:45. Further, Dr. 1 cannot recall any conversation regarding Patient A and Syntocinon until after the birth of Baby A.

The panel is satisfied, on the balance of probabilities having regard to all of the information before it, that on 31 January 2014 and/or 2 February 2014, you gave incorrect information to the Risk Management Midwife, in that you stated that you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A when you had not. **Accordingly charge 2 is proved.**

**Charge 3**
3. Your conduct as described at paragraph 2 was dishonest, in that it was intended to mislead the Risk Management Midwife as to the true facts of the care given to Patient A/Baby A on 29 and 30 January 2014

PROVED

The allegation of dishonesty made against you is that you gave incorrect information to Midwife A, in that you stated you had obtained a verbal order prior to 23:20 on 29 January 2014 from a consultant obstetrician to support the subsequent administration of Syntocinon to Patient A when you had not.

As already noted above in charge 2, you accept that Midwife A telephoned you at home on 31 January 2014 and met with you again on your next working shift.

In reaching its decision, the panel took into account the evidence from Ms 3, who the panel considered was a reliable and credible witness, Ms 3’s documentary evidence was supported by her oral evidence given to this panel as well as her consistent accounts given at the various times during the investigation.

Further, the panel considered that Ms 3’s testimony is supported by the concessions made by you in the notes of the Disciplinary Hearing on 7 January 2015.

TR: Said she did not refute that she started the Syntocinon with no verbal order. There was a culture around this and definitely given to aid care to the mums.

The panel also considered the answers you gave during the joint interview with the LSA and HSSD on 10 June 2014 in which you stated:

“I apologised to him [Dr. 1], I’m so sorry I did not inform you about Syntocinon, kicking myself big time kicking myself ever since.

In considering this charge in relation to dishonesty the panel, as well as considering the evidence before it, also considered the two stage test as set out in Ghosh. As advised by the legal assessor, the panel first considered the objective test and whether, on the
balance of probabilities, your actions would be deemed to be dishonest by the ordinary standards of reasonable and honest people. If the panel found that you had acted dishonestly by these standards, then it would move on to consider whether, on the balance of probabilities, you realised that your actions were, by those standards, dishonest.

Applying the first element of the test the panel considered whether or not your actions as set out in charge 2 were dishonest. The panel considered that any reasonable and honest person would consider that a midwife providing inaccurate and misleading information to a senior colleague regarding such a serious incident to be dishonest.

Applying the second element of the test, the panel is required to consider whether you realised that what you were doing was by the standards of reasonable and honest people, dishonest. The panel rejected your assertion that the conversation you had with Ms 3 did not involve a discussion regarding the earlier part of the evening of 29 January 2014 when you had telephoned Dr 1 to discuss another patient and assert that during this telephone call obtained a verbal order to start Syntocinon on Patient A when it was required. The panel determined this was a wholly implausible explanation given that at the time of the first phone call either at 21:15, or at the latest, 21:45 to Dr. 1, Patient A had just had an epidural and her labour at that time appeared to be progressing well.

The panel determined that you must have realised that the incorrect information provided by you to Midwife A was dishonest. The panel considered that the incorrect information you provided to Midwife A was self-serving, in the sense that you implicitly asserted you had had obtained a verbal order when you had not to administer Syntocinon during a telephone call to Dr.1 about another patient.

Further, the panel note that despite being asked on two separate occasions by Midwife A, who was senior to you to retrospectively document the verbal order, you did not do so. The inference the panel have drawn from you failing to do this is that you knew what you were doing was dishonest but by reducing the incorrect information to writing was a step too far.
The panel concluded that your behaviour in relation to this charge was deliberate and is satisfied on the balance of probabilities that your conduct was dishonest, in that you intended to mislead the Risk Management Midwife as to the correct facts of the care given to Patient A /Baby A on 29 and 30 January 2014. Accordingly, charge 3 is proved.

