Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

3, 4 & 18 September 2020

Virtual Meeting

Name of registrant:	Claire Rachel Howard
NMC PIN:	12A0605E
Part(s) of the register:	Registered Midwife – April 2012
Area of Registered Address:	Kent
Type of Case:	Misconduct & Lack of Competence
Panel Members:	Catrin Davies (Chair, Lay member) Marcia Smikle (Registrant member) Georgina Foster (Lay member)
Legal Assessor:	Andrew Granville-Stafford
Panel Secretary:	Caroline Pringle (3 & 4 September 2020) Xenia Menzl (18 September 2020)
Facts proved:	1, 2, 4, 7, 8, 9 and 11
Facts not proved:	3, 5, 6, 10 and 12
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim Order:	Interim suspension order (18 months)

Decision on proof of service

The panel considered whether notice of this meeting has been served in accordance with Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules").

The panel accepted the advice of the legal assessor. The panel noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a notice of hearing or meeting can be sent to a registrant's registered address by recorded delivery and first class post or to a suitable email address on the register.

The panel had sight of a witness statement from a NMC case coordinator confirming that the notice of this substantive meeting was sent to Mrs Howard by email to her address on the register on 29 July 2020. The notice informed Mrs Howard that a panel of the Fitness to Practise Committee would hold a meeting to consider her case on or after 1 September 2020. The notice included the charges which the panel would consider at the meeting, as well as informing Mrs Howard that the panel would consider whether her fitness to practise is currently impaired as a result of those charges and, if so, whether a sanction is required. Mrs Howard was asked to provide any relevant submissions or documents for the panel by 24 August 2020.

In these circumstances, the panel was satisfied that the notice was sent more than 28 days in advance of this meeting and had been served in accordance with the Rules. The panel also considered that, in the absence of any engagement or response from Mrs Howard, there would be little benefit in referring this matter to a hearing. As such, it was satisfied that it was appropriate to proceed with this meeting.

Details of charge

That you, a registered Band 6 midwife:

1) On or around 2 May 2018 made inaccurate entries on Patient A's notes including:

a. blood pressure **[Found proved]**
b. Temperature **[Found proved]**
c. respiration rates **[Found proved]**

2) Your actions at charge 1 above were dishonest because you knew that your records did not accurately reflect clinical observations of Patient A
[Found proved]

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

That you a registered midwife, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 6 midwife between 7th August 2018 and 31st January 2019, in that you:

3) On the 25th September 2018 failed to differentiate between degrees of perineal tears.
[Found NOT proved]

4) On the 25th September 2018 failed to independently suggest the most appropriate course of action for third stage of labour.
[Found proved]

5) On the 2nd October 2018 failed to ensure tasks and documents were completed and a full history was given during handover.
[Found NOT proved]

6) On the 11th October 2018 failed to differentiate between degrees of perineal tears.
[Found NOT proved]

7) On the 22nd November 2018 prepared incorrect medication.
[Found proved]

8) On the 22nd November 2018 required prompting to administer medication.
[Found proved]

9) On the 22nd November 2018 completed an e-learning package in a patient's room.
[Found proved]

10) On the 22nd November 2018 failed to provide assurances to the patient.
[Found NOT proved]

11) On the 6th December 2018 failed to devise appropriate care plan for a patient.
[Found proved]

12) On the 19th December 2018 required prompts from a mentor to undertake auscultation of foetal heart at appropriate interventions.
[Found NOT proved]

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence.

Background

Mrs Howard joined the NMC register as a registered midwife in April 2012. She began working at East Kent Hospitals University NHS Foundation Trust ("the Trust") in May 2012. In 2016 she joined the Folkstone Community Midwife team.

At the time of her referral to the NMC Mrs Howard was a midwife at the Singleton Midwifery Led Unit. A referral was made on 26 February 2019 by the Deputy Head of Midwifery and Gynaecology at the Trust.

