Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

23 July – 3 August 2018, 17 – 19 September 2018, and 10 – 12 December 2018

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Julia Susan Laban
NMC PIN:	93J1007E
Part(s) of the register:	Registered Nurse (sub part 1) Children's (30 September 1996) Registered Midwife (23 August 1999)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Edward Lucas (Chair, Lay member) Noreen Kent (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	Andrew Lewis (23 July – 3 August 2018) Ian Ashford-Thom (17 – 19 September 2018) Lachlan Wilson (10 – 12 December 2018)
Panel Secretary:	Sophie Cubillo-Barsi (23 July – 3 August 2018, 10 December 2018) Kathleen Picketts (17 – 19 September 2018) Edmund Wylde (11 - 12 December 2018)
Registrant:	Present and represented by Michael Collis, Counsel, instructed by Thompsons Solicitors
Nursing and Midwifery Council:	Represented by Jeremy Loran, Case Presenter
Facts proved:	**1.5, 2.2, 2.3, 2.4, 3.3, 4.1, 4.2.1, 4.2.2, 4.2.3**
Facts proved by admission:	**1.1, 1.2, 1.3, 1.4.1, 1.4.2, 1.6.1, 1.6.2, 1.6.3, 1.6.4, 1.7.1, 1.7.2, 4.3, 4.4, 4.5, 4.6**
Facts not proved:	**2.1, 3.1, 3.2**
Fitness to practise:	**Impaired**
Sanction:	**Strike Off**

Interim Order: **Interim Suspension Order (18 months)**

Details of charge:

That you, a Registered Midwife, whilst employed by Basildon and Thurrock University Hospitals NHS Foundation Trust ("the Trust") at Basildon Hospital ("the Hospital") as a Band 6 Midwife:

1. During your shift on 29 August 2015, whilst responsible for the care of Patient A and Baby C:

1.1 Did not ensure a plan of care was prepared and/or updated for when Patient A went into labour; ***Charge proved by way of admission***

1.2 Did not ensure a doctor considered whether or not to administer steroids to Patient A, in light of Patient A having reached 23+4 weeks gestation; ***Charge proved by way of admission***

1.3 At or around 10:00am, did not ensure observations were completed of Patient A's condition; ***Charge proved by way of admission***

1.4 When Patient A's condition changed and/or she demonstrated symptoms of labour, did not ensure that she:

1.4.1 was transferred to the delivery suite; and/or ***Charge proved by way of admission***

1.4.2 received active assistance from a doctor; ***Charge proved by way of admission***

1.5 Did not ensure that you or another midwife were present and providing assistance to Patient A during the delivery of her baby; ***Charge found proved***

1.6 Following the delivery of Patient A's baby, and having observed signs of life, did not immediately :

1.6.1 use a stethoscope to listen to Baby C's heart rate; and/or ***Charge proved by way of admission***

1.6.2 pull the emergency buzzer to seek assistance; and/or ***Charge proved by way of admission***

1.6.3 begin resuscitation of Baby C; and/or ***Charge proved by way of admission***

1.6.4 seek immediate assistance for Baby C from a doctor; ***Charge proved by way of admission***

1.7 After Patient A's baby had been transferred to the resuscitaire, did not:

1.7.1 remain or immediately return to Patient A to complete the third stage of labour; ***Charge proved by way of admission***

1.7.2 administer syntometrine and/or ensure that syntometrine was administered; ***Charge proved by way of admission***

2. Your action/s or omissions as described in the following paragraph/s caused an increased risk of harm to Patient A and/or Baby C:

2.1 Paragraph 1.6.2; ***Charge not proved***

2.2 Paragraph 1.6.3; ***Charge found proved***

2.3 Paragraph 1.6.4 ***Charge found proved***

2.4 Paragraph 1.7.2; ***Charge found proved***

3. Following the delivery of Patient A's baby, made inappropriate comments to Patient A and/or Person B, stating words to the effect of:

3.1 "Sorry [Patient A], your baby is going to die, because he is not 24 weeks yet"; ***Charge not proved***

3.2 "[Patient A], we need to let him die"; ***Charge not proved***

3.3 That Patient A and/or Person B needed to mourn Baby C's death; ***Charge found proved***

4. Failed to keep adequate records between 08:30 and 18:50 on 29 August 2015 in that you:

4.1 Did not accurately record the time at which Patient A delivered Baby C and/or your involvement in the delivery; ***Charge found proved***

4.2 Recorded that you were in two places at the same time at the following time/s:

4.2.1 08:30; ***Charge found proved***

4.2.2 11:30; ***Charge found proved***

4.2.3 13:30; ***Charge found proved***

4.3. Did not record within Patient A's antenatal records your rationale for the administration of medication to Patient A at the following time/s:

4.3.1 13:30 – paracetamol; ***Charge proved by way of admission***

4.3.2 17:30 – co-codamol; ***No case to answer***

4.4 Did not record on the corresponding medication chart for Patient A the administration of co-codamol to Patient A at 17:30 on 29 August 2015; ***Charge proved by way of admission***

4.5 Prior to 16:30, did not record within Patient A's antenatal records an earlier episode of abdominal pain;

4.6 Did not mark the records you completed for between 18:14 and 18:50 within Patient A's antenatal notes as having been completed retrospectively;

And in light of the above, your fitness to practise is impaired by reason of your misconduct

Decision and reasons on application pursuant to Rule 31

The panel heard an application made by Mr Collis, on your behalf, under Rule 31 of the Rules.

Mr Collis informed the panel that, in relation to the concerns raised by Patient A, Ms 6 carried out an investigation and produced a detailed 38 page report. He stated that within the report, Ms 6 incorporates the accounts provided by the midwives she interviewed during her investigation. Mr Collis informed the panel that this includes both your account and the account of another midwife, Ms 5. He submitted that within the report, you told Ms 6 that, after you had left Patient A with Baby C, you provided a handover to Ms 5. Within the report, Ms 5 denies that you provided her with a handover. Mr Collis submitted that the assertion that you did not provide a handover will be relevant to the panel's assessment as to the seriousness of your misconduct at Charges 1.7.1 and 1.7.2 and should therefore be redacted from the report.

