Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 1 February 2022
-
Wednesday, 09 February 2022

Resuming Hearing

Monday 16 May 2022 – Wednesday 18 May 2022

Virtual Hearing

Name of registrant:	Bethel Josephine Otaoghene
NMC PIN:	68Y1492E
Part(s) of the register:	Registered Nurse – Sub Part 2 Adult Nursing – Level 2 – January 1968 Registered Midwife – February 1972
Area of registered address:	London
Type of case:	Misconduct
Panel members:	David Crompton (Chair, Lay member) Helen Eatherton (Registrant member) June Robertson (Lay member)
Legal Assessor:	Alain Gogarty [1-9 February 2022] Gillian Hawken [16-18 May 2022]
Hearings Coordinator:	Xenia Menzl [1-9 February 2022] Vicky Green [16-18 May 2022]
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Ms Otaoghene:	Present and represented by Dr Abbey Akinoshun,
No Case to Answer:	1 (in its entirety)
Facts proved by admission:	4b), 6b)

Facts proved:	Charges 3a) 3b)i), 3b)ii, 4a), 5a)iii), 6a), 7a), 7b)
Facts not proved:	Charges 2a), 2b), 5a)i), 5a)ii), 7c), 7d)
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	Interim suspension order (18 months)

Details of charge (as amended)

That you, a registered midwife:

1) On 28 October 2016, following Patient A giving birth to Baby A: **[no case to answer]**

    a) Did not ensure Patient A's bed was fixed in place when it would have been clinically appropriate to do so due to the manner in which she was presenting. **[no case to answer]**

    b) Left Baby A: **[no case to answer in its entirety]**

        i) unattended;
        ii) unwrapped;
        iii) unlabelled;

        in a resuscitaire when there was no clinical need to do so.

    c) Did not calculate Patient A's Modified Early Obstetric Score when it would have been clinically appropriate to do so in the light of her presenting condition. **[no case to answer]**

    d) Did not replace Patient A's IV fluids after they ran out when it would have been clinically appropriate to do so in the light of her blood loss. **[no case to answer]**

    e) Did not escalate Patient A's care to a senior midwife or doctor when it would have been clinically appropriate to do so in the light of: **[no case to answer in its entirety]**

        i) her refusal to allow for the placenta to be delivered.
        ii) her refusal to allow her episiotomy wound to be sutured.
        iii) the quantity of blood she had lost.
        iv) her presenting condition.

2) On 22 July 2017:

    a) Intentionally pushed Colleague A into a wall with your shoulder. **[not proved]**
    b) Said to Colleague A 'You're just a little girl' or words to that effect. **[not proved]**

3) On 23 September 2017:

    a) Did not obtain a wheelchair for a patient when asked to do so by Colleague B. **[proved]**
    b) Did not communicate clearly with Colleague B in that:
        i) when asked whether a patient was mobile you replied ‘she’s changed’ or words to that effect. **[proved]**
        ii) when Colleague B indicated she did not understand what you meant by saying ‘she’s changed’ or words to that effect in response to Colleague B’s question, repeated ‘she’s changed’ and did not attempt to clarify your statement. **[proved]**

4) On 22 January 2018:

    a) Did not communicate effectively with Patient B in that you shouted and/or communicated aggressively. **[proved]**
    b) Administered Syntrometrine to Patient B when it was clinically contra indicated. **[proved by admission]**

5) On 08 February 2018:

    a) Did not ensure Patient C was:

        i) Cleaned up within a reasonable period of having been allocated her care. **[not proved]**
        ii) Transferred to a recovery room within a reasonable period of having been instructed to do so. **[not proved]**
        iii) Provided with a blood transfusion within a reasonable time of having been transferred to a recovery room. **[proved]**

6) On 18 July 2018:

    a) Did not insert a catheter into Patient D’s bladder prior to attempting to suture vaginal tears she had suffered. **[proved]**
    b) Sutured Patient D’s urethra closed. **[proved by admission]**

7) On or around 21 and/or 22 July 2018

    a) Were unable to provide clinical details for a patient in your care when required to do so. **[proved]**
    b) Were rude and/or aggressive and/or unprofessional when communicating with colleagues. **[proved]**
    c) Attempted to transfer a patient using an unsafe technique namely by grabbing the skin/muscle on their lower leg. **[not proved]**
    d) Said to Colleague C ‘you don’t like me, you treat me like a baby’ or words to that effect. **[not proved]**

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

Decision and reasons on application to amend charge

At the outset of the hearing the panel noticed that the drug name in charge 4b was spelled incorrectly. It determined to administratively amend the charge to correct the spelling mistake. Mr Kennedy and Mr Akinoshun agreed that it would be fair and appropriate to do so.

Original charge:

b) Administered **Syntrometrine** to Patient B when it was clinically contra indicated.

Amended Charge:

b) Administered **Syntometrine** to Patient B when it was clinically contra indicated.

During the course of the hearing the panel noted that Dr 7 stated that the incident in charge 6 took place on the 18 July 2018 and not on the 17 July 2018. The panel determined on their own volition to amend the charge to reflect this accordingly. It invited submissions by the parties, and both accepted that the amendment could be made without injustice.

During the course of the panel's deliberations it discovered that one of the incidents leading to charge 7b) may have happened on the 21 July 2018. The panel invited parties back into the hearing to get clarification on how to proceed with this information.

Mr Kennedy submitted that it would be appropriate and fair to amend the charge to state on or around 21 and/or 22 July 2018. He submitted that it would appropriately reflect the evidence before the panel and would purely be a point of clarification.

Dr Akinoshun supported the amendment to the charge. He submitted that you have been able to give oral evidence to both incidents referred to in this charge and that amending the charge would therefore not cause prejudice against you.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment as follows:

Original charge:

7) On 22 July 2018

Amended Charge:

7) On **or around 21 and/or** 22 July 2018

Decision and reasons on application for the application to allow hearsay evidence to be held in private

At the outset of the hearing, Mr Kennedy made a request that part of the application to admit Ms 1's written statement, as hearsay, into evidence be held in private on the basis that proper exploration of Ms 1's absence involves her and her family's health. The application was made pursuant to Rule 19.

