Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing

26 June 2019

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

Name of registrant:	Mrs Jayne Steel
NMC PIN:	09J0007E
Part(s) of the register:	Registered Midwife Midwifery (25 September 2009)
Area of Registered Address:	England
Type of Case:	Lack of Competence
Panel Members:	Julia Whiting (Chair, Registrant member) Rachel Jokhi (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	Nicholas Leviseur
Panel Secretary:	Anjeli Shah
Mrs Steel:	Present by telephone and not represented
Nursing and Midwifery Council:	Represented by Feryal Ertan, Case Presenter
Order being reviewed:	Conditions of Practice Order for 12 months
Fitness to Practise:	Impaired
Outcome:	Striking-off order to come into effect at the end of 16 July 2019 date in accordance with Article 30 (1)

Decision and reasons on review of the current order:

The panel decided to impose a striking-off order. This order will come into effect at the end of 16 July 2019 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) ("the Order").

This is the fifth review of a conditions of practice order, originally imposed by a panel of the Conduct and Competence Committee on 14 March 2014 for 24 months. That order was reviewed by a panel of the Conduct and Competence Committee on 10 March 2016 and a further 24 month conditions of practice order was imposed. At an early review of the order on 27 March 2017 a panel of the Conduct and Competence Committee varied the conditions of practice order. That order was reviewed by a panel of the Fitness to Practise Committee on 8 March 2018 and a suspension order was imposed for a period of three months. This order was reviewed by a panel of the Fitness to Practise Committee on 31 May 2018 and a conditions of practice order for a period of 12 months was imposed. The current order is due to expire at the end of 16 July 2019.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved, by way of admission, which resulted in the imposition of the substantive order were as follows:

That you, whilst employed as a band 5 midwife at Brighton and Sussex University Hospitals NHS Trust, did not demonstrate the standard of knowledge, skills and abilities required to practise without supervision in that you:

1. On 24 to 25 July 2010 whilst caring for Patient A you:

    (a) Failed to recognise a Post-Partum Haemorrhage
    Admitted and Found Proved

    (b) Failed to examine Patient A adequately or at all to locate the cause of the haemorrhage
    Admitted and Found Proved

    (c) Left Patient A unattended while she was haemorrhaging
    Admitted and Found Proved

    (d) Failed to call for assistance

Admitted and Found Proved

(e) Failed to provide an adequate 'CHAPS' handover to Ms 2 when requested to do so
Admitted and Found Proved

(f) Did not access Spencer Wells Forceps from the delivery pack within the birthing room as would have been appropriate in the circumstances.
Admitted and Found Proved

(g) Failed to adequately prepare a Syntocinon infusion when requested by a colleague to do so
Admitted and Found Proved

(h) Provided the anaesthetist with an inaccurate figure for the amount of blood lost by Patient A
Admitted and Found Proved

(i) Your note keeping was inadequate
Admitted and Found Proved

2. On 31 July 2010 whilst caring for Patient B you:

(a) Failed to adequately monitor the foetal heart rate
Admitted and Found Proved

(b) Sent Patient B's mother out of the room to seek assistance rather than summoning assistance yourself
Admitted and Found Proved

(c) Failed to immediately clamp and cut the umbilical cord following birth
Admitted and Found Proved

(d) Did not take umbilical cord gases when requested to do so
Admitted and Found Proved

(e) Left Patient B unattended whilst she was haemorrhaging
Admitted and Found Proved

3. Whilst undergoing a period of developmental practice between September 2010 and December 2010 you did not demonstrate that you had the necessary competencies to be capable of working unsupervised, more particularly, but not limited to:

(a) Your record keeping was at times inadequate in emergency situations
Admitted and Found Proved

(b) You failed to fully record observations on the 'MEOWS' charts as required
Admitted and Found Proved

(c) …

(d) On a date unknown when asked by Supervisor of Midwives Ms 4 what painkillers you would give to a patient in pain after childbirth you raised the possibility of Oramorph, which was contra-indicated in the circumstances
Admitted and Found Proved