Mr Loran informed the panel that the NMC had no prior warning that the said paragraph within the report was a substantial issue. He stated that the paragraph is not the sole and decisive evidence in relation to Charges 1.7.1 or 1.7.2. Mr Loran submitted that the evidence is fair and relevant and that the panel can give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

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 of the Rules provides that, so far as it is '*fair and relevant,'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered whether the evidence contained within the paragraph is relevant and whether it would be fair to admit this evidence. The panel was of the view that there was a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings The panel determined that any potential disadvantage to you could be reduced by the panel giving the evidence what it deemed to be the appropriate weight once it had heard and evaluated all the evidence. The

panel therefore concluded that the evidence contained within the paragraph was fair and relevant and rejected Mr Collis' application.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Loran, on behalf of the NMC, to amend the wording of Charges 1.71, 4.3.2 and 4.4.

The proposed amendment was to remove the word 'with' and add in the words 'or immediately return to' in Charge 1.7.1 and change the time from '17:50' to '17:30' in Charges 4.3.2 and 4.4, specifically:

"1.7.1 remain ***or immediately return to*** ~~with~~ Patient A to complete the third stage of labour

4.3.2 ~~17:50~~ ***17:30*** – co-codamol; and

4.4 Did not record on the corresponding medication chart for Patient A the administration of co-codamol to Patient A at ~~17:50~~ ***17:30*** on 29 August 2015"

It was submitted by Mr Loran that the proposed amendment would provide clarity and more accurately reflect the evidence.

Mr Collis did not oppose the suggested amendments.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> 28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—
>
> (a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel was of the view that such amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application of no case to answer

The panel considered a submission from Mr Collis that there is no case to answer in respect of Charges 2.1 and 4.3.2. This submission was made under Rule 24 (7) of the Rules. This rule 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 …
>
> 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.

In relation to Charge 4.3.2, Mr Collis referred the panel to Patient A's notes. He submitted that within the notes, a rationale was provided by you as to why co-codamol was administered. Further, Mr Collis reminded the panel that Ms 6 confirmed in her oral evidence that the description of 'abdominal pain' within Patient A's notes, amounted to a rationale for the administration of co-codamol. Mr Collis submitted that whilst the panel may be of the view that more information could have been recorded by you, particularly in relation to the first instance of abdominal pain, the information documented within Patient A's notes suffice as a 'rationale'.

With respect to Charge 2.1, Mr Collis submitted that this Charge alleges that, by not pulling the emergency buzzer to seek assistance (Charge 1.6.2), you caused an increased risk of harm to Patient A and/or Baby C.

Mr Collis reminded the panel that it is the evidence of Ms 2, Ms 3 and Ms 5 that an emergency buzzer was sounded for Patient A on the afternoon of 29 August 2015. Mr Collis accepted that it was the evidence of Patient A that an emergency buzzer was never activated. However, he submitted that the panel could safely reject that evidence because there was no other explanation before it as to why Ms 2 and Ms 5 would have attended Patient A's room had the emergency buzzer not been activated.

In light of this, Mr Collis submitted that there could only have been an increased risk of harm to Patient A and/or Baby C, if a second activation of the emergency buzzer would have achieved something that the first activation would not. He reminded the panel that it was the evidence of Ms 6 that, should the first activation of an emergency buzzer not elicit a response, then an individual may need to activate it again. However, Mr Collis submitted that Ms 2 and Ms 5 attended Patient A's room after the first activation of the emergency buzzer. Mr Collis invited the panel to consider that there is insufficient evidence before it to demonstrate that a second activation of the emergency buzzer would have achieved anything above and beyond that achieved by the initial one and that a failure to activate the emergency buzzer for a second time, could not have caused an increased risk of harm to Patient A and/or Baby C.

Mr Loran opposed both applications. In relation to Charge 4.3.2, he referred the panel to Ms 1's oral evidence, who stated that whilst Patient A's notes demonstrate an indication of a possible symptom for which the medication was administered, she was not prepared to state that there was a 'clear rationale' for the administration.

In relation to Charge 2.1, Mr Loran invited the panel to consider your admission to Charge 1.6.2, specifically that you did not activate the emergency buzzer to seek assistance immediately. He submitted that it was the evidence of Patient A that, rather than recognising the emergency situation, you began to make inappropriate comments about Baby C having passed away due to his gestation. It was Patient A's evidence that your delay in pulling the emergency buzzer, caused a delay in her receiving medical treatment.

In relation to the issue of a 'second emergency buzzer' needing to be activated, Mr Loran accepted that there is conflicting evidence as to who did activate the emergency buzzer on 29 August 2015. However, he reminded the panel that it was the evidence of Ms 3 that at first instance, she responded to a 'normal buzzer' and subsequently an emergency buzzer. Mr Loran submitted that the panel should assess all the evidence before it collectively, including your defence as to this charge. He concluded that it would be appropriate to hear your evidence rather than accede to a submission of no case to answer in relation to Charge 2.1.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel solely considered whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

In relation to Charge 4.3.2, the panel noted the entry within Patient A's notes at 17:30, providing a one line explanation as to why co-codamol had been administer. The panel was therefore of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of Charge 4.3.2 proved and determined that there was no case to answer.

In relation to Charge 2.1, the panel noted your admission at Charge 1.6.2, that you did not immediately activate the emergency buzzer. The panel considered the context to this Charge specifically that Baby C was born within a period of gestation in which it is unclear whether it may be capable of sustaining life (at 23 to 24 weeks gestation) and further, that Patient A had a known history of difficult and traumatic pregnancies. As such, the panel was of the view that in light of the conflicting evidence before it, it could not conclude that there was no case to answer in relation to this charge. The panel was satisfied that it would have to conduct an appropriate evaluation of all the evidence in relation to this charge, including any evidence from you. Accordingly, this submission is rejected.