Charge 4
4. In respect of care delivered to Patient C on 29 November 2013:

4.1 At or around 04:10, allowed the administration of an infusion of Syntocinon:

4.1.1 When there was no valid prescription

Admitted and found proved

4.1.2 Without a medical review of Patient C

Admitted and found proved

Charge 4.2

4.2 At or around 05.00 and/or 07.00 increased and/or oversaw the increase to the rate of infusion of Syntocinon:

4.2.1 When there was no valid prescription;

PROVED

4.2.2 Without a medical review of Patient C

PROVED

The panel had regard to the HSSD Policy for The Use of Oxytocin in Labour.

The panel also had regard to the answers you gave to Miss Higgins at this hearing under cross examination as follows:
Q. So even when the NICE guidelines, the HSSD guidelines, required involvement or escalation to an obstetrician, you did not do it because you felt this would make the obstetricians unhappy?
A. I was carrying my duties as I was expected of most Band 6s and I deeply regret that I did not do what I was supposed to do according to those policies.

The panel considered your responsibilities as Midwife Coordinator as set out in your job description which stipulated that in particular, as Midwife Coordinator you are required to:

3. To guide, advise and direct other staff in the assessment, planning, implementation and evaluation of the care received by mothers and babies.

5. To lead a team of staff in emergency and other acute situations, ensuring that the mother’s and baby’s needs are met and that significant others are supported.

It is submitted on your behalf that you were not in the room at the precise times of the increases in Syntocinon and that you cannot therefore be held responsible for the increases. It is accepted by you as per charge 4.1 that there was no valid prescription for Patient C and that a medical review was not carried out.

The panel determined that you would have been aware that once Syntocinon was commenced, it is increased as per the regime contained in the above mentioned policy. The panel rejects your submission in that you were not in the room at the precise times of the increases in Syntocinon. The panel determined that as Midwife co-ordinator on the shift on 29 November 2013, you had an overarching responsibility for the oversight of the care delivered to patients during the shift you were coordinating. Accordingly, charge 4.2 is proved in its entirety.

Charge 4.3
4.3 At or around 07:15, Patient C having given a “suspicious” CTG trace whilst the administration of Syntocinon continued, did not seek a review of Patient C’s condition from a consultant obstetrician

Admitted and found proved

Charge 5

5.Between approximately 2012 and 2014, as Local Supervisory Authority Contact Supervisor of Midwives and/or Band 6 ward coordinator:

5.1 Did not adequately challenge and/or participated in inappropriate working practices at the Hospital, namely:

5.1.1 Midwives accepting verbal orders for the use of Oxytocin;

Admitted and found proved

5.1.2 Midwives seeking to avoid contact with obstetricians at night, when contact was required according to policy;

Admitted and found proved

(remainder of charge 5 NOT PROVED)

Addendum

Following the handing down of the original draft determination on 20 September 2017, Miss Higgins on behalf of the NMC, and Miss Hamilton on your behalf, indicated that there were issues which they wished to raise in relation to the draft. It was agreed that these issues would be drawn to the panel’s attention and dealt with on the following day (21 September 2017), in order to allow the remainder of that day of the hearing to be utilised for the purpose of hearing live evidence from the third registrant, Midwife C, who had travelled from Greece for this purpose, together with a witness on her behalf, who was then in attendance.
When the hearing resumed on the following day, Counsel duly raised these concerns, which were then considered by the panel.

It was submitted by Miss Higgins, and by Miss Hamilton, that the draft determination handed down the previous day contained findings of fact in respect of charges 1.6 and 5 which were inconsistent with the panel’s previous conclusions in its determination on Counsel’s submission on your behalf of no case to answer.

The panel received advice from the legal assessor. He advised that, if the panel accepted these submissions, it was clearly desirable that these errors should be rectified as soon as possible. He further advised that it was implicit from the opening words of Rule 24 of the Rules\(^1\) that the panel had jurisdiction to revisit and reconsider its findings. Finally, he reassured the panel that it would not become \textit{functus officio}\(^2\) until the conclusion of the hearing.

The panel accepted the legal assessor’s advice.

In the course of its deliberations, the panel reconvened in open session on two occasions to invite further submissions and clarification from Counsel, which were helpfully provided by Miss Higgins and Miss Hamilton.

