Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 November 2023 –
Tuesday 21, November 2023

Virtual Hearing

Name of Registrant:	Sophie Addo
NMC PIN	99A0620E
Part(s) of the register:	Registered Nurse – Adult Effective – 14 March 2002 Registered Midwife Effective – 14 March 2005
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Hannah Harvey (Registrant member) David Anderson (Lay member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Amanda Ansah
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Miss Addo:	Not present and represented for only part of the hearing by Mr Walker
No case to answer:	Charges 2b, 2c(i), 2c(iv) in respect of 2c(i), 2d(i), 2f, 3, 4, 6
Facts proved:	Charges 1h(i) and 1h(ii)
Facts not proved:	Charges 1a – 1g, 1i, 1j, 2a, 2c(ii), 2c(iii), 2c(iv), 2d(ii), 2e, and 5a – 5c
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months with review)**

Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing by Miss Addo's representative, Mr Walker, that Miss Addo was not in attendance and that the Notice of Hearing letter had been sent to both her registered email address and that of her representative's by secure email on 3 October 2023.

Mr Joshi, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Addo's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Addo has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Addo

Before making a decision on proceeding in the absence of Miss Addo, the panel was informed by Mr Walker that he was here on a courtesy basis for Miss Addo to put forward her position but would not attend for the remainder of the hearing. Mr Walker requested that any decisions made be communicated to him by email.

The panel next considered whether it should proceed in the absence of Miss Addo. It had regard to Rule 21 and heard the submissions of Mr Walker who invited the panel to continue in the absence of Miss Addo. He submitted that no disrespect of any type is meant by her absence, and it is simply the case that she is unable to attend these

proceedings. He provided the panel with a detailed set of submissions along with a small bundle of supporting documents dealing with the facts and the misconduct stages, and an application for no case to answer in respect of some of the charges.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Addo. In reaching this decision, the panel has considered the submissions of Mr Joshi and Mr Walker and the advice of the legal assessor. The main considerations were:

- No application for an adjournment has been made by Miss Addo;
- Mr Walker has informed the panel that Miss Addo has received the Notice of Hearing and does not object to the hearing proceeding in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses are scheduled to attend the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2016 and 2017;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Addo in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her by her registered email address, she will not be able to challenge the evidence relied upon by the NMC in

person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any weaknesses in the evidence which it identifies. The panel will be assisted by Mr Walker's submissions and Miss Addo's witness statement. Furthermore, the limited disadvantage is the consequence of Miss Addo's decision to absent herself from the hearing.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Addo. The panel will draw no adverse inference from Miss Addo's absence in its findings of fact.

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Joshi, on behalf of the NMC, to amend the wording of charges 5b and 5c.

The proposed amendments submitted by Mr Joshi, are that the words "failed to" had been left out in Charge 5b and Charge 5c should read "failed to". He submitted that that the proposed amendments would provide clarity and enable the charge to make sense. He informed the panel that the amendments have been pointed out by the legal assessor and Miss Addo's representative makes no objections to them.

The panel also outlined amendments for charges 2)c) and 2)c)ii) recommending that the word "registrant" be changed to "registrar". The panel also recommended that the word "decelerations" in charges 1b(i) and 1b(ii) should be changed to contractions in light of advice it received from the registrant panel member with respect of decelerations. The panel further recommended the changing of the typographical error regarding charge 1c(iii) which was agreed.

Mr Joshi indicated that contraction seems to be the appropriate terminology but that some of the evidence from the witnesses refers to decelerations which are "part and parcel" of the contraction aspect. He informed the panel that if the evidence shifts in

terms of the witness evidence, then a further application to amend the charge may be necessary.

The proposed amendments read as follows:

"That you, a registered nurse:

1) On night of 18/19 July 2016, in relation to Patient B:

b) At, or around, 00:40 following prolonged decelerations failed to:

i) manually palpate the uterus / adequately assess the length of the ~~decelerations~~ **contractions**;

ii) manually palpate the uterus / adequately assess the strength of the ~~decelerations~~ **contractions**;

c) Following the CTG trace having stopped recording Patient B's contractions adequately, failed:

iii) record / document your actions / rationale in relation to the matter referred to in any or all of charges 1(c)(i)- 1(c)~~(ic)~~ **(ii)** above;

2) On 3/4 March 2017, in relation to Patient A, between 22:41 and 23:02 whilst Patient A's CTG trace was pathological:

a. at, or around, 23:00 having bleeped the ~~Registrant~~ **Registrar** who was busy, failed to:

ii) recommend to the ~~Registrant~~ **Registrar** that an urgent review was required / confirm that the CTG trace was pathological;

5) On 3/4 March 2017, following Patient A's CTG trace having started to show decelerations at, or around, 03:50:

a) failed **to** escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;

b) **failed to** record / document your actions / rationale in relation to the matters referred to in charge 5(a) and 5(b) above;

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for and as suggested, were in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Addo and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments to ensure clarity and accurately reflect the evidence.

Details of charges (as amended)

That you, a Registered Midwife, whilst working at Newham University Hospital ('the Hospital'):

Patient B

1) On night of 18/19 July 2016, in relation to Patient B:

    a) At, or around, 23:08 failed to:

        i) recognise the hyper stimulation;

        ii) reduce / stop the syntocinon;

    b) At, or around, 00:40 following prolonged decelerations failed to:

        i) manually palpate the uterus / adequately assess the length of the contractions;

        ii) manually palpate the uterus / adequately assess the strength of the contractions;

        iii) manually palpate uterus / adequately assess the frequency of the contractions;

        iv) monitor Patient B's contractions;

v) record / document your actions / rationale in relation to the matter referred to in any or all of charges 1(b)(i)- 1(b)(iv) above;

c) Following the CTG trace having stopped recording Patient B's contractions adequately, failed:

i) to manually palpate / feel for the contractions;

ii) adjust the transducer to pick up the contractions;

iii) record / document your actions / rationale in relation to the matter referred to in any or all of charges 1(c)(i)- 1(c)(ii) above;

d) Failed to classify / document the CTG trace:

i) every hour between 20:45 and 01:00;

ii) using a CTG sticker every hour between 20:45 and 01:00;

e) At, or around 02:40 failed to:

i) recognise hyper stimulation;

ii) reduce / stop the syntocinon;

f) At, or around 03:30, having raised a concern about the CTG trace failed to:

i) inform a co-ordinator / escalate Patient B's care having been advised to carry on by the doctor;

ii) recognise hyper stimulation of the uterus;

iii) use a CTG classification sticker;

g) At, or around, 3:50:

i) incorrectly classified the CTG trace as normal;

ii) failed to recognise the presence of hyper stimulation;

iii) failed to reduce / stop the syntocinon;

iv) failed to record / document your actions / rationale in relation to the matters referred to in any or all of charges charge(s) 1(g)(i) - 1(g)(iii) above;

h) Having documented that the CTG was pathological at 04:15:

i) failed to escalate Patient B's care / record such escalation;

ii) increased the syntocinon to 50mls an hour / failed to discontinue syntocinon;

i) failed to document the partogram in the notes after 03:45;

j) failed to record the PH (cord gases) on the baby's birth summary;

Patient A

2) On 3/4 March 2017, in relation to Patient A, between 22:41 and 23:02 whilst Patient A's CTG trace was pathological:

a) at, or around, 22:41, having recorded that the CTG remains "tacky" (tachycardic), failed to:

i) document prolonged decelerations;

ii) call for help / escalate Patient A's care;

b) failed to use a classification sticker to analyse the CTG;

c) at, or around, 23:00 having bleeped the Registrar who was busy, failed to:

i) use the "SBAR" handover when speaking to the Registrar;

ii) recommend to the Registrar that an urgent review was required / confirm that the CTG trace was pathological;

iii) escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;

iv) record / document your actions / rationale in relation to the matters referred to in charge(s) 2(c)(i), 2(c)(ii) and 2(c)(iii) above;

d) at, or around, 23:02:

i) discontinued the CTG trace, or had failed to notice that the CTG trace had discontinued, for a period of around 23 minutes;

ii) failed to document / record why Patient A had been taken off of the CTG trace and / or it had been discontinued;

e) failed to identify the CTG trace as pathological and / or the need for escalation;

f) failed to request a “fresh eyes” assessment;

3) On 3/4 March 2017, in relation to Patient A, failed to use a CTG classification sticker at 23:07;

4) On 3/4 March 2017, in relation to Patient A, failed to contemporaneously record in Patient A’s notes, the insertion of the epidural / observations taken at the time of insertion;

5) On 3/4 March 2017, following Patient A’s CTG trace having started to show decelerations at, or around, 03:50:

a) failed to identify the CTG trace as pathological / the need for escalation;

b) failed to escalate Patient A’s care to a Senior Midwife / co-ordinator / another Registrar;

c) failed to record / document your actions / rationale in relation to the matters referred to in charge 5(a) and 5(b) above;

6) On 3/4 March 2017, and in relation to Patient A, at around 04:39, failed to record the time / rationale for the emergency buzzer having been pulled;

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Joshi under Rule 31 to allow the hearsay testimony of Witness 4 into evidence. Mr Joshi told the panel that Witness 4 made a witness statement in the negligence proceedings detailing her experience during the date of the incident in question, which the panel have had sight of. Further, Witness 4 covered the period of time which Miss Addo was on a break and her statement details what happened during this time. He submitted that the evidence is clearly relevant to issues the panel need to consider factually.