Dr Akinoshun indicated that he supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to hear part of the application to admit hearsay evidence to be heard in private as it is intrinsically linked with Ms 1's personal circumstances and her family's health in order to maintain her privacy and confidentiality.

Decision and reasons on application to admit the written statement of Ms 1 into evidence

The panel heard an application made by Mr Kennedy under Rule 31 to allow the written statement of Ms 1 into evidence. Ms 1 was not present at this hearing. Mr Kennedy referred the panel to communication between Ms 1 and the Nursing and Midwifery Council (NMC) which laid out the reasons as to why Ms 1 was not able to participate in the Hearing. He submitted that whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to her personal circumstances.

Mr Kennedy submitted that Ms 1's written statement is relevant and speaks to charge 1 in its entirety. He submitted that it is the sole and decisive evidence speaking to charges 1a), 1b) and 1d).

Dr Akinoshun acknowledged that Ms 1's written statement was relevant to the entirety of charge 1, however, he submitted that the statement being admitted as hearsay evidence would be unfair to you. He submitted that the entirety of charge 1 stems from Ms 1's statement, however, the entirety of the charge is denied by you. Dr Akinoshun submitted that allowing the statement into evidence without the opportunity to challenge Ms 1's statement would not be fair to you. He submitted that there are discrepancies in Ms 1's evidence compared to Dr 2, who is also speaking to charge 1. He submitted that Dr 2 is herself not in agreement with Ms 1's version of events. Dr Akinoshun submitted that it is clear that Ms 1's and your account are completely different. He submitted that Ms 1's non-attendance means that the panel will not be able to test Ms 1's credibility, reliability and demeanour nor will it be able to test the consistency of her evidence. Further to this, Dr Akinoshun also stated that despite an ongoing issue in relation to this witness' attendance going back as far as last year, he was unaware that there was

going to be a hearsay application until the beginning of this hearing, which he considered to be prejudicial to his case. He submitted that it would therefore not be fair to the registrant to allow Ms 1's written statement into evidence as hearsay.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. He referred the panel to the case of *Thornycroft v NMC* [2014] EWHC 1565 (Admin) and in particular paragraph 45 of that decision. He also referred the panel to Rule 31 which provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel accepted that there was good reason for Ms 1 not to attend the hearing and that the NMC had taken appropriate steps to ascertain her availability.

In considering the application the panel had regard to all the matters set out in paragraph 45 of the above decision. It examined the issues in the case, the evidence to be called and the potential consequences of admitting the hearsay evidence. Having done so, it was not satisfied that the evidence of Ms 1 was either demonstrably reliable or alternatively that there would be some way of testing its reliability. Not only did Dr Akinoshun want to question the witness, the panel itself would have wished to put questions to her.

The panel noted that Ms 1's evidence was the sole and decisive evidence to charges 1a), b) and d). It was of the view that without Ms 1 giving evidence it could not challenge her evidence nor could it determine the credibility and reliability of it. It would also not be able to test the consistency of Ms 1's evidence. The panel noted that there was a dispute between Ms 1's and Dr 2's evidence and that it would not be able to test the differing views in questioning. The panel therefore concluded that it would not be fair to you to allow Ms 1's written statement into evidence as hearsay.

In these circumstances the panel refused the application.

Decision and reasons on application of no case to answer

The panel considered an application from Dr Akinoshun that there is no case to answer in respect of charges 1, in its entirety, and 6a). This application was made under Rule 24(7).

In relation to charge 1, Dr Akinoshun submitted that in respect of the panel's ruling with regard to Ms 1's written statement there is insufficient evidence before the panel to come to a conclusion on facts. He submitted that Ms 1's written statement appeared to be the sole and decisive evidence regarding the entirety of charge 1 and the evidence of Dr 2 relied solely on the patient notes of Patient A and Baby A. He further submitted that Dr 2's evidence supported your case with regards to charges 1c), d) and e).

In relation to charge 6a), Dr Akinoshun submitted that Dr 7 gave evidence that inserting a catheter before suturing is not mandatory. She confirmed that a confident clinician can suture without doing so. He submitted that there is no policy or instructions that you were required to insert a catheter prior to suturing. He therefore submitted that there is insufficient evidence before the panel that you were required to insert a catheter before suturing.

In these circumstances, Dr Akinoshun submitted that charge 1, in its entirety, and charge 6a) should not be allowed to remain before the panel.

Mr Kennedy accepted that in relation to charge 1a), 1b) in its entirety, 1e)i) and 1e)ii) Dr Akinoshun's application was well founded and that there was no case to answer for you in respect of these charges.

However, Mr Kennedy submitted that in relation to 1c) it was clinically appropriate to carry out an early obstetric score. He submitted that this evidence came from Dr 2 as Patient A had lost approximately 1.5 litres of blood. It is also evidenced that Patient A had a high pulse rate and low blood pressure, meaning that blood was still being lost. He submitted that these signs should have been noted on the early warning obstetric

score. Dr Kennedy submitted that Dr 2 had been specifically asked if such a score had been undertaken and she said no, however, it would have been appropriate to carry out the procedure due to the loss of blood, blood pressure and the patient's pulse rate. He therefore submitted that there is enough evidence before the panel to realistically find charge 1c) proved.

In relation to charge 1d) Mr Kennedy submitted that Dr 2 was clear that the volume of lost blood needed to be replaced by IV fluids. He submitted that there was nothing in the medical notes that it was replaced, however, there was evidence in the notes that there was a bipping sound, although it was unclear which machine was making the noise. He therefore submitted that there is enough evidence before the panel to find that this charge can be found proved.

With regards to charge 1e) Mr Kennedy submitted that there was evidence from Dr 7 and in the patient's notes to show that it would have been appropriate to escalate the incident to someone senior due to the blood loss and the presenting conditions. Mr Kennedy submitted that you did not do so and that there is enough evidence before the panel to demonstrate that you had enough time to do so. He submitted that there is enough evidence to find this charge proved.