On 2 May 2018 Mrs Howard attended to Patient A and falsely documented Patient A's blood pressure, temperature and respiration rate in her patient records.

On 3 May 2018 Patient A was seen by another midwife who confirmed Patient A's blood pressure was high. Mrs Howard had recorded it as being normal the day before. Patient A was referred to hospital where she received anti-hypertension medication.

On 10 May 2018 Mrs Howard attended a meeting with the Group Practice Leader for Folkestone Community Midwives where she admitted that she had falsely documented Patient A's blood pressure, temperature and respiration rate. An action plan was implemented.

In July 2018 Mrs Howard was given a verbal warning. In August 2018 she was moved out of the community and into a hospital setting.

Between September 2018 and December 2018 a number of further incidents occurred in relation to Mrs Howard's practice. These are detailed in charges 3 – 12.

In October 2018 Mrs Howard attended a meeting with Ms 2, Singleton Unit Lead Midwife at the Trust. At this meeting, Mrs Howard advised that she was feeling overwhelmed and stressed as a result of work. Ms 2 made a referral to Occupational Health.

In November 2018 Mrs Howard was given a month to demonstrate improvement against a new formalised action plan. An Occupational Health outcome letter confirmed that Mrs Howard was fit for work but would benefit from certain adjustments.

In December 2018 Mrs Howard was suspended from practice. In January 2019 she was dismissed from the Trust following a capability performance hearing.

Mrs Howard has made no formal response to the NMC in relation to the charges.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all of the documentary evidence before it. This included:

- A witness statement from Ms 1 – Group Practice Leader for Folkstone Community Midwives
- A witness statement from Ms 2 – Lead Midwife for the Singleton Unit
- A witness statement from Ms 3 – Professional Midwifery Advocate at the Trust
- Written notes and summaries of meetings with Mrs Howard
- Mentor feedback sheets in relation to Mrs Howard's practice
- Copies of Mrs Howard's action plans
- A capability management statement of case report

The panel 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.

Mrs Howard has made no formal response to the charges.

As a preliminary point, the panel noted that although charges 1 and 2 referred to Patient A, the NMC's statement of case and the documentary evidence before it in relation to these charges referred to a patient with a different set of initials – presumably the patient's own first and last name. Enquiries were made with the NMC and it was confirmed that this individual was Patient A, but that she had been further anonymised in the charges (which are publicly available) to reduce the risk of her being identified.

The panel considered each charge and made the following findings:

Charge 1

1) On or around 2 May 2018 made inaccurate entries on Patient A's notes including:
    a. blood pressure
    b. Temperature
    c. respiration rates

This charge is found proved in its entirety.

In reaching this decision, the panel had regard to the evidence of Ms 1 and Ms 2. In her witness statement, Ms 1 reports that in May 2018 concerns were raised to her about Patient A. Ms 1 states that Mrs Howard visited Patient A at her home and documented observations, including blood pressure, as normal. The following day Patient A called the unit and reported feeling unwell. A midwife attended her home and confirmed that Patient A's blood pressure was high. Patient A was subsequently admitted to hospital and given anti-hypertension medication.

According to Ms 1's statement, she met with Mrs Howard on 10 May 2018 to discuss the matter. Ms 1 states that Mrs Howard confirmed in this meeting that she had falsely documented Patient A's blood pressure, temperature and respiration rate but was unable to provide a reason as to why she had done this.

The panel had a copy of Patient A's NEWS chart and could see that, on 2 May 2018, Patient A's blood pressure, temperature and respiration rate have been documented by Mrs Howard. It also had a copy of the notes from a meeting between Ms 1 and Mrs Howard on 10 May 2018. These notes record Mrs Howard as admitting that she falsely documented these observations.

The evidence of Ms 2 in her witness statement is also consistent with that of Ms 1.

Taking account of all of the above, the panel was satisfied on the balance of probabilities that on or around 2 May 2018 Mrs Howard made inaccurate entries on Patient A's notes which included blood pressure, temperature and respiration rate.