Background

On 29 September 2015, the NMC received a referral from Patient A.

At the time of the referral, you were employed as a Band 6 midwife at Basildon Hospital ('the Hospital') which is part of Basildon and Thurrock University Hospitals NHS Foundation Trust ('the Trust). You first registered as a midwife in August 1999 and had worked for the Trust for approximately 16 years on the antenatal and/or postnatal wards at the Hospital for approximately five years at the time of the incident.

Patient A, the mother of Baby C, had suffered from a number of miscarriages and although Patient A had previously given birth to a healthy child, the birth had been complicated as Patient A had suffered from a post-partum haemorrhage following on from the birth which necessitated her having to spend a prolonged period of time in hospital.

At the start of her pregnancy with Baby C, Patient A informed the Midwifery Service at the Trust of her previous history and was advised that she should have a hospital birth. Patient A was also advised that she should receive syntometrine in order to mitigate against the risk of a further post-partum haemorrhage.

On 24 August 2015, Patient A's waters broke unexpectedly and she called an ambulance. Whilst waiting for the ambulance to arrive Patient A telephoned the Midwifery Unit at the Trust who informed her that she would be taken to a labour ward on arrival. However when Patient A arrived, she was informed that there was no room in the labour ward and she was taken to the Mayberry Ward instead. An examination was undertaken of Patient A (by an unknown Midwife) who confirmed that Patient A's waters had broken prematurely.

Later that evening Patient A was moved to the Cedar Ward where she remained until 29 August 2015. Though observations were taken by various medical staff Patient A did not feel that the doctors on the ward were communicating with her sufficiently.

On 27 August 2015, Patient A was sent for a scan as 48 hours had passed since her waters had broken. The scan established that the gestation period for the baby was 23 weeks and 2 days. On 28 August 2015 following the scan Patient A spoke with a Consultant. After this consultation Patient A formed the impression that staff at the hospital were now of the view that a live baby would be delivered and that this could be imminent. The Consultant advised that, should the pregnancy progress to 23 weeks plus four days gestation, steroid treatment was to be considered in order to aid maturity of the baby's lungs.

That night Patient A began to experience pain. The following morning (29 August 2015; 23 + 4 days gestation) at approximately 09.00hrs the registrant introduced herself to Patient A explaining that she would be taking over her care. Patient A states that she reported experiencing pain at this stage, but that you allegedly did not take any action other than to check the foetal heart rate.

Later that morning Patient A's pain began to intensify and she used the buzzer in her room to call for help. You attended to her and Patient A explained that she was experiencing pain in her lower abdominal area. You are said to have informed Patient A that you would speak to a doctor. By midday Patient A's pain was increasing. Patient A explained that she was in so much pain that she was unable to eat and asked for pain killers. Patient A states you brought her some paracetamol but did not take any other action.

Patient A states that the next time you entered the room she was kneeling on the floor in pain. You are said to have rubbed Patient A's back and told her that you would attempt to get her a place on the labour ward before leaving the room again. Patient A continued to press the buzzer and at one point noted that a mucus type substance was dripping from her. You assisted Patient A back into bed and helped her to position herself into a kneeling position on the bed.

Patient A states that she continued to experience more frequent pain but was nevertheless left alone in the room. Eventually she called Person B, her partner and the father of Child C, as she wanted him to attend the Ward quickly. Person B arrived at

approximately 17.30hrs. Shortly after Person B arrived, Patient A began to feel the urge to push however no midwife was present. Patient A could see that the baby's head was emerging and Person B ran to summon help. Patient A pushed and upon looking down realised that she had given birth to Baby C.

You are said to have come into the room at some point after the birth and, according to Patient A, approximately 20 minutes had passed between her giving birth and you attending at around 17:55hrs. It is alleged that when you did attend, you made comments about letting the baby die and mourning the baby. It is further alleged that you did not undertake any examination of Baby C despite Patient A's pleas to do so and did not use the emergency buzzer to summon assistance and did not listen to the baby's heart rate or seek assistance from a doctor.

Two other midwives and a Care Assistant are then said to have attended. Patient A describes seeing that Baby C was moving and says that she asked you to help Baby C but you did not. It was not until a doctor attended at approximately 18:14 that Baby C was taken for resuscitation.

When Baby C was taken for resuscitation Patient A was again left alone and was continuing to bleed. It is alleged that, despite her risk of post-partum haemorrhage Patient A was not given syntometrine by you or any other healthcare professional.

Patient A continued to bleed until another midwife attended to her and attempted to deliver the placenta. Eventually she was moved to the labour ward, however by this time she had begun to feel dizzy and faint. Eventually Patient A received emergency treatment and the placenta was delivered in theatre. Patient A was transferred to the Close Monitoring Unit and had to receive further blood transfusions due to her blood loss. She was discharged on 31 August 2015.

You do not face any charges relating to cause or contribution, and the NMC does not seek to assert that your actions or inactions did in fact impact on the health of Baby C. However, it is alleged that you caused an increased risk of harm to the mother and baby.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Loran, on behalf of the NMC, and those made by Mr Collis on your behalf.

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

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

The panel heard oral evidence from nine witnesses tendered on behalf of the NMC. In addition, the panel heard oral evidence from you.

Witnesses called on behalf of the NMC were:

- Person B;
- Patient A;
- Ms 1 – Specialist Midwife for Practice Development;
- Ms 2 – Band 6 Midwife;
- Ms 3 – Maternity Care Assistant ('MCA') at the time of the incident;
- Ms 4 – Band 7 Midwife Sister / Coordinator;
- Ms 5 – Registered Midwife;
- Ms 6 – Registered Midwife / Maternity Matron at the time of the incident;
- Ms 7 – Band 6 Midwife;
- Dr 1 – Consultant Obstetrician and Gynaecologist.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from, including you.

In general, the panel found the NMC witnesses to be reliable and credible in their evidence. However, it found Ms 1 and Ms 3 to be defensive, and less helpful. The panel found Ms 4 and Ms 6 to be clear, reliable, and consistent witnesses.