Lastly, Mr Kennedy submitted that in regard to charge 6a) the panel needs to consider the wording of the charge. He submitted that the charge did not state that you failed to insert a catheter. He submitted that the charge does not suggest that there was a duty for you to do so and you failed in your duty but rather as a matter of fact, you did not insert a catheter. He submitted that the wording of the charge solely addresses the fact of the matter that you did not insert a catheter and that a judgement on misconduct in this charge will be a decision for the panel later in the hearing to make. Mr Kennedy submitted that there is enough evidence before the panel to find this charge proved.

The panel took account of the submissions and accepted the advice of the legal assessor, who referred the panel to the test set out in *R v Galbraith* [1981] WLR 1039.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel accepted the parties submission regarding charges 1a), 1b) in its entirety, and 1e)i) and 1e)ii) and concluded that there was no case to answer in respect of these charges. The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1c), 1d) and 1e)iii) and 1e)iv) proved.

With regard to charge 1c) the panel determined after careful consideration of the evidence that it was vague. The panel noted Dr 2's evidence and that she confirmed that Patient A's Modified Early Obstetric Score (MEOWS) should have been calculated by both midwives. In her oral evidence Dr 2 stated that she was not able to confirm timings or a chronology of events as the notes were written up afterward. The panel was therefore of the view that it did not have enough evidence before it to establish either timelines or who was in charge. It therefore concluded that it had not have sufficient evidence upon which it could find charge 1c proved.

With regard to charge 1d) the panel noted that Mr Kennedy conceded that there was no clarity with regards to which machine was bipping. The panel was of the view that the evidence before it was vague and tenuous, it only had Ms 1's notes and no way of testing this evidence. The panel was of the view that there was no prospect of finding whether the fluids had actually run out. It was therefore of the view that it did not have sufficient evidence upon which it could find charge 1d) proved.

In relation to charge 1e), in its entirety. The panel was of the view that Dr 2 was not able to give clear answers as she had not been present during the incident and was referring solely to her interpretation of the patient's notes. It also noted that there was no consistent evidence before it regarding the timings and chronology of the incident and that the evidence overall was vague and inconsistent. The panel was of the view that

did not have sufficient evidence upon which it could find charge 1e), in its entirety, proved.

Lastly, in relation to charge 6a) the panel noted that the charge is not prefaced by the word failed and that therefore there is no prerequisite that you failed to do something. It was therefore of the view that it had sufficient evidence upon which it could find the charge proved. It therefore determined that with regard to charge 6a) you did have a case to answer.

Background

The charges arose whilst you were employed as a registered midwife by an agency.

It is alleged that on 28 October 2016 at King's College Hospital there were a number of failings regarding care of Patient A:

- Failure to recognise or act on Patient A's significant deterioration – she lost 1.3 litres of blood in the postpartum haemorrhage (PPH);
- Failure to deliver the placenta or take the necessary steps in the absence of the placenta not being delivered;
- Failure to effectively monitor Patient A's fluids;
- Left Patient A's new-born baby in the resuscitator, unlabelled.

It is also alleged that on 22 July 2017 whilst working at Newham General Hospital, a student midwife complained that she had been physically assaulted by you.

In September 2017 at Milton Keynes Hospital concerns were raised that you were unhelpful and did not communicate clearly to a colleague.

On 22 January 2018 at Queen Charlotte & Chelsea Hospital it is alleged that you communicated aggressively to a patient and also gave a patient with raised blood pressure Syntometrine when instructed to give the patient Syntocinon.

On 8 February 2018 another complaint from Queen Charlotte & Chelsea Hospital alleged that you lacked urgency in transferring Patient B for a blood transfusion and failed to initiate central monitoring of Patient B. In the event another midwife put up the blood transfusion.

In July 2018 at Aberdeen Maternity Hospital the following is alleged:

On 18 July 2018 concerns were raised that you sutured through the urethra of a woman following spontaneous vaginal birth and that you did not insert a catheter.

Also on following your shift on 22 July 2018 concerns were raised that you were not able to give clinical details for the woman you were caring for. Further, concerns were raised in relation to unprofessional and verbally aggressive behaviour by you.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Dr Akinoshun, who informed the panel that you made full admissions to charges 4b) and 6b).

The panel therefore finds charges 4b) and 6b) proved, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy, on behalf of the NMC, and by Dr Akinoshun, on your behalf.

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 a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Dr 2: Obstetrics Consultant for Kings college NHS Trust; (at time of incident)
- Colleague A: Student Midwife Bart's Health NHS Trust; (at time of incident)
- Colleague B: Advanced Neonatal Nurse Practitioner at Keynes University Hospital; (at time of incident)
- Ms 5: Co-Ordinator and Risk Manager for the labour ward at Queen Charlotte and Chelsea Hospital; (at time of incident)
- Ms 6: Assistant Ward Matron on the Labour Ward at Queen Charlotte and Chelsea Hospital; (at time of incident)
- Dr 7: Obstetrics and Gynaecology Consultant at Aberdeen Maternity Hospital; (at time of incident)
- Dr 8: Honorary Speciality Trainee Registrar at Aberdeen Maternity Hospital; (at time of incident)
- Colleague C: Bank Nurse for NHS Grampian.

The panel also heard evidence from you under affirmation.

The panel then considered each of the disputed charges and made the following findings.

Charge 2a)

2) On 22 July 2017:
    a) Intentionally pushed Colleague A into a wall with your shoulder.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's oral and written evidence and her email of complaint dated, 15 September 2017. It also took into account your evidence and your written statement regarding the incident, dated 28 August 2017.
The panel noted that you did not deny that there had been physical contact between you and Colleague A. It noted that there is no dispute on the fact that it had been a narrow corridor and that there was physical contact with Colleague A when rushing past. The panel noted that the charge states that you *intentionally* pushed Colleague A into a wall with your shoulder. It therefore focussed on your intention to push Colleague A.

