Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 26 April 2022 – Thursday 28 April 2022

Virtual Hearing

Name of registrant:	**Suzanne Andrea Millar**
NMC PIN:	96Y0050E
Part(s) of the register:	Registered Midwife – October 1999 Registered Nurse – Sub Part 1 Adult Nursing – November 2018 Registered Specialist Community Public Health Nurse – July 2004 Community Practitioner Nurse Prescriber – July 2004 Nurse Independent/Supplementary Prescriber – October 2010
Area of registered address:	Middlesex
Type of case:	Misconduct
Panel members:	John Penhale (Chair, Lay member) Carol Porteous (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Vanya Headley, Case Presenter
Ms Millar:	Present and represented by James Lloyd, Counsel instructed by Thompsons Solicitors

Facts proved by admission:	Charges 1a), b), c)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered midwife:

1. On 15 January 2017 between 16:00 hours and 20:30 hours, whilst caring for Patient A:

    a. failed to identify a deterioration in Patient A's Cardiotocography recording;

    b. failed to escalate to colleagues changes in Patient A's Cardiotocography recording;

    c. failed to document the changes in Patient A's Cardiotocography recording;

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

Background

You are a Registered Midwife, who qualified on 10 October 1999 and entered the NMC's register on 11 October 1999. On 1 July 2004 you qualified as a Specialist Community Public Health and Nurse and a Community Practitioner Nurse Prescriber. On 7 October 2010 you qualified as an Independent / Supplementary Prescriber. You became a Registered Adult Nurse on 20 November 2018.

On 21 December 2018, the NMC received a referral from London North West University Healthcare NHS Trust (the Trust) in relation to your fitness to practise. At the time of the concerns raised you were working as a Bank Band 7 Midwife at Northwick Park Hospital (the Hospital). You were employed at the Hospital from February 2005 until September 2018.

On 14 January 2017 at 17:02, Patient A was admitted in her first pregnancy at 40 weeks plus gestation to the Hospital with a history of Spontaneous Rupture of Membrane (SROM) meconium stained liquor was also noted at admission. Patient A was admitted in triage and then transferred to a room and her induction of labour commenced.

It is alleged that on 15 January 2017 at 16:00 you took over Patient A's care. From that point of handover, you did not inform the Delivery Suite Coordinator of any changes of Patient A's Cardiotocography (CTG). You failed to interpret Patient A's CTG appropriately and did not escalate the abnormalities it was showing. A check was carried out at 17:40, and no abnormalities were reported. You handed over Patient A's care to another midwife at 20:30 who immediately recognised the abnormal CTG recording and escalated Patient A's care to the medical Team. Patient A was taken for an emergency caesarean section. Baby A was born in poor condition and subsequently passed away on 24 January 2017.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Lloyd, on your behalf, who informed the panel that you made full admissions to charge 1a), b) and c).

The panel was provided with an agreed statement of facts which was agreed between you and the NMC. The statement of facts is as follows:

'***Preliminary***

1. *The Nursing and Midwifery Council ("the NMC") and Ms Suzanne Andrea Millar ("the Registrant"), PIN 96Y0050E, ("the Parties") agree as follows:*

The Charges

The Registrant admits the following charges: -

That you, a registered nurse and midwife:

1. *On 15 January 2017 between 16:00 hours and 20:30 hours, whilst caring for Patient A:*
    - *(a) Failed to identify a deterioration in Patient A's Cardiotocography recording;*
    - *(b) Failed to escalate to colleagues changes in Patient A's Cardiotocography recording;*

(c) *Failed to document the changes in Patient A's Cardiotocography recording;*

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

Background

2. *The Registrant is a Registered Midwife, who qualified on 10 October 1999 and entered the NMC's register of nurse and midwives, which now also includes nursing associates on 11 October 1999. On 1 July 2004 she qualified as a Specialist Community Public Health and Nurse and a Community Practitioner Nurse Prescriber. On 7 October 2010 she qualified as an Independent / Supplementary Prescriber. The Registrant became a Registered Adult Nurse on 20 November 2018.*
3. *On 21 December 2018, the NMC received a referral from London North West University Healthcare NHS Trust ("the Trust") in relation to the Registrant's fitness to practise.*
4. *At the time of the concerns raised in the referral, the Registrant was working as a Bank Band 7 Midwife at Northwick Park Hospital ("the Hospital"). She was employed at the Hospital from February 2005 until September 2018.*