Accordingly, charges 1(a), 1(b) and 1(c) are found proved.

Charge 2

2) Your actions at charge 1 above were dishonest because you knew that your records did not accurately reflect clinical observations of Patient A

This charge is found proved.

In reaching this decision, the panel had regard to paragraph 74 of the judgement in *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67, in particular: *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel noted that, in the meeting with Ms 1 on 10 May 2018, Mrs Howard admitted that she had falsely documented Patient A's clinical observations that she had not made. The panel considered that falsely documenting a patient's observations would undoubtedly be viewed as dishonest by the standards of ordinary decent people.

The panel was therefore satisfied that Mrs Howard's actions at charge 1 were dishonest, because she recorded clinical observations of Patient A that she had not actually made.

Accordingly, charge 2 is found proved.

Charge 3

3) On the 25th September 2018 failed to differentiate between degrees of perineal tears.

This charge is found NOT proved.

The panel noted that the evidence in support of this charge came from the witness statement of Ms 2. In her statement she states that Mrs Howard was unable to differentiate between degrees of perineal tears, and that this concern had been raised in the mentor feedback sheets dated 25 September 2018 and 11 October 2018.

The panel also had available to it the mentor feedback sheet, dated 25 September 2018. On this document, Mrs Howard had recorded the "Challenges of the day" as *'Inspecting a perineal tear that was difficult to classify'.* In the feedback section Mrs Howard's mentor had written *'be sure you know facts, i.e. when assessing a perineal tear we need to grade it (1st 2nd 3rd) and escalate if needed'.*

The panel considered that the mentor feedback sheet, from which Ms 2 had drawn her conclusions about Mrs Howard's practice, was not conclusive. While it implied that grading that patient's perineal tear was challenging, the panel was not satisfied that this was evidence that on 25 September 2018 Mrs Howard had failed to differentiate between degrees of perineal tears.

Accordingly, charge 3 is found not proved.

Charge 4

4) On the 25th September 2018 failed to independently suggest the most appropriate course of action for third stage of labour.

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 2. In her statement she states that concerns were raised regarding Mrs Howard's ability to undertake the third stage of labour in her mentor feedback form from 25 September 2018.

The panel also had available to it the mentor feedback sheet, dated 25 September 2018. On this feedback form, Mrs Howard's mentor has written *'need to think ahead – active 3rd stage if bleeding noted at or before delivery is probably preferable to physiological…..problem solve – if placenta not delivering – why? Discuss options more clearly with woman'.* In the Trust's 'capability performance management statement of case' report it is reported that, on 25 September 2018, the patient in question was experiencing heavier blood loss than was to be expected and therefore Mrs Howard should have recommended an active third stage, but she failed to react promptly or appropriately.

Taking this evidence into account, the panel was satisfied on the balance of probabilities that on 25 September 2018 Mrs Howard failed to independently suggest the most appropriate course of action for the third stage of labour.

Accordingly, charge 4 is found proved.

Charge 5

5) On the 2nd October 2018 failed to ensure tasks and documents were completed and a full history was given during handover.

This charge is found NOT proved.

The panel noted that the evidence in support of this charge came from the witness statement of Ms 2. In her statement she states that on 2 October 2018 Mrs Howard's

mentor recorded that Mrs Howard needed to ensure that tasks and documentation were completed and that a full history is given during handover.

The panel also had a copy of the relevant mentor feedback sheet, dated 2 October 2018. Under the "challenges" section reference is made to documentation, handover and task completion but the mentor has also recorded *'Good documentation with a clear plan of care. Vaginal assessment accurate with the correct management plan. Cannulation good and achieved first time. Spent time with the woman and her partner and built up a good relationship. Much more positive attitude today.'*

The panel considered that the references to documentation and hand over on the relevant mentor sheet suggested that Mrs Howard had satisfactorily completed documentation and handover, and therefore did not support the allegation that there was a failure in this regard. The panel was not satisfied that this evidence, from which Ms 2 had drawn her conclusions, was sufficient to prove on the balance of probabilities that on 2 October 2018 Mrs Howard failed to ensure that tasks and documents were completed and that a full history was given during handover.

