Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Order Review Hearing

15 April 2020

Virtual Hearing

Name of registrant:	Dawn Elizabeth Grix
NMC PIN:	96D0595E
Part(s) of the register:	Registered Midwife (March 2001) Registered Nurse – Adult (March 1999)
Area of Registered Address:	Staffordshire
Type of Case:	Lack of Competence
Panel Members:	Wendy Yeadon (Chair, lay member) Jude Bayly (Registrant member) Elaine Hurry (Registrant member)
Legal Assessor:	Fiona Barnett
Panel Secretary:	Tara Hoole
Mrs Grix:	Present, not represented
Nursing and Midwifery Council:	Represented by Zainab Mohamed, NMC Case Presenter
Order being reviewed:	Suspension Order (six months)
Fitness to Practise:	Impaired
Outcome:	Striking-off Order to come into effect at the end of 22 May 2020 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 22 May 2020 in accordance with Article 30 (1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a conditions of practice order, originally imposed by a Fitness to Practise panel on 20 October 2017 for a period of two years. This order was reviewed at a hearing on 18 October 2019 and a suspension order was imposed for six months. The current order is due to expire at the end of 22 May 2020.

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

The charges admitted and found proved which resulted in the imposition of the substantive order were as follows:

> *That, whilst employed as a Registered Midwife by the Heart of England NHS Foundation Trust ("the Trust") failed to demonstrate the standard of knowledge, skill and judgment required for practice without supervision as a Registered Midwife in that:*
>
> *1. On or around 11 October 2013 in relation to Patient A you:*
>
> *(a) failed to monitor the Fetal Heart Rate ("FHR") in the second stage of labour;*
> *(b) inappropriately increased the Syntocinon infusion;*
> *(c) inappropriately made retrospective additions to the maternity notes;*
> *(d) made inaccurate records in that you:*
> *(i) recorded inconsistent notes regarding the usage of Syntocinon infusion;*
> *(ii) recorded inconsistent notes regarding the time of Syntocinon infusion.*

2. *Between 27 November 2014 and 13 February 2015, you failed to cooperate with a Local Supervising Authority investigation.*

3. *Between 12 January 2015 and 29 May 2015, including whilst you were subject to the Trust's Performance and Capability Programme between February and 29 May 2015, you failed to demonstrate the standard of knowledge, skill and judgment required for practice without supervision as a Registered Midwife in that:*

   (a) your record keeping was inadequate including:

      (i) on 15 March 2015 in relation to Patient I in that you did not make your notes contemporaneously during your shift;
      (ii) on 16 March 2015 in relation to Patient K in that you did not make your notes contemporaneously during your shift;

   (b) you required prompting to carry out tasks expected of you including:

      (i) on 12 January 2015, in relation to Patient B, to enter the time and date in the records and to print your name;
      (ii) on 12 January 2015, in relation to Patient B, to discuss the provision of vitamin K to the patient's baby;
      (iii) on 20 January 2015 in relation to Patient C, to record the FHR rather than the maternal pulse;
      (iv) on 7 March 2015 in relation to an unknown Patient, to record oxygen and saturation levels;
      (v) on 2 May 2015, in relation to Patient O, to use an FSE to monitor the FHR.

   (c) you failed to correctly interpret Cardiotocographs ("CTG") including:

      (i) on 20 January 2015 in relation to Patient C;
      (ii) 21 February 2015 in relation to Patient G;

(iii) on 25 April 2015 in relation to Patient M;

(iv) on 25 April 2015, in relation to Patient U;

(v) on 17 May 2015, in relation to Patient P.

(d) on 21 February 2015, in respect of Patient G you:

(i) failed to use the Trust's Fresh Eyes Sticker Procedure;

(ii) incorrectly calculated the patient's MEWS;

(iii) failed to check the patient's MEWs at 30 minute intervals;

(iv) did not escalate the patient to a doctor;

(v) amended the patient's MEWS in the records;

(vi) failed to obtain cord blood samples in the required timeframe.

(e) on 28 February 2015, in respect of patient H you:

(i) failed to demonstrate rationale for wanting to undertake a vaginal examination;

(ii) failed to auscultate the FHR abdominally following the removal of the FSE.

