Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 February 2022 – Wednesday 9 February 2022
Thursday 1 September 2022 – Tuesday 6 September 2022
Thursday 8 September 2022 – Tuesday 13 September 2022
Tuesday 28 November 2023 – Thursday 30 November 2023

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ
Hybrid Virtual Hearing

Name of registrant:	Angela Lisa Jones
NMC PIN:	05L0524E
Part(s) of the register:	RM, Midwife (01 March 2003)
Relevant Location:	Leicestershire
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, Lay member) Laura Wallbank (Registrant member) Robert Cawley (Lay member)
Legal Assessor:	Paul Housego (7 February 2022 – 13 September 2022) Sean Hammond (Tuesday 28 November 2023 – Thursday 30 November 2023)
Hearings Coordinator:	Anya Sharma
Nursing and Midwifery Council:	Represented by Samuel March, of Counsel (7 February 2022 – 13 September 2022) Represented by Mary Kyriacou (Tuesday 28 November 2023 – Thursday 30 November 2023)
Ms Jones:	Present and represented by Wafa Shah, of Counsel (Monday 7 February 2022), Present and represented by Briony Molyneux, of Counsel (Tuesday 8 – Wednesday 10 February 2022, Thursday 1 – Tuesday 13 September 2022, Tuesday 28 November 2023 – Thursday 30 November 2023)

Facts proved by admission:	**Charges (as amended) 2b, 2d, 2f, 2g, 2h, 2i, 2j, 2m(i), 2m(iii), 2n(v) and 3**
Facts proved:	**(as amended) 1a, 2a, 2c, 2k, 2l, 2m (ii), 2m(iv), 2n and 2o**
Facts not proved:	**(as amended) 1b, 2e and 4**
Fitness to practise:	**Impaired**
Sanction:	**Conditions of Practice Order (18 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Decision and reasons on application to postpone until Tuesday 8 February 2022

Ms Shah on your behalf made an application to postpone proceedings until tomorrow (Tuesday 8 February 2022) on the basis that Counsel briefed to represent you is unable to attend today, being required to present closing submissions in a case which overran from last week. Ms Shah also informed the panel that there are proposed redactions which have not yet been agreed upon, and the original representative would be the best person to speak to regarding this.

Ms Shah explained that you have received representation from a union and Counsel has been instructed and preparing for this case. She submitted that the schedule of charge includes the very serious allegation of dishonesty.

Ms Shah explained that your Counsel has been held back in the Crown Court on a jury trial and is therefore unable to attend today.

Ms Shah submitted that communication regarding this was relayed to the Nursing and Midwifery Council (NMC) on Friday 4 February 2022 and it had not been possible to secure alternative representative given the lack of time. Ms Shah advised that she was instructed only in respect of the application to postpone, after which she would be required to withdraw. She explained that she was not in a position to represent you, as she had not prepared your case, nor was she available for the rest of this week.

Ms Shah referred the panel to the NMC Guidance on Postponements and Adjournments. She submitted that whilst this is a matter for the panel, it would be unfair for you to be unrepresented at a hearing when you have sought and obtained representation and therefore are not prepared to represent yourself. Ms Shah submitted that this is not a fault of yours, and that you are present and ready to engage.

Ms Shah referred the panel to Article 6 of the European Convention on Human Rights (ECHR) and that all hearings should be fair for all parties.

Ms Shah submitted that the witnesses for the NMC's case are, she was told, available tomorrow and any injustice to the NMC would therefore be insignificant. She submitted that the only concern in this case would be that the panel lose a day of the hearing. Ms Shah submitted that given the number of charges in this case and the number of witnesses that are due to attend over the next few days, it would be unlikely that this case would conclude in five days and this case would therefore go part-heard, as was accepted by Counsel for the NMC.

On behalf of the NMC, Mr March submitted that it is currently not clear whether the witnesses that were warned for today at 11:00am are also available tomorrow. He submitted that one witness, Student A, was due to be attending the hearing centre at 11:00am.

There was a short adjournment during Mr March's submissions to allow Student A to arrive. Mr March informed the panel that Student A had attended a different address in London and was making her way to 2 Stratford Place (2SP) having called reception for the correct address. He submitted that it is the NMC's instruction that he opposes the application for a postponement because there is a public interest in the expeditious disposal of this case, and fairness to all parties included the NMC. Mr March submitted that he will be able to make further comments on his application once Student A arrived at 2SP and he had the opportunity to speak to her.

There was a short adjournment until 11:45 to allow Student A time to arrive at 2SP and for Mr March to speak with Student A. At 12:15, he had been able to do so.

Mr March then explained to the panel that by the time the NMC had contacted Student A on Friday 4 February 2022 about the change in the hearing, she was already on a night shift and was therefore unable to respond. He submitted that Student A had therefore decided to attend today along with a friend, a colleague who is also a midwife, for emotional support.

Mr March submitted that enquiries had been made on the possibility of Student A and her friend's shifts being changed to allow them to come back on any other day this week

for Student A to give evidence. He submitted that her manager (another witness in the case) and the matron said that this was not possible due to staffing levels which meant that their absence, singly or jointly, would reduce staffing to below critical levels, and therefore this could not be arranged.

Mr March submitted that even if Student A and her friend were available on Thursday or Friday, it would be so late in the week at that point that the hearing would go part heard. While accepting that this was not your fault, and appreciating the difficulty in which this placed you, he was therefore instructed to oppose the application for a postponement due to the inconvenience caused by the late notice that the representative was not available today.

Ms Shah submitted that it was through no fault of yours that this situation has arisen and that should the panel decide to read the charges and proceed, you would not be in position that you are prepared to ask questions/cross examine Student A. Ms Shah submitted that you should therefore be released for the rest of the day and be permitted to return tomorrow with your representative. She pointed out that the hearing could not proceed until the redactions had been agreed and the panel had been provided with, and read, the bundle of documents.

Mr March submitted that although he was instructed to oppose the application, he could not challenge the submission of Ms Shah that it would be unfair for you to be expected to question Student A unrepresented, and without opportunity to prepare.

The panel heard and accepted the advice of the Legal Assessor, which was that it would be inconsistent with the panel's obligations under Article 6 of the European Convention on Human Rights to proceed today.

The panel considered that it would be wholly unfair for you to be expected to question Student A given that you are not prepared and currently unrepresented today. The panel noted that Student A is very anxious at the prospect of giving evidence and is emotionally supported by her friend. The panel further noted that there are other things that are yet to be organised for this case, in particular redactions being agreed, and the

panel will need time to read the bundle of documents. The panel was therefore of the view that it was necessary to adjourn proceedings until tomorrow (Tuesday 8 February 2022), and to try to agree directions at the start of the afternoon.

