Nursing and Midwifery Council

Voluntary Removal Decision

5 July 2021

Registrant: Victoria Lund

PIN: 01U1276E

Part(s) of the register: Registered Midwife
Midwifery

Area of Registered Address: England

Type of case: Misconduct

REGISTRAR'S DECISION

A decision has been made by the Registrar to approve the application for voluntary removal based on the assessment of the relevant criteria. The reasons for the decision to grant voluntary removal from the Register are below.

Details of charge

That you, a registered midwife:

1 In relation to Baby C, on 6 June 2016:
(a) failed to check the details of an electronic name band with a second member of staff or the baby's mother

(b) failed to check the details of an electronic name band against patient notes

(c) applied a name band bearing the incorrect surname to newborn Baby C

2 In relation to Patient D, on 4 April 2018 allowed a student midwife to:
(a) prepare medication for Patient D without supervision

(b) administer medication to a Patient D without supervision

3 In relation to postnatal Patient A, on 12 August 2018:
(a) failed to check Patient A's discharge prescription against the medication kardex

(b) failed to record discharge information regarding
i. the medication prescribed

ii. the dose of the medication prescribed
iii. the duration of the medication prescribed

(c) failed to check the details of the medication being provided to the patient

(d) discharged the patient with the incorrect dose of Tinzaparin

4 In relation to Patient B, on 25 September 2018, administered a third dose of Prostin without seeking and/or securing a medical review.

REGISTRAR'S REASONS

The following documents were considered when assessing this voluntary removal application:

- Voluntary removal application form
- Draft charge
- Response from the maker of the allegation dated 15 June 2021
- Reflective Statement from Registrant dated 4 June 2021
- Case Examiners' decision letter dated 17 November 2020
- Case Examiners' decision letter dated 11 January 2021
- Evidence bundle

Background

Victoria Lund has made an application to remove her name from the Nursing and Midwifery register through our voluntary removal process. She is currently waiting for the concerns raised about her practice to be considered by the Fitness to Practise Committee.

Concerns were raised by the Director of Nursing at North Tees and Hartlepool NHS Foundation Trust (the Trust) on 18 December 2018. The background to the allegations are:

Victoria Lund was working at University Hospital of North Tees (the Hospital) at the time of the incidents. She had been employed as a midwife at the Trust since 2004.

On 6 June 2016 Victoria Lund put a name band containing incorrect details on to newborn Baby C. The name band listed an incorrect surname. The Trust investigated the incident and found that Victoria Lund hadn't carried out the required checks when putting the band on the newborn. Although she had checked the name on the temporary handwritten label, she didn't conduct the check again when changing it for the printed label. The outcome was a verbal warning, to be held on file for 6 months.

On 4 April 2018 Victoria Lund was working on the prenatal and postnatal ward and allowed a student midwife to prepare and administer pain relief to a patient without direct supervision. This was against Trust guidance and NMC standards for medication management at the time. Following an investigation Victoria Lund was given a final written warning, which would be held on file for 12 months.

Victoria Lund also had to undertake a medication management assessment, which she successfully completed in June 2018.

On 12 August 2018 Victoria Lund discharged a postnatal patient with the incorrect prescription for Tinzaparin. Tinzaparin is an anticoagulant and is used to help prevent blood clots following surgery. Patient A was a young woman who had an emergency caesarean section on 6 August 2018. There were some factors that meant she was at risk of developing blood clots, so was initially prescribed 4500u Tinzaparin injections for ten days postpartum.

Patient A developed an infection and this further increased her risk of thromboembolism. Her prescription was then changed to 7000u to be taken for six weeks. The pharmacy issued both prescriptions to the ward, but told them that the earlier prescription should be returned. This didn't happen and Victoria Lund discharged Patient A with the lower dose of 4500u Tinzaparin, having not checked the medication against the discharge prescription and inpatient kardex.

Patient A attended Accident and Emergency on 17 August 2018 and was diagnosed with pneumonia. She was treated accordingly and discharged. Sadly, on 29 August 2018 she then collapsed at her home and could not be revived. She is thought to have developed a pulmonary embolism. Her death was investigated by the Trust as a serious incident and the error Victoria Lund made with the Tinzaparin was discovered.

On 25 September 2018 Victoria Lund administered Patient B a third dose of Prostin medication within 24 hours of the first dose. Prostin is a medication used to induce labour. This was done in line with the prescription that the doctor had given. However, NICE guidance is that only two doses should be given within 24 hours.

The medication administration concerns on 12 August and 25 September were investigated by the Trust. The Trust's disciplinary panel considered that there were factors that had contributed to the error that occurred on 12 August. This included the system for returning unused medication to the pharmacy which left staff vulnerable to making the type of error that Victoria Lund had made. However, ultimately they considered that Victoria Lund should have carried out the relevant medication discharge checks.

The panel also found that the Trust guidelines on administering Prostin were not clear when a third dose should be given. In light of the fact there was no breach to Trust guidelines this incident was not formally considered as part of the disciplinary outcome.

The panel took in to account that Victoria Lund was still subject to the final written warning following the incident on 4 April 2018. On 2 April 2019 Victoria Lund was dismissed from her employment due to failing to follow the Safe and Secure handling of Medications Policy.