Mr Joshi provided the panel with a hearsay bundle, detailing the unwillingness of Witness 4 to attend the hearing demonstrated by an exchange of emails between the

relevant caseworkers at the NMC and Witness 4's daughter. There is also a ticket booked in relation to Witness 4 travelling out of the country and therefore being unavailable in any event. He submitted that the NMC have tried to get this witness to attend and as her evidence is relevant to the facts the application is to have that statement read into the record.

Mr Joshi further informed the panel that Miss Addo's representative had no objection to the evidence being produced as hearsay and his position was that it probably assists Miss Addo in terms of some of the matters contained therein.

The legal assessor referred the panel to Rule 31(1) which emphasises the importance of relevance and fairness when the panel is deciding whether to admit a witness statement of a witness who is not going to give oral evidence. He advised that the panel could properly admit this evidence as both representatives accepted that it was relevant and that it should be admitted.

The panel gave the application in regard to Witness 4 serious consideration. The panel noted that there had been no objection to the application by Miss Addo or her representative, and that the NMC had followed the necessary procedures to get Witness 4 to attend.

The panel determined that it would be fair and relevant to accept the hearsay evidence of Witness 4 but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Decision and reasons on application of no case to answer

At the conclusion of the NMC's case on facts, the panel considered a written application from Mr Walker that there is no case to answer in respect of charges 2-6. This application was made under Rule 24(7).

In relation to this application, Mr Walker provided the following written submissions:

"…

Half time submission – Patient A allegations

1. *The registrant submits that there is no case to answer in respect of the allegations relating to Patient A, namely Particulars 2 - 6.*

Half time submissions

2. *No useful purpose is served by a Panel continuing proceedings if, based upon the case which it has been put before the Panel there is no real prospect of the NMC proving the facts alleged or of the Panel concluding that the facts amount to the statutory ground of the allegation (misconduct) and, in turn, that fitness to practise is impaired.*

Rules and guidance

3. *The power to make such applications is contained within the NMC Fitness to Practice Rules 2004 at rule 24(7) & (8).*

Rule 24 (7) - Facts

4. *The NMC has provided guidance for panels deciding half time submissions as follows:*

   There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:
   No evidence;
   Some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.
   The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account.

5. *The relevant authority is the case of R v Galbraith [1981] 1 WLR 1039, as per Lord Lane CJ at 1042 B-D:*

   "If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case. The difficulty arises where there is some evidence but it is of a tenuous character, for

example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.

Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury."

6. *The approach which Panel should adopt in dealing with half-time submissions is first to address the following question in respect of each disputed allegation (or element of an allegation):*

- *has the NMC presented any evidence upon which the Panel could find that allegation or element proved?*

7. *If not, then the answer is straightforward. The burden of proof has not been discharged and there is no case to answer in respect of that allegation or element.*

8. *Where the NMC has presented some relevant evidence, then the Panel should move on to address the following questions:*

- *is the evidence so unsatisfactory in nature that the Panel could not find the allegation or element proved?*

- *if the strength of the evidence rests upon the Panel's assessment of the reliability of a witness, is that witness so unreliable or discredited that the allegation or element is not capable of being proved?*

9. *In addressing these questions, the Panel must take care in applying the burden and standard of proof, remembering that it is for the NMC to prove the facts alleged and that the requisite standard of proof is the balance of probabilities.*

10. *If either question is answered in the affirmative, then again there is no case to answer in respect of that allegation or element.*

11. *It is submitted that the evidence in relation to allegations 2 - 6 is either such that it is:*

    insufficient to permit the Panel to find the allegation or element proved, or; that it is so unsatisfactory in nature that the Panel could not find the particular proved and/or;
    the evidence of CBF is so unreliable or discredited that the allegation is not capable of being proved.

Rule 24(8) - Impairment

12. *If the case proceeded to its conclusion, the decision of whether the registrant has a case to answer as to her alleged impairment would require the Panel to determine whether, in its judgement, the facts alleged:*

    a. *amount to the statutory ground of the allegation; and*
    b. *in turn, establish that a registrant's fitness to practise is impaired.*

13. *Consequently, it is further submitted the panel should consider whether the evidence which the NMC has presented in relation to R's care of Patient A is such that, when taken at its highest, no reasonable Panel could properly conclude that the registrant's fitness to practise is impaired.*

14. *It is submitted that this may arise in one of two ways, either that*

a. *the evidence is unsatisfactory, for example, being tenuous, vague, weak or inconsistent, as submitted above; or*
b. *the allegation is misconceived, in that even if the factual allegations are found proven, they are insufficient to establish the statutory ground of misconduct and, in turn, impairment.*

15. *If either limb is found to arise, then the Panel is entitled to conclude that there is no case to answer in respect of that allegation or element.*

16. *Given that evidence going to impairment generally comes at a later stage, in practice the exercise at this stage requires the panel to consider whether the evidence presented by the NMC could properly provide a basis for a finding of misconduct.*

Statutory ground - Misconduct

17. *In Roylance v General Medical Council (No 2) [2000] 1 AC 311 the House of Lords stated that misconduct is a:*

"word of general effect, involving some act or omission which falls short of what would be proper in the circumstances... It is not any professional misconduct which will qualify. The professional misconduct must be serious."

18. *In Khan v Bar Standards Board [2018] EWHC 2184 (Admin), Warby J at para 36 said:*

"The authorities make plain that a person is not to be regarded as guilty of professional misconduct if they engage in behaviour that is trivial, or inconsequential, or a mere temporary lapse, or something that is otherwise excusable, or forgivable. There is, as Lang J put it, a "high threshold". Only serious misbehaviour can qualify."

19. *The test as to whether conduct falls to be considered as professional misconduct is seriousness; and there is a distinction between conduct that can be considered as non-serious misconduct, and conduct that amounts to serious misconduct.*

20. *The effect of the two cases is that the NMC must by the close of its case, have shown that the conduct alleged, could, by a reasonable panel properly directed, be found to amount to conduct that surmounts that high threshold, and to be more than "trivial, or inconsequential, or a mere temporary lapse, or something that is otherwise excusable, or forgivable".*

21. *Each allegation must be considered separately. This is not a case where a panel could permissibly cumulate the allegations in assessing misconduct/impairment.*

22. *It is submitted that should the panel find that there is a case to answer in relation to any of the factual particulars, the evidence presented by the NMC is insufficient to establish that the conduct alleged amounts to anything more than instances of non-serious misconduct that does not surmount that high threshold.*
…"

Mr Joshi submitted that the totality of the evidence provided by way of the various witness statements and NMC witness evidence and exhibits is what is being considered, and in relation to the evidence as it came out, one of the real issues is the strength and the quality. He submitted that as far as the NMC witnesses are concerned, they are of such a standard and quality that this needs to be taken into account.

Mr Joshi submitted that Witness 1 and Witness 2 have considerable experience and knowledge with regard to the evidence they provided with respect of the charges. He submitted that the great deal of objections in respect of the CTG scans and their interpretations in respect of charges 2 -6 is because there is another additional aspect to them, namely a statement that was obtained by Witness 5. He submitted that there is a significant difference in terms of the evidence as it is being put by Miss Addo and her representative.

Mr Joshi submitted that Witness 3's background is of a sufficient quality and calibre to be able to comment quite properly and professionally on her views of the incidents given that she qualified as a registered midwife in 1985 and has had considerable

experience on everything from immunisation programs to actual training of doctors and midwives, and CTG interpretation. He submitted that the quality and calibre of this witness is something that is *"very much to the fore"* and it is not as though she is an individual who has been practising for a short time. He submitted that it is fair to say that in terms of the issues as they arose, there are obviously differing viewpoints, which Witness 3 herself stated when referring to the report provided by Witness 4.

