Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Order Review Meeting

18 September 2019

Nursing and Midwifery Council, 114-116 George Street, Edinburgh, EH2 4LH

Name of registrant:	Francette Anne Passave
NMC PIN:	99I2210E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – November 2002 Registered Midwife Midwifery – March 2005
Area of Registered Address:	Leicester
Type of Case:	Misconduct
Panel Members:	Timothy Cole (Chair, Lay member) Angela O'Brien (Registrant member) Jane McLeod (Lay member)
Legal Assessor:	Maria Clarke
Panel Secretary:	Sam Headley
Order being reviewed:	Suspension order (6 months)
Outcome:	Striking-off order to come into effect at the end of 2 November 2019, in accordance with Article 30 (1)

Service of Notice of Meeting

The panel received information from the legal assessor concerning service of the notice of meeting. Notice of the meeting was sent to Miss Passave's registered address by first class post and by recorded delivery on 6 August 2019, stating that a meeting would be held no sooner than 16 September 2019 and that she should contact the NMC by 16 September 2019 if she wanted to provide the panel with any written evidence. Notice of this meeting was also sent to Miss Passave's representatives on 6 August 2019.

The panel noted that this was delivered to Miss Passave's registered address on 7 August 2019 according to the Royal Mail Signed For service, and that it had been signed for by 'PASSAVE'.

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

The panel noted that the appropriate notice had been served on 6 August 2019 which was more than 28 days before this meeting. The panel was satisfied that there was good service of the notice dated 6 August 2019 in accordance with Rules 11A and 34 of the Fitness to Practise Rules 2004 (as amended) (the Rules).

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 2 November 2019 in accordance with Article 30 (1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a suspension order, originally imposed by a Fitness to Practise panel on 29 March 2018 for 12 months. The suspension order was extended on 12 April 2019 for 6 months. The current order is due to expire on 2 November 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, a registered midwife, on 7 May 2016, in relation to Patient A:

1. Failed to plan and/or provide appropriate care during labour in that you;

    a. Prior to the artificial rupture of the membranes ("ARM");

        (i). Did not conduct or record any assessment of the cardiotocograph ("CTG").
        Admitted and Found Proved

        (ii). Did not conduct and/or record any assessment of Patient A's contractions.
        Admitted and Found Proved

    b. Did not make a plan of care for the active phase of labour.
    Admitted and Found Proved

    c. Did not seek a "fresh eyes" review from another midwife every hour.

Admitted and Found Proved

d. Between 09:28 and 13:01 did not conduct or record adequate assessments of Patient A's condition in the maternal notes.
Admitted and Found Proved

e. Did not conduct or record any assessment of pain.
Admitted and Found Proved

f. Between 09:50 and 10:50 did not commence the fluid balance chart when it was clinically appropriate to do so.
Admitted and Found Proved

g. At around 10:00 conducted a CTG review after the CTG had only been on for a period of four minutes when a period of at least 20 minutes is required for an informed assessment.
Admitted and Found Proved

h. Between 10:00 and 11:40 did not analyse the CTG frequently enough.

Admitted and Found Proved

i. Between 10:50 and 12:50 did not commence a partogram when it was clinically appropriate to do so.
Admitted and Found Proved

j. At around 11:00 did not measure the amount of urine passed.
Admitted and Found Proved

k. At around 12:00:

(i). When the CTG showed reduced variability did not increase frequency of observations.

Admitted and Found Proved

(ii). When the CTG showed that the uterus was hyperstimulating did not put in place a plan to observe for any change.
Admitted and Found Proved

l. At around 12:35 did not offer or record that you offered pain relief.
Admitted and Found Proved

2. Failed to plan and/or provide appropriate care following labour in that you:

a. At around 13:05, failed to commence an infusion of 40 units of Syntocinon immediately after delivery.
Admitted and Found Proved

b. Did not escalate Patient A to medical staff:

(i). At 13:05 after an estimated loss (“EBL”) of 400-500mls of blood.
Admitted and Found Proved

(ii). At 13:30 after an EBL of 500-1000mls and/or when a second dose of syntocinon was required.
Admitted and Found Proved

c. At around 14:34 bleeped for the obstetrician when the emergency bell should have been activated.
Admitted and Found Proved

3. Failed to ensure appropriate documentation was undertaken in that you:

a. Did not document observations in the MEOWS chart.
Admitted and Found Proved

b. At around 09:50 failed to document that Patient A was a high risk patient.

Admitted and Found Proved

c. At around 10:50 did not record a clear rationale for administering Hartmann's solution.

Admitted and Found Proved

d. At around 11:00:

(i). Did not record rationale as to why a catheter is inserted.

Admitted and Found Proved

(ii). Did not record that there had been no acceleration in the CTG.

Admitted and Found Proved

e. At around 12.00 did not record that Patient A was hyperstimulating.

Admitted and Found Proved

f. At around 12:25 did not record the midwife coordinator's review.

Admitted and Found Proved

g. At around 12:30 did not record a full description of Patient A's condition in the maternal notes when requesting medical assistance.

Admitted and Found Proved

h. At around 13:20, when abnormal bleeding occurred:

(i). Did not record abnormal bleeding in the notes.

Admitted and Found Proved

(ii). Did not record observations every 5 minutes.
Admitted and Found Proved

i. You recorded blood of 1.9 litres at 13:50 when in fact this was only noticed at 14:45.
Admitted and Found Proved

4. At around 13:50 administered Voltarol when this was contraindicated.
Admitted and Found Proved

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

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

"The panel has considered carefully whether Miss Passave's 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 has had regard to all of the documentation before it, including the supplementary bundle of documents, which includes a summary of a telephone call from Miss Passave's representative dated 19 March 2019, and a summary of correspondence between Miss Passave's representative and the case officer dated 10 and 11 April 2019. It has also taken account of the submissions made by Ms Piff, on behalf of the NMC.