The panel also re-read the following documents:

- Its determination in respect of the submission of no case to answer, handed down on 17 July 2017;
- The oral submissions made on 16 February 2017, set out in the transcript of the hearing on that date, by Miss Hamilton on your behalf and by Miss Higgins on behalf of the NMC in respect of that submission of no case to answer;
- The associated written submissions by Miss Hamilton and by Miss Higgins, both dated 16 February 2016.

Having re-considered its findings in the light of the above, the panel reached the following conclusions.

\(^1\) “\textit{Unless the Committee determines otherwise}, [the initial hearing of an allegation shall be conducted in the following stages}.”

\(^2\) “\textit{Having discharged a duty}.”
The panel accepted that its findings in respect of charges 1.6 and 5 in the original draft determination handed down on 20 September 2017 were inconsistent with its earlier findings in its determination in respect of the submission of no case to answer dated 17 July 2017.

In the light of this conclusion, the panel had no doubt that both the findings involved, and the reasons for those findings\(^3\), were erroneous and could not stand.

The panel had no doubt that it was essential to rectify those errors as soon as possible. The draft determination was revised accordingly as above by the panel on 21 September 2017.

The panel wishes to reassure you of the following matters. The panel is an experienced, professional panel, all of whose members have in the past in the course of hearings been called upon to disregard material which has come to its attention but which has had no relevance, or ceased for some reason to be relevant, to issues which it has yet to decide.

Accordingly, the panel will put out of its mind and disregard entirely the original findings and reasons, which have now been rectified.

The panel confirms, for the avoidance of any doubt, that it gave separate consideration to each of the charges. The panel is satisfied that its reasoning and the evidence referred to in its findings, which have now been rectified, played no part in its consideration of any of the other charges. Accordingly, the findings which stand, and the reasons for those findings, have in no way been “tainted” by those errors.

In the course of her submissions, Miss Hamilton submitted that these errors demonstrated a lack of focus on the part of the panel in its deliberations. Whilst the panel regrets and accepts full responsibility for its errors, the panel does not consider that this criticism is justified. The panel believes that the errors arose as a result of a

\(^3\) See in particular pages 19 – 20 and pages 32 – 37 of the original determination dated 20 September 2017.
number of factors, not least of which were the scale of the panel’s task at this stage, the multiplicity of charges to be considered, the complexity of the numbering of the charges and their sub-divisions and the length of, and the unfortunate delays arising from, the hearing repeatedly going part heard and having to be re-listed.

Panel’s determination on application by Counsel for Mrs Roussel for panel to recuse itself

Shortly before the close of the hearing on 21 September 2017, the panel reconvened in open session, announced its decision, and handed down its revised determination on facts of that date.

Miss Hamilton on your behalf then indicated that she had a further application, which arose from the panel's decision and the contents the Addendum to the revised determination, which had just been read into the record by the Chair.

Miss Hamilton then made an application for the panel to recuse itself.

In support of her application, Miss Hamilton made detailed oral submissions.

Miss Hamilton submitted that your case was not a case which simply involved the panel disregarding material which had earlier come to its attention which had ceased, for some reason, to be relevant to issues which it had yet to decide.

Miss Hamilton further submitted that, in the course of its earlier deliberations, which had led to the erroneous conclusions contained in the original determination on facts dated 20 September 2017, namely that charges 5.2, 5.4, 1.1.3 and 1.1.4 were found proved, the panel must, in the course of those earlier deliberations, have formed opinions upon which those conclusions were based, which opinions were no longer valid.

Miss Hamilton submitted that it was now impossible for the panel to put out of its mind the opinions which it had earlier formed and which were no longer valid.

Miss Hamilton further submitted that, as the panel had erroneously believed that your responsibilities as a Midwife extended beyond your actual role, it was now impossible
for any incorrect findings in the original determination to be remedied by erasing them or striking them out with a pen.

Miss Hamilton submitted that you needed to be confident that the panel would judge you fairly, and that it would follow the correct route before arriving at any adverse conclusions in the next two crucial stages of the hearing. This could only be achieved, she submitted, by way of a fresh hearing before a differently constituted panel.

On behalf of the NMC, Miss Hamilton opposed your application. She submitted that the fair-minded observer, aware of the facts, would conclude that your case could still be continued fairly before this panel.