Mr Joshi reminded the panel that it is Witness 3's position that she agreed with some aspects and not others and one of those was in relation to the panel's question of whether 30 minutes of a CTG trace was sufficient to be able to judge whether there was a pathological reading or not. He reminded the panel that one of the things Witness 3 said was that her opinion was based on the guidance that was operating at the time (the NICE guidance). However, the issue of the trace being normalised but initially pathological is something that she disagreed with as far as Miss Addo's aspects were concerned.

Mr Joshi also submitted that none of the individuals who have given evidence including Witness 3, have any real knowledge of Miss Addo either professionally or personally so it was *"a set of fresh eyes"* that considered the evidence a year or so later. He submitted that this is obviously of concern given that one of the things that has essentially been pointed out is that Miss Addo was being singled out perhaps in her own terms almost as a scapegoat and a victim. There is also an assertion that actions have been taken against Miss Addo because of her background. Mr Joshi submitted that he refuted this assertion simply on the basis that there was not a personal aspect to any of the evidence heard by the panel and there is nothing to suggest that either of the witnesses had in their mind anything to do with Miss Addo's background. Rather, it was simply two individuals approaching the matter at a later stage in relation to an investigation and putting forward their professional views of what they considered to be failures in the way the patients were treated.

Mr Joshi submitted that Witness 3 goes into this case in considerable detail as she provided all the relevant notes in relation to the triage, the admission, the interpretation of the classification stickers, the particular guidelines that were in place at the time and

the patient notes along with the CTG traces. He submitted that these are all the relevant parts of evidence available and there is sufficient evidence from the witnesses namely Witness 3, in terms of saying Miss Addo did not live up to the expectations, and they consider this to be a failure.

Mr Joshi further submitted that it is a matter for the panel as to whether there is sufficient evidence but given the witness statements and certain aspects of the evidence and their interpretation, there is sufficient evidence available which can be relied upon.

Panel's decision

The panel took account of the written submissions made by Mr Walker and the oral submissions by Mr Joshi and accepted the advice of the legal assessor. He advised the panel to apply the test set out in the NMC guidance, as quoted by Mr Walker and accepted by Mr Joshi.

The panel was mindful that it was not deciding whether any of the disputed charges were proved, only whether, applying the *Galbraith* test to the NMC evidence, it could find the charges proved.

In reaching its decision, the panel has made an initial assessment of all the evidence presented to it at this stage. It's an important feature of all charges that the panel had to consider whether there was evidence of a breach of duty on Miss Addo's part: this followed from the use of the word "failed" in respect of each charge. The panel was solely considering whether sufficient evidence had been presented, such that it *could* find the facts proved and whether Miss Addo had a case to answer in respect of the following relevant charges. After that exercise, the panel would consider whether a finding of impairment could be made on each of charges 2-6.

2) On 3/4 March 2017, in relation to Patient A, between 22:41 and 23:02 whilst Patient A's CTG trace was pathological:

When considering charge 2 and the subsequent subsections of this charge, the panel had regard to the evidence presented by Witness 3 that Patient A's CTG trace between 22:41 and 23:02 could, in her opinion, be classified as pathological.

Charge 2a), i), and ii) –

a) at, or around, 22:41, having recorded that the CTG remains "tacky" (tachycardic), failed to:

   i) document prolonged decelerations;

   ii) call for help / escalate Patient A's care;

There is a case to answer in respect of these charges.

The panel determined that in respect of both of these charges, there is evidence before it, namely the oral evidence and witness statement provided by Witness 3. It determined that the weight to be given to this evidence will be determined at a later stage. However, it is not tenuous, and it is supported by contemporaneous records such as the CTG trace and the patient notes. The panel determined that any properly instructed panel could find this charge proved and there is sufficient evidence before it that there is a case to answer.

The panel also considered whether this charge if found proved, could give rise to a finding of impairment. It determined that it could amount to misconduct and consequent impairment.

The panel therefore determined that there is a case to answer in respect of these charges.

Charge 2b – failed to use a classification sticker to analyse the CTG;

There is no case to answer in respect of this charge.

The panel accepted that there is evidence that Miss Addo did not use a classification sticker to analyse the CTG. The panel heard evidence that whilst a classification sticker

could have been used, there was no evidence provided of any requirement for it to be used as the CTG trace had not been running for 30 minutes. As such, Miss Addo could not be found to have failed to use a classification sticker. The panel therefore determined that there is no case to answer in respect of this charge.

Charge 2c) i) – at, or around, 23:00 having bleeped the Registrar who was busy, failed to:

i) use the "SBAR" handover when speaking to the Registrar.

There is no case to answer in respect of this charge.

The panel accepted that there is evidence that Miss Addo did not use the SBAR handover when speaking to the Registrar. However, there is no evidence before it that suggests that Miss Addo had a duty to use the SBAR handover. The panel heard evidence from Witness 2 and Witness 3 to the contrary as they stated that the SBAR process had not been fully implemented at the time and potentially 50% of staff were and 50% were not using it. Training was still ongoing with regard to use of the SBAR handover. The panel determined that there is not enough evidence to establish that Miss Addo failed in this regard.

The panel therefore determined that there is no case to answer in respect of this charge.

Charge 2c) ii) – at, or around, 23:00 having bleeped the Registrar who was busy, failed to:

ii) recommend to the Registrar that an urgent review was required / confirm that the CTG trace was pathological;

iii) escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;

There is a case to answer in respect of these charges.

The panel determined that there is sufficient evidence to continue with these charges and possibly find them proved. It noted the evidence provided by Witness 3 and the contemporaneous patient notes that there was a potential action that should have been taken and therefore there could have been a failure. The panel noted that the charge is at or around 23:00, and the patient notes state that the doctor did not arrive until 23:50. The weight of this evidence will be determined at a later stage.

The panel also considered whether this charge if found proved, could give rise to a finding of impairment. It determined that it could amount to misconduct and consequent impairment. If the trace was pathological at that time, an urgent review would have been required by the doctor. The absence of an urgent review could have affected patient safety.

The panel therefore determined that there is a case to answer in respect of these charges.

Charge 2c) iv) – at, or around, 23:00 having bleeped the Registrar who was busy, failed to:

iv) record / document your actions / rationale in relation to the matters referred to in charge(s) 2(c)(i), 2(c)(ii) and 2(c)(iii) above;

There is a case to answer in respect of this charge in respect of 2c(ii) and 2c(iii).

The panel has found that there is no case to answer in respect of charge 2c(i). However, there is evidence from Witness 3 and the patient documents that there is a requirement of nurses to record their rationale for taking or not taking any actions. Therefore, a properly instructed panel could find this charge proved in respect of charges 2c(ii) and 2c(iii).

The panel also considered whether this charge if found proved, could give rise to a finding of impairment. It determined that it could amount to misconduct and consequent impairment as record keeping is a basic nursing skill and a requirement of the NMC code.

The panel therefore determined that there was a case to answer in respect of this charge.

Charge 2d(i) – at, or around, 23:02:

i) discontinued the CTG trace, or had failed to notice that the CTG trace had discontinued, for a period of around 23 minutes;

There is no case to answer in respect of this charge.

The panel noted that the written evidence of Witness 3 stated that the CTG trace had been discontinued for 23 minutes but in her oral evidence, stated that this had been provided in error and was actually discontinued for 7 minutes. The panel considered whether to invite an amendment to the charge but decided not to do so because a period of 7 minutes of discontinuance or failure to notice such discontinuance is too short a period to establish misconduct and impairment. This is because there are likely alternative explanations for short periods of discontinuance, as borne out by the evidence of Witness 2 that the machine needed to be restarted on a few occasions. Further, Witness 2 and Miss Addo both provided evidence that there was loss of contact during this time. Temporary loss of contact would often not be immediately observed by the midwife because of the other demands of the situation.

The panel therefore determined that there was no case to answer in respect of this charge.

Charge 2d(ii) – at, or around, 23:02:

ii) failed to document / record why Patient A had been taken off of the CTG trace and / or it had been discontinued;

There is a case to answer in respect of this charge.

The panel has been provided with evidence consisting of Witness 3's witness statement (which was modified by her oral evidence), the patient notes, and a partial CTG trace.

This indicates that there was a 7-minute break which had not been documented. There was no record from Miss Addo explaining this. The panel determined that any properly instructed panel could find this charge proved and there is sufficient evidence before it that there is a case to answer.

The panel also considered whether this charge if found proved, could give rise to a finding of impairment. It determined that it could amount to misconduct and consequent impairment as record keeping is a basic nursing skill and a requirement of the NMC code.

The panel therefore determined that there was a case to answer in respect of this charge.

Charge 2e) – failed to identify the CTG trace as pathological and / or the need for escalation;

There is a case to answer in respect of this charge.