The panel appreciated hearing from Person B and Patient A about what was a clearly traumatic experience for them. The panel accepted that Patient A had been left alone for long periods of time while her pain escalated, including during the birth of Baby C. However, given all of the evidence, the panel believed that the estimates of time given by Patient A and Person B were unlikely to be precise.

The panel did not find you to be a credible witness. Allowing for the passage of time, the panel found your evidence to be contradictory at times and was struck by your continuing lack of insight. Further, it noted that on a number of occasions, you resiled from an acceptance of error which you had made during investigations carried out by Ms 1 and Ms 6.

The panel have paid close attention to the arguments made by both advocates in your case. Having had the chance to consider all the evidence before and after considering your evidence, the panel accepted the NMC's submissions that your state of mind at the time, with regards to Baby C, had been determined before his birth. Your belief that the baby would not be viable, guided and determined your actions throughout 29 August 2015.

At the start of this hearing you admitted the following charges;

That you, a Registered Midwife, whilst employed by Basildon and Thurrock University Hospitals NHS Foundation Trust ("the Trust") at Basildon Hospital ("the Hospital") as a Band 6 Midwife:

1. During your shift on 29 August 2015, whilst responsible for the care of Patient A and Baby C:

1.1 Did not ensure a plan of care was prepared and/or updated for when Patient A went into labour; ***Charge proved by way of admission***

1.2 Did not ensure a doctor considered whether or not to administer steroids to Patient A, in light of Patient A having reached 23+4 weeks gestation; ***Charge proved by way of admission***

1.3 At or around 10:00am, did not ensure observations were completed of Patient A's condition; ***Charge proved by way of admission***

1.4 When Patient A's condition changed and/or she demonstrated symptoms of labour, did not ensure that she:

1.4.1 was transferred to the delivery suite; and/or ***Charge proved by way of admission***

1.4.2 received active assistance from a doctor; ***Charge proved by way of admission***

1.6 Following the delivery of Patient A's baby, and having observed signs of life, did not immediately :

1.6.1 use a stethoscope to listen to Baby C's heart rate; and/or ***Charge proved by way of admission***

1.6.2 pull the emergency buzzer to seek assistance; and/or ***Charge proved by way of admission***

1.6.3 begin resuscitation of Baby C; and/or ***Charge proved by way of admission***

1.6.4 seek immediate assistance for Baby C from a doctor; ***Charge proved by way of admission***

1.7 After Patient A's baby had been transferred to the resuscitaire, did not:

1.7.1 remain or immediately return to Patient A to complete the third stage of labour; ***Charge proved by way of admission***

1.7.2 administer syntometrine and/or ensure that syntometrine was administered; ***Charge proved by way of admission***

4.3. Did not record within Patient A's antenatal records your rationale for the administration of medication to Patient A at the following time/s:

4.3.1 13:30 – paracetamol; ***Charge proved by way of admission***

4.4 Did not record on the corresponding medication chart for Patient A the administration of co-codamol to Patient A at 17:30 on 29 August 2015; ***Charge proved by way of admission***

4.5 Prior to 16:30, did not record within Patient A's antenatal records an earlier episode of abdominal pain; ***Charge proved by way of admission***

4.6 Did not mark the records you completed for between 18:14 and 18:50 within Patient A's antenatal notes as having been completed retrospectively; ***Charge proved by way of admission***

These charges were therefore announced as proved.

The panel then went on to address your mind set at the time of the admitted charges. The panel approached these facts in the same way it approached all findings of fact.

The panel was concerned by your failure to properly review the notes of Patient A, a high risk patient. The panel was of the view that had you reviewed her notes, you would have been aware of her previous post-partum haemorrhage ('PPH') when delivering

Child D and further, the requirement to administer steroids to Patient A at 23+4 weeks gestation. The panel determined that as the midwife in charge of the care of Patient A, you should have acted as her advocate but that you failed to do so.

Further, the panel does not accept your evidence that Patient A's condition suddenly changed at 16:30 on 29 August 2015. When considering the evidence of Ms 7, specifically that you informed her around 13:00 to 14:00 that Patient A had abdominal pains and analgesic was administered, it is the view of the panel that at this time a revised multi-disciplinary plan of care would have been imperative.

In relation to transferring Patient A to the delivery suite, the panel rejected your evidence that these changes took place at 16:30, when a complaint of abdominal pain was made. You told the panel that you sought a review of Patient A, which would have involved consideration of a transfer to the delivery suite. It is your case that this review was requested in an exchange with Dr 2 at or around 17:50. Despite this, the panel noted that it was the evidence of a number of witnesses, including Dr 1 that pre-term deliveries can occur extremely quickly and that at the first sign of labour, you should have moved Patient A to the delivery suite. The panel determined that you should have escalated concern in regard to Patient A's condition at or around 13:30 and that this became critical at 16:30.

Finally, the panel considered your evidence that you were under the impression that Ms 5 had taken over the care of Patient A at the third stage of labour. The panel noted that there was no evidence before it of any handover to Ms 5. The panel found that no meaningful handover took place, in a way that could have absolved you of the responsibility for dealing with the third stage of labour or the administration of syntometrine.

The panel then went on to consider the disputed charges.

Charge 1.5

1.5 Did not ensure that you or another midwife were present and providing assistance to Patient A during the delivery of her baby;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered all the evidence before it.

The panel noted that it was the evidence of both Patient A and Person B that they were left alone when Patient A was delivering Baby C. Patient A states within her witness statement:

"When I gave birth to Baby C, other than Child D, no one else was present in the room with me. Person B as stated above, was trying to find a Midwife to attend to me, so he was not there. Julia, although she was the Midwife allocated to me that day, was not there and nor was anyone else to help."

The panel then went onto consider your submission that Ms 3 was informed by Person B that the baby was about to arrive and within seconds of this information being conveyed, you entered the room. This account of events was explained by you in your 'statement of events/factual account', within which you state:

"I was collecting medication for other patients in the main office. The emergency buzzer sounded, I attended immediately Ms 3 emerged from the room and said the baby was delivering. Ms 3 had placed a sheet over the patient. I looked and found baby had delivered."