Accordingly, charge 5 is found not proved.

Charge 6

6) On the 11th October 2018 failed to differentiate between degrees of perineal tears.

This charge is found NOT proved.

The panel noted that, as with charge 3, the evidence in support of this charge came from the witness statement of Ms 2. In her statement she states that Mrs Howard was unable to differentiate between degrees of perineal tears, and that this concern had been raised in the mentor feedback sheets dated 25 September 2018 and 11 October 2018.

The panel also had available to it the mentor feedback sheet, dated 11 October 2018. On this document, Mrs Howard had recorded the "positive aspects" of the day as *'correctly assessed 3º tear – clarified with ward sister and Snr Midwife'* and the "challenges" as *'Being told by Registrar that the tear was 2º not 3º. Despite having my assessment clarified'.*

The panel considered that the mentor feedback sheet, from which Ms 2 had drawn her conclusions about Mrs Howard's practice, was not conclusive. While it was evident that the Registrar had disagreed with Mrs Howard's assessment of the tear, the panel noted that she had checked her assessment with her mentor who agreed with her assessment of it as a 3º tear. In these circumstances, the panel was not satisfied that the NMC had produced sufficient evidence to prove that Mrs Howard's assessment of the tear was incorrect or that on 11 October 2018 she was unable to differentiate between degrees of perineal tears.

Accordingly, charge 6 is found not proved.

Charge 7

7) On the 22nd November 2018 prepared incorrect medication.

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 2. In her statement she reports that on 22 November 2018 Mrs Howard was caring for a high risk first time mother, and refers to the mentor feedback form from the shift.

The panel had regard to the relevant mentor feedback, dated 22 November 2018. In the feedback the mentor writes that:

'Claire was required to prepare syntocinon infusion for augmentation of labour. As a community midwife Claire has not been required to do this for some time. I would

expect Claire to prepare the drugs in accordance with the prescription or access the guideline if she did not know the protocol. Claire started preparing the drugs without following these actions. Upon verbal instruction on how to prepare the drugs Claire was unable to do this and drew up too much normal saline and therefore diluted her syntocinon infusion. Best practice would have been to draw up the normal saline first, ensuring that 50mls was obtained and then draw up the 5IU syntocinon.'

The panel considered that the mentor's feedback was clear and detailed and explicitly set out how Mrs Howard had incorrectly prepared the medication. The panel was therefore satisfied that, on the balance of probabilities, on 22 November 2018 Mrs Howard prepared incorrect medication.

Accordingly, charge 7 is found proved.

Charge 8

8) On the 22nd November 2018 required prompting to administer medication.

This charge is found proved.

The panel noted that the evidence for this charge also came from the feedback from Mrs Howard's mentor on 22 November 2018. In her feedback the mentor writes: *'The patient required drugs on occasions throughout the day i.e. ranitidine 150 mg PO every 4 hours and intravenous antibiotics every 4 hours. Claire required prompts to administer medications at the right time.'*

The panel considered that the mentor's feedback was clear and detailed. The panel was therefore satisfied that, on the balance of probabilities, on 22 November 2018 Mrs Howard required prompting to administer medication.

Accordingly, charge 8 is found proved.

Charge 9

9) On the 22nd November 2018 completed an e-learning package in a patient's room.

This charge is found proved.

The panel noted that the evidence for this charge also comes from the feedback from Mrs Howard's mentor on 22 November 2018. In her feedback the mentor writes:

'I did not address this with Claire at the time but I did notice Claire using the computer in the patient's room to complete her RCOG e-learning. This seemed inappropriate and demonstrated incorrect prioritisation. Initially I thought this was a one off case in preparation for tomorrow's study day but Claire did proceed to continue with the e-learning far longer than anticipated. I had used the computer to commence E3 in real time therefore maybe Claire misconstrued the accepted use of a computer in the patient's room.'