Factual Background to the Charges

5. *On 14 January 2017 at 17:02, Patient A was admitted to the Hospital with a history of Spontaneous Rupture of Membrane ("SROM"). Patient A was admitted in triage and then transferred to a room and her induction commenced.*
6. *The Registrant took over Patient A's care on 15 January 2017 at 16:00. From that point of handover, the Registrant did not inform the Delivery Suite Coordinator of any changes of Patient A's CTG. The Registrant failed to interpret Patient A's Cardiotocography ("CTG") appropriately and did not escalate the abnormalities it was showing. A check was carried out at 17:40, and no abnormalities were reported.*

7. *By reading the CTG, you are able to tell if a baby is distressed or in a hypoxic state and if the CTG is not escalated it can have damaging effects on the baby.*
8. *The Registrant handed over Patient A's care to another midwife at 20:30. This midwife immediately recognised the abnormal CTG recording and escalated Patient A's care to the medical team. Patient A was taken for an emergency caesarean section. Baby A was born in poor condition and subsequently passed away on 24 January 2017.*
9. [Midwife 1]*, Delivery Suite Coordinator, states at paragraph 7 of her NMC witness statement that the Registrant began providing care for Patient A at 16:00 on 15 January 2017. 9. [Midwife 1] states that they were the lead midwife on shift on 15 January 2017.* [Midwife 1] *states that throughout the Registrant's care to Patient A, the Registrant did not inform them that there were any changes to the CTG recording, even though it was the Registrant's duty to do so.* [Midwife 1] *states that the CTG recording was showing that the baby was very distressed and that the Registrant should have escalated any concerns regarding the CTG.* [Midwife 1] *also states at paragraph 8 that the Registrant did not get the CTG reviewed hourly as per policy.*
10. [Midwife 1] *continues to state at paragraphs 9-13 that Patient A was reviewed by the Registrar at 17:40 due to her state and she was fully dilated. The Registrar spoke to the consultant and the plan was to leave Patient A for one hour without pushing in order for the baby's head to descend and then to commence pushing.* [Midwife 1] *states that there were a number of emergencies happening on Delivery Suite so they could not keep a close eye on Patient A's CTG.* [Midwife 1] *states at paragraph 11 that the Registrant did not recognise that the CTG was abnormal and that the Registrant should have pulled the emergency bell to get the attention of the doctors.* [Midwife 1] *states that when the Registrant handed over to the nightshift midwife, they immediately escalated Patient A to the consultant.* [Midwife 1] *states that Patient A was very quickly taken to theatre and a caesarean section was performed.*
11. [Ms 1]*, Divisional Governance Coordinator, states at paragraph 4 of her NMC witness statement that there were concerns about the level of care that Patient*

A received from the Registrant between 16:00 and 20:30. [Ms 1] *also states at paragraph 9 that the Registrant failed to use any judgement in assessing the CTG and did not use any of the set categories to interpret it. The night shift midwife immediately saw that the CTG was abnormal and put into place the actions that needed to be taken.*