In the alternative, Miss Higgins submitted that, should the panel decide that it should recuse itself, your case should be severed from those of Mrs Granville and Miss Manousaki. Miss Higgins referred the panel to Rule 29 of the Rules which, she submitted, conferred on the panel the power to achieve such an outcome.

Miss Higgins’ submission was opposed by Miss Hamilton on your behalf. Miss Hamilton submitted that, were the panel to accede to her application, Rule 29 by its terms required the panel to recuse itself from all three of these cases, which are now joined as one, and which cannot, therefore, be separated.

In support of their submissions that your case should, if necessary, be severed from those of Mrs Granville and Miss Manousaki, Mr Elton and Mr Collis made comprehensive submissions as to the factors affecting their respective clients which, they submitted, militated against reaching an opposite conclusion.

At the outset of the resumed hearing on 22 September 2017, the panel received advice from the legal assessor. This included a reminder that the panel was not bound to accept or prefer the legal assessor's advice or opinions to any of the submissions made by the parties’ Counsel.

The panel accepted the advice and, in so far as they differed from the parties’ submissions, the opinions expressed by the legal assessor.
The panel was greatly assisted by the quality of Counsels’ submissions, which clearly and concisely defined the relevant issues for the panel’s consideration. The panel asked itself the question whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the panel was biased.

The panel decided that the answer to this question would be in the negative. The panel rejected Miss Hamilton’s submissions that it was now impossible for the panel to disregard material previously considered and/or opinions formerly formed and/or conclusions previously expressed which were no longer relevant and/or valid. The panel did not accept Miss Hamilton’s submission that you could not now be confident that the panel would judge you fairly or that the panel would follow the correct route before arriving at any adverse conclusion in the future. The panel reminded itself of the steps already taken by the panel and the reassurance already provided as referred to in its Addendum to the revised determination. The panel took into account the fact that nowhere in Miss Hamilton’s submissions had she identified any specific step which the panel might take to convince or further reassure you of its intentions with regard to the future conduct of the hearing of your case. Accordingly, the panel decided to reject the application made by Miss Hamilton on your behalf.

The panel went on to consider whether, if it should instead have reached the opposite conclusion, it would have severed your case from those of Mrs Granville and Miss Manousaki.

The panel first considered whether or not it would have had jurisdiction under Rule 29 to achieve such an outcome.

The panel had no doubt that it would have had such jurisdiction.

The panel next considered whether it would, in the exercise of its discretion, have decided to sever your case from those of Mrs Granville and Miss Manousaki.
The panel concluded that it would have so decided. The panel was satisfied that the weight of the factors identified by Mr Elton and Mr Collis in their submissions pointed overwhelmingly to such a conclusion.

Submissions on misconduct and impairment:

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

The panel heard further evidence from you (via Videolink from Guernsey) as well as from Ms 17, Ms 18 and Ms 19. The panel also considered a bundle of documents marked as exhibit 40 and which contained numerous testimonials. The panel gave careful consideration to all of this additional documentary material.

Miss Higgins reminded the panel that there is no burden of proof at this stage and the decision on misconduct is for the panel’s independent judgement. Miss Higgins referred the panel to the case of Roylance v General Medical Council (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. She reminded the panel that, in order to constitute misconduct, any departure from proper standards must be serious.

Miss Higgins invited the panel to take the view that your actions amounted to serious breaches of The Code: Standards of conduct, performance and ethics for nurses and midwives 2008 ("the Code") and the Midwives Rules and Standards. She directed the panel to specific paragraphs and identified where, in the NMC’s view, your actions amounted to misconduct.

Miss Higgins submitted that your actions fell seriously short of what was proper and were also dishonest. Miss Higgins therefore submitted that your conduct in relation to
the charges found proved, collectively, amounts to serious and significant breaches of
the standards expected of a registered midwife, and therefore amounts to misconduct.
Miss Higgins then moved on to the issue of impairment, and invited the panel to
conclude that your fitness to practise is impaired. 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), particularly paragraph 76 of Mrs Justice Cox’s
judgement, wherein she endorsed the questions formulated by Dame Janet Smith in her
Fifth Shipman Report.