The panel noted that in the interview held on 13 October 2015 with yourself, Ms 1 and Ms 6, you accepted that you should not have left Patent A unattended and admitted that she had delivered the baby with nobody else present. Further, when asked during your oral evidence whether you had concerns about leaving Patient A in the room without a midwife you replied 'not at that point' and confirmed that at that time, 'her partner had not arrived so yes she was on her own.'

It therefore rejected your evidence that you were present at the birth of Baby C and concluded that on 29 August 2015, you did not ensure that you or another midwife were present and providing assistance to Patient A.

Before considering each limb of Charge 2, the panel noted and agreed with the general assertion that overall, your actions had the impact of increasing the risk of harm, rather than minimising it. Further, you did not act as an advocate for Patient A as you failed to support her and escalate her condition so that the right medical assistance could be provided to her.

Charge 2.1

2. Your action/s or omissions as described in the following paragraph/s caused an increased risk of harm to Patient A and/or Baby C:

2.1 Paragraph 1.6.2;

Charge found NOT proved

When considering whether your omission to activate the emergency buzzer to seek assistance resulted in an increased risk of harm to Patient A and/or Baby C, the panel considered all the evidence before it.

The panel noted your admission at Charge 1.6.2, that you did not immediately pull the emergency buzzer but that you entered Patient A's room in response to it already having been activated.

The panel considered Patient A's evidence that your delay in pulling the emergency buzzer, caused a delay in her receiving medical treatment. The panel noted that the NMC accept that there is conflicting evidence as to who pulled the emergency buzzer. However, the panel considered the evidence of Ms 2, Ms 3 and Ms 5, who stated that

an emergency buzzer was sounded on the afternoon of 29 August 2015, which resulted in Ms 2 and Ms 5 attendance at Patient A's room.

The panel accepted this evidence.

Whilst it could not determine who had pulled the emergency buzzer, the panel was satisfied that one was sounded and staff attended Patient A's room. The panel had no other logical explanation before it as to why Ms 2 and Ms 5 would have attended Patient A's room at the relevant time, unless they were in fact responding to an emergency buzzer. In light of this, the panel could not be satisfied that, on the balance of probabilities, there was an increased risk of harm to Patient A and/or Baby C by your failure to immediately pull the emergency buzzer. This charge is therefore found not proved.

Charge 2.2

2.2 Paragraph 1.6.3;

This charge is found PROVED

The panel accepted Mr Collis submission that it could only conclude that you had increased the risk to Patient A and/or Baby C if it concluded that you had a duty to commence resuscitation.

When determining whether your failure to begin resuscitation of Baby C resulted in an increased risk of harm to Patient A and/or Baby C, the panel considered all the evidence before it.

The panel considered the written statement of Dr 1, within which he explains:

"Where a baby is unable to independently breathe and pass oxygen to the brain, it is important that efforts to resuscitate start quickly, without delay. It is important where

resuscitation is required to ensure it takes place as quickly as possible, in order to minimise the risk of harm being caused to the baby's brain."

The panel noted that Dr 1's evidence was supported by the oral evidence of Ms 6, who confirmed when questioned that, if a baby is not breathing well, oxygen is not going to the baby's brain and that this "could impair the baby significantly."

The panel accepted this evidence, which was not contradicted by any other evidence.

The panel also took into account Dr 1's opinion within his written statement, that 'the decision of resuscitation is one for a paediatrician to make, not a midwife or obstetrician'. However, during his oral evidence, he confirmed that if a baby is born showing signs of life, the expectations of a midwife would be to commence initial resuscitation and alert the paediatrician immediately.

In resolving this question of what you were obliged to do, the panel gave the expression "commence resuscitation" its ordinary meaning, namely to take the first steps in resuscitation, in other words keep the baby warm, prepare the resuscitaire, assess the baby's heart rate and ensure that the baby is assisted to breathe.

The panel reminded itself that it was the evidence of a number of witnesses that preserving life is a fundamental role of a midwife, particularly where there are clear signs of life. The panel therefore determined, that on the balance of probabilities, your failure to begin resuscitation of Baby C resulted in an increased risk of harm to Baby C.

The panel therefore determined, that you were obliged to commence resuscitation, to the limited extent set out above and your failure to begin resuscitation of Baby C, resulted in an increased risk of harm to Baby C.

Charge 2.3

2.3 Paragraph 1.6.4

This charge is found PROVED

When determining whether your admitted omission to seek immediate assistance for Baby C from a doctor resulted in an increased risk of harm to Patient A and/or Baby C, the panel considered all the evidence before it.

The panel noted the written statement of Ms 7, within which she states:

"I decided to call for the neo-natal registrar, as I thought the parents should have some support. Within minutes, the neo-natal registrar arrived with the consultant. They examined Baby C, who was in the room with Patient A, and made the decision to transfer him to neo-natal resuscitaire.

At no point in the shift did Julia ask for my advice, or ask me to call a doctor on her behalf."

The panel also considered your submission that you did not seek assistance from a doctor as you were under the impression that Ms 7 was doing this. It noted that it was the evidence of Ms 7 that she left Patient A's room, intending to call 2222, but was stopped from doing so by Ms 4.

Nevertheless, the panel bore in mind Ms 7's oral evidence, during which she confirmed that it would be your responsibility, as the midwife in charge, to call a doctor or instruct another person to do so.

The panel accepted this evidence. It determined that it was not appropriate to simply assume that a doctor had been called and that you should have sought immediate assistance for Baby C. Instead of doing so, by your own admission, you wrapped the baby in a blanket, handed him to his parents and told Patient A and Person B to 'mourn the baby'. The consequence of you not taking responsibility for calling the doctor to assist Baby C, and saying to the parents to mourn their baby, was a confused situation. The result of you not taking responsibility for calling a doctor to assist Baby C was a confused situation in which the first call to the neonatal registrar was made by someone

seeking confirmation that Baby C was dead and not someone seeking urgent assistance.