Ms Piff outlined the background of this case to the panel and submitted that Miss Passave is currently impaired. She invited the panel to continue a period of suspension.

The panel heard and 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 Miss Passave's fitness to practise remains impaired.

Regarding Miss Passave's insight, the panel noted that the last panel found that Miss Passave had a developing insight into the gravity of her errors and acknowledged that training is required to improve the gaps in her practice.

At this hearing the panel noted that Miss Passave was not present and had not engaged with the proceedings. Miss Passave has not provided the panel with any documents to suggest any detailed reflection on her personal accountability. She has not reflected on how her actions put the patient at risk of harm. Miss Passave has not demonstrated an appreciation of her errors and how these impacted negatively on the nursing and midwifery profession or expressed any remorse for her failures or taken steps to remediate.

This panel has received no new information of any material change of circumstances. In light of this the panel determined that Miss Passave was liable to repeat matters of the kind found proved. The panel decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing and midwifery professions and upholding proper standards of conduct and

performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is required.

For these reasons, the panel finds that Miss Passave's fitness to practise remains impaired."

The first reviewing panel determined the following with regard to sanction:

"Having found Miss Passave's 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 has also taken into account the NMC's Sanctions Guidance (SG) and has borne 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 or to impose a caution but concluded that this would be inappropriate in view of the risk of repetition identified and seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to apply either sanction.

The panel next considered a conditions of practice order. Whilst the charges in this case involve a single instance of misconduct, they considered that a conditions of practice order is not sufficient to protect the public or to uphold the reputation of the nursing and midwifery professions. Miss Passave's conduct demonstrated a wide range of failings and placed a patient at significant risk of harm. Those failings have not been remediated as Miss Passave has not practised as a registered midwife since September 2016. In light of the wide ranging failings and lack of remediation, the panel concluded that patients would still be at risk directly or indirectly, if Miss Passave were subject to conditional registration. The panel considered the lack of engagement from Miss Passave, and determined that no set of conditions could be formulated that could be reasonable or workable.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow Miss Passave further time to reflect on her previous failings. The panel concluded that a further 6 month suspension order would be the appropriate and proportionate response and would afford her adequate time to develop insight and to remediate.

The panel finally considered a striking off order but determined that it would not be appropriate or proportionate at this time, as this would not allow Miss Passave sufficient time to reflect or submit her future intentions formally.

In the judgment of this panel, a future panel reviewing the order will be assisted by her attendance and by receiving information from her to assist in its assessment of her fitness to practise as a Registered Nurse and/or Midwife at that time, which she should provide to the NMC in advance of the date of the review hearing. That information could include the following:

- *A detailed written reflection, addressing her personal accountability for all aspects of the misconduct by reference to the specific elements of the Code that she concludes are applicable. In particular this should reflect upon the effect of such misconduct on patients and the wider public, articulating the lessons learnt and how she would act differently in the future in comparable circumstances;*
- *Verifiable evidence, ideally in writing, of all efforts taken, for example, by accessing i-learning via the Royal College of Nursing and/or Royal College of Midwives intended to maintain skills and knowledge, with particular reference to:*

    a. normal management of labour through the continuum of stages 1-3;

    b. recognising and acting appropriately in response to any deviation from normal labour, including escalation;

    c. management of the clinically compromised patient;

d. understanding the use of and responding to early warning systems for example, MEOWS.

- *Up to date references in relation to any work undertaken, whether paid or unpaid, in a health care setting;*
- *Any other evidence which demonstrates fitness to practise."*

Decision and reasons on current fitness to practise

The panel has considered carefully whether Miss Passave's 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 has had regard to all of the documentation before it, including the NMC bundle of documents and the on-table documents which detail that Miss Passave has not been in contact with her representatives.

The panel heard and 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 decided that Miss Passave's fitness to practise remains impaired.

The panel was mindful that Miss Passave admitted all of the charges found proved at the substantive hearing. The panel noted that there had been no further communication or information from Miss Passave in relation to her failings. It therefore had no evidence of developed insight or attempts to remediate her midwifery practice.

The last panel determined that Miss Passave was liable to repeat matters of the kind found proved. This panel has received no new information to undermine that previous finding. In light of this, the panel determined that Miss Passave remains liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel had borne in mind that its primary function was 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 determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Miss Passave's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Miss Passave's 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 has also taken into account the NMC's Sanctions Guidance and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel decided to impose a striking-off order, to come into effect at the end of the current order, namely at the end of 2 November 2019.

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 seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered whether to impose a caution but concluded that this would be inappropriate in view of the risk of repetition identified and seriousness of the case.

The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel considered imposing a conditions of practice order. However, in light of Miss Passave's non-engagement with the regulatory proceedings, the panel determined that it was unlikely to be workable or practicable in Miss Passave's case.

The panel next considered imposing a further suspension order. The panel noted that the previous panel imposed a period of suspension to give Miss Passave adequate time to address these failings. Miss Passave has not demonstrated full or developed insight into her previous failings. As nothing has happened in this six months, the panel determined that a further period of suspension would not serve any useful purpose. The panel determined that it was necessary to take action to prevent Miss Passave 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.

In accordance with Article 30 (1) of the Nursing and Midwifery Order 2001, this striking-off order will come into effect upon the expiry of the existing suspension order, namely at the end of 2 November 2019.

This decision will be confirmed to Miss Passave in writing.

That concludes this determination.