Based on this evidence the panel was satisfied that, on the balance of probabilities, on 22 November 2018 Mrs Howard completed an e-learning package in a patient's room.

Accordingly, charge 9 is found proved.

Charge 10

10) On the 22nd November 2018 failed to provide assurances to the patient.

This charge is found NOT proved.

The panel noted that the evidence in support of this charge came from the feedback from Mrs Howard's mentor on 22 November 2018. In her feedback the mentor writes that:

'The patient required reassurances throughout the day and asked questions like:-

‘is my baby’s heart beat okay?’

‘what is the recovery like for a caesarean section?’

Claire did not appear to take the lead in answering the patient’s questions and so I stepped in as the patient was requiring a lot of reassurances, as expected.’

The panel noted that the mentor reported that Mrs Howard ‘didn’t appear to take the lead’ in answering the patient’s questions. However, it considered that this was different from failing to provide assurances. The panel had no evidence about the dynamic between Mrs Howard and her mentor, or who had primary responsibility for the patient. The panel was of the view that the evidence in support of this charge was weak and insufficient to prove, on the balance of probabilities, that on 22 November 2018 Mrs Howard had failed to provide assurances to the patient.

Accordingly, charge 10 is found not proved.

Charge 11

11) On the 6th December 2018 failed to devise appropriate care plan for a patient.

This charge is found proved.

In reaching this decision the panel had regard to the mentor feedback form, dated 6 December 2018 and the PMA discussion form, dated 7 December 2018.

On the mentor feedback form Mrs Howard’s mentor has documented that Mrs Howard *‘made a plan and explained this to the woman well’.* However, further details are given on the PMA discussion sheet, dated 7 December 2018. Here it is documented that *‘Claire has produced a good plan of care for a low risk woman in the latent phase of labour. [The patient] however was not low risk and had significant risk factors in her*

history which are well documented in the hand held notes and on E3. Unfortunately these risk factors have not been acknowledged nor reflected in the care plan'.

From the evidence, it appeared that although Mrs Howard had formulated an appropriate care plan for a low risk woman, she had failed to identify a number of risk factors for her patient, which meant that the care plan was inappropriate for that individual. The panel was therefore satisfied, on the balance of probabilities, that on 6 December 2018 Mrs Howard failed to devise an appropriate care plan for a patient.

Accordingly, charge 11 is found proved.

Charge 12

12) On the 19th December 2018 required prompts from a mentor to undertake auscultation of foetal heart at appropriate interventions.

This charge is found NOT proved.

In reaching this decision the panel had regard to a handwritten feedback sheet regarding an observation that took place on the 19 December 2018. This feedback sheet stated: *'I felt the need to ask her [Mrs Howard] on 2 occasions of she was due to auscultate'.* The panel considered that this evidence was vague and that asking if Mrs Howard was due to auscultate the fetal heart did not necessarily amount to "prompting".

In her witness statement, Ms 2 referred to a PMA discussion with Mrs Howard regarding this incident on 19 December 2018. However, the latest PMA sheet before the panel was dated 17 December 2018, some two days prior to this alleged incident, and does not refer to auscultating a fetal heart. The panel noted that Mrs Howard's action plan refers to Mrs Howard requiring *'numerous prompts from her mentor to undertake auscultation at appropriate intervals in the first and second stage of labour'.* However, the panel had no evidence before it of 'numerous prompts' being made. The only direct evidence the panel had in relation to auscultating the fetal heart was the feedback from

Mrs Howard's mentor which, for the reasons set out above, the panel was not satisfied was sufficient to prove the charge.

The panel was therefore not satisfied that, on the balance of probabilities, on 19 December 2018 Mrs Howard required prompts from a mentor to undertake auscultation of foetal heart at appropriate interventions.