The panel is satisfied that this caused some delay in a doctor examining Baby C in circumstances where all the evidence supports the view that any delay increases the risk.

Charge 2.4

2.4 Paragraph 1.7.2;

This charge is found PROVED

When determining whether your omission to administer syntometrine and/or ensure that syntometrine was administered resulted in an increased risk of harm to Patient A and/or Baby C, the panel considered all the evidence before it.

The panel reminded itself of Ms 4's oral evidence, within which she stated that it is a midwife's responsibility to familiarise themselves with a patient's previous medical history. Further, Ms 1 explained in an interview held on 26 January 2016, that:

"as a practising midwife, my role would be to stay with that woman and then manage the remainder of her care and that is the expectation I would have…

Given her (Patient A) history of a massive haemorrhage, I would have given her syntometrine at that time and actually managed the delivery of that placenta."

The panel considered your evidence, specifically that it was your belief that Ms 5 had taken over the care of Patient A for the third stage of labour and that the decision as to whether or not syntometrine was administered, was one for Ms 5 to make. However, it also noted your admission during the interview held on 6 May 2015, during which you stated:

“I wasn’t aware I must admit that she had haemorrhaged in previous pregnancies.”

The panel was satisfied that, by your own admission, you had not read Patient A’s notes sufficiently well to be aware of Patient A’s previous history of haemorrhage and hence her need for syntometrine.

The panel also found that, whatever assumptions you may have made, you had not carried out a meaningful handover to Ms 5 that would have transferred responsibility from you to her. The panel is satisfied that the responsibility remained yours.

The panel accepted the un-contradicted evidence of a number of witnesses that failure to administer syntometrine, particularly to a patient with previous PPH, would have increased the risk of harm to Patient A. In light of this, the panel finds this charge proved.

Charge 3.1 and 3.2

3. Following the delivery of Patient A's baby, made inappropriate comments to Patient A and/or Person B, stating words to the effect of:

3.1 "Sorry [Patient A], your baby is going to die, because he is not 24 weeks yet";

3.2 "[Patient A], we need to let him die";

This charge is found NOT proved

The panel considered both of these charges individually and together collectively. The panel noted written statement of Patient A, within which she states:

“When Julia came in, she said that as the baby was born before I had reached 24 weeks of my pregnancy that we needed to let my baby die…”

The panel also had regard to Patient A's oral evidence and the evidence of all the midwives who were present with Patient A shortly after the birth of Baby C.

The panel also considered your admission that you said that Patient A and Person B should mourn their baby.

Taking all this evidence together, the panel decided that there was a real risk that the words you are alleged to have used above were an interpretation of what you said under Charge 3.3 rather than additional things you said. The panel determined that there was insufficient evidence before it to enable the NMC to discharge the burden of establishing that you used these words in addition to the ones set out at charge 3.3 below.

Charge 3.3

3.3 That Patient A and/or Person B needed to mourn Baby C's death;

Charge found PROVED

When considering this charge, the panel noted the written statement of Patient A, within which she states:

"She said words to the effect of 'sorry Patient A your baby is going to die, because he is not 24 weeks yet and Patient A we need to let him die'. She also said that I needed to mourn the loss of my baby."

You accepted using the word 'mourn'. However, you stated that this word was not used in the context of Baby C's death. You stated that the use of the word 'mourn' does not necessarily mean death, and you used the example of "mourn the passing of the summer." Further, when questioned, you accepted that when you wrapped Baby C in a towel and handed him to Patient A, you expected Baby C to die.

The panel then referred to the notes of the meeting held on 6 May 2016, within which you explain:

"The father was encouraging her to give the baby back to me and I said I think it is quite important for your wife to have this time with her baby it is important that she mourns."

The panel was of the view that your explanation of the use of the word 'mourn' was implausible and that the normal meaning of the word would imply death. The panel determined that your use of such a word to Patient A and Person B, parents of a baby showing signs of life, was wholly inappropriate and insensitive. The panel therefore found this charge proved.

Before turning to the charge relating to your record keeping, the panel considered whether there was a common underlying theme to these charges. Having considered all the evidence the panel accepted the NMC's submissions that your state of mind at the time, with regards to Baby C, had been determined before his birth and your belief that the baby would not be viable, guided and determined your actions throughout 29 August 2015. Your approach may well have been guided by the approach originally taken to Patient A's care when she was admitted but you failed to adapt to the change that was brought about by the passage of time and the significance of the day when you were responsible for Patient A.

Charge 4.1

4. Failed to keep adequate records between 08:30 and 18:50 on 29 August 2015 in that you:

4.1 Did not accurately record the time at which Patient A delivered Baby C and/or your involvement in the delivery;

This charge is found PROVED

When considering this charge, the panel referred to Patient A's antenatal notes, within which you have recorded that Patient A gave birth to Baby C at 18:15.

It noted that your recorded entry did not correspond with the evidence of Ms 1, who states within her written statement:

"I contacted the Hospital switchboard in order to try to confirm the times at which calls for assistance had been made after the birth of Patient A's baby, and then compared them to the records completed by Julia. The switchboard advised that the call to the neonatal registrar was made at 18:07. In the records completed by Julia, she recorded that her colleague Ms 7 bleeped the paediatric registrar, which appears to be the only corresponding record, at 18:16. The 2222 call for the emergency crash team was recorded by the switchboard as made at 18:21, whereas Julia recorded it as having taken place at 18:18."

When considering this submission, the panel noted that it was the evidence of Ms 6 that the switchboard was an accurate and reliable source in relation to timings. Further, the panel reminded itself that during your oral evidence, you accepted that your records on 29 August 2015 were inadequate. When considering the chronology of events and timings in respect of the birth of Baby C, the panel determined that the timings provided by you did not fit with the other evidence produced in this case and that any record you made, was completed retrospectively. The panel preferred the evidence that the switchboard was an accurate measure of time, in comparison to your use of your watch. In light of this, the panel find this charge proved.