Details of charge

That you, Band 6 Midwife,

1. On 30 October 2018, during Patient A's first admission you:
    a. did not auscultate the foetal heart rate after conducting a vaginal examination

2. On 30 October 2018, during Patient A's second admission you:
    a. did not perform an abdominal palpation before conducting a vaginal examination;
    b. did not allow Student A to perform an abdominal palpation;
    c. did not undertake a full assessment of Patient A;
    d. did not auscultate the foetal heart rate prior to conducting a vaginal examination;
    e. did not auscultate the foetal heart rate after conducting a vaginal examination;
    f. incorrectly used the first stage partogram to document the second stage of labour;
    g. did not auscultate the foetal heart rate every five minutes during the second stage of labour;
    h. did not document in the patient notes and/or the partogram the reasons you did not auscultate the foetal heart rate every five minutes;
    i. did not document in the patient notes/and or the partogram that you completed a "partial palpation" of Patient A's abdomen on her return to established labour;
    j. did not document in the patient notes/and or the partogram that you completed an auscultation on the foetal heart rate following the vaginal examination during Patient A's first admission;
    k. left Student A alone on one or more occasions during the second stage of labour;
    l. when you left the room you did not inform Student A where you were going;
    m. did not wash your hands before conducting the birth of Baby A;
    n. did not wear gloves:
        i. during the birth of Baby A

ii. whilst conducting an vaginal examination on Patient A
iii. during the delivery of the placenta
iv. to remove a blood clot in the birth pool
v. when touching the umbilical cord KW 38-40

o. did not obtain consent and/or inform Patient A that you were going to undertake an vaginal examination during the birth of Baby A;
p. during the third stage labour you inappropriately pulled/tugged on the umbilical cord;

3. On or around 1 December 2018, whilst discharging Patient B home you prescribed “Diclofenac” by adding it to the “to take out” TTO form when you did not have the authority to do so.

4. Your actions as described in Charge 3 were dishonest in that you:
    a. knew that Diclofenac had not been prescribed by Doctor A
    b. created an impression that Doctor A had prescribed Diclofenac for Patient B

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

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, Ms Molyneux made a request that this case be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

Mr March indicated that he supported the application to the extent that any reference to [PRIVATE] should be heard in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may

hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised.

Decision and reasons on application to admit video link evidence

The panel heard an application made by Mr March under Rule 31 to allow Ms 1 and Ms 2 to give their evidence over video link. Mr March informed the panel that Ms 1 was not present at this hearing and explained she was unable to attend today due to having tested positive for Covid-19. Mr March informed the panel that Ms 2 was also not present at this hearing and was unable to attend today due to having to care for her newborn baby.

Ms Molyneux submitted that given the circumstances of the witnesses and the case she does not object to the application and that it is a matter for the panel to consider.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Ms 1 and Ms 2 serious consideration. The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 1 and Ms 2 to that of video link evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Ms 1 to give evidence remotely over the telephone/via video link but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Molyneux, who informed the panel that you made admissions to charges number 2b, 2d, 2f, 2g, 2h, 2i, 2j, 2n(i), 2niii), 2n(v) and 3a.

The panel therefore found charges numbers 2b, 2d, 2f, 2g, 2h, 2i, 2j, 2l, 2m, 2n(ii), 2n(v) and 3a proved, by way of your admissions.

The numbers given in the decision section of this determination are different. This is because allegation 2.j related to the first admission and so the charges were amended to move 2.j to become 1.b. This means that all the charges from 2.k to the end of charge 2 all moved back one letter.

In reaching its decisions on the disputed facts, the panel considered all the oral and documentary evidence in this case together with the submissions made by Mr March on behalf of the NMC and by Ms Molyneux on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

Background

Mr March provided the panel with a background to the case and the charges.

The charges arose whilst you were employed as Band 6 registered midwife within the Maternity Unit at Leicester General Hospital (the Hospital), which is part of University Hospitals of Leicester NHS Trust (the Trust), where you had worked as a midwife since

2006. In 2013, you were promoted to a Band 7 midwifery role, until you stepped down to a Band 6 role in 2018.

A first-year student midwife (Student A) was allocated to work with you. This was Student A's second placement and they had witnessed only two births within their training when they first worked with you.

Student A wrote a 'Clinical Placement Experience' for the university where they were studying and this was then escalated to the Hospital, as there were some concerns with how you had supported Student A during their placement. The former midwifery matron was initially investigating the matter, but on their retirement, the investigation was handed over to Ms 1.

In the document, Student A refers to the care of Patient A on 30 October 2018, when they were working with you. Patient A was in labour with her first baby, was 'hypnobirthing' and wanted a pool birth. The concerns raised by Student A included you:

- not palpating Patient A's abdomen prior to performing a VE
- not allowing Student A to perform an abdominal palpation under supervision
- not listening to the foetal heart every five minutes in the second stage of labour
- leaving Student A and Patient A alone for long periods of time during the second stage of labour
- not adhering to infection control procedures in that you did not wash your hands or wear gloves during the birth of the baby or the placenta
- pulling on the umbilical cord when Patient A was undergoing a physiological third stage of labour

While the matter was investigated, you were required to work on the ante/postnatal ward. On 1 December 2018, you were in the process of discharging Patient B home.

You noticed that Patient B had not been prescribed any analgesia ‘to take out’ (TTO), but had been prescribed an anticoagulant.

A midwifery colleague, Ms 3, heard you voice your concern that the TTO form did not include an analgesic. You then asked them to check the TTO form with you, which then included diclofenac (an analgesic). Ms 3 did not raise concerns with you at the time, but later raised this with a more senior midwife. Ms 3 was concerned that you had written on the prescription and in effect prescribed the diclofenac, which was outside the scope of your professional practice.

Ms 1 also investigated this concern and spoke to the doctor who prescribed the anticoagulant medication on the TTO form, Doctor A, who said they did not prescribe the diclofenac.

You later admitted that the writing on the TTO form for the diclofenac was your writing, but did not recall caring for or discharging Patient B. This was considered a dishonest act as you had added the diclofenac to the prescription already written by Doctor A.

The investigation culminated in a disciplinary hearing on 13 June 2019, resulting in your instant dismissal.

You are not currently working in any capacity as a midwife.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr March on behalf of the NMC, to amend the wording of charges 2(a), 2(k) and 2(n).

The proposed amendment was to move charge 2.j to become 1.b, and to renumber the rest of charge 2. The other amendments were sought by Mr March to provide clarity and more accurately reflect the way you responded to the allegations.

2. On 30 October 2018, during Patient A's second admission you:

a. did not perform a~~n~~ **sufficient** abdominal palpation before conducting a vaginal examination;

k. left Student A alone **without another member of staff** on one or more occasions during the second stage of labour;

n. did not wear gloves:

i. during the birth of Baby A
ii. whilst conducting an vaginal examination on Patient A
iii. during the delivery of the placenta
iv. to remove a blood clot in the birth pool **with your bare hands**
v. when touching the umbilical cord

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

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

The panel also heard a further application from Mr March to amend the placement of charge 2(j).