On 11 January 2021 the Case Examiners referred the concerns to the Fitness to Practise Committee because of the public protection risk.

Public interest considerations

Victoria Lund has consistently admitted the allegations. A number of the witnesses involved in investigating the errors commented that Victoria Lund admitted the errors from the outset and took responsibility for her actions. After allowing the student nurse to administer medication without direct supervision she self-reported the incident to her manager.

In her voluntary removal form dated 1 June 2021 Victoria Lund formally admitted to the charges.

Victoria Lund is no longer practising as a midwife following her dismissal from the Trust. As such there would be a risk to the public as she has not been able to show she can practise safely and effectively. Voluntary removal would mean that Victoria Lund would be immediately removed from the register and would not be able to work as a midwife. This would remove the risk to the public. However, the public interest also needs to be considered.

Our guidance explains that the seriousness of the concerns will be a key factor in considering whether voluntary removal is suitable or whether we need to take further action in the public interest. In cases about clinical practice this is likely to only be needed where the concerns are so serious that they can't be put right.

Certain concerns are more difficult to put right and mean that we are more likely to need to take action. This may include causing deliberate harm to patients or breaching the professional duty of candour when something has gone wrong. In such cases the misconduct may be so serious that it's fundamentally incompatible with being a registered professional.

The concerns in this case relate to Victoria Lund failing to carry out the appropriate checks for a newborn identity tag and when carrying out a discharge prescription process. Further errors were made in not following the necessary guidance in allowing a student midwife to prepare and administer medication and administering medication without a medical review. Although are a number of incidents, they are confined to a two year period during Victoria Lund's 15 year career as a midwife. The clinical failings and her reflections don't suggest there is an underlying issue with her attitude towards people in her care; following each incident Victoria Lund cooperated with the investigations and worked with her employer to improve her practice. The clinical failings are capable of remediation, but Victoria Lund has chosen not to continue practising because of the impact these events have had on her confidence to work as a midwife.

Sadly a young woman died after being discharged with a lower dose prescription of Tinzaparin than she should have been given. We take it extremely seriously when patients suffer harm and recognise that past actions which lead to death or serious injury could undermine the reputation of nurses, midwives or nursing associates. However, we need to balance this with our need to help keep patients safe by avoiding a culture of blame or cover up.

Whilst not underestimating the impact the young woman's death will have had on her family, her death does not mean that voluntary removal is an unsuitable outcome in this case.

Our guidance explains that our role is not to punish people on our register for making genuine clinical mistakes if there is no longer a risk to patient safety and they have been open about what went wrong and demonstrate they have learned from it. The death or serious injury of a patient would usually only make a case more serious where the nurse, midwife or nursing associate deliberately chose to take an unreasonable risk with the safety of the patient.

In this case Victoria Lund made a clinical mistake and didn't follow the Trust policy for checking medication on patient discharge or fully record the discharge information. However, I've also taken into account the systemic factors that contributed to the incident. The system in place for returning unused prescriptions to the pharmacy meant the old prescription of 4500u Tinzaparin was available for Victoria Lund to incorrectly pick up. There's no evidence to suggest she deliberately chose to cause harm to Patient A or take an unreasonable risk, but that she picked up the old prescription in error. In her reflective piece Victoria Lund clearly shows significant remorse for what happened and for the errors she made. Whilst she hasn't remediated her failings, this is because she has chosen not to continue practising, not because the concerns are not capable of remediation

It is clear that Victoria Lund cooperated with the investigations that the Trust carried out and has been open and honest about her failings. She sought to learn from these errors, including by completing the medication administration course in 2018. She has reflected on the incidents and what she should have done. She has shown insight into what happened. She sets out in her reflective statement what she should have done on these occasions and what went wrong. She also says:

> *"I have been able to help and support many couples in their journey to parenthood, these mistakes have undone all this good. I did harm, I take full responsibility for this. I hope you can see that this standard of care is not my norm and how deeply I feel about my failures."*

These allegations are not so serious to be fundamentally incompatible with being on the Nursing and Midwifery register. Having considered the sanctions guidance and Victoria Lund's reflection and insight in to her errors, I consider it unlikely that a Fitness to Practise Committee will impose a striking off order. The allegations aren't so serious that the public interest requires voluntary removal to be rejected in this case.

Victoria Lund has said that she currently works as a therapist and hypnotherapist and has no intention to return to midwifery practice. She's provided information about her current work and says that it allows her to still have a positive effect on others' lives. She has been consistent in her stated intention that she does not want to return to midwifery practice since her dismissal from the Trust. In her reflective statement she says that:

> *"I will never forgive myself for the mistake I made and leaving midwifery was the correct and moral decision for me."*

She has also signed a declaration that she will not make an application to return to the register for at least five years.

Victoria Lund's employer, the maker of the allegation, was contacted for their views on her application to voluntarily remove herself from the register. They have no objections to voluntary removal.

Registrar's decision

I've decided to grant Victoria Lund's application for voluntary removal from the register. The concerns don't involve the type of conduct that is fundamentally incompatible with being on the register. I consider that the public interest is met by the publishing of this decision and by the immediate removal of Victoria Lund from the register.