The panel considered the evidence provided by Witness 3. In the panel's view, if it found that the trace was pathological, then Miss Addo's non-identification of it could constitute a failure. The evidence provided by Witness 3 is that it is clear that the trace was pathological, therefore there was a duty on Miss Addo to have identified that trace as pathological and then to carry out any subsequent actions required as a result including escalation.

The panel also considered the documentary evidence of the patient notes, the CTG trace and the evidence provided by Witness 3. It determined that the weight to be given to this evidence will be decided at a later stage but there is evidence before it that a properly instructed panel could find the charge proved.

The panel also considered whether this charge if found proved, could give rise to a finding of impairment. It determined that it could amount to misconduct and consequent impairment.

The panel therefore determined that there was a case to answer in respect of this charge.

Charge 2f) – failed to request a “fresh eyes” assessment;

There is no case to answer in respect of this charge.

The panel noted the evidence provided to it regarding a requirement for a “fresh eyes” request is that it should have been conducted 2 hours after the first CTG trace. The CTG trace in question had not been running for 2 hours; therefore there was no requirement for a “fresh eyes” request to have been made. The panel considered the evidence that it would have been best practice if the trace was pathological for a “fresh eyes” request to have been made but noted that this was not a requirement. The panel was not satisfied that there was sufficient evidence to find this charge proved.

The panel therefore determined that there is no case to answer in respect of this charge.

Charge 3 – On 3/4 March 2017, in relation to Patient A, failed to use a CTG classification sticker at 23:07;

There is no case to answer in respect of this charge.

Witness 1, Witness 2 and Witness 3 gave evidence that 30-40 minutes of a trace was required before one should use a classification sticker. The panel was not satisfied that it had evidence that Miss Addo was required to use a classification sticker at 23:07. Having started at 22:40, the requirement to use a CTG sticker would only have been at 23:10 at the earliest. The panel was of the view that whilst it might have been preferable to review the trace and use a classification sticker at 23:07, the requirement to do so had not arisen at that stage.

The panel therefore determined that there is no case to answer in respect of this charge.

Charge 4 – On 3/4 March 2017, in relation to Patient A, failed to contemporaneously record in Patient A's notes, the insertion of the epidural / observations taken at the time of insertion;

There is no case to answer in respect of this charge.

The panel found that there is evidence that Miss Addo failed to make contemporaneous notes as she was required to do. The panel was provided with evidence that Miss Addo did make an openly retrospective entry on the patient notes regarding this matter. Because of that retrospective entry, the panel would not be satisfied that her failure amounted to misconduct or impairment, given that the entry was made only a short time later, and as she had complied with the guidance on retrospective entries.

The panel therefore determined that there is no case to answer in respect of this charge.

Charge 5a,b,c) – On 3/4 March 2017, following Patient A's CTG trace having started to show decelerations at, or around, 03:50:

a) failed to identify the CTG trace as pathological / the need for escalation;
b) failed to escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;
c) failed to record / document your actions / rationale in relation to the matters referred to in charge 5(a) and 5(b) above;

There is a case to answer in respect of these charges.

The panel considered the evidence from Witness 3, the CTG trace, and the patient notes. The panel heard evidence from Witness 3 that there were decelerations at that time and there was a requirement for Miss Addo to identify this, which she failed to do. The panel noted that the expert report provided by Witness 5 provides a counter argument to this. However, the weight this will be given should be determined at a later stage. The panel was of the view that there was enough evidence presented that a properly instructed panel could find this charge proved.

If the charge is found proved, then this could amount to misconduct and subsequent impairment, because a pathological trace is a very serious matter and provides

important information to health professionals on which they base decisions affecting the mother and baby's safety.

The panel therefore determined that there is a case to answer in respect of these charges.

Charge 6 – On 3/4 March 2017, and in relation to Patient A, at around 04:39, failed to record the time / rationale for the emergency buzzer having been pulled;

There is no case to answer in respect of this charge.

The panel had no evidence before it to show a requirement to record the time and rationale for the emergency buzzer being pulled. It was of the view that even if it could find a case to answer for failing to record the time and rationale for the emergency buzzer, this would not amount to misconduct. The evidence before the panel is that according to the patient notes there was a buzzer pulled, but nothing has been recorded in respect of that and there is no evidence of a requirement to record the time and rationale for this.

The panel had evidence from the patient notes that the emergency buzzer was pulled at 04:39 and there is no entry contained within the notes from Miss Addo recording the time or rationale around that. However, there is a subsequent entry from the Registrar explaining the rationale and reasons as to why the buzzer was pulled and the subsequent actions. That entry was made in retrospect. The panel considered that there is an obligation on nurses to document situations of an emergency type. Miss Addo was the duty nurse in charge and was obliged to complete patient notes to the best of her ability. The panel therefore determined that there is a case to answer in respect of the evidence presented to it. However, even if this was found proved, the panel are of the view that given the notes subsequently made by the Registrar and the emergency situation Miss Addo found herself in, the actions of failing to record the time and the rationale within the notes in these circumstances could not amount to misconduct.

The panel therefore determined that there is no case to answer in respect of this charge because it is incapable of amounting to misconduct and subsequent impairment.

Background

The charges arose whilst Miss Addo was employed as a Registered Midwife by ICG Medical Limited (the agency) and was working shifts at the Newham University Hospital (the hospital). Miss Addo was first entered on to the NMC register in 1999 as a nurse, and then as a midwife in 2005. She began working at the agency in 2012 and worked her last shift in March 2017.

With respect to Patient B, Miss Addo was working a shift at the hospital on the night of 18/19 July 2016, providing labour care for Patient B. Patient B was undergoing an induction of labour and she had already had a rupture of the membranes and meconium stayed liquor which means that the foetus had passed material during that labour and at that time, Patient B was receiving syntocinon, a synthetic hormone that actually increases contractions. Patient B also had an epidural, a painkilling injection when pain is intense.

During the labour, the syntocinon caused the uterus to contract too often and this is referred to as hyperstimulation and a risk (referred to by the witnesses) of decelerations or contractions had been noted on the cardiotocography chart (CTG, measures the foetal heart rate and the uterine or uterus contractions). This meant that action had to be taken and it is alleged that the syntocinon should have been decreased or discontinued but was rather increased. The documentation shows that certain things were recorded, but not all, and some of the measurements made by Miss Addo were entered after the event.

It is alleged that Miss Addo did not escalate the concern as per the proper process and procedure and following her actions in increasing the syntocinon, the baby was born by emergency caesarean section and developed various difficulties and problems. Following an investigation by the Trust, Miss Addo and the doctor involved in Patient B's care were excluded from working with women who required foetal heart monitoring until a CTG assessment had been completed. Miss Addo did undertake a CTG assessment but did not reach the required pass mark. The NMC allege that as a result of this failing, the onus was on her to consider what work she could and could not do, however it was

her position that she was not told about what steps should be taken and that she should not have been on wards.

Following the failing of the CTG assessment, on the night of 3/4 March 2017, Miss Addo booked herself to work on the birth centre and began to care for Patient A. Patient A had been transferred to the labour ward following her request for an epidural and the CTG was started at 22:41. The CTG showed prolonged decelerations or contractions, a tacky cardia, and a fast foetal heart rate.

Miss Addo noted only that there was tachycardia, and intravenous fluids were given for rehydration. The CTG is alleged to have been pathological between 22:41 and 23:02, and then normal until 03:50 in the morning when there were more decelerations, and it was regarded as being pathological in terms of some intervention was needed and there was considerable cause for concern. A doctor responded to the emergency buzzer at 04:39 in the morning and the foetal heart was described as being bradycardic at this stage, meaning that there was a slow heart rate. An emergency caesarean section was performed. Baby A was born at 04:55 and developed complications in relations to the birth and the aftermath.

Miss Addo left the agency. Subsequently, a referral was made to the NMC by the Head of Midwifery on 4 May 2018.

Decision and reasons on facts

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 Joshi on behalf of the NMC and the written submissions by Mr Walker.

The panel has drawn no adverse inference from the non-attendance of Miss Addo.

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 it occurred as alleged.

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

- Witness 1: Consultant Midwife in Public Health;
- Witness 2: Consultant in Obstetrics & Gynaecology/Early Pregnancy Lead;
- Witness 3: Consultant Midwife;

The panel also heard live evidence from Witness 5, an expert midwife, who was called by the panel to give oral evidence in relation to the report provided by the NMC within the documentation.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. He advised that for the panel to be satisfied that Miss Addo failed to do something, it must be satisfied that she breached a duty to do it. It considered the witness and documentary evidence provided by both the NMC and Mr Walker.

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

Charges 1a) i & ii

1) On night of 18/19 July 2016, in relation to Patient B:

    a) At, or around, 23:08 failed to:

        i) recognise the hyper stimulation;

ii) reduce / stop the syntocinon;

These charges are found NOT proved.