Miss Higgins submitted that all of the limbs in paragraph 76 of Mrs Justice Cox’s
judgement in the case of Grant are engaged in this case. Miss Higgins invited the panel
to consider your level of insight and remediation.

Ms Hamilton on behalf of Mrs Roussel provided the panel with written submissions and
informed the panel that Mrs Roussel accepts that the acts and omissions admitted by
her and found proved by the panel fell short of what would be proper in the
circumstances. Miss Hamilton submitted that it is not accepted that Mrs Roussel’s
fitness to practise is currently impaired and referred the panel to the case of Meadow v

Ms Hamilton further submitted that a finding of impairment would reverse the process
that has been put successfully in place to bring about Mrs Roussel’s remediation. She
highlighted that Mrs Roussel was separated from her family whilst completing the
LSAPP in Devon. Ms Hamilton submitted that Mrs Roussel had engaged fully with the
process and has done everything that she could have to re-build confidence in her and
the public perception of the midwifery profession.

Ms Hamilton directed the panel to paragraph 74 in the case of Grant and submitted that
the circumstances on the Loveridge Ward at the time of the events were unique. Ms
Hamilton further submitted that the steps Mrs Roussel has taken since 2014
demonstrates that she is fit to practise without restriction.
The panel heard and accepted the advice of the legal assessor.
The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Roussel’s fitness to practise is currently impaired as a result of that misconduct.

**Decision on misconduct:**

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of *The code: Standards of conduct, performance and ethics for nurses and midwives 2008* (the Code).

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own independent professional judgement.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered midwife, and that her actions amounted to a breach of the Code. Specifically:

The Preamble where it states:

*The people in your care must be able to trust you with their health and wellbeing*

To justify that trust, you must:

- work with others to protect and promote the health and wellbeing of those in your care...

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

- be open and honest, act with integrity and uphold the reputation of your profession.

As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.

**Paragraphs from the Code:**
28. You must make a referral to another practitioner when it is in the best interest of someone in your care.

32. You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.

33. You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.

35. You must deliver care based on … best practice.

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 had regard to the NMC Standards for Medicines Management. The panel appreciated that breaches of the NMC Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved were, individually and collectively, sufficiently serious to amount to misconduct. The panel considered that the administration of Syntocinon was a clear breach of the Standards for Medicines Management. You have accepted that Syntocinon was administered without prescription therefore putting you outside of your scope of practice as a registered midwife.

The panel determined that you, as the Midwife Coordinator failed to seek reviews of suspicious CTG’s which were in need of escalation and review by an obstetrician which she had a clear duty to do. Also she did not persist in ensuring such a review took place. The panel has found as a fact that your failures to escalate concerns in relation to Patient A increased the risk of harm to Patient A and /or Baby A.

Further, the panel considered that honesty is a fundamental part of any midwives practice as clearly set out in the preamble to the NMC Code.

The panel therefore determined that your actions and omissions did fall seriously short of the conduct and standards expected of a registered midwife and therefore amount to misconduct.
Decision on impairment:

The panel next went on to decide if as a result of this misconduct your fitness to practise is currently impaired.

The panel was mindful of the need to consider not only whether you continue to present a risk to members of the public, but also whether the need to uphold and declare proper professional standards, to maintain public confidence in the profession and the in NMC as regulator would be undermined if a finding of impairment were not made in the particular circumstances of her case.

In determining whether your fitness to practise is currently impaired the panel considered the judgement of Mrs Justice Cox in the case of Grant. 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 approve the following questions when considering current impairment, in Paragraph 76:

“*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. has in the past acted dishonestly and/or is liable to act dishonestly in the future”.

The panel considered that your misconduct had engaged all the limbs in Grant. The panel concluded that she has in the past acted so as to put patients at risk of potential harm.

The panel had regard to the fact that patients and the public place trust in the midwifery profession, and that midwives are expected to act in a way which justifies that trust. It is fundamental to maintaining that trust that midwives make it a priority to deliver the best possible care to their patients. The panel considered that these were fundamental tenets of the profession which you breached. Her actions were also of such a nature as to bring the profession into disrepute and she acted dishonestly. Further, the panel noted that prior to you working in Guernsey from 1999, you had spent nine months working in a mainland maternity unit and therefore had experience of working within UK guidance and practices.