12. [Ms 1] *notes in her statement at paragraph 7 that Patient A was reviewed in the morning. However in the afternoon the doctor failed to recognise that the CTG was abnormal and also failed to return to conduct further observations later on in the day. At paragraph 8,* [Ms 1] *states that when the doctor returned he assessed to ensure everything looked normal, but sometimes everything can appear normal from a short observation. She also notes that the coordinator should have checked the mother and the board to see the progress in every room. There was a period of a long gap, therefore they had time to check for at least five minutes but the coordinator expressed that she was too busy.*
13. *[*Ms 1] f*urther notes in her statement, at paragraph 10, that the Registrant did not complete Royal College of Obstetricians and Gynaecologists CTG Masterclass and it was a failure of the organisation to ensure that this happened.*
14. [Midwife 3], *Head of Midwifery, states at paragraph 5 in their NMC witness statement, that recognising and escalating a deteriorating CTG is a general skill and a basic standard of care expected from a midwife and that throughout all of the Registrant's training and experience as a midwife, would have been aware of this. The Registrant would have been aware of this through her training as a midwife and set out in the Care of Women in Labour Guideline (Exhibit SK/02) and Maternity Safer Staffing and Escalation Guideline (Exhibit SK/03).*
15. [Midwife 2]*, Registered Midwife, states at paragraph 5 in their NMC witness statement that they were caring for Patient A prior to the Registrant.* [Midwife 2] *states at paragraph 15 that Patient A's CTG was overall normal when they handed over the care to the Registrant at 16:00.*
16. *Between 17:40 and 20:30, when the Registrant handed over to the night shift midwife, there was a two hour and 50 minute time period where the evidence*

could suggest that the Registrant should have recognised the abnormal CTG recording and escalated it.

17. *On 12 June 2017, the Trust completed a Serious Incident Report ("SIR") for the incident on 15 January 2017. The SIR (Exhibit DS/01) shows that several opportunities were missed by the Registrant to identify that the CTG was abnormal.*'

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Ms 1: Divisional Governance Coordinator in the Woman and Children Division at London North West Healthcare NHS Trust;
- Midwife 1: Delivery Suite Coordinator at London North West Health Care;
- Midwife 2: Band 6 Midwife at Northwick Park Hospital;
- Midwife 3: Divisional Head of Midwifery and Gynaecology Nurses at London North West University Health Care NHS Trust.

In the panel's analysis of all the material that had been placed before it at the fact finding stage, the panel identified significant parts of that material in relation to the admitted charges. However, their relevance will be more appropriately engaged at the misconduct and impairment stage.

The panel noted the Serious Incident Investigation Report which identifies that there were things that should have been done differently, missed opportunities, and a lack of senior oversight from an early part of Patient A's admission (some of these failings occurred prior to your involvement with Patient A.).

The panel was satisfied that there was sufficient evidence to support your admissions, this was not withstanding that it was not currently provided with any explanation from you. It is clear from your admissions that you have accepted your failings in this matter.

In light of this, the statement of fact and your admissions to all charges the panel finds charges 1a), b) and c) proved in their entirety, by way of your admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Your evidence

The panel heard from you. You told the panel that you chose to become a midwife because you are passionate about caring for women and children and wanted to help. You kept progressing in your career as you fundamentally believe that midwifery and nursing are your vocation in life and you progressed as jobs arose. You found yourself in positions where you cared for people who do not necessarily get support from mainstream services.

You told the panel about the time leading up to the incident on the 15 January 2017. You explained that you worked very busy shifts and that you barely had a chance to take breaks. You told the panel about an incident which occurred on your previous shift which was a night shift of the 13/14 January 2017 when there was miscommunication about you taking a break at the same time as taking over the care of a patient which resulted in a report being made to the matron. You stated that the matron was of the view that it was a miscommunication, however, after that you felt that you could not communicate to colleagues or the coordinators when you needed a break and were not able to stand up for yourself. You stated that you felt like you were forced to do something that you knew you should not have done, in this case working without having a break.

You explained that on the 15 January you had been on duty since 07:30 and that you were asked to take over the care for Patient A at 16:00. You stated that you were involved continually throughout the day with a patient in room 9. Immediately after finishing with this patient at 16:00 but before you had been able to finish their notes, you were required to take over the care of Patient A. This meant you were not able to take a break and had to finish your notes whilst also caring for Patient A. However, due to the previous incident, you did not feel like you could speak up. You explained that whilst you were caring for Patient A, you were not mentally present. You now recognise that you should not have taken over Patient A's care while feeling this way. You acknowledged that you made a mistake and that you did not give Patient A the best care that was up to the standard expected of a midwife. You explained that the outcome of this is still haunting you to this day.