The proposed amendment was for charge 2(j) to be shifted under charge 1 and become 1(b) to remove the requirement for 'during Patient A's first admission' to be repeated within the charge.

1. On 30 October 2018, during Patient A's first admission you:
   a. did not auscultate the foetal heart rate after conducting a vaginal examination
   b. ~~2(j)~~ did not document in the patient notes/and or the partogram that you completed an auscultation on the foetal heart rate following the vaginal examination ~~during Patient A's first admission~~;

The proposed amendment for charge 2(j) to become 1(b) additionally changed the lettering for the remainder of the sub charges under charge 2.

The panel also heard an application from Mr March to amend the wording of charges 2(n)(ii) and 2(o). Mr March submitted that a 'vaginal examination' may not be the best description in a charge given the evidence of Student A,

2. On 30 October 2018, during Patient A's second admission you:

n. did not wear gloves:

ii. ~~whilst conducting an vaginal examination on~~ **when touching** Patient A**'s genitalia and/or perineum with bare hands whilst assisting Patient A to give birth**

o. did not obtain consent and/or inform Patient A that you were going to **touch her genitalia and/or perineum with bare hands** ~~undertake an vaginal examination~~ during the birth of Baby A;

Details of Charge (as amended)

That you, Band 6 Midwife,

1. On 30 October 2018, during Patient A's first admission you:
    a. did not auscultate the foetal heart rate after conducting a vaginal examination
    b. did not document in the patient notes/and or the partogram that you completed an auscultation on the foetal heart rate following the vaginal examination

2. On 30 October 2018, during Patient A's second admission you:
    a. did not perform sufficient abdominal palpation before conducting a vaginal examination;
    b. did not allow Student A to perform an abdominal palpation;
    c. did not undertake a full assessment of Patient A;
    d. did not auscultate the foetal heart rate prior to conducting a vaginal examination;
    e. did not auscultate the foetal heart rate after conducting a vaginal examination;
    f. incorrectly used the first stage partogram to document the second stage of labour;
    g. did not auscultate the foetal heart rate every five minutes during the second stage of labour;
    h. did not document in the patient notes and/or the partogram the reasons you did not auscultate the foetal heart rate every five minutes;
    i. did not document in the patient notes/and or the partogram that you completed a "partial palpation" of Patient A's abdomen on her return to established labour;
    j. left Student A alone without another member of staff on one or more occasions during the second stage of labour;
    k. when you left the room you did not inform Student A where you were going;
    l. did not wash your hands before conducting the birth of Baby A;
    m. did not wear gloves:
    i. during the birth of Baby A
    ii. when touching Patient A's genitalia and/or perineum with bare hands whilst assisting Patient A to give birth
    iii. during the delivery of the placenta

iv. to remove a blood clot in the birth pool with your bare hands
v. when touching the umbilical cord KW 38-40
n. did not obtain consent and/or inform Patient A that you were going to touch her genitalia and/or perineum with bare hands during the birth of Baby A;
o. during the third stage labour you inappropriately pulled/tugged on the umbilical cord;

3. On or around 1 December 2018, whilst discharging Patient B home you prescribed "Diclofenac" by adding it to the "to take out" TTO form when you did not have the authority to do so.

4. Your actions as described in Charge 3 were dishonest in that you:
a. knew that Diclofenac had not been prescribed by Doctor A
b. created an impression that Doctor A had prescribed Diclofenac for Patient B

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

Decision and reasons on application of no case to answer

The panel considered an application from Ms Molyneux that there is no case to answer in respect of charges 2(e) and 4(b). This application was made under Rule 24(7).

In relation to this application, Ms Molyneux referred the panel to the test set out by the Court of Appeal in the case of *R v Galbraith [1981] 1 WLR 1039.* She submitted that the second limb of the *Galbraith* test is engaged in that there is some evidence, but that the evidence that has been presented to the panel on behalf of the NMC which it relies on to prove these charges is inherently weak.

Ms Molyneux submitted that charge 2(e) comes from the evidence of Student A and referred the panel to the relevant parts of the exhibit bundle. She submitted that the NMC document is inaccurate and that the evidence to support this charge is not capable of finding it proved. Ms Molyneux submitted that the NMC's own evidence sits

outside the charge and is inconsistent with what Student A has stated in her witness statement and oral evidence.

Ms Molyneux submitted that should the panel accept her submissions, it should not allow the charges to go further. In these circumstances, it was submitted that these charges should not be allowed to remain before the panel.

Mr March submitted that he opposed the application that there is no case to answer in respect of charges 2(e) and 4(b).

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

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

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel heard evidence from the following witnesses called on behalf of the NMC. All the witnesses except Doctor A gave live evidence. You accepted the evidence of Doctor A.

- Ms 1: Band 8 Midwifery Matron at the Trust at the time of the incidents

- Doctor A: Doctor at the Trust at the time of the incidents, who prescribed on the TTO form for Patient A

- Ms 2: Midwife at the Trust at the time of the incidents
- Ms 3: Midwife at the Trust at the time of the incidents
- Student A: Student Midwife at the time of the incidents

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and Ms Molyneux.

Charge 1a

1. On 30 October 2018, during Patient A's first admission you:
a. did not auscultate the foetal heart rate after conducting a vaginal examination

This charge is found proved.

In considering this charge the panel had regard to Patients A's written records, which refers to the first admission of Patient A on 30 October 2018. The panel noted that a foetal heart rate of 135-140 bpm was recorded after the abdominal palpation at 12:45. At 13:15 a vaginal examination was also recorded but no foetal heart rate was documented following this examination. The panel noted that the next entry recorded in Patient A's medical notes at 13:40 stated 'home to await events'.

The panel also had regard to the Trust's meeting notes dated 7 March 2019 and noted that there was no explanation for the foetal heart rate having been omitted.

The panel then had regard to your written evidence dated 4 February 2022 and noted that your account is that you carried out a vaginal examination and then tried to

auscultate the foetal heart rate, but the Doppler device used to measure heart rate was defective. You said that you then went and got another with batteries held in by Sellotape, and then conducted the auscultation. You also said that you were distracted by Patient A's questions and omitted to document your findings of the foetal heart rate. You stated that by this time Patient A was ready to go home, and that you overlooked writing this up in the notes before Patient A left.

In oral evidence you said that by the time you performed the auscultation the notes had been put in the car by Patient A's husband, and after Patient A had left you "realised that you hadn't written the foetal heart rate down".