(e) On a date unknown you failed to administer fluids to a patient who had received an epidural
Admitted and Found Proved

(f) On a date unknown you were unable to distinguish between the foetal heart rate and the mother's heart rate
Admitted and Found Proved

4. Whilst undergoing a period of supervised practice between January 2011 and June 2011 you did not demonstrate that you had the necessary competencies to be capable to working unsupervised, more particularly, but not limited to:

(a) On 8 February 2011 in respect of a premature birth you failed to:

(i) Immediately clamp and cut the umbilical cord after birth
Admitted and Found Proved

(ii) Take the cord gases
Admitted and Found Proved

(iii) Give the patient syntometrine to minimise blood loss
Admitted and Found Proved

(b) On 16 February 2011 in respect of a patient in the care of you and Ms 3:

(i) Failed to articulate sufficiently that an induction was recommended after finding meconium in the patient's waters
Admitted and Found Proved

(ii) Failed to carry out any or any adequate vaginal examination before being prompted
Admitted and Found Proved

(iii) Did not appreciate the importance of conducting a vaginal examination before administering syntocinon
Admitted and Found Proved

(iv) Inappropriately increased the rate of syntocinon
Admitted and Found Proved

(v) Your record keeping was inadequate
Admitted and Found Proved

(c) On 10 March 2011 in respect of a patient in the care of you and Ms 3:

(i) You did not prepare an adequate plan for the care of the patient
Admitted and Found Proved

(ii) You recorded in the patient's notes that she did not suffer from any allergies without first confirming that that was the case
Admitted and Found Proved

(iii) You got too close to the baby's head which may have given the impression that you would touch it before delivery in the birthing pool was complete
Admitted and Found Proved

(iv) You did not administer syntometrine
Admitted and Found Proved

(v) You were unable to adequately assess the state of the patient's perineum after birth to see if stitching was required
Admitted and Found Proved

d) On 4 April 2011 in respect of a patient in the care of you and Ms 4:

i) You did not immediately cut the umbilical cord after birth
Admitted and Found Proved

ii) You failed to adequately document the foetal heartbeat
Admitted and Found Proved

iii) You failed to administer syntometrine after birth
Admitted and Found Proved

e) On 11 April 2011 in respect of a patient in the care of you and Ms 3:

i) You did not fill in the daily record sheet for the patient
Admitted and Found Proved

ii) You failed to record why you had been unable to listen to the foetal heart rate for one minute between contractions
Admitted and Found Proved

iii) You failed to record the foetal heart rate as an average
Admitted and Found Proved

iv) You failed to write and/or implement a reassessment for the patient
Admitted and Found Proved

v) …

vi) You failed to put sharps in the sharps bin
Admitted and Found Proved

vii) You inappropriately drained the patient's urine into an IV tray
Admitted and Found Proved

viii) You did not check the resuscitaire machine on this occasion
Admitted and Found Proved

f) On 16 May 2011 in respect of a patient in the care of you and registered midwife Ms 5:

i) The standard of your note keeping was inadequate
Admitted and Found Proved

ii) You did not articulate with sufficient clarity the rationale for the care you provided when requested to do so
Admitted and Found Proved

g) On 18 June 2011 in respect of patient(s) in the care of you and registered midwife Ms 6

i) You had to be prompted to commence CTG monitoring on a patient
Admitted and Found Proved

ii) You required assistance to monitor the foetal heart rate
Admitted and Found Proved

iii) You did not prepare the room for a possible episiotomy in adequate time
Admitted and Found Proved

iv) You did not communicate with the doctor when a patient had shoulder dystocia
Admitted and Found Proved

v) The manner of your note keeping was inappropriate
Admitted and Found Proved

vi) You left the labour room in an inappropriate manner
Admitted and Found Proved

h) On 27 June 2011 in respect of a patient in the care of you and Ms 6 your record keeping and/or time management was inadequate
Admitted and Found Proved