(f) on 24 May 2015, in respect of Patient S, you failed to correctly follow the consultant's instructions in respect of Syntocinon.

(g) on 19 April 2015 following delivery of Patient L's Baby ("the Baby"):

(i) you failed to recognise that the cord was around the Baby's neck and unwrap the cord;

(ii) you failed to put out an emergency call for assistance while the Baby was being resuscitated;

(iii) you failed to check the cord gases following the delivery of the Baby;

(h) on 25 April 2015 in respect of patient U, you retrospectively altered the FHR in the patient's records;

(i) on 24 May 2015 in respect of Patient T you:

(i) failed to commence the partogram when taking over the patient's care;

(ii) failed to record or escalate the presence of thick meconium.

AND in light of the above, your fitness to practise is impaired by reason … your lack of competence … in relation to any and/or all of charges 1 and 3.

(The original panel found the charge of misconduct not proved)

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

'The panel noted that the original panel found that Mrs Grix had significant developing insight. At this hearing the panel had no information or evidence before it that showed any insight into her clinical failings as there had been no communication from Mrs Grix since the substantive hearing in October 2017.

In its consideration of whether Mrs Grix has remedied her practice, the panel took into account that the original panel noted she had kept her clinical knowledge up-to-date with journals and training courses. At today's hearing, the panel had no new evidence of any further remediation. The panel also noted that it had no evidence to suggest that Mrs Grix has complied with the conditions of practice order.

The original panel noted that despite the remedial action taken at the time, Mrs Grix's lack of competence had not been remedied. Consequently that panel determined Mrs Grix was liable to repeat matters of the kind found proved. Today's panel has no evidence or information that would suggest that the risk to patients has been remediated. In light of this, this panel determined that Mrs Grix is still 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 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 profession and upholding proper standards of conduct and performance. The panel determined that in light of the lack of engagement with her regulator, in this case, a finding of continuing impairment on public interest grounds is also required.

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

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

'The panel first considered whether to take no action but concluded that this would be inappropriate. This is due to Mrs Grix's lack of competence not being remediated and 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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Grix's practice would not be appropriate in the circumstances. The SG 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 Mrs Grix's lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing a conditions of practice order on Mrs Grix's registration would still be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel noted that Mrs Grix has not engaged with the NMC since the imposition of the conditions of practice order on 20 October 2017 and there is no information before it to conclude that she is willing to comply with any conditions imposed upon her practice. The panel found that whilst there were identifiable areas of Mrs Grix's practise that were in need of assessment – and/or retraining, her current disengagement with this regulatory process made a further conditions of practice order unworkable.

On this basis, the panel concluded that a conditions of practice order is no longer the appropriate order in this case.

The panel determined therefore that a suspension order is the appropriate sanction which would both protect the public and satisfy the wider public interest. The panel noted that Mrs Grix's lack of engagement with the NMC contravenes the requirements of the original panel. Accordingly, the panel determined to impose a suspension order for a period of 6 months which would provide Mrs Grix with what is likely to be a last opportunity to re-engage with the NMC and take steps to remediate the previous concerns. It considered this to be the most appropriate and proportionate sanction available at this stage.

The panel seriously considered imposing a striking off order but determined that it would be disproportionate. However the panel noted that this option would be available to the next reviewing panel.

This suspension will take effect upon the expiry of the current conditions of practice order, namely the end of 22 November 2019 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- *Your re-engagement with the NMC;*
- *Your attendance at the next review hearing;*
- *Any references or testimonials from future employers pertaining to paid or unpaid work;*
- *A reflective statement stating your future intentions regarding your midwifery career and an explanation as to why you have not engaged with the NMC since the last hearing.'*

Decision on current fitness to practise

The 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 has had regard to all of the documentation before it. It has taken account of the submissions made by Ms Mohamed on behalf of the NMC and those made by you.

Ms Mohamed took the panel through the background to the case. She submitted that you have not yet remediated the failings in your practice, therefore a risk of repetition remains. Ms Mohamed therefore invited the panel to find that your fitness to practise remains impaired.