Charge 4.2.1 and 4.2.3

4.2 Recorded that you were in two places at the same time at the following time/s:

4.2.1 08:30;
4.2.3 13:30;

This charge is found PROVED

The panel decided to consider both of these charges together.

The panel referred to Patient A's antenatal notes, within which you make a record at 08:30 and 13:30 in relation to Patient A's care. It then referred to Patient C's notes where you also make records at those times respectively.

The panel noted your acceptance that you had in fact recorded the same time on separate occasions, giving the impression that you were in two places at once. You explained to the panel that you would enter a general time when completing several patient's records.

When comparing the evidence before it and when considering your admission, the panel determined that these records of timings were plainly unreliable and therefore find this charge proved.

Charge 4.2.2

4.2 Recorded that you were in two places at the same time at the following time/s:
4.2.2 11:30;

This charge is found PROVED

When considering this charge, the panel acknowledged that you had queried whether or not the entry in Patient D's notes relating to the commencement of the CTG is in fact timed at 11:50. However, the panel have carefully examined this record and have determined that the time recorded was 11:30. The panel therefore found this charge proved for the same reasons provided for Charges 4.2.1 and 4.2.3.

This hearing is a split event and is scheduled to resume from 10 December 2018 to 13 December 2018.

Submission on misconduct and impairment:

Having announced its finding on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel heard evidence from Ms 8, Manager of the Antenatal Clinic at the Hospital, on behalf of the NMC. Whilst under investigation, you had been re-deployed to the Antenatal Clinic.

Ms 8 informed the panel that you failed to be proactive with regards to completing the competency framework. She told the panel that she had a number of one to one meetings with you, during which you failed to produce evidence of compliance with the competency framework and that you did not have the paper form with you, which Ms 8 found 'worrying'. Ms 8 stated that she would have expected you to have the competency framework in your possession each and every shift in order for you to be signed off as having observed, or as being competent by your colleagues.

When questioned, Ms 8 accepted that you were only working two shifts a week during your time at the Antenatal Clinic. Ms 8 agreed that, during your first two weeks working at the Clinic, you were observing other staff members and may not have been able to be signed off as 'competent' during that time. Ms 8 accepted that after meeting with you on 28 October 2015, you commenced some of the training requirements identified by Ms 8, including the Gestation Related Optimal Weight training. Ms 8 told the panel that she could not sign your competency sheet as completed as she had not observed you perform these competencies. However, on 2 December 2015, at one meeting when you did bring your competency framework with you, she signed a number of competencies to say that she had discussed these with you.

The panel also heard evidence from you.

You informed the panel that during the six week period working at the Antenatal Clinic, you found some situations to be 'difficult' as members of staff were aware that you had been referred to the NMC. You informed the panel that when shadowing other staff members, you were 'fairly familiar' with most competencies within the framework but that you felt as though people 'were jumping' on you when you asked any questions.

You explained that by 28 October 2015, you had asked a number of colleagues to sign off certain competencies but that many staff members within the Clinic were 'obstructive' and told you that you could only be signed off as competent once you had completed work within other clinics and had your framework signed by Ms 8. Despite this, you told the panel that between October 2015 and November 2015 you had completed most of the competencies within the framework and that only a small number remained incomplete. In response to panel questions, you acknowledged that you did not escalate concerns regarding allegedly obstructive treatment by other staff, and your inability to complete the competency framework.

You explained that, on reflection, you now realise the devastating experience Patient A must have gone through during your shift on 29 August 2015 and apologised for your failings. When questioned, you stated that you do not wish to return to the midwifery profession. You accepted that your fitness to practise is currently impaired on both public protection and public interest grounds.

In his submissions Mr Loran invited the panel to take the view that your actions amount to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* ('the Code'). He then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Mr Loran referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

He submitted that your conduct fell far short of what was expected in the circumstances and that your failings were sufficiently serious so as to amount to misconduct. He

reminded the panel that the failings in respect of the care provided to Patient A and Baby C included multiple examples of poor practice such as failing to read the patients notes; failing to recognise and respond to the clear signs that Patient A was in labour; leaving Patient A alone as she gave birth; failing to be present for the third stage of labour and failing to keep adequate records throughout her shift. Mr Loran submitted that as a result of your omissions in care, Patient A and Baby C were put at risk of harm. He invited the panel to consider that you have demonstrated a flippant and lackadaisical approach to the care of Patient A, which has on this occasion had serious consequences for this patient.

Mr Loran then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Loran referred the panel to the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin),* specifically paragraph 76:

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

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

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

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

d. …

Mr Loran submitted that the first three limbs of the test are engaged in your case. He invited the panel to consider that your clinical failures not only exposed Patient A to the risk of harm, but also caused Patient A to suffer extreme distress whilst giving birth to Baby C. Further, he submitted that your clinical failings have brought the profession into disrepute and breached a fundamental tenet of the midwifery profession.

In respect of insight, Mr Loran submitted that you have demonstrated a woeful lack of insight and evidenced an inability to take responsibility for your errors and omissions in care. He invited the panel to consider that your inability to reflect on your errors and failure to take responsibility for them, compounds the already grave and serious misconduct. Mr Loran submitted that given your attitude, there is no real prospect of you remedying your behaviour and repetition of the conduct found proved is therefore highly likely. Mr Loran concluded that a finding of impairment should be made on both public protection and public interest grounds.

Mr Collis informed the panel that you accept your fitness to practise is currently impaired on both public protection and public interest grounds. However, he asked the panel to bear in mind that you are remorseful for your failings on 29 August 2015 and have demonstrated an understanding of the experience suffered by Patient A during that time.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant, these included: *Roylance v General Medical*

Council (No 2) [2000] 1 A.C. 311, Nandi v GMC [2004] EWHC 2317 (Admin), and *GMC v Meadow [2007] QB 462 (Admin).*

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, your 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: Professional standards of practice and behaviour for nurses and midwives (2015).*

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 professional judgement.

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

1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

6 Always practise in line with the best available evidence

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice.