The fourth reviewing panel determined the following with regard to impairment:

"This panel considered whether your fitness to practise remains impaired. It took into account all the documentation which you have provided, including your

reflective piece and two testimonies. The panel also took into account the comprehensive chronology which you put before it, which begins on 29 November 2009 and details all the problems which you have faced, with a commentary, as well as the statement dated 29 May 2018, in which you summarise your wishes for the outcome of this review hearing. The panel noted that these describe the problems which have arisen at various stages of your career as a midwife, and comment upon the levels of support you have received and the various processes which you have been through both at the NMC and other disciplinary matters.

While understanding the frustrations that you must feel over the events of the last few years, the panel considered that the reality is that you have not adequately remediated your failings as a midwife despite extensive prolonged and protracted attempts to do so. It noted that it had not been provided with evidence of any further training relevant to the charges found proved, and considered that your reflective piece focusses more on how you felt at the time of the incidents, rather than on why they occurred and how you would act differently in the future; in the reflective piece, you did not take responsibility for your actions and fell short of addressing the fundamental failings arising from the referral and how they might be remediated.

Taking into account the seriousness of the charges proved as well as the matters referred to above, the panel determined that, as you have not demonstrated sufficient insight to remedy your clinical failings, your fitness to practise remains currently impaired; it made this finding on public protection grounds, as well as the wider public interest of maintaining public confidence in the profession and the NMC as regulator."

The fourth reviewing panel went on to determine the following with regard to sanction:

"The panel considered substituting the current suspension order with a conditions of practice order. It bore in mind your concern that an administrative failure at the last review hearing appears to have led to the imposition of a suspension order.

This panel noted that previous panels have found you to be open, honest and credible and this panel was ready to take you at your word that there was a misunderstanding and that you had been willing to contribute to the last hearing by telephone.

The panel therefore considered afresh whether a conditions of practice order would be sufficient, appropriate and workable in this case; it was greatly assisted by your attendance at this hearing.

The panel considered that it would be possible to formulate practicable and workable conditions, which if complied with, may lead to your unrestricted return to practice and would serve to protect the public and the reputation of the profession in the meantime. The imposition of such an order is the nearest proportionate sanction to allow you to “start again”, whilst also appropriately protecting the public. The panel were impressed by your real determination to return to midwifery practice.

The panel considered that the imposition of a conditions of practice order for a period of 12 months would allow you sufficient time to find a position and comply with the conditions below, while reflecting your determination to return to the register as soon as possible.

The panel decided that the public would be suitably protected as would the reputation of the profession by the re-implementation of the following conditions of practice:

1. At any time that you are employed or otherwise providing midwifery you must place yourself and remain under the supervision of a work place line manager, mentor or supervisor nominated by your employer, such supervision to consist of working at all times under the direct observation of a registered midwife of band 6 or above.

2. You must work with your line manager, mentor or supervisor (or their nominated deputy) to create a personal development plan designed to address the concerns about the following areas of your practice:

    i. fetal heart monitoring including CTG;
    ii. obstetric emergencies, including post-partum haemorrhage;
    iii. recognition of a deteriorating patient;
    iv. drug administration; and
    v. documentation.

3. You must meet with your line manager, mentor or supervisor (or their nominated deputy) at least every four weeks to discuss the standard of your performance and your progress towards achieving the aims set out in your personal development plan.

4. You must forward to the NMC a copy of your personal development plan within 28 days of the date on which these conditions become effective or the date on which you take up an appointment, whichever is sooner.

5. You must send a report from your line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance and your progress towards achieving the aims set out in your personal development plan to the NMC 14 days prior to any NMC review hearing or meeting.

6. You must inform the NMC of any professional investigation started against you and /or any professional disciplinary proceedings taken against you within 14 days of receiving notice of them.

7. You must within 14 days of accepting any post or employment requiring registration with the NMC, or any course of study

connected with nursing or midwifery, provide the NMC with the name/contact details of the individual or organisation offering the post, employment or course of study.