The panel noted that Colleague A in her email, dated 15 September 2017, stated:

> '*I saw Bethel Otaghene, the agency midwife coming out of the bed allocation room. As I had just passed the pillar by the nursing station and assessed the situation. I thought it would safer to move closer to the wall on my left and not to be too close the trolley with the hot meals and to also allow RM Bethel Otaghene to pass safely. RM Bethel then came close to me and used the right side of her body to shove me into the wall on my right side and carried on walking to the nursing station. I was shocked and looked at the other staff and asked if they saw what happened*.' [sic]

The panel noted that there were some differences between Colleague A's more contemporaneous email and her witness statement to the NMC. The panel noted that the complaint email was written around two months after the incident occurred. When asked during the hearing Colleague A stated that she '*initially doubted* [her]*self and had*

a few weeks out of the ward and then thought no, I cannot let this happen to anyone else. That's when I raised it.' The panel further noted that the email states that you said to Colleague A '*You just want to prove yourself stubborn!*'. The panel also considered the fact that Colleague A took this matter further, including a meeting with the Royal College of Midwives (RCM) and noted that this supported the fact that Colleague A felt unsafe and attacked by you.

The panel noted your explanation in your written statement dated 28 August 2017 in which you state:

> '*As I was rushing back from the file room which was close to the kitchen where the food trolley was, I accidentally bumped on to the student midwife, she followed me to the staff base and stood in front of me saying why did I push her whilst I was still speaking to the help desk staff on the phone. When I finished speaking to the help desk, I then explained to her that I accidentally bumped onto her whilst rushing back to speak to the help desk staff who was being held on the phone and that I did not do it intentionally*'

The panel noted that there was no evidence before it from any other colleagues or witnesses present at the time. The evidence in this case was Colleague A's word against your word.

It was common case that there was no precipitating event by way of a prior dispute or ill-feeling which would provide a context in which the panel could infer that the physical contact was intentional rather than accidental. The panel had regard to the inherent unlikelihood that you would physically assault someone without a context to it. Further, it was common case that the area where the contact occurred was narrow and that you were in a hurry.

It concluded that Colleague A is of the belief that you 'bumped' into her intentionally, which is why Colleague A felt unsafe and pursued the complaint further with her employers. However, the panel was of the view that whilst your behaviour seems careless and possibly rude, as you had only apologised for bumping into Colleague A

when confronted, there is not enough evidence before the panel to find that you did intentionally bump into Colleague A.

The panel was therefore not satisfied, that it had enough evidence before it to find that it is more likely than not that on the 22 July 2017 you intentionally pushed Colleague A into a wall with your shoulder.

Charge 2b)

2) On 22 July 2017:
   b) Said to Colleague A 'You're just a little girl' or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's oral and written evidence and her email of complaint dated 15 September 2017. It also took into account your evidence and your written statement regarding the incident, dated 28 August 2017.

The panel noted its findings with regard to charge 2a). It noted that you denied the charge.

The panel found that Colleague A's witness evidence is not entirely consistent in this regard. The email dated 15 September 2017 stated that you said:

> '"I *have full respect for you Ma and do not address you by your first name in public. I am* […] *we were taught to respect our elders and your old enough to be my grandma, why would I want to offend you" I reiterated the question differently and asked" Have I done anything to offend you today". RM Bethel responded my repeating the question back at me. At this point I looked at the senior staff for support and said to Bethel "as we are no making any progress and it as at the nursing station, I will leave it"*
> *I then left went to the handover room, visibly upset and burst into tears.*

The second time, was during the same shift and I was coming round the corner and so was she RM Bethel from the opposite direction. I decided that I should move myself from any wall and rather be in an open space and said "Please, I don't want to be pushed again". RM Bethel responded "You are a rude little girl" [sic]

While the witness statement omits much of the above mentioned detail and just refers to you saying '*you're just a little girl'.*

The panel noted that again this charge is Colleague A's word against your word. It noted that you have been consistent with the description of events and have provided a written explanation prior to Colleague A's complaint email. The panel noted that it had no evidence before it from other witnesses, nor any notes from the meeting that followed. Whilst the panel considers Colleague A to believe that you have said '*you're just a little girl*', or words to that effect to her, it was not satisfied that it had enough evidence before it to conclude that you have said such words to Colleague A.

The panel was therefore not satisfied, that it had enough evidence before it to find that it is more likely than not that on the 22 July 2017 you said to Colleague A 'You're just a little girl' or words to that effect.

Charge 3a)

3) On 23 September 2017:
    a) Did not obtain a wheelchair for a patient when asked to do so by Colleague B.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written and oral evidence, and her email of complaint to her employer, dated 23 September 2017, as well as your written and oral evidence.

The panel noted that Colleague B stated in her email complaint, dated 23 September 2017:

> '*I left the mother with the father and went and asked Bethnal (as she was the only member of staff visible at the time) if she could get me a wheelchair so I could take the mother back to her bed. She asked where the mother was from and I told her ward nine but that I needed a chair and some help from a midwife as I had an unwell mum. She stated if I got the chair that she would then come and help me, I replied I could not leave the mother any longer and that I needed some help now as the mum was unwell. She stayed sitting down and told me to 'stop raising my eyes at her', I said again in need some help now! I then saw* [another colleague] *and told her I needed some help who then looked for a chair end helped me move the mother back to her bed* […]'

This is consistent with her written statement to the NMC.

The panel also noted that you explained that you were on the telephone and busy caring for a woman in labour who was in distress and did not have the time to get a wheelchair for Colleague B.

The panel noted that you do not factually deny the subject matter of the charge and that you admit that you did not get a wheelchair for Colleague B as requested.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on the 23 September 2017 you did not obtain a wheelchair for a patient when asked to do so by Colleague B.

Charge 3b)

3) On 23 September 2017:
    a. Did not communicate clearly with Colleague B in that:

i. when asked whether a patient was mobile you replied ‘she’s changed’ or words to that effect.
ii. when Colleague B indicated she did not understand what you meant by saying ‘she’s changed’ or words to that effect in response to Colleague B’s question, repeated ‘she’s changed’ and did not attempt to clarify your statement.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B’s written and oral evidence, and her email of complaint to her employer, dated 23 September 2017, as well as your oral evidence.

The panel noted you stated in your oral evidence to the panel that you cannot remember communicating with Colleague B on that day and that you were too absorbed with the patient you were caring for to remember a conversation with Colleague B.