The panel noted the entry in Patient A's records at 13:40 that state the patient went home 'to await events'. That is a note written by you and follows a record of the vaginal examination at 13:15. The panel was therefore of the view that it could not have been the case that the notes were in the car, because you wrote in those notes the time Patient A left. It follows that there was no reason why the foetal heart rate could not be noted if the auscultation was performed.

In your written evidence you stated that you realised that you had omitted to record the foetal heart rate, not that the notes were in the car. The reason given in the oral evidence conflicts with that given in the witness statement, and with the notes.

The panel therefore determined, on the balance of probabilities, that you did not perform the auscultation, because if you had done so you would have recorded it. Further, the panel did not accept the explanation now offered because of the inconsistencies in your account and the contemporaneous document. It therefore found charge 1 a proved.

Charge 1b

b. *did not document in the patient notes/and or the partogram that you completed an auscultation on the foetal heart rate following the vaginal examination*

This charge was not considered by the panel.

The panel had regard to the fact that the premise in Charge 1b is that an examination was carried out but was not recorded. The panel was therefore of the view that charge 1b only falls for determination if an examination was carried out. Having found charge 1a proved, it follows that charge 1b falls away, for there could not be a record as there was no examination.

Charge 2a

On 30 October 2018, during Patient A's second admission you:

a. did not perform sufficient abdominal palpation before conducting a vaginal examination;

This charge is found proved.

In consideration of this charge the panel had regard to Patient A's records, in particular pages 70 and 71 of Exhibit 2, appendix 20 the Trust Intrapartum Care Guidelines, Student A's witness statement and oral evidence, and your written and oral evidence.

Your evidence was that you had carried out a full abdominal palpation on Patient A's first admission at 12:45 on 30 October 2018. Your evidence was that on the second admission the foetal lie was visible during contractions and that were able to see that the baby was in the same position, because Patient A was slim and there was a significant reduction in amniotic fluid due to the spontaneous rupture of membranes earlier in the day. You said that on Patient A's readmission you checked the baby's position with a brief touching of Patient A's abdomen and that this was sufficient, in combination with your visual assessment of the shape of Patient A's abdomen and of the finding of the previous examination.

The panel also had regard to the written evidence of Student A which states:

'As I knew the registrant was planning to do a VE, I asked if she wanted me to Palpate (examine by touch) Patient A's abdomen. She said no and did not give a further explanation as to why I was not allowed to do this and the registrant did

not palpate Patient A herself.'

The panel found Student A's oral evidence was consistent with her written evidence as set out above.

The panel had regard to the Trust guidance on Intrapartum care, which reflects the NICE guidance: Intrapartum care for healthy women and babies. It is noted in these documents that abdominal palpation should include assessment of the fundal height and the lie presentation, position and engagement of the foetus. Both documents recommend that an abdominal palpation is offered during the initial assessment in labour, and four hourly, prior to vaginal examinations during labour.

The panel was of the view that Patient A's second admission was a significant time after the first admission and required a full risk assessment of Patient A's progress in labour and whether it was still appropriate for her to be cared for on the birth centre. The panel was of the view that it is not good practice, or sufficient, to carry forward an assessment of a patient which was conducted four hours before the readmission. Self-evidently Patient A's labour was at an early stage at the first admission, because Patient A was allowed to go home, and equally self-evidently Patient A returned in very established labour. You accepted that you were obliged to carry out a sufficient palpation of Patient A. During the panel's questions you accepted that a visual assessment of Patient A's abdomen was not a recognised way to determine foetal lie on its own. During cross examination you accepted that in this particular situation that the limited contact that you reported with Patient As abdomen was probably not sufficient to give you the information that you needed.

Having considered the evidence above, and the Trust and NICE guidance, the panel was of the view that the abdominal palpation was not sufficient. It therefore found this charge proved.

Charge 2b

b. did not allow Student A to perform an abdominal palpation;

This charge is found proved.

The panel noted that you accepted this allegation. It found the following facts about this allegation: Patient A had a birth plan for a water birth using hypnobirthing. This is a birth with minimal midwifery input consistent with a safe delivery. It is intended to be as hands off as possible. The panel was of the view that it was not unreasonable for you to put the needs and wishes of Patient A ahead of Student A's wish to acquire further experience. It is to be expected that an experienced midwife would be swifter than a trainee. However, you should then have carried out the assessment yourself if you did not wish Student A to carry it out. The panel therefore found this charge proved.

The panel was mindful that any finding in respect of charge 2c would involve the consideration of its findings in relation to charges 2d and 2e. It therefore decided to consider charges 2d and 2e ahead of charge 2c.

Charge 2d

d. did not auscultate the foetal heart rate prior to conducting a vaginal examination;

This charge is found proved.

You accepted that you did not undertake an auscultation prior to conducting a vaginal examination, and so the allegation is found proved. You said that it was not your practice to auscultate prior to a vaginal examination, and that it was not best practice to do so. You said that there was no Trust or NICE guidance requiring auscultation before a vaginal examination. However, the Trust policy is set out chronologically and sets out that there should be an auscultation of the foetal heart and maternal pulse prior to abdominal palpation and vaginal examination. NICE guidance states that vaginal examinations should be offered after an abdominal palpitation and foetal heart rate recording. The panel was of the view that the Trust and NICE guidance recommend a foetal heart recording prior to a vaginal examination. It therefore found this charge proved.

Charge 2e

e. did not auscultate the foetal heart rate after conducting a vaginal examination;

This charge is found not proved.

This allegation relates to a vaginal examination carried out by you on Patient A at about 17:45 on 30 October 2018. It refers to the same vaginal examination referred to in charge 2d.

Your Counsel made an unsuccessful application that there was no case to answer in respect of this allegation. It was challenged on the basis that the foetal heart rate shown in Patient A's partogram at 17:45 was the same foetal heart rate as was recorded in Patient A's notes at 18:00.

However, when you came to give oral evidence, you said that these were two separate auscultations.

Mr March, for the NMC, said that it was implicit that the auscultation after the vaginal examination must be soon after the vaginal examination, and not another foetal heart auscultation conducted as part of subsequent monitoring.

It appears to be the NMC's position that there should have been an auscultation prior to the vaginal examination then the vaginal examination, then another auscultation before Patient A entered the birthing pool. The allegation does not say that.

While the way you put your case about this allegation was highly confusing and self-contradictory, the burden of proving the allegation is on the NMC.

It is not suggested by the NMC that either of the entries at 17:45 and 18:00 are fraudulent in any way, although the NMC doubt how accurate they are.

The panel looked carefully at the words of the allegation. It is not disputed that there was an auscultation recorded by you at 18:00, nor that this was subsequent to the vaginal examination at 17:45.

Therefore, the allegation was not found proved.

Charge 2c

c. did not undertake a full assessment of Patient A;

This charge is found proved.