Accordingly, charge 12 is found not proved.

Decision on misconduct

When determining whether charges 1 and 2 amounted to misconduct the panel had regard to the terms of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code). It accepted the advice of the legal assessor who referred the panel to *Roylance v GMC (No 2)* [2000] 1 A.C. 311 and *Nandi v GMC* [2004] EWHC 2317 (Admin).

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 Mrs Howard's actions in respect of charges 1 and 2 did fall significantly short of the standards expected of a registered midwife, and that her actions amounted to a breach of the Code. Specifically:

> ***10 Keep clear and accurate records relevant to your practice***
> *This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.*
> *To achieve this, you must:*
> *10.3 complete all records accurately and without any falsification…*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times…

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it bore in mind that honesty and integrity are the bedrocks of the nursing and midwifery professions, and that inaccurate observations can have serious implications for patient care and safety. The panel considered that Mrs Howard's actions, namely dishonestly falsifying a patient's observations, fell seriously short of the standards expected of a registered midwife and would be viewed as deplorable by fellow members of the profession. Her actions not only put her patient at risk of harm but also have the potential to severely undermine the reputation of the midwifery profession.

Accordingly, the panel was satisfied that charges 1 and 2 amounted to misconduct.

Decision on lack of competence

The panel then moved on to consider whether charges 4, 7, 8, 9 and 11 amounted to a lack of competence. The panel accepted the advice of the legal assessor, who referred the panel to the NMC's guidance regarding lack of competence, derived from the case of *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin):

'…Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse or midwife.

Substandard care that calls into question a nurse or midwife's competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of the nurse or midwife's work, which could put patients at risk, . For instance when a nurse or midwife demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'

The legal assessor further advised the panel that it should judge Mrs Howard's competence by the standards of the role she was in at the time, namely a band 6 midwife, as per *Holton v GMC* [2006] EWHC 2960.

The panel, in reaching its decision, had regard to the public interest and accepted that there is no burden or standard of proof at this stage and exercised its own professional judgement. It bore in mind that Mrs Howard should be judged by the standards of the reasonable average band 6 registered midwife and not by any higher or more demanding standard.

The panel considered each of the charges in turn:

Charge 4 – failed to independently suggest the most appropriate course of action for the third stage of labour

The panel had regard to the evidence before it. It was of the view that a reasonably competent band 6 midwife should be able to manage the third stage of labour. Mrs Howard had demonstrated a basic lack of understanding in this regard. The panel considered that this was an unacceptably low standard of professional conduct and amounted to a lack of competence.

Charge 7 – prepared incorrect medication

The panel had regard to the evidence before it. It was of the view that a reasonably competent band 6 midwife should have an understanding of how to prepare and administer syntocinon, and understand the implications and dangers of administering an incorrect dose. Mrs Howard was unable to prepare the medication in accordance with the prescription and continued to make mistakes despite instructions and guidance from her mentor. The panel considered that this was an unacceptably low standard of professional conduct and amounted to a lack of competence.

Charge 8 – required prompting to administer medication

The panel had regard to the evidence before it. It noted that the patient in question had required ranitidine and intravenous antibiotics every four hours. However, Mrs Howard had to be prompted to do this. It considered that a reasonably competent band 6 midwife should be able to administer drugs at the correct times, without prompting, and that Mrs Howard's failure to do so represented an unacceptably low standard of professional conduct which amounted to a lack of competence.

Charge 9 – completing an eLearning package in a patient's room

The panel considered that completing an eLearning package in a patient's room could be inappropriate and unprofessional. However, it had no evidence regarding how long Mrs Howard was on the computer for, nor any evidence that this interfered with her ability to care for her patient. In these circumstances, the panel was not satisfied that charge 9 amounted to a lack of competence.