The panel noted that Colleague B gave clear evidence that you communicated with her on that shift. Her oral evidence supports her witness statement to the NMC and her complaint email dated 23 September 2017 which states:

> ‘*the second incident was when I asked her if one of her patients in bay two was mobile yet as the father stated mum was not mobile, before I invited the lady to bring her baby for NIPE. She just stated to me that the lady was changed. I asked again if she had been up and mobile and to the bathroom etc and again she just stated she was changed and just ask the mother. I did reply that I was asking whether the mother was mobile and again she just replied that she was changed.*’

The panel noted that the email was contemporaneously written shortly after Colleague B’s shift and concluded that Colleague B’s memory will have been best at that point. Further, the panel considered that Colleague B’s account of the incident did not differ at all from the very first complaint on the day of the incident.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on the 23 September 2017, you did not communicate clearly with Colleague B in that when asked whether a patient was mobile you replied ‘she’s changed’ or words to that effect and when Colleague B indicated she did not understand what you meant by saying ‘she’s changed’ or words to that effect in response to Colleague B’s questions, repeated ‘she’s changed’ and did not attempt to clarify your statement.

Charge 4a)

4) On 22 January 2018:
    a) Did not communicate effectively with Patient B in that you shouted and/or communicated aggressively.

This charge is found proved.

In reaching this decision, the panel took into account of Ms 5's oral and written evidence, her complaint to your employer, dated 28 March 2018 and your written and oral evidence.

The panel noted that you stated that you were speaking in a low voice to Patient B and were encouraged by Ms 5 to shout at the patient. You state in your written statement:

> '*When the period of pushing commenced, I was encouraging the client to push with each contraction in a caring, compassionate and respectful manner, but the Co-ordinator* [Ms 5] *said that I was not shouting enough to the client to push, that my voice was very low. I know I was speaking loud enough for the client. I was mindful of my tone as I do not want to be accused by the client of not being compassionate enough.*'

The panel noted that you used the same wording when you were giving evidence in chief.

The panel also noted Ms 5's contemporaneous complaint which states:

> '*I felt that Bethel was not encouraging the woman in an appropriate manner due to the tone of her voice which I felt to be slightly. I therefore took the lead in encouraging and directing the woman to the stage where birth was imminent.*
> […]

In this case the tone of voice used to direct this woman was not appropriate. In my opinion her tone was not encouraging or helpful and created fear for the woman.'

During cross examination Ms 5 confirmed that you were speaking aggressively. The panel noted that there were some differences in phrases used by Ms 5 to describe the event. Whilst the panel was of the view, that the evidence shows that you were talking in an aggressive manner, creating an atmosphere of fear for the woman in labour the panel did consider whether you had been shouting at the woman. The panel was of the view that due to the inconsistencies between Ms 5's statements it was not clear whether you had been shouting or not. The panel also took the view that it was highly improbable that Ms 5 would have advised you to shout or raise your voice because it would be contrary to established midwifery practice.

The panel was therefore satisfied, that it was more likely than not, that on the 22 January 2018 you did not communicate effectively with Patient B in that you communicated aggressively.

Charge 5a)i)

5) On 08 February 2018:
    a) Did not ensure Patient C was:
        i. Cleaned up within a reasonable period of having been allocated her care.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 6's written and oral evidence as well as your written and oral evidence.

The panel noted that the accounts given by Ms 6 and you were completely contrary to each other. It noted that there is no dispute that you were given responsibility to look after Patient C, however, it noted that there is a dispute whether you had cleaned up Patient C within a reasonable period of time.

The panel noted that you were given responsibility for Patient C's care at handover at around 08:30, after she had given birth around 04:00 in the morning.

The panel noted that Ms 6 stated in her written statement to the NMC:

> '*At around 10:30 however, I was shocked to see that the patient had still not been moved and was feeling increasingly unwell. Not only had the patient not been moved, but the Registrant did not seem to have done anything for her, including cleaning her up*'

The panel noted that Ms 6 gave a similar account during her oral witness evidence.

You on the other hand stated that Patient C had already been cleaned up by the night staff and that you had changed her pad.

The panel was of the view that it was unlikely that the patient was not cleaned up after having given birth at around 04:00.

The panel was therefore not satisfied, that is was more likely than not, that on the 8 February 2018 you did not ensure that Patient C was cleaned up within a reasonable period of having been allocated her care.

Charge 5a)ii)

5) On 08 February 2018:
    a. Did not ensure Patient C was:
        ii. Transferred to a recovery room within a reasonable period of having been instructed to do so.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 6's written and oral evidence as well as your written and oral evidence.

The panel noted that Ms 6 stated that Patient C was not transferred to a recovery room until 10:30. The panel noted that Ms 6's initial complaint states:

> '*Despite this I had to go in and assist in the transfer as there did not seem to be any urgency in the matter for Bethel.*'

The panel noted that the written statement, produced around 18 months after the event had a specific time regarding the transfer, however, the initial complaint did not. It also noted that it did not have any patient notes or any other contemporaneous evidence before it to confirm the time of the transfer.

It noted that you state Patient C was transferred to a recovery room around 09:00 and that you were assisted by another midwife. It noted that you stated the transfer was delayed due to the patient not having a wristband when you were handed over her care.

The panel noted that there was no further evidence regarding the timings of the transfer and that it was Ms 6's word against yours.

The panel was therefore not satisfied that it had enough evidence to establish, that it is more likely than not, that on the 8 February 2018 you did not ensure Patient C was transferred to a recovery room within a reasonable period of having been instructed to do so.

Charge 5a)iii)

5) On 08 February 2018:
    a. Did not ensure Patient C was:
        iii. Provided with a blood transfusion within a reasonable time of having been transferred to a recovery room.

This charge is found proved.

In reaching this decision, the panel took into account Ms 6's written and oral evidence as well as your written and oral evidence.

The panel reminded itself of its findings in regard to charge 5a)i) and 5a)ii). It noted that there was no dispute that you had been handed responsibility for Patient C. However, it also noted that it could not be satisfied at what time Patient C was eventually transferred to a recovery room.