Having previously found charges 2a and 2d proved, the panel was satisfied that a full assessment of Patient A could not have been undertaken. It therefore found this charge proved.

Charge 2f

f. incorrectly used the first stage partogram to document the second stage of labour;

This charge is found proved by way of admission.

Charge 2g

g. did not auscultate the foetal heart rate every five minutes during the second stage of labour;

This charge is found proved

The panel took into account the NICE guidance, which states that a midwife should listen to the foetal heart rate after every contraction in the second stage to a maximum of every five minutes.

You admitted this charge, on the basis that as contractions occurred every three minutes it was not possible to auscultate every five minutes because of the arithmetic of gaps between contractions. You said that you did so between most contractions, and so for the most part every three minutes. You accepted that you had not done so between every contraction and the next, so that it might on occasion there may have been six minutes between auscultations. You said that you might record two or even three records of foetal heart rates at the same time, remembering earlier ones until the next was taken and then recording both or all.

The panel do not accept your version of events as the partogram shows one foetal heart rate at 17:45 and one at 18:00. Student A in her evidence said that the gap was 10-15 minutes between auscultations.

You deny this. It considered that whilst the partogram provides this information within a time frame, there are no timings for any of the auscultations as you did not use the second stage partogram. There are however a series of dots on the partogram which are documented within 30-minute time frames. The foetal heart rates documented between 19:00 and 20:00 are all very similar. The panel placed limited weight on the partogram with the dots as none of them are timed and are all similar heart rates.

On the balance of probabilities, you did auscultate more frequently than every 10-15 minutes, but not as often as you claimed in your oral evidence. Your explanation of recording two to three foetal heart rates in one go is not best practice and the panel does not accept that they were done every five minutes, as claimed, for the reasons given above.

Charge 2h

> *h. did not document in the patient notes and/or the partogram the reasons you did not auscultate the foetal heart rate every five minutes;*

This charge is found proved

The panel found this charge proved by way of your admission and by consideration of the partogram supplied. It considered that there are dots documented on the partogram to evidence foetal heart rates between the times of 18:00 and 20:00. There is no evidence of the exact times these foetal heart rates were auscultated and there is no evidence in Patient A's records of attempted foetal heart rate auscultations which you said were unsuccessful due to the frequency of Patient A's contractions.

The panel's observations about the dots in the foetal heart rate record are also relevant to this charge.

Charge 2i

i. did not document in the patient notes/and or the partogram that you completed a "partial palpation" of Patient A's abdomen on her return to established labour;

This charge is found proved.

The panel find this charge proved by way of your admission. It took into account that neither the notes nor the partogram record such an examination and there is no mention of partial palpitation, which you accepted during your oral evidence is not a recognised clinical procedure. You accepted that your documentation in respect of Patient A was inadequate. The panel did not accept that any part of a palpation can be performed visually. The term palpation refers to clinical judgment through touching the abdomen.

Charge 2j

j. left Student A alone without another member of staff on one or more occasions during the second stage of labour;

The panel found this charge proved by your admission. You admitted this charge on the basis that on three occasions you had left Patient A, her husband and Student A in the room without another member of staff present. The panel considered that in your written

evidence you said that this was initially for six or seven minutes, but in your oral evidence you had told the panel that this was for three of four minutes at most.

You said in your evidence that there was no medical need or practice requirement for Patient A to have a midwife present all the time. You said there were periods when it was appropriate to leave Patient A. You said you had left Patient A on three occasions. One was to collect the Doppler machine, one to collect a birth pack, and the third to relieve wind. You also said that there were alarm bells to press if Student A was concerned about Patient A.

Student A said that she was not told where you were going or for how long, and that you were gone for lengthy periods, and is the next allegation.

Charge 2k

k. when you left the room you did not inform Student A where you were going;

This charge is found proved.

The panel in reaching its decision noted its findings in charge 2j. It noted that whilst you had explained in your evidence that you told Patient A's husband where you were going, and that Student A must have heard, you had not informed Student A directly. The panel was of the view that effective communication required you to obtain some acknowledgement from Student A that she knew where you were going. You assumed that she knew. The panel accepted Student A's evidence that she did not know.

The limit of your defence to this was within your witness statement (repeated in your oral evidence) that 'Patient A's husband was aware that I was leaving each time and did not voice any concerns that I did so'

Charge 2l

l. did not wash your hands before conducting the birth of Baby A;

This charge is found proved

The panel find this charge proved by way of your admission. You initially denied this charge when the charges were put to you, but during your oral evidence you had accepted that you did not wash your hands. Throughout this birth you washed your hands on the way out of the pool rather than on the way in.

Charge 2m(i)

m. did not wear gloves:
i. during the birth of Baby A

This charge is found proved.

The panel find this charge proved by way of your admission.

Charge 2m(ii)

ii. when touching Patient A's genitalia and/or perineum with bare hands whilst assisting Patient A to give birth

This charge is found proved

In reaching its decision, the panel took into account your evidence and the evidence of Student A.

The panel accept the evidence from Student A and note that she was close enough to see everything that was taking place, to the extent that you had her use her mobile phone as a torch that you might better see.

The panel do not accept your evidence that you had used a big pad in which you wrapped your hand or used a gauze swab. The panel noted that there is no evidence

before it that protection of the perineum was being performed during this hands-off birth. You explained to the panel that you saw the perineum becoming white, indicating extreme stretching prior to tearing. You said that you were using the pad for perineal support. You said that it was physically impossible for you to do what was alleged.

The panel considered that on your own account you were physically able to touch the perineum and it was possible for you to put your fingers around the perineum to assess whether or not it would stretch.

The panel next considered whether you had done so, which is the charge. In the original Trust interview, you stated that you had no reason to go near the vagina. However, in evidence to the panel, both written and oral, you stated that you were trying to protect the perineum by using a pad.

On the balance of probabilities, the panel prefers the evidence of Student A as it is consistent. It is to be found in her clinical placement reflection notes, in her interview with the NMC and in her witness statement, and her record was based (the panel accepted) on a contemporaneous record she made in a notebook about her mentorship.

It is of the view that during the delivery of Patient A's baby, you touched the perineum and labia with bare hands. Therefore, the panel finds this charge proved.

Charge 2m(iii)

iii. during the delivery of the placenta

This charge is found proved

The panel find this charge proved by way of your admission. You accept that you did not wear gloves during the delivery of the placenta. Whether or not a vomit bowl was used to scoop up the placenta, gloves should had been worn to do this. The panel noted that you would have had time to put gloves on to deliver the placenta, which was up to 30 minutes after the birth of the baby.

Charge 2m(iv)

iv. to remove a blood clot in the birth pool with your bare hands

This charge is found proved

In reaching its decision the panel considered the evidence of Student A. The panel noted that Student A said in her evidence that you had used your hand, not a sieve. It noted that if a sieve was used it would have been obvious and Student A would have seen it continuously.