In relation to sanction, Ms Mohamed submitted this was a matter for the panel. She suggested that a conditions of practice order may allow you time to demonstrate remediation of your failings. However, she reminded the panel that all sanctions were available to it in reviewing the order today.

[PRIVATE].

You told the panel that you regret what happened and that you have reflected a lot on the incident [in 2013] and what you would have done differently. You told the panel that you did not know what had happened that day, it was not your regular practice, and that you had not had problems before. You said you could see afterwards what you should have done and that you accept responsibility for your actions that day. [PRIVATE].

You told the panel that midwifery had always been your passion, you had loved your job and given it your all. You said that, in light of the current Covid-19 pandemic you felt guilty that you were not using your nursing and midwifery qualifications. You said that you know it would not be easy to return and that you recognise you would have a lot of work to undertake but that you hoped the panel would be willing to impose a conditions of practice order to allow you to return to practise. When questioned, you admitted that you have done very little to keep your skills or knowledge up to date in the last 18 months. [PRIVATE]. You told the panel that you now wanted to return to your midwifery career.

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 your fitness to practise remains impaired.

The panel noted that the failings found by the original panel have not been remedied. You said you originally did some online training but you have not kept your knowledge up to date nor completed any training in the last 18 months. Further, you have had another two years away from clinical practice since the original hearing.

The panel considered that you have a lack of insight into your lack of competence; you spoke about “the incident on one single day” in 2013 but made no acknowledgement that the matters which brought you to the NMC involved a wide-ranging lack of

competence over a lengthy period, rather than a single incident in 2013. You failed to address your failings following the incident, which continued over a period of 18 months during which your practice was formally supervised. In addition, you have failed to recognise the potential impact your failings had on your patients, their families, your colleagues and the reputation of the profession.

In light of this the panel determined that you remain liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment, due to your lack of competence, 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 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 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 30 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 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 order but concluded that this would also be inappropriate in view of the risk of repetition identified and seriousness of the case. In addition, having found your fitness to practise impaired on public protection grounds a caution order would provide no restriction on your practice. The panel

therefore determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered substituting the current suspension order with a conditions of practice order. The panel noted that you had been under a performance management plan in your midwifery role but you had not responded to this successfully. You were then subject to an NMC conditions of practice order for a period of two years but you chose to pursue an alternative career rather than use this opportunity to remediate your practice. The panel was also concerned regarding your lack of insight into the wide-ranging and basic errors made in the 18 months whilst you were under supervision. The panel considered that these errors were numerous and related to fundamentals of midwifery care. The panel noted that you have not practiced since this time nor have you kept your knowledge or skills up to date. The panel was of the view that considerable evidence would have been required to show that you were fit to practise even with restrictions but you have not produced any evidence. Given all of the above the panel was not satisfied that there were workable conditions which would be stringent enough to protect the public.

The panel next considered imposing a further suspension order. The panel noted that you have been under a suspension order for six months and a conditions of practice order for two years. During this time you have not engaged with the NMC process, until the last couple of weeks, nor have you made any meaningful efforts at maintaining your knowledge and skills. The panel considered that you are still displacing your responsibilities by focussing on the actions and responsibilities of the other professionals in the room at the time of the incident in 2013 rather than your own. Further, you did not acknowledge your other failings which gave rise to the finding of a lack of competence at the hearing in 2017. The panel considered that you have demonstrated extremely limited insight into your previous failings.

The panel was of the view that, whilst your failings may have been remediable at the time of the previous hearings, given your lack of recognition of the full extent of your failings and the time which has now elapsed since you last practiced, these are no longer remediable. The panel considered that the ongoing risk to the public therefore

remains. The panel determined that a further period of suspension would not serve a useful purpose in all of the circumstances.

In addition, the panel considered that it was not in the public interest to continually suspend a midwife nor is it in your interest. The panel considered that public confidence in midwives could not be maintained by allowing you to remain on the register. It considered that, in the circumstances, your failings along with the lack of insight or remediation at this time are fundamentally incompatible with your remaining on the register. The panel therefore 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 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 22 May 2020.

This decision will be confirmed to you in writing.

That concludes this determination.