Charge 11 – failed to devise an appropriate care plan for a patient

The panel noted that, in this charge, Mrs Howard had failed to complete a holistic assessment of her patient and therefore failed to identify risk factors and incorrectly assessed her as low risk. The care plan that she subsequently devised was therefore inappropriate. The panel considered that appropriate care planning, having regard to a patient's risk factors, was a fundamental midwifery skill and one which a reasonably competent band 6 midwife should be capable of. The panel considered that Mrs

Howard's failings in this regard demonstrated an unacceptably low standard of professional conduct and amounted to a lack of competence.

The panel bore in mind the guidance that a single clinical mistake or error will not generally indicate a lack of competence. However, the panel considered that charges 4, 7, 8 and 11 represented a series of failings in a range of basic midwifery skills which a reasonably competent band 6 midwife should be able to perform.

Furthermore, Mrs Howard's failings occurred during a time when Mrs Howard had the benefit of additional support from her employer, specifically designed to address and improve her standard of performance in these areas. However, despite this additional and specific support, Mrs Howard's performance did not improve and, in January 2019, she was dismissed following a capability performance hearing.

Having regard to all of the above, the panel concluded that Mrs Howard's practice fell significantly below the standard expected of a reasonably competent band 6 midwife. In all the circumstances, the panel determined that Mrs Howard's performance in respect of charges 4, 7, 8 and 11 demonstrated a lack of competence.

Decision on impairment

The panel next went on to decide if, as a result of this misconduct and/or lack of competence, Mrs Howard's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined it as a registrant's suitability to remain on the register unrestricted. The panel accepted the advice of the legal assessor, which included reference to the cases of *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

The panel first considered the test adopted by Mrs Justice Cox in the case of *Grant* at paragraph 76:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

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

The panel found that Mrs Howard's misconduct had breached all four limbs of the *Grant* test. By falsifying patient observations she placed her patient at unwarranted risk of harm, brought the profession into disrepute, breached fundamental tenets of the nursing profession, and acted dishonestly.

The panel considered that Mrs Howard's misconduct was capable of being remediated, although it noted that dishonesty is more difficult to remedy. It noted that Mrs Howard fully accepted her dishonesty during the internal proceedings at the Trust. However, she has not engaged with these NMC proceedings. The panel therefore has no evidence of any further insight Mrs Howard may have developed into her dishonesty, nor any steps that she may have taken to remediate her misconduct.

In the absence of any evidence of insight or remediation into her misconduct, the panel concluded that Mrs Howard remains liable to repeat similar misconduct in the future, which could leave patients and the public exposed to a risk of harm.

With regards to Mrs Howard's lack of competence, the panel determined that this also breached limbs (a), (b) and (c) of *Grant.* The panel considered that Mrs Howard's lack of competence would be capable of remediation through retraining, support and learning. However, it noted that despite being subject to an action plan and receiving significant support and supervision, the deficiencies in Mrs Howard's practice persisted. The panel has no evidence from Mrs Howard to suggest that she has taken any steps to improve her competence and attain the required standard of performance since leaving the Trust in January 2019.

In the absence of any evidence of insight or remediation of either Mrs Howard's misconduct or lack of competence, the panel concluded that there remains a significant risk of repetition if Mrs Howard were allowed to practise unrestricted. This would leave her patients exposed to a risk of harm. The panel therefore determined that a finding of current impairment was required on public protection grounds.

The panel also 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 and protect the wider public interest. This includes promoting and maintaining public confidence in the midwifery profession and upholding the proper professional standards for members of that profession. The panel determined that Mrs Howard's dishonesty and her lack of competence both had the potential to undermine public confidence and trust in the midwifery profession. The panel also considered that the public would expect a regulator to take action in a case where a midwife had acted dishonestly and failed to demonstrate the standards of knowledge, skill or judgement required for safe and effective practice. The panel therefore determined that a finding of current impairment on public interest grounds was also required to maintain proper professional standards and public confidence in the profession.

Having regard to all of the above, the panel was satisfied that Mrs Howard's fitness to practise is currently impaired.