In reaching this decision, the panel considered the written and oral evidence provided by Witness 1, the patient notes, the CTG trace and the guidelines that were in place at the material time. The panel also took into account the written response from Miss Addo with regard to this charge. The panel had sight of the evidence in the patient notes and the CTG trace showing that the syntocinon was started at 23:05. When asked if whether 3 minutes on or around 23:08 was enough time to start the syntocinon, recognise hyperstimulation and reduce or stop the syntocinon, Witness 1 was clear in her oral evidence that on/or around 3 minutes was not enough time to recognise hyper-stimulation. Witness 1 further went on to say that you would need longer than 3 minutes to see if the hyperstimulation has settled in order to reduce or stop the syntocinon.

The panel noted that Patient B was having mild contractions and the syntocinon was introduced to increase the intensity of her contractions. The panel took into account the oral evidence of Witness 3 who stated that 5 contractions or more in a ten-minute period amounted to hyper-stimulation. The panel also had sight of Miss Addo's submissions that hyperstimulation was 5 or more contractions, every 10 minutes, in a 30-minute period. The panel was not provided with any NICE or hospital guidelines to show how long would be needed to classify hyperstimulation.

The CTG trace at 23:08 shows 6 contractions in a 12-minute period. Witness 1 gave evidence that she believed this amounted to hyperstimulation and Miss Addo should have recognised that. However, the panel noted that the syntocinon was started at 23:05 and by 23:08, there was not enough time for Miss Addo to recognise that it was hyperstimulation, which Witness 1 made clear in her oral evidence when being cross-examined.

The panel had evidence that the contractions began to settle down. It determined that Miss Addo's actions in watching and waiting for this to happen were appropriate. It was reasonable for Miss Addo to pause in this way. The panel was of the view that although there is some hyperstimulation as defined by Witness 3, given that Witness 1's

evidence was that 3 minutes was not long enough to recognise hyperstimulation, Miss Addo could not have possibly reduced or stopped the syntocinon before getting a clearer picture of Patient B's contractions. The panel was satisfied that Miss Addo's actions in continuing to monitor Patient B's contractions were appropriate and therefore does not find these charges proved.

Charges 1b) i, ii, iii & iv

b) At, or around, 00:40 following prolonged decelerations failed to:

   i) manually palpate the uterus / adequately assess the length of the contractions;

   ii) manually palpate the uterus / adequately assess the strength of the contractions;

   iii) manually palpate uterus / adequately assess the frequency of the contractions;

   iv) monitor Patient B's contractions;

These charges are found NOT proved.

In reaching this decision, the panel noted that it had no evidence before it that Miss Addo had a duty to carry out the actions outlined in these charges at that material time. Witness 1 indicated that this would have been good practice, but it was not a requirement. The panel had evidence before it that Miss Addo pulled the emergency buzzer, called the Registrar, and turned Patient B on her left side. The panel considered that this was evidence of Miss Addo recognising that there were prolonged decelerations and taking subsequent actions to address this. Witness 1 told the panel in her oral evidence that she would have taken the same actions Miss Addo did in the same circumstances.

The panel was of the view that given the absence of any evidence that Miss Addo was under a duty to carry out the actions stated in the charges, there was no failure. It noted the evidence provided by Witness 1 in her statement that *"a huge part of training and practice is to recognise deviations and escalate issues to labour ward co-ordinator and*

to the obstetrics team." The panel determined that these are the actions Miss Addo took upon recognising a deviation from the norm within the CTG trace. Therefore, she did take appropriate action. The panel determined that whilst the actions of manually palpating the uterus to assess the length, strength and frequency of the contractions was considered good practice, it was not a requirement; therefore, it did not find these charges proved.

The panel had no evidence before it that Miss Addo was not monitoring the contractions at 00:40. It noted that the NMC were relying on Witness 1's statement and her interpretation of the CTG. Witness 1 stated that she would have expected Miss Addo to monitor the contractions as maybe Patient B was having too much syntocinon on the drip and therefore too many contractions. However, the panel was of the view that Miss Addo was clearly monitoring the contractions and the overall clinical picture, as a CTG monitor was running, and she reacted by pulling the emergency buzzer and notifying the Registrar when she noticed the decelerations.

The panel also had regard to Miss Addo's entry in the patient notes and determined that she had documented her observations. The panel was of the view that the only evidence the NMC have presented in relation to failure to monitor is Witness 1's statement that she would have liked Miss Addo to have monitored the contractions. However, the patient notes make it clear that Miss Addo was monitoring the CTG and pressed the emergency buzzer in respect of this. The CTG findings were included as a sticker which was written at 01:00 where observations had been written down including to observe trace, that there were no contractions at the time, that the risk factors were normal and classification was normal. Therefore, as no evidence has been produced that Miss Addo was not monitoring Patient B's contractions, it cannot be said to be a failure. The panel finds that as Miss Addo pressed the emergency buzzer and completed a CTG scan, it is clear that she was monitoring Patient B at this stage and the NMC have not provided any evidence contrary to this. The panel therefore finds these charges not proved.

Charge 1b) v

v) record / document your actions / rationale in relation to the matter referred to in any or all of charges 1(b)(i)- 1(b)(iv) above;

This charge is found NOT proved.

As the panel finds that charges 1b) i – iv are not proved, there is no requirement that Miss Addo should have recorded or documented her actions and rationale in respect of it. The panel heard evidence that Miss Addo pressed the emergency buzzer, called the registrant, documented the actions within the patient notes and followed this up with the CTG sticker which recorded various aspects of the care undertaken at that stage therefore there was no requirement on her to record or document her actions or rationale in respect of whether she had undertaken the actions as contained within charges i – iv in that having heard evidence from Witness 3 that the care given to patients at this stage is quite intense.

It is clear that Miss Addo carried out a number of actions regarding the care of the patient at that time and to expect her to record something that she was not required to do was considered too onerous in the panel's view. This was supported by the oral evidence provided by Witness 3 that negatives are not recorded and that there is no expectation that you would record your reasons or rationale for not doing something, rather, it is your actions that you would document. The panel also heard from Witness 5 who stated that expecting a midwife to record what was not done was *"asking too much"* and that *"there is no requirement to record what was not done and this is not substandard care"*. The panel therefore finds this charge not proved.

Charges 1c) i, ii and iii

c) Following the CTG trace having stopped recording Patient B's contractions adequately, failed:

i) to manually palpate / feel for the contractions;

ii) adjust the transducer to pick up the contractions;

iii) record / document your actions / rationale in relation to the matter referred to in any or all of charges 1(c)(i)- 1(c)(ii) above;

These charges are found NOT proved.

The panel was of the view that only Witness 1's witness statement presumes that the CTG trace is not picking up contractions. However, there is evidence within the patient notes that Miss Addo went on a break between 01:35 and 02:35. Miss Addo did not care for Patient B during this hour therefore it was not her responsibility to do anything at this stage. The CTG was still recording during this time and did not appear to document any contractions. The patient notes also stated:

- at 01:35, CTG monitoring on, no contractions noted,
- at 02:00, one contraction in 10 minutes,
- at 03:00 a classification sticker stating that the patient is not contracting,
- at 03:45, the patient was contracting *"6 in 10 mild".*

There is no evidence to suggest that the CTG trace ever stopped recording Patient B's contractions.

Therefore, there is evidence from the patient notes that Patient B's contractions were being monitored.

The panel determined that the NMC has not discharged the burden of proving that the CTG trace had stopped recording. As the NMC have failed to do this, it cannot be said that Miss Addo failed to carry out the actions outlined in these charges. It follows that she would not have been required to document her rationale in relation to them. The panel therefore finds these charges not proved.

Charges 1d) i & ii

d) Failed to classify / document the CTG trace:

i) every hour between 20:45 and 01:00;

ii) using a CTG sticker every hour between 20:45 and 01:00;

These charges are found NOT proved.

The panel had regard to the oral evidence from Witness 1. When asked if a CTG sticker should be used every hour, she answered yes from 23:05 it should have been. The classification should have been taken every hour. There was a classification taken at 20:45 and there was not another one until 01:00. After this point, there was one taken at every hour.

The panel noted that in her oral evidence, Witness 1 stated that "*once the woman is in established labour, CTG classification stickers should be used hourly."* Witness 1 went on to say that *"it appears that Patient B wasn't in established labour as she hadn't started her induction of labour, it appears appropriate to do 4-hourly observations and once the syntocinon was started then they would need to do regular hourly assessments."* Therefore, there has been no evidence presented to the panel that a CTG trace was required up until 23:05 when syntocinon was commenced. The panel has evidence that the syntocinon and the CTG trace started at 23:05. Although the charge states that there was a failure to classify and document the CTG trace, there was no requirement for a CTG trace between 20:45 and 23:05.