The panel also had regard to the fact that you were also a SoM and as such would have had to have successfully completed the preparation course for supervisors. Part of your role as SoM was to advise your supervisees on best practice.

The panel had regard to your evidence at the facts stage of this hearing and answers to questions around communication with consultants at the Hospital put to her by Miss Higgins, on behalf of the NMC, she stated:

Q. That is the truth, is it not that you adapted your working practices due to how obstetricians behaved in Guernsey?
A. I adopted my working into the culture of the whole unit
Q. And that lack of effective communication with the consultants affected patient care?
A. I concede now that this is the case.
Q. It lowered the standard of the midwifery care provided in Guernsey?
A. I absolutely see that that was happening at the time.

As regards the risk of repetition and insight, the panel had regard to the approach to be adopted as set out in the case of Cohen v GMC [2007] EWHC 645 (Admin), namely:

Is the misconduct found proved capable of remediation?
Has it been remedied?
What is the risk of repetition?

The panel considered that your misconduct in clinical areas is capable of remediation. The panel acknowledged that you successfully completed the 450 hours LSAPP and the panel noted the comments of Ms 17 “Tuija impressed me personally with the level of knowledge she exhibited at the summative meeting and her enthusiasm and drive to succeed. Following completion of the programme I had no concerns regarding her fitness to practice”. Whilst the panel considered the positive comments expressed by Ms 17, the panel considered that the issue of dishonesty is always difficult to remediate.

As regards insight, the panel determined that you have demonstrated a degree of insight and made admissions to some of the charges. However, the panel considered that it has not heard anything during the course of this hearing to indicate that you have addressed the dishonesty and nothing to reassure the panel as to what she has learnt about her dishonest conduct. The panel further considered that you did not demonstrate sufficient insight so as to take full responsibility for your actions had on patients, the public and the reputation of the midwifery profession. The panel considered that your insight is self-focused and does not address in any meaningful way these wider considerations.

In the panel’s judgement, the absence of evidence of a full and developed insight and reflection, together with the absence of sufficient remediation leads to a conclusion that there is a risk of repetition. Such repetition would have a consequential risk of harm to
patients bring the profession into disrepute and involve further breaches of the fundamental tenets of the profession.

The panel determined that your fitness to practise is currently impaired on the grounds of public protection.

The panel then went on to consider whether the need to uphold and declare proper professional standards, to maintain public confidence in the profession and the NMC as its regulator would be undermined if, in the particular circumstances of this case, a finding of impairment was not made. The panel has had regard to all of the circumstances of the serious misconduct it has found. The departures from acceptable midwifery practice were significant. It considers that the need to uphold and declare proper professional standards, to maintain public confidence in the profession and the NMC as its regulator would be undermined if a finding of impairment was not made in these particular circumstances.

The panel also finds that your fitness to practise is currently impaired on the grounds of public interest.

**Decision on sanction**

Having considered the findings in this case, the panel has decided to make a striking-off order. The effect of this order is that your name will be removed from the register. She will not be able to apply for restoration until a period of five years has elapsed.

In reaching this decision the panel has had regard to all the evidence that has been adduced in this case together with the submissions of Miss Higgins, on behalf of the NMC and Miss Hamilton on your behalf.

Miss Higgins submitted that sanction is a matter for the panel’s professional judgement taking into account its decision that your fitness to practise is impaired. She referred to the case of Parkinson v NMC [2010] EWHC 1898 (Admin) which she submitted is
relevant when considering the issue of dishonesty. She reminded the panel that it should consider proportionality when deciding which sanction to impose.

Miss Higgins highlighted the aggravating factors she considered to be relevant. Miss Higgins referred the panel to the former Indicative Sanctions Guidance (ISG) which applies to this case.

Ms Hamilton invited the panel to impose a caution order for the maximum period of 5 years. Miss Hamilton informed the panel that you have done and will do anything to address the failures that this panel have found still exist. She informed the panel that you continue to work in a non-clinical role at the Hospital and has the full support of your current Head of Midwifery.