When considering what is known of the chronology of the event the panel considered it highly relevant that you were allocated responsibility for this patient at 08:30 and at that point it was made clear she was tachycardic and required a blood transfusion. Thereafter the versions of chronology differ. In calculating what constitutes a reasonable amount of time for this charge it would be artificial to ignore the rough chronology of events before the transfer to the recovery room. On your version of events the patient was moved to the recovery unit at 09:00 and there was a two hour delay in obtaining blood. Ms 6 on the other hand states that the patient was moved to the recovery unit at 10:30 and that delivery of the blood should have taken no more than an hour. It is not in dispute that the blood transfusion was eventually given at 12:30, this on your account would have been three and a half hours after the patient was moved to the recovery unit and the panel considered this delay unreasonable. Even when taking into account the timings given by Ms 6 regarding the patient being moved to the recovery unit the panel did not consider that you provided the blood transfusion within a reasonable time in view of the fact that you took over specific responsibility for the patient at 08:30.

The panel was therefore satisfied, that it is more likely than not, that on the 8 February 2018 you did not provide Patient C with a blood transfusion within a reasonable time of having been transferred to a recovery room.

Charge 6a)

6) On 17 July 2018:

a. Did not insert a catheter into Patient D's bladder prior to attempting to suture vaginal tears she had suffered.

This charge is found proved.

The panel noted that you denied there was a requirement for you to insert a catheter, but that you did not deny that it was not done.

Due to you admitting that you did not insert a catheter, the panel finds this charge proved. It has already been stated that it is not a prerequisite to finding this charge proved for the NMC to establish the duty to insert a catheter.

Charge 7a)

7) On or around 21/22 July 2018:
    a) Were unable to provide clinical details for a patient in your care when required to do so.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Dr 8 as well as your evidence.

The panel noted that you do not deny the fact that you were not able to give details for the patient in charge 7a), however, you deny that the patient was in your care.

The panel noted that two midwives were assigned to the patient. You stated that you were supernumerary on that shift as it was only your third or fourth shift at this hospital and that you were therefore assigned to Ms 10 who was the primary midwife.
The panel noted that it had no evidence before it to clarify whether you were supernumerary on that shift. However, the panel concluded that even as the secondary midwife, on a supernumerary shift, you should have been able to provide basic details

about the patient you and Ms 10 had been looking after. The panel was therefore of the view that the patient was in your care and should have known the details of the patient.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on or around the 21/22 July 2018 you were unable to provide clinical details for a patient in your care when required to do so.

Charge 7b)

7) On or around 21/22 July 2018:
    b) Were rude and/or aggressive and/or unprofessional when communicating with colleagues.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Dr 8 and Colleague C, as well as your written and oral evidence.

The panel noted that this charge related to two different incidents, one involving Dr 8 and one involving Colleague C. These incidents were separate, the panel therefore determined to look at the incidents individually.

The panel noted that it was Dr 8's word against yours. Dr 8 stated that she got your first name wrong, however, that your reaction to it was disproportionate and that you became rude and aggressive. Dr 8 stated that she felt the need to apologise to the patient about your behaviour.

It noted that you stated that you had told Dr 8 your name after she got it wrong and that Dr 8 then mimicked and sang your name.

The panel noted that whilst there had been several people in the operating room there were no further witnesses called regarding this incident. It further noted that it had no contemporaneous note or complaint from Dr 8 regarding the incident. The panel was

therefore of the view that it did not have enough evidence before it to find this charge proved, with regard to the incident with Dr 8.

The panel then moved on to consider the incident with Colleague C.

The panel noted that Colleague C had written a detailed contemporaneous report regarding the incident stating that you shouted at her in a derogative manner:

> '*During a case in theatre, which she failed to participate appropriately thereby placing a significant burden of work on the midwife she was co-caring for the patient with, she shouted at me in a derogative manner during the transfer of a patient*.'

The panel found that this was consistent with her witness statement and her oral evidence.

In your written statement you note:

> '*when the client was ready to be moved into the soft bed, the scrub nurse/ODA whom I could not remember her name, instructed me rudely in a loud voice, go and bring the bed into the op theatre, so I responded that I cannot move the bed on my own, so the obstetric consultant said I should come and she will push the bed into the theatre with me which she did. When the client was rolled on her side to place the slide pad under her, the Scrub nurse shouted at me to come here, in a rude manner, then when I went to the side she asked me to go. As I moved closer to her side, the Scrub Nurse pulled my wrist roughly and with a commanding tone*'

However, the panel noted that during oral evidence you were not consistent with your written account and it concluded that your account of events was implausible.

The panel determined that it preferred Colleague C's account over your account. It noted that Colleague C's email of complaint was written shortly after the incident and

was detailed and consistent with her oral evidence before the panel. It further noted that Colleague C, who was a bank nurse, felt so strongly about this event, that she had turned down further work with the hospital that had already been allocated. The panel therefore found that in relation to the event of the 22 July 2018 you were rude and aggressive and unprofessional when communicating with Colleague C.

The panel was therefore satisfied that, it is more likely than not, that on or around 21/22 July 2018 you were rude, aggressive and unprofessional when communicating with colleagues.

Charge 7c)

7) On 22 July 2018:
    c) Attempted to transfer a patient using an unsafe technique namely by grabbing the skin/muscle on their lower leg.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague C, as well as your written and oral evidence.

The panel noted that whilst this incident is described in Colleague C's written statement to the NMC she does not reference it in her email of complaint to her employer, dated 22 July 2018. In her email she states:

'*During a case in theatre, which she failed to participate appropriately* […]' [sic]

The panel noted that whilst Colleague C gave a more detailed account in her witness statement regarding the transfer, it was over a year after the incident occurred. The panel was of the view that this was inconsistent with her email of complaint where the incident is barely mentioned. The panel considered that there is mention of some incident in the email, it was not detailed enough to conclude that the sentence above clearly related to the transfer of the patient.

The panel also noted your account of the event, as quoted in charge 7b) and noted that it was not consistent with your oral evidence.