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision on impairment

The panel next went on to decide whether your fitness to practise is currently impaired as a result of this misconduct. The panel acknowledged the fact that you admit that your fitness to practise is currently impaired on public protection and public interest grounds and that you have declared that you will not be returning to the midwifery profession. However, the issue of your impairment remains a matter for the panel to determine.

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*

The panel accepted the NMC's submissions that the first three limbs of the test are engaged. The panel found that your failings placed Patient A and Baby C at an unwarranted risk of harm and that your misconduct breached fundamental tenets of the profession and brought the midwifery profession into disrepute.

Whilst the panel note that you have demonstrated some remorse for your misconduct, it did not have any evidence before it that you understand how your actions placed Patient A and Baby C at a risk of harm or how your misconduct had a negative impact

on the reputation of the midwifery profession. The panel determined that the attitudinal issues highlighted at the fact finding stage remain relevant and it was concerned by your continuing failure to accept responsibility for your misconduct and your tendency to blame others for your failings.

In its consideration of whether you have remedied your practice the panel took into account the evidence of Ms 8 who described to the panel how you failed to remediate concerns raised regarding your practice whilst working at the Antenatal Clinic. The panel did not have any evidence before it of any training you have undertaken since the charges arose and as such, the panel is of the view that there is a risk of repetition of the misconduct found proved. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that, in this case, a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Submissions on Application for Voluntary Removal

Mr Collis, on your behalf, indicated to the panel that you were, at this stage, making an application to the Registrar for voluntary removal from the NMC register. He invited the panel to make a recommendation to the Registrar, who is required to take into account any such recommendation, and informed the panel of the factors which will be taken into account in such a decision. Mr Collis submitted that this hearing should not continue until such matters are dealt with by the Registrar.

The panel took into account the submissions of Mr Collis and Mr Loran on the matter.

The panel heard and accepted the advice of the Legal Assessor.

Recommendation to Registrar on Application for Voluntary Removal

The panel initially noted it was making its recommendation in the absence of comments from the maker of the allegation, in response to the application for voluntary removal. The panel noted that this is a matter that the Registrar is obliged to take into account before reaching a final decision on the application.

The panel made the recommendation to the Registrar that it did not support your application for voluntary removal from the NMC register. The panel considered that, given its findings, voluntary removal in this case would be a means of sidestepping the regulatory process. In coming to this decision, the panel took into account:

- there are twenty-four charges proved or admitted in this case;
- some of the charges are extremely serious;
- they did result in harm to a patient and, whilst definitely causing emotional harm, had the potential to cause physical harm;
- you did not commence resuscitation on an infant showing signs of life – a breach of a fundamental duty to preserve life;
- your conduct involved multiple breaches of the Code;

- you have demonstrated a continuing lack of insight, as shown by your tendency to deflect blame onto others;
- your lack of acknowledgement of your professional responsibility.

The panel therefore recommends to the Registrar that your application for voluntary removal is not accepted. The panel strongly recommends that the Registrar considers this application urgently.

Determination on sanction:

The panel was initially informed of the Registrar's decision on your application for voluntary removal from the NMC register, namely that your application was rejected. In light of this, the panel went on to consider what would be the appropriate sanction in your case.

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor. It took into account the submissions of Mr Collis, on your behalf, and those of Mr Loran, on behalf of the NMC. 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 had careful regard to the Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered the aggravating factors in this case to be as follows:

- the charges found proved or admitted are extremely serious;
- your misconduct resulted in harm to a patient and, whilst definitely causing emotional harm, had the potential to cause physical harm;
- you did not commence resuscitation on an infant showing signs of life – a significant breach of a fundamental duty to preserve life;
- your misconduct involved multiple breaches of the Code;
- you have demonstrated a continuing lack of insight, as shown by your tendency to deflect blame onto others; and
- you have demonstrated a lack of acknowledgement of your professional responsibility.

The panel considered the mitigating factors in this case to be as follows:

- you have fully engaged with the NMC process, and have demonstrated courtesy to the panel throughout these proceedings.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Furthermore, such a course of action would not appropriately protect the public.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order. Furthermore, such a course of action would not appropriately protect the public.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case; such a sanction would furthermore be impracticable, as one of the major issues in this case concerns your attitudinal issues. The misconduct identified in this case was not something that can be addressed through retraining. The panel also noted that you have repeatedly expressed a clear desire not to return to midwifery, and was therefore not satisfied that you would engage with a conditions of practice order, were one able to be formulated at all. Furthermore the panel concluded that the placing of conditions on your registration

would not adequately address the seriousness of this case and would not appropriately protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. It concluded that such an order would not be appropriate, nor in the public interest, given the seriousness of your misconduct. It further considered that it has heard evidence of a deep-seated attitudinal problem on your part (namely, that you have sought to shift blame to others, and have not acknowledged your professional responsibility), and that you have demonstrated a persistent lack of insight into your actions, or even any meaningful recognition of the severity and impact of what you did. The panel also determined that a suspension order would serve little purpose in the circumstances of this case, given your repeated indication that you do not wish to, and will not, return to midwifery.

Balancing all of these factors, the panel has therefore determined that a suspension order would not be an appropriate or proportionate sanction.

The panel reminded itself of the aggravating factors in the case, which are laid out above. It considered that your misconduct raised fundamental questions about your professionalism, and reminded itself that it had heard evidence that, while re-deployed following the incident, you showed clear failings in remediating and updating your competencies in that area of practice.

Your misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by your actions are significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with your remaining on the register. It took into account your lack of remediation of your practice; you have not worked as a midwife since the incidents, and have demonstrated a clear and continuous lack of insight into your behaviour and its impact on patients, colleagues, and the wider public.

The panel was of the view that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. It considered

that, given the serious breaches of the Code which your misconduct relates to, there is a high degree of public interest in this case and concluded that this would only be adequately served by your permanent removal from the NMC register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

Determination on Interim Order

The panel has considered the submissions made by Mr Loran that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Mr Collis made no observations.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.