The panel considered that whilst the sieve is disposable, it is disposable per patient and not per use. It is of five to six inches in diameter. The sieve would therefore had been visible in the room, in a bowl for example so it could have been continuously used. It noted that the use of a sieve is mentioned in your statement to the Trust, but on the basis that there was no clot at all, but that had there been one you would have used one. In that interview the sieve was hypothetical, and your account was that you would have followed best practice and was not a recollection of what you actually did on that occasion. Only later did you say that you recalled a “show” with attendant mucus which you say you removed using a sieve. This inconsistency is damaging to the credibility of your account.

The panel noted that Student A had mentioned this in her clinical placement experience document and further referred to it in interview on 07 March 2019.

Your account in interview is ‘no, I would do it with a sieve if it was small enough, I would leave it to sink to the bottom’. You did not accept that there was a blood clot which was removed either in your interview or at any time before this hearing. In your witness statement of 4 February 2022, you stated only that ‘to reduce contamination in the birthing pools a midwife will often use a sieve… It is entirely possible that I used a sieve to scoop a clot … without wearing gloves…’ This is all hypothetical, and not evidence that you did use a sieve to remove a clot, as evidenced by Student A.

On the balance of probabilities if a sieve had been in use in the room, it would not have been there only for sieving out one clot, it would have remained in the room. It is more likely that not that Student A would have seen the sieve. Student A's evidence is consistent from her contemporaneous notes to her written and oral evidence. Your evidence has been unclear. You say what you think you would have done. The panel find that Student A's recollection is credible and prefer her evidence to yours on this matter.

Your evidence about this charge was generic, in saying what you would have done, rather than what you actually recall. The panel did not attribute great weight to your evidence that with the passage of time your recall had improved. The panel did not doubt the sincerity with which you gave your answers, but found, on the balance of probabilities, that your memory has been constructed subconsciously by projecting your previous customary good practice onto the treatment afforded to Patient A. Student A's account is more credible because she was clear that as a trainee midwife experiencing a water and hypnobirth she was paying particular attention to what occurred. The panel understood that Student A's notes made at the time were destroyed, but accepts that her first statement was based on this notebook. The witness statement of Student A is a year after the events, but the panel accepts that the account is a recall of memory, preferable to your account. In forming this view the panel took account of the fact that Student A's report was subsequent to a mid-placement assessment by you which was unflattering, and could be motive for embellishing the complaint, which was about matters some time before. The panel decided that the mid placement review with her tutor present was the opportunity to raise this.

The panel considered that this was the case in other charges as well, and that this was the clearest example.

Charge 2m(v)

v. when touching the umbilical cord

This charge is found proved

The panel find this charge proved by way of your admission. It took into account that your original evidence was that you had touched the umbilical cord to feel for a pulse. The panel found that there was no reason as why you did not have time to put on gloves prior to touching the umbilical cord.

Charge 2n

n. did not obtain consent and/or inform Patient A that you were going to touch her genitalia and/or perineum with bare hands during the birth of Baby A;

This charge is found proved

In reaching its decision the panel took into account the evidence of Student A. Student A explained in her evidence that she had not heard any discussion with Patient A about doing this. You explained in your evidence that this was discussed at Patient A's first admission at 12:45 on 30 October 2018 and consent would have been obtained in advance with Patient A, and as Patient A was having a hypnobirth, this would have been acceptable.

This charge is predicated upon charge m(ii) which has been found proved. Charge 2n is found proved because it found that the events set out in charge 2m(ii) occurred, and there was no evidence of consent being sought. It was not part of the birth plan.

Although you state in your evidence that you had a discussion with Patient A at the first admission about her consent for interventions when discussing her birth plan, there is no evidence before the panel to suggest that you had those discussions with Patient A or with Patient A's birthing partner. There are no notes in Patient A's records of any discussions and or consents obtained as would be expected.

Charge 2o

o. *during the third stage labour you inappropriately pulled/tugged on the umbilical cord;*

This charge is found proved

The panel took note that with a physiological (no drugs given) third stage of labour the placenta is delivered solely by maternal effort. It noted that the Trust Guidelines specify that the midwife should not pull on the umbilical cord.

In your oral evidence to the panel, you described holding the clamps you had attached to the umbilical cord and lifting the umbilical cord at the same time as maternal effort to scoop the placenta into a receiver. You said that you did not start this until you were able to see that the placenta had separated by observing the blood vessels at the insertion point of the umbilical cord externally. The panel was of the view that by lifting the umbilical cord there is some degree of pull, which is inappropriate in the physiological third stage.

The panel noted that Student A's account in her mid-placement notes were of 'traction on the cord' and 'aided placental delivery'.

There has been an evolution of your evidence about this. In your witness statement of 4 February 2022, you stated that you had 'touched the cord to ascertain whether there was separation' and the panel finds that this was by pulling on it. In your oral evidence you were 'guiding' the placenta, and by holding the clamps 'guided' it into a receptacle and upwards.

The panel resolves the conflict between your evidence and that of Student A in favour of the evidence of Student A and so found the charge proved.

Charge 3

3. *On or around 1 December 2018, whilst discharging Patient B home you prescribed "Diclofenac" by adding it to the "to take out" TTO form when you did not have the authority to do so.*

This charge is found proved

The panel found this charge proved by way of your admission.

Charge 4a and 4b

4. *Your actions as described in Charge 3 were dishonest in that you:*
   a. *knew that Diclofenac had not been prescribed by Doctor A*
   b. *created an impression that Doctor A had prescribed Diclofenac for Patient B*

This charge is found not proved

In reaching its decision, the panel took into account your evidence and the evidence from Ms 3, and of Doctor A.

The panel found that you knew that the Diclofenac had not been prescribed by Doctor A. You accepted that this was the case.

You denied that this created an impression that Doctor A had prescribed this drug. You did so on the basis that Ms 3 knew you had done so and was not misled. The charge is not of misleading Ms 3. A document which purports to be a prescription made by a doctor for a particular patient for a specific drug is misleading if that doctor did not prescribe it.

The issue was whether or not you were dishonest in doing so.

The panel was not assisted by the way your account had changed over time.

Initially you stated, in interview, that you were unable to recollect anything about any particular patient in regard to that shift.

Then it was that you did not know what you were thinking, and ‘did not know where your head was’.

By the conclusion of your evidence, you stated that you thought you could prescribe Diclofenac and that this was ‘an honest mistake’, based on being able to prescribe for in patients (within set parameters).

The panel decided that it had first to make findings of fact about your state of knowledge, and then decide whether an informed member of the public would consider what you did was dishonest.