You explained to the panel what you would now do differently. You told the panel that you recognise triggers and have researched the psychology behind your response to them. You told the panel that you were severely stressed that day, but that you now have the tools to reduce and deal with stress. At the time you did not have the language and were not able to express how you felt. You stated that you have learned to speak up to express your needs, particularly in order to deliver a better service to your patients/clients.

[PRIVATE] how it affected your life but also other things that were going on in your life at the time. You stated that it gave you the opportunity to look at how you felt about what had happened and what you would now do differently. You explained that it gave you access to resources and to reflect on how being treated at work had affected you, how you deal with other staff and patients.

You explained that you are now working in nursing, as the lead working with school nurses, and that you have a managerial role but also deliver training for partners. You stated in managing other nurses, you are very focussed on their mental health and support them in speaking up for themselves and taking breaks when necessary. You learned that by doing so nurses and midwives are able to deliver a service that is up to the standard expected of a registered nurse/midwife. You explained that the experience has shaped and influenced your approach as a manager. You stated that as a lead for school nurses you are mostly dealing with safeguarding and you explained how being equipped with the skills that you have learned is important to deal with such situations.

You told the panel that you had undertaken further training after the incident. You stated that this was mandatory training. However, you no longer have access to the training platform as this was with your previous employer, and are therefore not able to provide the panel with certificates. You explained that you have revalidated your registration twice since the incident.

You explained to the panel that without your PIN you would not be able to continue working in a field that you really enjoy, outside the ‘mainstream’ care working with children

and young people. You explained that whilst you enjoy working with your current team, you would like to eventually go back to midwifery.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Headley invited the panel to take the view that the facts found proved amount 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) in making its decision.

Ms Headley identified the specific, relevant standards where she considered your actions amounted to misconduct. She submitted that your failings on the 15 January 2017 were related to basic midwifery practice and have placed Patient A and Baby A at a serious risk of harm. She submitted that it was a failing in the essential skills of midwifery and a failure to escalate. Ms Headley submitted that the failings were serious and fell far below the standard expected of a registered midwife. She invited the panel to find that the facts found proved by admission amount to misconduct.

Mr Lloyd reminded the panel that you admitted that your failings amounted to misconduct and he submitted that you do not seek to retract from this admission.

Submissions on impairment

Ms Headley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Headley submitted that the first three limbs of *Grant* were engaged. She submitted that your failings put Patient A and Baby A at a real risk of harm, that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Ms Headley submitted that there is a continued risk to the public and invited the panel to find that your fitness to practise is impaired on the ground of public protection.

Ms Headley submitted that your misconduct was remediable through education, training, reflection, insight and supervision. She submitted that you have reflected on your misconduct and that you stated that you have strengthened your practice in the relevant areas. However, she submitted that you have not provided the panel with further evidence regarding training certificates or testimonials from your current employer or work colleagues. She submitted that whilst you reflected on your misconduct, you have not gained full insight into your failings. She therefore submitted that there is a risk of repetition.

Ms Headley also invited the panel to find that your fitness to practise is impaired on the ground of public interests. She submitted that public confidence in the profession and the NMC as a regulator would be undermined if a finding of impairment were not made.

Mr Lloyd submitted that the context of your failings was important to this case. He stated that you have been working as a registered midwife for more than 20 years and that your failings in 2017 were the only regulatory concerns raised in that period. He reminded the panel that this was four hours in a 20-year midwifery career. He also reminded the panel that there was no repetition or escalation of your misconduct since the incident and that the incident was one patient, on one shift. He invited the panel to bear this in mind when considering your current fitness to practise.

Mr Lloyd submitted that you have produced a measured and thoughtful reflective piece that explains your attempts to "*grapple*" and come to terms with the consequences of that shift in 2017. He submitted that you have engaged in the NMC process and were eager to give evidence to the panel. He submitted that you have told the panel how you processed the event and that you can now explain how you felt. Mr Lloyd submitted that there is evidence that you have taken steps to understand what happened, how it happened and how to avoid something like this happening again. He submitted that you demonstrated deep insight and a commitment to learn from your past mistakes.