8. You must immediately inform the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the charges and a copy of the NMC decision letter setting out the conditions of practice and the panel's determinations in full:

    a. Any organisation or person employing, contracting with or using her to undertake midwifery work.
    b. Any agency you are registered with, or apply to be registered with to undertake midwifery work at the time of application.
    c. Any prospective employer for midwifery services at the time of application.
    d. Any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course, at the time of application.

The panel considered that a suspension order would be a disproportionate measure, not necessary nor appropriate in this case.

This reviewing panel considered that a future panel would be assisted by:

- Your attendance at the next reviewing hearing.

- A reflective piece addressing the clinical concerns that lead to your referral, as in the charges found proved; these should include what went wrong at the time of the incidents, what the potential impact was on your

patients, colleagues, and the reputation of the profession, and how you would manage such situations in the future.

- Evidence of you keeping up to date with developments in the midwifery profession, as well as any relevant training.

- A summary of your attempts and successes in finding a role related to midwifery.

- Any further relevant references which you can provide before the next reviewing panel."

Decision on current fitness to practise

This panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. It has noted the decision of the last panel. However, it has exercised its own judgment as to current impairment.

The panel had regard to all of the documentation before it, including a reflective piece written by you dated June 2019 and a summary of your career as a midwife. It took account of the submissions made by Ms Ertan, on behalf of the NMC, and those made by you.

Ms Ertan submitted, on behalf of the NMC, that you made clinical errors at an early stage of your career as a midwife, having registered as a midwife in 2009, and with these incidents occurring in 2010. She informed the panel that you have not practised as a midwife since 2011. Ms Ertan submitted that these errors were wide ranging and encompassed basic skills. She submitted that a number of errors occurred during a short period of time.

Ms Ertan submitted that you had not returned to midwifery practice since the conditions of practice order was imposed in 2018. Whilst there was no evidence that the conditions of practice order had been breached, Ms Ertan submitted that you had not provided any evidence of compliance with it, nor of any steps taken to reflect on your lack of competence.

In relation to the recommendations made by the previous reviewing panel, Ms Ertan informed the panel that you had provided a reflective piece and a detailed summary of recent steps you have taken to return to practice, which had been unsuccessful. You had also remained engaged with the NMC's proceedings throughout. However, Ms Ertan submitted that you had not provided any evidence of keeping up to date with the profession, including evidence of training nor had you provided any relevant references.

Ms Ertan submitted that there was a real risk of repetition and a risk of harm to patients if you were allowed to practise without restriction. She therefore invited the panel to find that your fitness to practise remains impaired.

In relation to sanction, Ms Ertan submitted this was a matter for the panel's judgement. She invited the panel to have regard to the NMC's Sanctions Guidance ("SG"), the need to protect the public and to have the public interest at the forefront of its mind, which included maintaining confidence in the profession and in the NMC as a regulator and the declaring and upholding of proper standards of conduct and behaviour. Ms Ertan submitted that there were real concerns in this case regarding a risk of repetition, and that there was a length of time where you have not been able to practise as a midwife.

You told the panel that you definitely wish to protect the public which is why you went into midwifery. You said that, however, you need protecting. You said that you had "been through hell", including being in the media, and you had suffered a lot. You asked where midwives and nurses stood in terms of protection from the NMC and upholding standards. You spoke of training being unavailable or unaffordable to you. You said that you were currently working as a carer to earn a living.

You said you were happy to keep coming to these hearings and doing what you could. You said you thought support should be there for students and upon qualification as a midwife, in case of incidents like these occurring, which you said was "dreadful" and "life changing". You said that there should be somewhere for nurses and midwives to do training, rather than just appearing before panels.

You informed the panel about the incidents which arose in this case whilst you were working at Brighton and Sussex University Hospitals NHS Trust ("the Trust"), and how you were first placed on a developmental practice programme, and then on a supervised practice programme. You said you felt this was all badly managed, and you did not finish the supervised practice programme. You said you were then suspended by the Local Supervising Authority Midwifery Officer ("LSAMO"), and you found it all really stressful.