The panel noted from the evidence that the requirement for a CTG trace would have been 00:05, however this is not what the charge alleges. The panel considered inviting Mr Joshi to apply to amend the charge to limit the allegation to a single omission at about 00:05. On reflection, the panel considered that such a single omission in the context of regular subsequent actions would not give rise to a finding of misconduct. Accordingly, there would be no point in amending the charge in this way at this late stage.

The panel therefore finds these charges not proved.

Charges 1e) i & ii

e) At, or around 02:40 failed to:

i) recognise hyper stimulation;

ii) reduce / stop the syntocinon;

These charges are found NOT proved.

The panel had regard to Miss Addo's submission that hyperstimulation should be monitored for 30 minutes before any action is taken. The panel noted that there is a CTG trace that has 5 contractions in 10 minutes but then normalises after this period. The panel referred to its reasons in Charge 1a above and was of the view that Miss Addo could not have possibly reduced or stopped the syntocinon before getting a clearer picture of Patient B's contractions. The panel was satisfied that Miss Addo's actions in continuing to monitor Patient B's contractions constituted satisfactory care. The panel therefore do not find these charges proved.

Charges 1f) i, ii, & iii

f) At, or around 03:30, having raised a concern about the CTG trace failed to:

i) inform a co-ordinator / escalate Patient B's care having been advised to carry on by the doctor;

ii) recognise hyper stimulation of the uterus;

iii) use a CTG classification sticker;

These charges are found NOT proved.

The panel noted the entries within the patient notes in which Miss Addo detailed her concerns about the CTG trace and relayed this to the doctor. At 03:30, Miss Addo recorded these concerns and took appropriate action by having the doctor come and review Patient B. The doctor carried out the review and classified the CTG trace as "normal", advising Miss Addo to "carry on." The NMC provided no evidence that Miss Addo had concerns about the care being proposed by the doctor. The panel was of the view that the instruction to carry on given by the doctor was not obviously wrong so as to give rise to Miss Addo being concerned or disagreeing with the treatment being provided. She acted reasonably by escalating her concerns to the registrar and following their directions. The panel was not satisfied that this amounted to a failure.

The panel was of the view that as an agency nurse, there may have been some difficulty in Miss Addo challenging the advice of the registrar. Witness 1 accepted this in her oral evidence.

The CTG trace is not clear in respect of whether there was hyperstimulation. It was not noted in the patient notes, and the registrar carried out a review and did not note that there was hyperstimulation. Therefore, the panel did not conclude that there was hyperstimulation of the uterus at the material time; and consequently, Miss Addo should not be found to have failed to do anything about it. The requirement to use a CTG sticker following on from the CTG classification sticker being used at 03:00, is for it to be used at 04:00. There is no requirement for it to be used at 03:30, therefore there cannot be a failure to use it. The panel therefore found these charges not proved.

Charges 1g) i, ii, iii, and iv

g) At, or around, 3:50:

   i) incorrectly classified the CTG trace as normal;

   ii) failed to recognise the presence of hyper stimulation;

   iii) failed to reduce / stop the syntocinon;

   iv) failed to record / document your actions / rationale in relation to the matters referred to in any or all of charges charge(s) 1(g)(i) - 1(g)(iii) above;

These charges are found NOT proved.

The panel had regard to the CTG sticker and the patient notes. In the CTG sticker at 03:50 the panel noted a number of decelerations and Witness 1 gave evidence that this is not normal. This continues on until just before 04:00, when there is another group of decelerations. The panel noted that the registrar then carried out a review and classified this as normal. There is no evidence as to why this classification was made, only an entry that it will be reviewed again in an hour. The panel also heard evidence that decelerations in the trace can be caused by other factors, such as movement of the patient or the loss of contact, none of which are detailed within the notes. There is no

evidence before the panel that Miss Addo incorrectly classified the CTG trace as normal at or around 03:50. The registrar made this classification after the review. Rather, at 04:15 Miss Addo classified it as pathological.

The panel had evidence that Miss Addo was monitoring the contractions as there is an entry in the patient notes stating “contractions 6 in 10, mild” made at 03:50. The panel noted that Patient B was having mild contractions and the syntocinon was introduced to increase the intensity of her contractions. The panel took into account the oral evidence of Witness 3 who stated that 5 contractions or more in a ten-minute period amounted to hyperstimulation. The panel also had sight of Miss Addo’s submissions that hyperstimulation was 5 or more contractions, every 10 minutes, in a 30-minute period. The panel was not provided with any NICE or hospital guidelines to show how long would be needed to classify hyperstimulation.

Miss Addo had noted that there was some form of hyperstimulation in place, but not for a long enough time to categorise it and act such as reducing or stopping the syntocinon. Miss Addo was carrying out the instructions of the registrar at the time. It was not her duty to reduce or stop the syntocinon and go against what a senior doctor had told her to do. Therefore there was no failure on her part to reduce or stop the syntocinon.

In respect of charge 1g(iv), the panel determined that as it cannot be said that Miss Addo failed to carry out the actions outlined in the above charges, she would not have been required to document her rationale in relation to them.

The panel therefore finds these charges not proved.

Charges 1h) i & ii

h) Having documented that the CTG was pathological at 04:15:

i) failed to escalate Patient B’s care / record such escalation;

ii) increased the syntocinon to 50mls an hour / failed to discontinue syntocinon;

These charges are found proved.

The panel had regard to the oral evidence given by Witness 1, Witness 2, and Witness 3 that if a trace was classified as pathological, urgent escalation is required as the baby's condition called for immediate delivery. Miss Addo found that the CTG was pathological, but there is no evidence before the panel that a doctor was called before 05:00. The panel noted Miss Addo's submissions that she was in close contact with the obstetric SPR throughout this period of time and was acting in accordance with their direction as a senior member of the team at the relevant time. The panel noted that this was also not documented within the patient notes and there is no evidence of any escalation of care. There is evidence within the CTG that Miss Addo did increase the syntocinon to 50mls an hour. The panel was satisfied that Miss Addo failed to escalate care, increased synticinon and failed to discontinue it. The panel therefore finds these charges proved.

Charge 1i)

i) failed to document the partogram in the notes after 03:45;

This charge is NOT proved.

The panel had no evidence before it that there was a requirement for Miss Addo to document the partogram at 03:45. There is no partogram document within the patient notes after 03:45. Witness 1 in her oral evidence, told the panel that it would have been helpful and good practice to have documented it after 03:45. However, the panel heard no evidence that it was a requirement for it to be done, therefore the panel could not conclude that this was a failure. The panel noted that the NICE guidelines stated that a partogram should be documented, but it was not a requirement: *"all observations should be documented on the partogram"* as opposed to *must* be recorded, which would constitute a duty on Miss Addo. The panel therefore finds this charge not proved.

Charge 1j)

j) failed to record the PH (cord gases) on the baby's birth summary;

This charge is NOT proved.

The panel had regard to the baby's birth summary in which there are no PH (cord gases) recorded within it. The panel also heard evidence from Witness 1 that this would have been the responsibility of the doctor carrying out the caesarean to document. Whilst they may have delegated this task to a midwife, the responsibility ultimately lay with the doctor to ensure this was done. The panel noted that a retrospective entry by the doctor was made stating that cord gases has been taken, therefore there was no duty upon Miss Addo to have carried out this action. The panel therefore finds this charge not proved.

Charges 2a (i), (ii), 2c (ii), (iii), (iv) 2d(ii), 2e

2) On 3/4 March 2017, in relation to Patient A, between 22:41 and 23:02 whilst Patient A's CTG trace was pathological:

   a) at, or around, 22:41, having recorded that the CTG remains "tacky" (tachycardic), failed to:

      i) document prolonged decelerations;

      ii) call for help / escalate Patient A's care;

   c) at, or around, 23:00 having bleeped the Registrar who was busy, failed to:

      ii) recommend to the Registrar that an urgent review was required / confirm that the CTG trace was pathological;

      iii) escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;

      iv) record / document your actions / rationale in relation to the matters referred to in charge(s) 2(c)(i), 2(c)(ii) and 2(c)(iii) above;

   d) at, or around, 23:02:

      ii) failed to document / record why Patient A had been taken off of the CTG trace and / or it had been discontinued;

   e) failed to identify the CTG trace as pathological and / or the need for escalation;

These charges are found NOT proved.

The panel heard contrasting views around a CTG trace that was produced. Witness 3 indicated to the panel that the trace was pathological and pointed out the abnormal features. The panel noted that these abnormal features fall into the guidelines of what is considered a pathological trace. Witness 3's interpretation of the CTG trace is that there were pathological features contained within it, including decelerations for over 3 minutes and other abnormal features around the baseline.