Mr Lloyd submitted that you have [PRIVATE], opened up and started to address the root causes of your emotional state at the time. He reminded the panel that you had undertaken further reading yourself and that you have developed and progressed since 2017. He submitted that you are now conscious about taking breaks and are assertive when it comes to your needs in order to deliver the best possible care to your patients.

Mr Lloyd submitted that you have a deep seated passion for midwifery and that it was obvious throughout your oral evidence how much you care for your patients. He submitted that you have shown genuine commitment and have done everything you can to address the main issues in this case. He submitted that the events of 2017 are still haunting you to this day and that given your evidence, the risk of repetition is very low.

Mr Lloyd submitted that you expressed a significant degree of remorse, did not seek to blame others and have not sought to rely or hide behind the clinical failings of others. He

submitted that you admitted that you played a part in the events of the 15 January 2017 that you have learned from your failings and have apologised. Mr Lloyd submitted that you take full accountability, have shown genuine remorse and that this played a part in your desire to strengthen your practice.

Mr Lloyd invited the panel to find that the risk of repeating your misconduct is very low in this case and that therefore a finding of impairment is not necessary on the ground of public protection.

Mr Lloyd reminded the panel that you accept that your current fitness to practice is impaired. He acknowledged that in the particular circumstances of the case the public interest needs to be acknowledged. He stated that it is a matter for the panel to determine whether your fitness to practise is impaired on the ground of public interest.

The panel accepted both the oral and written advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered midwife, and that your actions amounted to a breach of the Code.

Specifically:

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your failure to read the CTG led to you not escalating the changes to your colleagues and not documenting them. The panel was of the view that these were failings in basic midwifery skills and elevated the risk of harm to Patient A and Baby A.

When looking at the question of seriousness the panel considered the conclusions of the Serious Incident Investigation Report as compelling evidence as to the seriousness of your failures. The panel noted that there had been several failures in the management of Patient A's labour by the clinical team, such as not appreciating the significance of meconium stained liquor, the management of labour with Prostin rather than Syntocinon, lack of senior oversight and that Baby A was compromised due to an intrauterine infection. However, your particular failure not to recognise and act on a deteriorating CTG contributed to the poor outcome.

The panel found that your actions did fall seriously short of the conduct and standards expected of a midwife and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'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) […]*'*

The panel finds that Patient A and Baby A were put at a real risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that you have shown significant insight into your own state of mind at the time of your misconduct and were able to articulate what the circumstances were, how you felt and what you would now do differently. However, the panel was of the view that you were not able to demonstrate that you have gained insight into the misinterpretation of the CTG which is a basic midwifery skill. The panel was of the view that you were not able to explain why you misread the CTG and failed to recognise that it was deteriorating. The panel was therefore of the view that you have demonstrated only some insight.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel accepted your statement that you have taken further courses, but do no longer have access to these records. The panel was of the view that you were able to identify your personal failings in not speaking up when you needed a break and looking after your own mental health to be able to deliver a high standard of care. It concluded that you have addressed this part of your failings. However, the panel was of the view that there is no evidence before it to demonstrate that you have addressed the failings in your basic midwifery skills and competencies, have undertaken further training in reading CTGs, escalation of concerns and record keeping. It was therefore of the view that you have not yet fully remediated your practice.

Therefore, the panel is of the view that there is a risk of repetition based on the developing insight and the lack of full remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Headley outlined what the NMC contended were the aggravating and mitigating features of the case. She submitted that you put Patient A and Baby A at a serious risk of harm and that you have only provided the panel with limited remediation. She submitted that you provided the panel with personal mitigation, and explanation as to your state of mind on the day in question, you admitted to the regulatory concerns early in the process and showed remorse.

Ms Headley submitted that, due to the risk of harm identified, to take no further action or to impose a caution order would not be appropriate and would not reflect the seriousness of the case.

Ms Headley submitted that a conditions of practice order would address the identified risk in this case. She submitted that you have cooperated with the NMC proceedings and have shown a willingness to engage. She submitted that you have had a long unblemished career prior to the incident and that your failings were clinical in nature and capable of being remediated.