In response to questions from the panel in relation to your opportunities to remediate during the developmental and supervised practice programmes, you said this all happened in a short space of time, where you were working part-time and you had only recently qualified as a midwife. You said you should have gone off sick but you just continued and everything spiralled out of control. You said you understood why you were placed on these programmes, in order for your practice to be scrutinised.

When asked about the impact your actions had on patients, colleagues and on the reputation of the midwifery profession, you said it was “absolutely devastating in every possible way” and “unbelievable”. You said you feel you did not achieve your competencies at the Trust as you got so upset and did not think you were fit to work. You said you were too devastated by everything.

In relation to keeping your clinical knowledge and skills up to date, you told the panel that you read websites, such as that of the Royal College of Midwives and the National Child of Maternal Health Network (“ChiMat”). You said you recently read up on skills drills for an interview and about mental health in maternity. You also said that you read various magazines. You said that you wished to attend training courses but you could not afford to do so. You said that you had not yet undertaken any online learning or attended any study days or conferences. You said that you had provided lots of references in the past but you did not consider doing so for this hearing. When asked about why you had not provided evidence of any training undertaken or any references, you said that you had a lot of paperwork and had provided so much information previously, and you just did not think about it this time.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel had regard to the recommendations made by the previous reviewing panel. The panel noted that you had complied with some of these, in that you had provided a written reflective piece, and you had provided a detailed summary of your attempts to obtain a position as a midwife. The panel noted that you told it you had been keeping up to date with developments in midwifery, by reading websites and magazines, although you had not provided evidence of this.

The panel also noted that you had not provided any evidence of having undertaken any training, nor had you provided any references in relation to any work you have been undertaking since the last review hearing. When asked about why you had not complied with these particular recommendations, the panel noted that you gave it no assurances that this information could be provided. You stated that you had previously provided references and other information, but you did not think about doing so in relation to this hearing. The panel noted that you told it you have been unable to afford to undertake certain training courses, although you did wish to attend these. When asked about whether you had thought about undertaking free online training or study days or conferences, you stated you had not done so.

The panel considered whether there was any evidence of remediation. The panel noted that you had made persistent attempts to return to practising as a midwife, by seeking placements on a return to practice course and positions as a midwife, however these had been unsuccessful. The panel therefore considered that you had not had the opportunity to work towards meeting the conditions of practice order, and as such, you have not been able to remediate the identified areas of concern with your clinical practice.

The panel considered whether you had demonstrated evidence of insight into your original failings, and whether you had demonstrated an understanding of their impact on patients, colleagues and on the reputation of the midwifery profession. In this regard, the panel had regard to your reflective piece and the submissions you made at this hearing. The panel considered that whilst you attempted to demonstrate insight, this was extremely limited. The panel considered that you failed to show an appreciation of how your actions could have impacted on patients, colleagues and the reputation of the

midwifery profession, despite having been given a number of opportunities to do so, in response to this panel's questions to you. The panel considered that in your reflective piece, and during your submissions, you appeared to focus on the impact the incidents and the NMC's proceedings have had on you, and sought to deflect blame as a way of explaining these matters. The panel therefore considered that your insight was extremely limited.

Given the lack of evidence of insight and remediation of the original failings in this case, the panel considered that a significant risk of repetition remained, bearing in mind that the original failings concerned basic and fundamental midwifery practice, and the incidents arose when you were newly qualified as a midwife. The panel determined that a finding of impairment remains necessary on the grounds of public protection.

The panel bore in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel also determined that a finding of impairment remains necessary on public interest grounds.

For these reasons, the panel finds that your fitness to practise remains impaired.

Determination on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 29 of the Order. The panel also took into account the SG and bore in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition identified and the seriousness of the case. The panel determined that taking no action would not protect the public and it would not satisfy the public interest.