The panel noted that whilst there were further witnesses in the operating room, participating in the transfer of the patient, none of these were called before the panel.

It was of the view that it had conflicting information and did not have enough evidence before it to come to conclusion.

The panel was therefore not satisfied, that it had enough evidence before it to find that it is more likely than not that on or around 22 July 2018 you attempted to transfer a patient using an unsafe technique namely by grabbing the skin/muscle on their lower leg.

Charge 7d)

7) On 22 July 2018:
    d) Said to Colleague C ‘you don’t like me, you treat me like a baby’ or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague C, as well as your written and oral evidence.

The panel noted that you deny the charge and state that you confronted Colleague C as she had pulled your wrist during the transfer of a patient. You stated that you do not remember saying this to Colleague C and the panel noted that this form of words was not put to you closer to the incident. In your oral evidence you stated that it would be “*childish*” to say something like this.

The panel noted that Colleague C states that you said '*you don't like me, you treat me like a baby*' in her written statement to the NMC and also in her oral evidence, however, never mentioned this in her contemporaneous email of complaint. The panel was of the view that it was clear that Colleague C felt upset and intimidated.

The panel noted that this was again Colleague C's word against yours. However, it was of the view that it did not have enough evidence before it to find this charge proved.

The panel was therefore not satisfied, that it had enough evidence before it to find that it is more likely than not that on or around the 22 July 2018 you said to Colleague C 'You don't like me, you treat me like a baby' or words to that effect.

[This hearing resumed on 16 May 2022]

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.

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.'*

Mr Kennedy drew the panel's attention to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code). He identified the specific, relevant standards that in his submission meant your actions amounted to misconduct. Mr Kennedy invited the panel to take the view that the facts found proved amount to misconduct. He submitted that you did not work collaboratively,

were verbally abusive, made a drugs error, exposed patients to harm, did not treat your colleagues with respect and that the care you provided was sub-optimal. Mr Kennedy submitted that your actions fell below the standards expected of a registered midwife.

Dr Akinoshun in his submissions accepted that the facts found proved amounted to misconduct.

Submissions on impairment

Mr Kennedy 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC *927* (Admin). Mr Kennedy referred the panel to the 'test' set out in the case of *Grant* and submitted that you have in in the past acted and/or are liable in the future to act (a) so as to put a patient or patients at unwarranted risk of harm; and/or (b) to bring the profession into disrepute and/or (c) to breach one of the fundamental tenets of the profession.

Mr Kennedy submitted that your actions spanned four different healthcare trusts and took place over a period of approximately 10 months. He further submitted that you have not worked as a midwife since January 2019 and you have not provided evidence of full insight or remediation. Mr Kennedy submitted that you have been working as a Healthcare Assistant (HCA) but you have not provided any references or testimonials that attest to your interpersonal skills or patient care. Mr Kennedy submitted that given the nature of the charges found proved, there may be some attitudinal issues which are difficult to remediate. Mr Kennedy submitted that in view of your lack of full insight and in the absence of evidence of remediation, there remains a risk of repetition of the misconduct. He invited the panel to find current impairment on public protection and public interest grounds.

Dr Akinoshun submitted that you are not currently impaired. He drew the panel's attention to your *"robust"* reflective statement and a number of training certificates. He

submitted that you have fully reflected on the charges that were found proved and have done everything in your power to remediate your practice. Dr Akinoshun submitted that you have completed a number of training courses which directly address the concerns identified. He submitted that you have been unable to obtain any references or testimonials about your performance as a HCA as you undertake work through an agency.

Dr Akinoshun submitted that you have worked as a registered midwife from 1972 until 2014 without incident. He submitted that in view of your previous long unblemished record, your remediation and insight, the risk of repetition of the conduct is nil. Dr Akinoshun therefore invited the panel to find that your fitness to practise is not currently impaired on public protection grounds and that a finding of impairment is not required to satisfy the public interest in this case. He also submitted that it is in the public interest to return an experienced midwife to practice.

The panel accepted the advice of the legal assessor.

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 nurse, and that your actions amounted to breaches of the Code. Specifically:

> **1.2** make sure you deliver the fundamentals of care effectively
>
> **1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
>
> **2.1** work in partnership with people to make sure you deliver care effectively

8.2 maintain effective communication with colleagues

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

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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 in failing to communicate effectively with other professionals you placed patients at risk of harm. The panel also considered that your conduct in acting aggressively towards patients and colleagues was unprofessional and fell far below the standards expected of a registered midwife. In respect of the medication error, whilst it was an isolated incident, the panel determined that it was serious and had the potential to cause harm. The panel determined that delaying a patient's blood transfusion could have negatively impacted them. The panel determined that by incorrectly suturing a patient you could have caused significant harm and it resulted in a 'near miss'.

Having regard to all of the above, the panel found that all charges, with the exception of charge 6.a., your actions did fall seriously short of the conduct and standards expected of a registered midwife and amounted to misconduct. In respect of charge 6.a. the panel determined, following the evidence of Dr 7, that inserting a urinary catheter was not mandatory in the circumstances and in not inserting one you did not depart from any recognised standards.

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. They 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 patients were put at risk of physical and emotional harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the midwifery profession, namely, treating patients and colleagues with dignity and respect and providing safe and effective care and therefore brought its reputation into disrepute.

In considering insight, the panel had regard to your reflective statement. The panel noted that you offered an apology to patients and colleagues and you appear to demonstrate some genuine remorse for the consequences of your conduct. The panel noted that in your reflective statement you stated that you have reflected on your conduct and you would act differently in the future, however, it was of the view that your statement lacked specificity and clarity on how you would act differently in the future or what you have learned. The panel also considered that your reflective statement did not set out the root cause of why these incidents occurred. Therefore the panel found that you had incomplete but developing insight into your misconduct.

The panel was of the view the clinical failings are remediable but attitudinal concerns are inherently more difficult to remediate. The panel had sight of a number of certificates from training courses that you have completed which included the following:

- Communicating Effectively (15 January 2022).
- Assessing Needs (15 January 2022).
- Moving and Handling (17 January 2022).
- Person Centred Care (17 January 2022).
- Mandatory Training for Midwives: Skills and Drills Workshop (21 January 2022).