Miss Hamilton referred the panel to the numerous positive testimonials provided and urged the panel to take the course of action that will allow you to continue practising as a midwife.

In relation to the matter of dishonesty, Ms Hamilton asked the panel to consider the guidance given in cases of dishonesty in the new NMC Sanctions Guidance (SG). She submitted that the new guidance is more relevant as it gives a more comprehensive account of the legal position and the development of the law through recent cases on the matters to be taken into account in cases of dishonesty.

Ms Hamilton submitted that if the panel were not with her on imposing a caution order, she would ask for a short conditions of practice order which would include you being supervised on her return to clinical practice and to report back to the NMC on her settling in process as well as providing a further reflective piece.

Miss Hamilton concluded that neither a suspension order nor striking off order was appropriate in this case as both of these sanctions would prevent you as a midwife with a previously unblemished career returning to midwifery practice.

The panel heard and accepted the advice of the legal assessor. In relation to the matter of dishonesty, he referred the panel to the cases of Parkinson v NMC [2010] EWHC.
Atkinson v GMC [2009] EWHC 3636 (Admin) and 2017; Watters v NMC EWHC 188 Admin.

The panel has borne in mind that any sanction imposed must be appropriate and proportionate, and, although not intended to be punitive in its effect, may have such consequences. The panel has had careful regard to the ISG. The panel was mindful of its duty to protect the public and satisfy the public interest. This includes: the protection of patients; maintenance of public confidence in the profession and in the NMC as its regulator; declaring and upholding proper standards of conduct and behaviour.

The panel recognised that the decision on sanction is a matter for its own independent judgement.

The panel first considered the aggravating and mitigating factors.

The panel determined that the aggravating factors are:

- You acted dishonestly.
- You were a Band 6 Midwifery Coordinator and a SoM.
- Your misconduct was of a repetitive nature.
- Your insight is insufficient and self-focussed.

The panel determined that the mitigating factors are:

- No previous adverse regulatory findings.
- You have engaged in the NMC proceedings and has attended this hearing and given evidence.

The panel noted the case law quoted by the Legal Assessor. The panel accept that not all forms of dishonesty are the same and dishonesty must be approached on the facts of each individual case and in consequence any sanction is not predetermined.

The panel first considered whether to take no further action but decided that the misconduct was serious and that this would be wholly insufficient to address the public interest issues in this case and this case involved dishonesty.
The panel next considered imposing a caution order. The panel rejected this since imposing such an order even at the maximum length of time would be insufficient to address the public interest issues in this case and this case involved dishonesty. The panel next considered whether placing conditions of practice on your registration would be an appropriate and proportionate response. The panel note that you have successfully completed an LSAPP of 450 hours. However, given the seriousness of your misconduct such an order would be insufficient to address the public interest issues in this case and this case involved dishonesty.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to paragraphs 67 of the ISG and considered the seriousness of your misconduct. The panel consider it relevant that you had experience of practising as a midwife in a hospital environment on mainland UK before relocating to Guernsey. In consequence, you had experience of the boundaries of acceptable midwifery practice. Nevertheless, you adapted your practice to the unacceptable methods in Guernsey.

Not only were you an experienced midwife, you were also a SoM and as such had undergone additional training to enable her to protect the public by empowering midwives to practise safely and effectively.

You were also a Band 6 Coordinator and advised and oversaw the clinical practice of more junior midwives working with her on shift. By her failure to escalate suspicions CTG traces and her unacceptable use of Syntocinon not only was your midwifery practice far beyond the normal scope of practice but as a SoM and Coordinator, you were permitting other more junior midwives to also practice in this way and thereby compounding the issue.

As regards dishonesty, you gave evidence at the second stage of this hearing and made no reference to this aspect of the panels finding. The panel determined that your dishonesty is aggravated in two respects. Firstly, it impeded a timely and proper investigation into the death of Baby A; secondly, during this hearing you alleged that Ms 6’s (the whistle-blower) evidence of a conversation with her regarding care given to
Patient A and Baby A was not correct. Your position was that Ms 6’s testimony was
driven by a grudge against you. The panel has found that there was no substance to
such a claim.