The panel then considered whether to impose a caution order but concluded that this would also be inappropriate in view of the risk of repetition identified and the seriousness of the case. The panel determined that imposing a caution order would not protect the public and it would not satisfy the public interest.

The panel next considered whether to impose a further conditions of practice order. The panel noted that you have made persistent attempts to obtain a role as a midwife, in order to work towards meeting the conditions of practice order imposed at the previous review hearing. You have also applied for numerous return to practice opportunities, all of which have been unsuccessful.

The panel considered whether conditions of practice remain workable and appropriate. The panel had regard to the SG, and the factors to consider in deciding whether conditions are appropriate. The panel considered that there still remained identifiable areas of your clinical practice in need of retraining, assessment and oversight, bearing in mind the wide ranging nature of the clinical errors which arose during the original incidents. However, the panel was not satisfied that you had demonstrated a continued willingness to respond positively to retraining. Whilst you told the panel that you did want to undertake training but you could not afford to do so, the panel noted that you had not utilised opportunities to undertake any free online training, and during questions from the panel at this hearing, you did not demonstrate a positive indication of a willingness or ability to undertake such training in the future.

The panel noted that conditions of practice may not be appropriate where there is evidence of general incompetence. The panel had regard to the original charges, which concerned basic and fundamental areas of midwifery practice, and which occurred shortly after qualifying as a midwife. These have yet to be remediated nine years after the incidents in question. The panel considered that there was some evidence of general incompetence in this case. The panel bore in mind that you had been subject to conditions of practice orders for a period of five years, during which time you had not practised as a midwife (nor had you practised as a midwife since 2011), and had therefore made no progress in remediating your practice.

The panel considered whether to impose a suspension order. The panel considered that this would not serve any useful purpose, so far as remediating the identified deficiencies in your practice. The panel also considered whether it would be appropriate to impose a suspension order in the circumstances of this case, and this respect, the panel had regard to the SG. The panel considered that your insight was extremely limited, noting that, as stated previously, you had failed to appreciate the effect of your actions on patients, colleagues and on the reputation of the profession, whilst focusing more on the effect these incidents and the proceedings have had on you. As it considered your insight was limited, the panel considered that you posed a significant risk of repeating your behaviour. The panel noted that the original substantive hearing took place in 2014, and since then, there was little evidence of a significant development of insight into the original failings on your part. The panel therefore considered that a suspension order would not be appropriate.

The panel considered whether to impose a striking-off order. The panel bore in mind that you have remained engaged with these proceedings throughout, having participated in a number of hearings. You have provided evidence of your attempts to address the concerns of previous panels, including having provided a reflective piece and a summary of your attempts to obtain a position as a midwife to this panel. However, the panel also noted that you have been subject to conditions of practice orders for a period of five years, during which time you have made little progress in attempting to address the deficiencies in your practice. These concern wide ranging areas of basic midwifery practice, which occurred very early during your career as a midwife, and despite being placed under practice programmes in order to support you in

addressing such deficiencies. Furthermore, you have demonstrated a lack of insight since the original substantive hearing, failing to appreciate the impact your actions could have had on patients, colleagues and on the reputation of the midwifery profession. Whilst you had made some attempts to keep your clinical skills and knowledge up to date, such as reading websites and magazines, the panel considered that these had not been substantial, and you had not utilised resources such as online training available to you, nor had you demonstrated a positive willingness at this hearing to utilise such resources in the future.

The panel considered that it was not in the public interest to continue proceedings when they had little chance of facilitating the return of a midwife to safe and effective practice. The panel determined that it was necessary to take action to prevent you from practising in the future and concluded that the only sanction that would adequately protect the public and serve the public interest was a striking-off order. The panel therefore directs the registrar to strike your name off the register.

In accordance with Article 30 (1) of the Order, this striking-off order will come into effect upon the expiry of the existing conditions of practice order, namely at the end of 16 July 2019.

This decision will be confirmed to you in writing.

That concludes this determination.