Ms Headley suggested that the following conditions could address the identified failings:

- direct supervision from a band 7 midwife, while reading and analysing CTG;
- working on the same shift as but not always directly observed by, another registered midwife; and
- work with your line manager, mentor or supervisor to create a personal development plan to address the concerns identified in your practice.

Ms Headley invited the panel to impose such an order for a period of 12 months. She further submitted that your misconduct does not require that you are temporarily or permanently removed from the register and that such an order would be disproportionate.

Mr Lloyd agreed with the aggravating and mitigating features set out by Ms Headley. He also agreed with Ms Headley that, due to the risk of harm identified and the seriousness of the case to take no further action would not be appropriate. He submitted that a caution order would not mandate you to remediate your failings and therefore also not adequately address the risk identified.

Mr Lloyd submitted that a conditions of practice order would be appropriate and proportionate in this case. However, he reminded the panel that the concerns raised were only raised in relation to your midwifery practice. He therefore invited the panel that any conditions imposed should be relevant to your midwifery practice and not restrict your work as a nurse.

Mr Lloyd agreed with Ms Headley's suggested conditions and stated that further training and supervision would be appropriate and proportionate in this case. He submitted that the length of such an order is a matter for the panel.

However, Mr Lloyd submitted that any more severe sanction would be disproportionate as this is not a case where the misconduct identified has been repeated, you have disengaged, are unwilling to engage with your regulator or address your failings.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne 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 had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Misconduct that put Patient A and Baby A at a risk of harm; and
- Serious failure in basic midwifery practice which has not yet been addressed.

The panel also took into account the following mitigating features:

- You have shown remorse;
- You have developed some level of insight; and
- There is personal mitigation, in your case the workplace environment.

The panel first considered whether to take no action but concluded that this would be inappropriate 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 your 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 your misconduct 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 placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel considered that all the above was applicable in your case.

The panel therefore determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that, other than these incidents, you have had an unblemished career of 20 years as a midwife. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a midwife.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the midwifery profession, and will send the public and the profession a clear message about the standards of practice required of a registered midwife.

The panel was of the view that there were no concerns regarding your nursing practice. It therefore determined that any conditions imposed only apply to your midwifery practice.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a midwifery role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

These conditions only apply to your midwifery practice.

1. You must ensure that you are supervised any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered midwife of at least a band 6.

2. You must be supervised during any Cardiotocography (CTG) recording, including interpretation of and documentation of findings by another registered midwife until signed off as competent by your supervisor, line manager, mentor or deputy.

3. You must work with your supervisor, line manager mentor or deputy to create a personal development plan (PDP). Your PDP must address the concerns identified, particularly in relation to CTG, and should include the completion of an appropriate electronic fetal monitoring course. You must:
    a) Send your case officer a copy of your PDP within 4 weeks of creation.
    b) Meet at least monthly with your supervisor, line manager mentor or deputy to discuss your progress towards achieving the aims set out in your PDP.
    c) Send your case officer a report from supervisor, line manager mentor or deputy before any review hearing. This report must show your progress towards achieving the aims set out in your PDP.

4. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

5. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any

condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the review hearing, in person or virtually;
- References from any work undertaken, whether paid or voluntary; and
- Any evidence of professional development and training.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Headley. She submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in their determination until the substantive conditions of practice order comes into effect. She therefore invited the panel to impose an interim conditions of practice order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

Mr Lloyd did not oppose this application.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest, so as to maintain public confidence in the profession and its regulatory process. In reaching a decision to impose an interim order the panel had regard to facts found proved, to the risk which it had identified of potential harm to patients and the reasons set out in its decision for the substantive order. The panel took account of the impact, financial and professional, an interim order will have on you.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order. The period of that order is 18 months, to allow for the time which may elapse before an appeal may be heard.

The panel is satisfied that this order, for this period, is appropriate and proportionate in the circumstances of your case.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after the decision of this hearing in writing is sent to you.

That concludes this determination.