[PRIVATE]

You had been provided with no support. You were moved to a post-partum ward, on which you had not worked for many years. You were given no support or refresher training. When you arrived at work the midwife in charge did not know you were coming. [PRIVATE] This was how you came to be dealing with the discharge of patients.

It was not disputed (it was the evidence of Ms 3) that you had read the TTO form out loud and observed orally in front of Ms 3 that there was no pain relief prescribed for Patient B, and that there should be. You then wrote on the form, in your own handwriting, in full view of Ms 3. You then went to get the drugs, including Diclofenac with Ms 3, who was fully aware that Doctor A had not prescribed Diclofenac.

The NMC accept that you were intending to be helpful. The patient had been prescribed Diclofenac during her period in the hospital. The panel accept that you were trying to be helpful, and that there was no other motive.

You had taken Ms 3 with you to get the prescribed medication, and she was aware that initially there was no Diclofenac on the prescription.

The panel was troubled by the way your evidence had evolved, but focused on the evidence at the date of the TTO documentation.

The panel noted that indicators of dishonesty are gain to oneself, or detriment to another, and concealment. None of these were present here. That does not preclude it being dishonest, but the absence of any of these indicators of dishonesty is relevant to the assessment the panel makes.

There were very many references attesting to your professionalism. That is also relevant to credibility and to the propensity, or otherwise, to be dishonest.

The panel was of the view that your actions were not good practice and were misleading. While there is no medical evidence to support a medical reason behind this action, it is entirely credible (and the panel so finds) that at a time of very great strain, attending for work the next shift after the accusations were made, feeling that you could not go off sick because of attendance monitoring, working in an unfamiliar environment, you would not be thinking straight. In trying to do the right thing, you went about it entirely the wrong way, as you now fully accept.

While all midwives are aware (and you were aware) that midwives cannot prescribe on a TTO form, the panel does not find that the well-informed member of the public would consider your actions dishonest.

Plainly the logical thing to do in these circumstances would be to refer to the doctor or ask Ms 3 what should be done.

It is credible (and the panel accepts) that someone not thinking logically is highly likely to do something illogical.

Having done so, the panel concluded that the well- informed member of the public would not consider that you were acting dishonestly.

Accordingly, while the facts set out in charges 4a and 4b are found proved by the panel (in that Diclofenac had not been prescribed by Doctor A and that this was misleading) the panel do not find that you were acting dishonestly and so the charge is dismissed.

Fitness to practise

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

Submissions on misconduct

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

Ms Kyriacou invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Kyriacou identified the specific, relevant standards where your actions amounted to misconduct. She submitted that whilst breaches of the Code do not automatically result in a finding of misconduct, your behaviour falls significantly short of the standards expected of a registered midwife. You compromised the safety of Patient A and her baby on the date in question, placing them at a significant risk of harm. Ms Kyriacou submitted that whilst no actual harm was caused, the risk was there. Further, the care that Student A witnessed was not a 'role model' behaviour that a student should aspire to. She submitted that concerns were raised about how you had supported Student A, following student A's write-up of her placement and your behaviour fell far short of what is expected of a registered midwife.

Ms Kyriacou submitted that you have failed to uphold the following tenets of the profession, with the first being to 'prioritise people'. She submitted that you have failed to comply with this tenet in your failure to obtain consent from Patient A and in leaving Student A alone with Patient A without explanation. Ms Kyriacou submitted that you also failed to 'practise effectively', leaving a vulnerable patient alone with an inexperienced student midwife on three occasions, without explaining where you were going or how long you would be.

Ms Kyriacou submitted that in relation to the tenet to 'preserve safety', you caused significant risks to Patient A's safety and the safety of her baby, by failing to auscultate the foetal heart rate every 5 minutes in the second stage of labour, failing to complete an abdominal palpation before a vaginal examination, not washing your hands and not wearing gloves, risking contamination and infection. She submitted in relation to 'promote professionalism and trust', the public and expectant mothers would be highly concerned if they were to hear about the level of care provided by you on the specific day in question. Ms Kyriacou submitted that one must consider the vulnerability of mothers in labour and the importance of their experience and their safety, which to a

large extent, is out of their control. A huge reliance is placed on midwives' professionalism and their expertise to provide the best and safest care.

Ms Kyriacou invited the panel to take the view that the facts found proved do amount to misconduct.

Ms Molyneux submitted that misconduct is accepted.

Submissions on impairment

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

Ms Kyriacou submitted that nurses and midwives occupy a position of privilege and trust in society, and so patients and their families must be able to trust nurses with their lives and their lives with their loved ones. To justify that, nurses and midwives must be honest and open with their patients and act with integrity. They must make sure that their conduct at all times justifies both their patients and the public trust in the professions. Ms Kyriacou submitted that your conduct fell far short of this, and with Patient A and her baby being placed at a risk of harm, public confidence in the profession and the need to uphold proper professional standards could be undermined if a finding of impairment were not made.

Ms Kyriacou referred the panel to the case of *Grant* in which Mrs Justice Cox referred to Dane Janet Smith's test to apply when considering whether the registrant's fitness to practise is impaired. She submitted that the test contains 4 limbs, and it is the NMC's case that limbs (a), (b) and (c) are engaged. The first limb is whether the registrant 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. She submitted that this limb of the test is engaged as Patient

A and her baby were placed at risk of harm in your care during Patient A's labour in both their first and 2nd admission to hospital. You did not follow guidelines with regard to the auscultation of the foetal heart rate and abdominal palpation, which as an experienced midwife you should have done, as the guidelines are there to ensure safety and to mitigate risk.

You failed to inform a student midwife of where you were going or for how long. On each of the three occasions, you left Student A alone with Patient A and her partner. Ms Kyriacou further submitted that you failed to follow the basics of midwifery practise, namely, to wash hands and wear gloves to minimise the risk of infection and also in your record keeping in that you failed to document why you did not auscultate the foetal heart rate at every 5 minutes in the second stage of labour. You also failed to obtain consent in this instance in regard to the touching of Patient A’s perineum.

Ms Kyriacou submitted that the second part of the limb is future looking, namely whether the registrant is liable in the future to place patients at risk of harm. She submitted that the panel must ask itself in considering this issue is whether you reflected on the incident and the care that you gave to the patient; specifically, if you have insight into what went wrong, what you should have done, and what you would do differently in the future. The panel should assess whether you understand the risk that you caused to Patient A, and it must be satisfied that lessons have been learned and that the risk of repetition has been minimised. She submitted that in doing so, the panel may wish to turn its mind to the evidence that has been produced by you regarding strengthening your midwifery practice and remediation, such as reflections and training undertaken.

Ms Kyriacou submitted that in respect of this, a large number of documents have been produced, particularly in relation to extremely positive testimonials. She submitted, however, that what the panel do not have before them is evidence of strengthening practise insofar as you have not been working as a midwife and therefore have not demonstrated safe practise as a midwife since the incident.