As regards insight, the panel has found that your insight is self-focussed and lacks any
meaningful appreciation of how detrimental her misconduct has been, and is, to the
wider public interest; namely:- the need to declare and uphold proper professional
standards; and the need to maintain public confidence in the profession and in the NMC
as its regulator.

The panel find the seriousness of your misconduct was significant. For the reasons
indicated above, the panel considers that a suspension order is insufficient to address
the public interest in this case.

The panel therefore went on to consider the sanction of a striking-off order. In respect of
the ISG, the panel has concluded that all of the following paragraphs are applicable in
the particular circumstances of this case:

71 A striking-off order results in the removal of the nurse or midwife’s name from the
register, thus preventing them from working as a registered nurse or midwife.
They may not apply for restoration until a period of five years has elapsed since
the striking-off order was made. An application for restoration will not be granted
unless a panel of the CCC or HC is satisfied that the applicant meets the
requirements for admission to the register and in addition, is a fit and proper
person to practise as a nurse or midwife.

71.1 Is striking-off the only sanction which will be sufficient to protect the
public interest?

71.2 Is the seriousness of the case incompatible with ongoing registration

71.3 Can public confidence in the professions and the NMC be sustained if
the nurse or midwife is not removed from the register?
72 This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following (this list is not exhaustive):

72.1 Serious departure from the relevant professional standards as set out in key standards, guidance and advice including (but not limited to):
   72.1.1 The code: Standards of conduct, performance and ethics for nurses and midwives

72. Doing harm to other or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity, either deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to patients. Harm may include physical emotional and financial harm. The panel will need to consider the seriousness of the harm in coming to its decision.

72.6 Dishonesty, especially where persistent or covered up

72.7 Persistent lack of insight into seriousness of actions or consequences

The panel considered that your actions and omissions were serious and significant and involved multiple departures from the standards expected of a registered midwife.

Your failures and omissions exposed numerous patients to risk.

You were dishonest.

In conclusion your misconduct is fundamentally incompatible with remaining on the register. The panel consider that a striking off order is the only sanction that will adequately satisfy the public interest, this includes: the protection of patients; maintenance of public confidence in the profession and in the NMC as its regulator and the declaring and upholding proper standards of conduct and behaviour.
The panel has considered the principle of proportionality and acknowledge the adverse impact the loss of her registration may have on you. However, in this case the wider public interest outweighs your interests.

The panel has determined to make a striking-off order.

**Determination on interim order**

The striking off order will take effect 28 days from the date when notice of it is deemed to have been served upon you.

The panel considered whether it was appropriate to impose an interim order to cover the appeal period before the substantive order takes effect, or to cover any time required for an appeal of the substantive decision in this case to be heard. Article 31 of the Order outlines the criteria for the imposition of an interim order. The panel may make an interim order on one or more of three grounds:

- Where it is satisfied that it is necessary for the protection of members of the public;
- Where it is satisfied that such an order is otherwise in the public interest;
- Where it is satisfied that such an order is in the interests of the registrant.

The panel may make an interim conditions of practice order or an interim suspension order for a maximum period of 18 months.

Miss Higgins made an application for the imposition of an interim suspension order for a period of 18 months on the grounds that it was necessary for public protection and that it was otherwise in the public interest. She submitted that an interim suspension order was appropriate and proportionate, in light of the panel’s determinations thus far. She further submitted that an 18 month interim order was necessary to allow for any appeal process.

Miss Hamilton on your behalf made no submissions.
In reaching its decision, the panel had regard to the submissions made by Miss Higgins and it accepted the advice of the legal assessor.

For all the reasons set out in the panel’s determination thus far, and in all the circumstances of this case, the panel decided to impose an interim suspension order on the grounds that it was necessary for public protection and that it was otherwise in the public interest. To do otherwise would be inconsistent with the panel’s previous determination.

The panel determined that the order should run for a period of 18 months to allow for any appeal process. The panel considered this to be an appropriate and proportionate period.

If at the end of the appeal period of 28 days you have not lodged an appeal, the interim order will lapse and will be replaced by the substantive order. On the other hand, if she do lodge an appeal, the interim order will continue to run until the conclusion of the appeal.

That concludes these proceedings.