The panel also had regard to evidence from Witness 5 who interpreted the CTG trace as not being pathological, as there were no decelerations in excess of 3 minutes. Further, that there were other explanations for the abnormal features such as loss of contact, and the fact that Patient A had been turned on to her left side. In Witness 5's opinion, whilst the CTG trace was difficult to interpret, it was not pathological. The panel also heard evidence from Witness 5 that it would be extremely unusual for a pathological CTG trace to normalise following a period of it being pathological. The panel also heard from Witness 5 that had the trace become pathological between 22:41 and 23:02, the baby would not have survived a 4-and-a-half-hour delay until delivery.

The panel noted that there were 4 and a half hours of normalised trace after the period of alleged pathological trace.

The panel also had regard to Miss Addo's submission that in her view, the trace was not pathological. In addition, it considered the evidence provided by Witness 3 accepting that an emergency caesarean should have been undertaken if the CTG trace been pathological. A registrar had also reviewed the CTG trace and classified it as normal, which further reinforces that the NMC have not proved that the trace was pathological.

As the panel have found that the NMC have not proved that the trace was pathological, then the subsequent actions set out in the charges above were not required to be undertaken by Miss Addo.

The panel therefore finds these charges not proved.

Charge 5a) – c)

5) On 3/4 March 2017, following Patient A's CTG trace having started to show decelerations at, or around, 03:50:

   a) failed to identify the CTG trace as pathological / the need for escalation;

   b) failed to escalate Patient A's care to a Senior Midwife / co-ordinator / another Registrar;

   c) failed to record / document your actions / rationale in relation to the matters referred to in charge 5(a) and 5(b) above;

These charges are found NOT proved.

The panel had regard to evidence from Witness 3, that on her interpretation of the CTG trace, at 03:50 there is clear prolonged deceleration which makes the trace pathological. This was countered by Witness 5 that Miss Addo's actions in turning Patient A on to her left side may have resulted in a loss of contact and a subsequent deceleration. The panel concluded that Miss Addo's actions at the time in monitoring Patient A and informing the registrar, were appropriate. The panel was of the view that the NMC has not discharged its burden of proof to demonstrate that the CTG was pathological. Therefore, there could not be a failure to identify the CTG as pathological on Miss Addo's part. Consequently, there would be no need to escalate it to a senior midwife, co-ordinator, or another registrar.

There is evidence before the panel that the registrar subsequently at around 04:20 – 04:30 carried out a review on Patient A, which the panel considers to be at or around 03:50. The panel had regard to the guidelines on actions that should be taken if a CTG trace is considered suspicious, and the actions Miss Addo took complied with these guidelines.

The panel determined that as it cannot be said that Miss Addo failed to carry out the actions outlined in charges 5a and 5c, she would not have been required to document

her rationale in relation to them. This was supported by the oral evidence provided by Witness 2 who told the panel in her oral evidence, that negatives are not recorded and that there is no expectation that you would record your reasons or rationale for not doing something, rather it is your actions that you would document. The panel also heard from Witness 5 who stated that there is no requirement to record what you have not done but as long as you document what you have done, then it is not considered substandard care. The panel therefore finds these charges not proved.

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 Miss Addo's 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 ability to practise kindly, safely, and professionally.

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, Miss Addo's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Joshi invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code)'.

Mr Joshi identified the specific, relevant standards where in his submission, Miss Addo's actions amounted to misconduct. He submitted that the panel will have to consider the seriousness of the concerns and referred it to the NMC's guidance on seriousness at FTP-3. He reminded the panel that when addressing whether a concern is serious, the guidance looks at what risks are likely to arise if the nurse, midwife, or nursing associate does not address or put the concerns right. In addition to this, it also looks at public trust and confidence.

Mr Joshi submitted that Miss Addo's statement does not directly deal with the facts as the panel found them and it is a matter for the panel as to what it finds, but the public interest aspect is about an individual looking at the facts found proved and thinking that if they should be a patient under the care of Miss Addo, what sort of care would they expect? He submitted that this may be difficult because this was such a sensitive and high-risk area, and failing to act when a duty is required is capable of amounting to misconduct.

Submissions on impairment

Mr Joshi 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) (*Grant)*.

Mr Joshi submitted that whether the facts found proved amount to current impairment will depend on Miss Addo's attitude and what evidence the panel has of the strengthening of her practice. He reminded the panel that the incidents took place some time ago and that this was one of the reasons why in the interests of fairness to Miss Addo, he asked if there were any further submissions, she was willing to make. Although Mr Walker did not indicate that there were, given the absence of a response to the email containing the decision and reasons on facts, sent by the Hearings

Coordinator to Mr Walker, Mr Joshi submitted that this does not take away from the panel's fundamental duty to consider current impairment.

Mr Joshi further submitted that Miss Addo was a qualified midwife from some time ago, has had considerable experience, and was regularly employed as an agency nurse. He reminded the panel that it has already heard about the training aspects and other aspects that were put into place for her, and that the emails in relation to the training that took place noted that most of the training was after what had taken place in the facts found proved. However, in the interest of fairness, the panel will have to consider that that has now dealt with the public interest concern.

After the panel had retired to determine its decision on misconduct and impairment, Mr Walker emailed the following written submissions in response to the email sent by the Hearings Coordinator:

> *"[Miss Addo] is very grateful for the careful consideration the panel have plainly given to this case, resulting in the dismissing of almost the entirety of the case against her, as either not capable of proof or not being proved.*
>
> *Having reviewed the submissions made in respect of misconduct, those submissions remain apt.*
>
> *The thrust of [Miss Addo's] submissions on misconduct focus on the isolated nature of any failings. Given the panel found two sub-particulars proved from 23 sub-particulars under allegation 1, those submissions are greatly reinforced.*
>
> *We would invite the panel to consider that isolated nature carefully, along with the contemporaneous response from the referrer, and [Miss Addo's] subsequent good practice. It is submitted that the 1h(i) and (ii) would not have been considered matters that could have impaired fitness to practice by themselves - they would not have been referred - and in the circumstances, it would be appropriate for a finding that the conduct does not amount to misconduct."*

The panel accepted the advice of the legal assessor. In relation to misconduct, he advised that the breach of duty must be serious if it is to amount to misconduct. In relation to a single instance of negligence, it must be very serious. In relation to impairment, he quoted from *Grant.*

After Mr Walker had sent in his written submissions, the legal assessor quoted to the panel, from the decision of Mr Justice Eady in *Aga v General Medical Council* [2012] EWHC 782 (Admin):

Mere negligence does not constitute 'misconduct'… Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to 'misconduct'.

A single negligent act or omission is less likely to cross the threshold of 'misconduct' than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as 'misconduct'.

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 Miss Addo's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Addo's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

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 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively.

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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,

10.2 recording if the notes are written some time after the event

10.3 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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. It looked at the NMC guidance on seriousness and was of the view that the evidence presented before it was not enough to demonstrate that the harm caused was deliberate. The panel determined that this was a one-off clinical incident. However, due to the fact that there was a potential of serious harm to the patient and the baby, and the absence of evidence that there is no longer a risk to patient safety or that Miss Addo has demonstrated that she has learnt from the incident, her actions amount to misconduct.

The panel found that Miss Addo's actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 be honest and open and act with integrity. 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 *Grant* in reaching its decision. At 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.’

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

The panel finds that a mother and baby were put at risk and were caused physical and emotional harm as a result of Miss Addo's misconduct. Miss Addo's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Dishonesty did not apply in this case.

Regarding insight, the panel considered Miss Addo's willingness to improve by sitting the CTG test, although she did not meet the required standard. However, due to the lack of evidence provided around how this was engaged with, the procedures to go through to do it, or any personal matters or effects this had on her, the panel did not take it into account in respect of impairment, because although she failed the test, this does not necessarily make her currently impaired.

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 Miss Addo has taken steps to strengthen her practice. The panel took into account the written submissions of Mr Walker and the training Miss Addo had previously undertaken. However, the panel had not been presented with any further recent evidence that Miss Addo had strengthened her practice. It noted that she had practised safely for a long period of time. However the incident was serious, and Miss Addo has

not provided any evidence that reassures the panel that she understands the reasons behind her misconduct.

The panel is of the view that there is a risk of repetition based on the absence of any evidence of insight, remediation, and retraining. The panel determined that Miss Addo was liable to put the profession into disrepute. The panel noted that Miss Addo had stated that she had retired and did not intend to return to practice, however there is no concrete evidence around this and given that she had retired previously and returned to practice, she may do this again. 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.