- Interpersonal Skills Workshop (26 January 2022).
- Record Keeping (27 January 2022).
- Safe Administration of Medicines (28 January 2022).
- Medication Safety Practice Workshop (29 January 2022).

The panel considered that the courses that you have completed are relevant, however, in the absence of full insight and references or testimonials, the panel was unable to satisfy itself regarding whether you have put what you have learned in these courses into practice.

Having regard to all of the above, the panel concluded that in the absence of full insight and remediation, a risk of repetition of your misconduct and consequent risk of harm remains. The panel therefore determined that a finding of current impairment is necessary on public protection grounds.

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.

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 very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Kennedy informed the panel that in the Notice of Hearing, the NMC had advised you that the sanction bid was for either a conditions of practice order or a suspension order for a period of 6 months, if your fitness to practise was found to be currently impaired. Mr Kennedy referred the panel to the NMC Sanctions Guidance (SG), and he suggested some aggravating and mitigating features that may be applicable in this case. Mr Kennedy submitted that your misconduct is remediable and that your behaviour is not fundamentally incompatible with remaining on the register. Nevertheless, he submitted that what sanction is appropriate in the circumstances is ultimately a matter for the panel.

The panel also bore in mind Dr Akinoshun's submissions. He submitted that you made early admissions to two of the charges, you accept the panel's findings and you have demonstrated insight into, and have learned from your misconduct. Dr Akinoshun submitted that you are passionate about the midwifery profession, and despite being subject to an interim suspension order, you have done everything in your power to maintain your midwifery knowledge and develop your practice. He submitted that you have continued to work in the healthcare profession as a HCA. Dr Akinoshun submitted that you have made efforts to obtain references but due to the nature of your position as an agency HCA you have been unable to.

Dr Akinoshun submitted that the charges arose whilst you were employed as an agency midwife, and you therefore received limited support. He submitted that no concerns had been raised about your practice and that you practised safely and consistently for a period of 40 years. Dr Akinoshun submitted that your previous record of a long and

unblemished career should alleviate any concerns about your ability to practise safely in the future.

Dr Akinoshun submitted that you have been subject to an interim suspension order since January 2019, and through no fault of your own, it has taken the NMC three years to progress your case to be considered at a substantive hearing. He submitted that the interim suspension order has caused you financial hardship and a further period of suspension would continue to cause you financial hardship. Dr Akinoshun submitted that the panel should take into account that you have already been subject to an interim suspension order for three years when it considers what sanction is most appropriate.

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:

- A pattern of misconduct which occurred during the course of employment at three different trusts and occurred over a significant period of time.
- The misconduct was wide ranging, involving clinical and attitudinal concerns.
- Patients were placed at risk of physical harm resulting from clinical errors.
- Your behaviour caused significant distress to colleagues and had the potential to cause emotional harm to patients and colleagues.

The panel also took into account the following mitigating features:

- You made some admissions to the charges.

- In your reflective statement you expressed remorse and demonstrated developing insight into your misconduct.
- Previous long and unblemished career.

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, the attitudinal concerns 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 as it relates to cases where misconduct has been found:

- *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 is of the view that whilst conditions could be formulated to address the clinical elements, there are no practical or workable conditions that could be formulated to address the attitudinal concerns identified which were wide-ranging. The panel determined that the misconduct relating to your behaviour was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent in cases relating to misconduct:

- *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;*

The panel noted that your behaviour caused one colleague to be too frightened to be alone with you in the car park and another to immediately cancel all of her future shifts as she did not feel comfortable working with you. The panel considered that this behaviour raises concerns about your attitude and, taken together with a number of other instances of misconduct which had the potential to cause harm, demonstrate a pattern of misconduct. Nevertheless, the panel was cognisant of your previous long and unblemished career, your apparent dedication to the midwifery profession which you have demonstrated in undertaking numerous and relevant training courses and developing insight. The panel was however concerned about the lack of references and testimonials from any employer or colleagues commenting on your interpersonal and communication skills since these charges arose.

The panel was satisfied that whilst the misconduct was serious for the reasons set out above, it was not fundamentally incompatible with you remaining on the register at this stage.

Given the attitudinal nature and pattern of misconduct and the effect it had on colleagues, the panel gave serious consideration as whether a striking-off order would be proportionate however, the panel concluded that it would be disproportionate at this stage. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive to impose a striking-off order without giving you the opportunity to fully on reflect on your conduct and provide evidence that you have strengthened your practice and remediated the concerns identified.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the financial hardship such an order will inevitably cause you however, it determined that this is outweighed by the public interest in this case. The panel was mindful of Dr Akinoshun's submission that it should take into account that you have already been subject to three years suspension resulting from the interim order that was imposed whilst the NMC carried out its investigation. Given the seriousness of this case, the attitudinal and public protection concerns identified, the panel determined that the only order that would satisfy the public interest in this case is that of a suspension order for 12 months. In addition, the panel took the view that a 12 months suspension order will give you sufficient time to obtain references and testimonials, ideally including at least one from a supervisor, which demonstrates your team work and communication skills in the workplace.

The panel considered that this order is 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 determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at the review hearing.
- A further detailed reflective statement. This statement should include information about how you have implemented learning from training courses, in particular, what actions you have taken to address the concerns identified.
- References and testimonials from employers, colleagues or patients commenting on your interpersonal skills.
- Evidence of how you have kept your midwifery knowledge up to date.

Interim order

As the suspension 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 suspension order takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted an interim order is necessary on the grounds of public protection and it is otherwise in the public interest. Mr Kennedy submitted that if no interim order is imposed you would be able to work without restriction and in view of the panel's findings, the public would not be protected and the public interest would not be satisfied. Mr Kennedy invited the panel to impose an interim suspension order for a period of 18 months, he submitted that if no appeal is made then the interim order will lapse and the suspension order will take effect.

Dr Akinoshun made no submissions.

The panel accepted the advice of the legal assessor.

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. 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.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in its

determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover the appeal period.

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

That concludes this determination.

This will be confirmed to you in writing.