Determination on sanction

The panel considered this case and decided to make a 12 month suspension order, to be reviewed before its expiry.

In reaching this decision, the panel had regard to all the evidence that it had read in this case, as well as the Sanctions Guidance published by the NMC. The panel accepted the advice of the legal assessor and bore 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 noted that the NMC had proposed that a 12 month suspension order would be the appropriate and proportionate sanction. However, the panel reminded itself that the decision on sanction was a matter for the panel, exercising its own independent judgement.

The panel considered that the mitigating factors in this case were:

- Mrs Howard made full admissions to her dishonesty at a local level;
- There is no evidence of actual patient harm as a result of either her misconduct or lack of competence;
- There is some evidence that Mrs Howard was experiencing difficult personal circumstances at the time (although the panel had little information about the details of these circumstances, nor the specific effect they had on her ability to work).

The panel could identify no aggravating factors.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition identified. Taking no further action would not restrict Mrs Howard's practice and would therefore be insufficient to protect the public. The panel also decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order but decided that this would be inappropriate for the same reasons, as a caution order would not restrict Mrs Howard's practice.

The panel then moved on to consider a conditions of practice order. It was of the view that conditions could be formulated to address the specific deficiencies in Mrs Howard's competence. However, it recognised that Mrs Howard has already been subject an action plan and significant additional support, which did not produce the required level of improvement. The panel was therefore not reassured that any conditions it imposed would necessarily protect the public or produce any improvement in Mrs Howard's competence. The panel also decided that, in absence of any engagement from Mrs Howard, a conditions of practice order would not be workable. The panel further determined that a conditions of practice order would be insufficient to address the public interest concerns arising out of Mrs Howard's dishonesty. For all of these reasons, the panel concluded that a conditions of practice order would not be proportionate or appropriate.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The Sanctions Guidance indicates that a suspension order may be appropriate where some of the following factors are apparent:

- *'a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*

- *the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*
- *…*
- *in cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions'*

The panel had already decided that a conditions of practice order would not be sufficient to protect the public, given the concerns about Mrs Howard's competence, her lack of improvement while subject to the Trust's action plan, and her lack of engagement with these proceedings. A suspension order was therefore required to protect the public from the risk of harm posed by Mrs Howard's practice. It would also give Mrs Howard an opportunity to engage with these proceedings, reflect on her practice, and seek the necessary support to remedy her failings.

The panel was also of the view that a suspension order would serve to mark the seriousness of Mrs Howard's dishonesty.

The panel considered whether Mrs Howard's misconduct was so serious as to warrant a striking-off order. It bore in mind that any dishonesty by a nurse or midwife will always be viewed as serious. However, having regard to the NMC's Sanctions Guidance and its guidance regarding dishonesty, the panel concluded that a striking-off order would be disproportionate in this case. As Mrs Howard's dishonesty was an isolated instance of misconduct, which she admitted to at a local level, the panel was satisfied that a suspension order would be sufficient to uphold the public interest in this case.

The panel noted that, at this time, a striking-off order was not an available sanction in relation to the lack of competence charges.

For these reasons, the panel decided that a suspension order was the appropriate and proportionate sanction in this case, which would protect the public and uphold the public interest.

The panel considered that a 12 month suspension 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.

The panel directs that this order should be reviewed before its expiry. At the review, the panel may revoke the order, or it may confirm the order, or it may replace the order with another order. Any future panel may be assisted by:

- Mrs Howard's engagement with the NMC;
- Her attendance at the hearing;
- A reflective piece demonstrating insight into her failings and how she proposes to address them;
- Information regarding how Mrs Howard has kept her midwifery skills and knowledge up-to-date.

Determination on interim order

Having determined that a suspension order was the appropriate and proportionate sanction, the panel considered whether to impose an interim order to cover the appeal period.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order was necessary for the protection of the public and was 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 suspension order 28 days after Mrs Howard is sent the decision of this hearing in writing.

That concludes this determination.