The panel determined that a finding of impairment on public interest grounds is required because an informed member of the public aware would be surprised to know that a finding of impairment were not made in the circumstances given the seriousness of the fact found proved.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months with review. The effect of this order is that Miss Addo's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about Miss Addo's registration will be informed of this order.

Submissions on sanction

The panel were provided with the following written submissions on sanction from Mr Walker:

"

102. The panel's findings in relation to misconduct and impairment are noted.

103. In Towuaghantse v General Medical Council [2021] EWHC 681 (Admin), Mr Justice Mostyn said at para 77:

"I reiterate my opinion in GMC v Awan at [40] that the absence of any significant gap between the findings of fact and the commencement of the impairment and sanctions phases means that it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the Judgment Approved by the court for handing down. Towuaghantse v GMC iimpairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him. In my opinion the capacity of the registrant to remediate sincerely should be judged by reference to evidence unconnected to his forensic stance in the fact-finding phase (unless the fact-finding decision included findings of blatant dishonesty by the registrant)."

104. It is submitted that it would be even more unrealistic to expect a volte face from R, where, out of 42 particulars/sub-particulars, only two had been found proven.

105. The registrant is not in a position to demonstrate full remediation by that full acceptance.

106. She can and does however point to full remediation by other means.

107. The panel have found that R's actions were not deliberate. They have found that due to the absence of evidence that there is no longer a risk to patient safety or that Miss Addo has demonstrated that she has learnt from the incident, R's action amount to misconduct. Respectfully, we disagree with that analysis. The panel found further that there is a risk of repetition based on the absence of any evidence of insight, remediation, and retraining. Again, respectfully we disagree.

108. R was subject to the recommendations made by her employer following the internal investigation around the care given to Patient B. Those recommendations included reflective learning. R is not in a position to evidence the reflective learning carried out. However, as far as is known, the panel have not heard evidence gainsaying that reflective

learning was carried out. Moreover, it is obvious that given the investigation report and the recommendations made, R would have been monitored to a greater extent that usual, in order to ensure that the concerns were not repeated, in accordance with the rationale for the recommendations.

109. In the NMC's guidance on Insight and Strengthened practice, it is set out in the section "Sufficient Steps to address the concern", that such steps are not just limited to reflective pieces. They include:

> *Successfully completing a period of supervised practice targeted at the concerns arising from the alleged behaviour.*
> *Periods of employment during which the nurse, midwife or nursing associate has practised in similar clinical fields, or carried out similar procedures to those where the original failings or concerns arose. Decision makers should look for clear evidence that the employer was aware of the areas of concern within the nurse, midwife or nursing associate's practice and what has been observed or assessed regarding these.*

110. R relies on the fact that during a period when she was doubtless subject to increased supervision relating to concerns around her care of Patient B, no further legitimate issues arose. Reference has been made and the panel is reminded of the same, to R's care of Patient A several months later, which it is submitted was subject to expert scrutiny and found to be of an appropriate professional standard.

111. As a result, the panel does have before it evidence of remediation, whether framed either as a period of supervised practice or a period of employment where R practised in the same clinical field. The period ended with what can be taken a dip test of her competence in the relevant area, and she passed with no concerns, as illustrated by both the report of SB, but also by the panel's findings. She has, we say, adequately demonstrated remediation.

112. In assessing what is the appropriate sanction, the panel will approach the sanctions in ascending order of severity, and will consider the mitigating and aggravating factors.

113. The panel is invited to consider the following mitigating factors:

1) *The fact that the matters found proved amount to a one-off clinical incident that was not deliberate;*

2) *The lack of previous regulatory matters;*

3) *The fact that the incident was caused because of a multi-disciplinary failing;*

4) *The fact that R has been subject to interim restriction since 2018. This factor is of particular significance. On 4 June 2018, the registrant was made subject to an interim suspension order. She remained subject to that order until 19 April 2023, shortly after the author was instructed, when at an Early Review, the panel substituted an interim conditions of practice order. This was of course too late for R, who would now need to sit a competence test or take a return to practice course in order to further practise as a midwife. The panel will note that R has not had any opportunity to demonstrate her fitness to practice through practice since that restriction was imposed. In the circumstances, restriction by suspension has been shown by subsequent findings to have been grossly unfair to R.*

114. In Akhtar v GDC [2017] EWHC 1986 (Admin), HHJ McKenna affirmed the principle that common fairness dictates that Panels must take into account any interim order and its effect on the registrant when deciding on whether a sanction is proportionate. The effect of the interim order on R has been devastating, and has largely contributed to the end of her career.

115. Accordingly, taking into consideration the NMC's guidance on Sanction, the panel is invited to impose the least restrictive sanction in light of both the registrant's own interests and the overriding objective."

Mr Joshi submitted that given the panel's findings on misconduct and impairment, a non-restrictive outcome such as a caution order or no further action, is unsuitable. He referred the panel to the Sanctions Guidance (SG) in relation to conditions of practice orders and the relevant bullet points from that regarding when conditions of practice orders are appropriate. He submitted that this may raise a question mark over the potential and willingness of Miss Addo to respond positively to retraining because she has, by all accounts, retired. However, it is fairly obvious from the documentation submitted by Mr Walker that she has shown willingness in the past to undertake retraining and there is inconclusive evidence that she intends to remain in retirement.

Mr Joshi submitted that the seriousness of the case requires a restrictive sanction, but not a suspension order, in order to protect the public or uphold the public interest. As such, the sanction bid the NMC propose is for a 12-month conditions of practice order with review. He reminded the panel that the decision is ultimately down to it, but the conditions should address the clinical deficiencies. He further submitted that the period

of 12 months is to take account of Miss Addo not currently practising as a midwife and that there is little merit in an early review because should she choose to return to work, there would not have been much time for the conditions to have any meaningful effect.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found Miss Addo's 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:

- Lack of insight into failings.
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- One-off clinical incident which was not deliberate.
- Absence of any previous regulatory proceedings.

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 Miss Addo's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower*

end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Miss Addo's 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 Miss Addo's 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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, Miss Addo has practised as a midwife for many years without any regulatory concerns. The panel was of the view that it was in the public interest that, with appropriate safeguards, Miss Addo should be able to return to practise as a midwife.

Balancing all of these factors, the panel determined 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 Miss Addo's case because the areas of concern identified are capable of being addressed through retraining.

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 profession and will send to the public and the profession a clear message about the standards of practice required of a registered midwife.

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 nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.*

1. Until you are assessed by your line manager or supervisor as competent in the areas listed below, you must ensure that you are being directly supervised by a registered midwife band 6 or above any time you are working:
    - CTG training and analysis
    - Escalation of care
    - Drugs administration
    - Record keeping

2. You will send your case officer evidence that you have successfully been assessed as competent in the following areas:
    - CTG training and analysis
    - Escalation of care

- Drugs administration
- Record keeping

3. You must keep a reflective practice profile. The profile will include:
    - Detail of cases where you demonstrate competencies in the areas outlined above.
    - Set out the nature of the care given.
    - Be signed by your line manager or supervisor.
    - Contain feedback from your line manager or supervisor on how you gave the care. You must send your case officer a copy of the profile every 3 months.

4. You must work with your line manager or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about the areas outlined above. You must:
    - Send your case officer a copy of your PDP before the next review hearing.
    - Send your case officer a report from your line manager or supervisor before the next review hearing. This report must show your progress towards achieving the aims set out in your PDP.

5. You must engage with your line manager or supervisor on a frequent basis to ensure that you are making progress towards aims set in your personal development plan (PDP), which include:
    - Meeting with your line manager or supervisor at least once every month to discuss your progress towards achieving the aims set out in your PDP.

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

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

8. You must immediately give a copy of these conditions to:
    - Any organisation or person you work for.
    - Any agency you apply to or are registered with for work.
    - Any employers you apply to for work (at the time of application).
    - Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    - 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.

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

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    - Your line manager or supervisor.
    - Any current or future employer.
    - Any educational establishment.

- Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months with review.

Before the order expires, a panel will hold a review hearing to see how well Miss Addo has 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 with another order.

Any future panel reviewing this case would be assisted by Miss Addo's:

- Engagement with the NMC and attendance at future hearings.
- Written statement clarifying whether she intends to retire permanently as a midwife.
- Reflective piece addressing the concerns raised.

This will be confirmed to Miss Addo 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 Miss Addo's own interests 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 Mr Joshi. He submitted that even though the panel have made a substantive order for 12 months, the NMC seek an

interim order for 18 months to cover the period taken by any appeal by Miss Addo upon receiving notice of the order.

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 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 for a period of 18 months to cover any potential appeal period.

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 Miss Addo is sent the decision of this hearing in writing.

That concludes this determination.