Ms Kyriacou set out that the panel also have before it the registrant bundle which includes some reflection. She submitted that your witness statement largely deals with the actual allegations as this was submitted before the fact-finding stage. There is also some reflection in relation to record keeping, more than the failure in your actions. Ms Kyriacou invited the panel to have sight of this when considering the level of insight that you have demonstrated.

Ms Kyriacou submitted that the second limb of the test is whether a registrant has in the past brought or is liable in the future to bring the medical profession into disrepute. She submitted that you certainly have in the past by way of these incidents, brought the profession into disrepute. Ms Kyriacou submitted that members of the public and expectant mothers and their families would be concerned to hear of such conduct and further concerned about the level of care you provided and of their safety with midwives. She submitted that your conduct on the days in question fell significantly below that expected of a midwife and therefore, trust in the profession would be undermined if an informed member of the public were to be aware of the circumstances and details of this case. With that in mind, it is also quite possible that an informed expectant mother could be reluctant to access the services of a midwife as a result.

Ms Kyriacou submitted that the third limb which is engaged, is whether it has in the past breached or is liable to breach one of the fundamental tenets of the profession. She submitted that you failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust and your actions in each charge to at least some degree has breached each of these fundamental tenets.

Ms Kyriacou submitted that the conduct in this case is remediable, and it is a question for the panel to determine whether your reflection as provided in the registrant bundle is sufficiently in depth and whether the learning has been applied. She submitted that whilst it is the NMC's case that there is a risk of repetition, it is for the panel to weigh up whether it considers the risk is minimal or significant.

Ms Kyriacou submitted that the panel are aware that you have not practised as a midwife for some time. You have continued to work in a non-midwifery role with

numerous exemplary references. She referred the panel to the NMC Guidance on Insight and strengthened practice, reference FTP-13, which states that evidence of the midwife's insight and any steps they have taken to strengthen their practise will usually be central to deciding whether their fitness to practise is currently impaired. Ms Kyriacou submitted that it cannot be said that there is direct evidence of strengthening practise in respect of working in a midwifery role for the reasons the panel have heard. However, this is not the sole decisive factor to whether or not a registrant's fitness to practise is impaired.

Ms Kyriacou submitted that whilst it is noted that the incident took place five years ago, lapses in time without incident is not sufficient to just demonstrate that your fitness to practise is no longer impaired. She invited the panel to find your fitness to practise impaired if it is not persuaded that you have demonstrated sufficient insight, reflection and remediation to minimise the risk of repetition.

Ms Molyneux in her submissions emphasised three different relevant periods of time. She submitted that it has been five years since the incidents have occurred, which is a significant amount of time. Ms Molyneux informed the panel that Baby A is now at primary school, and she wishes to remind the panel how old these matters are for context.

Ms Molyneux submitted that the second period of time is 15 years, which is how much unblemished practise you have had as a midwife without any incident, without any complaint, and indeed actually positive good character when it comes to your practise. She further submitted that the third period of time is two days, as the entirety of the misconduct took place over two days.

Ms Molyneux submitted that for two days out of 15 years practise five years ago is what the panel are now looking at and deciding whether or not your fitness to practise is impaired. Your shifts, for which the charges operate are between 30 October 2018 to 1 December 2018. She submitted that putting all these numbers together, there is an extremely compelling argument that there is no current impairment. Ms Molyneux submitted that what we have here are some 'blips' when it comes to your practise,

which massively stand out as being uncharacteristic when looking at the entirety of the rest of your practise up until that date.

Ms Molyneux submitted that the panel must evaluate current impairment; as of today. She submitted that you have excellent credentials, glowing references, and have been involved in the births of over 1000 healthy babies, which is quite the milestone for any midwife.

Ms Molyneux submitted that the panel at the facts stage in relation to your evidence set out in its determination that there were no doubts about the sincerity of your presentation, but simply there were doubts as to whether you had got things wrong. She submitted that of course, you were giving evidence several years after the event that happened back in 2018 [PRIVATE].

Ms Molyneux submitted that the panel are also aware that you are somebody who has climbed the career ladder with extreme efficiency. You were promoted to a Band 7 during your time as a midwife, which is a senior position. However, that senior position ‘comes with what must be quite exceptional stresses that come with being a coordinator at that level’. She submitted that the panel may think that such strains will be even more prominent for those midwives that are really passionate about what they do, because for them it is no longer just a job, it is a vocation. There are so many struggles with the NHS services, and there has been a constant pressure to fill all the gaps and put one's own needs behind that of the trust.

Ms Molyneux set out that the panel are aware that you ultimately stepped down to a Band 6 role [PRIVATE], and you had to ‘hit the ground running’ because it was expected of you, even though the nature of jobs was very different. To suddenly have students following you around was something that would have been quite difficult even for the most able of practitioners, [PRIVATE]. She submitted that this is highly relevant to the conditions at that time and those conditions at the time are going to help the panel in deciding whether or not your fitness to practise is impaired, and whether that is a situation that has changed over time or whether the situation as it was then was so

exceptional that it is not something that is indicative of your future practise or of the way that you would conduct yourself during other shifts.

Ms Molyneux informed the panel that it is indicated in some of what the referees have written about you, as well as what you have quite candidly said yourself [PRIVATE], which is why you stepped down from the Band 7 role. She submitted that you were not supported by the Trust at the time [PRIVATE], and you should have had the opportunity to familiarise yourself with the job role and the changes in documentation. Ms Molyneux submitted that these are quite pressing and exceptional circumstances that you were operating in. Ms Molyneux referred the panel to the references in the registrant bundle, which attest to this.

Ms Molyneux submitted that you were someone who was almost at the highest echelons of this profession, having progressed to a Band 7 position, completed a Master's degree while still working, having gone on to be a university lecturer, a mentor and sitting on the faculty of De Montford University School of Midwifery undergraduate programme. [PRIVATE].

Ms Molyneux submitted that during this hearing, there were a lot of facts proved by admission and by partial admissions, the panel have found proved other elements of the charge. She explained that a lot of those charges are interlinked and codependent on each other, including professional competence issues and instances of poor practise or where documentation has not been ‘up to scratch’ and it comes down to misremembering or misapplication of some of the trust principles. Ms Molyneux submitted that you were someone who was ‘rusty’ when you stepped down to a Band 6 role, having done the other role for so long, and this certainly be viewed as somebody working under quite ‘strained circumstances’, having not been made familiar with changes in documentation and having to reteach herself.

Ms Molyneux submitted that these are not issues that would prohibit you from being a very safe, competent and effective midwife again at any point if you chose to go back to the profession. You are somebody that has absolutely shown yourself to be dedicated to the profession, to learning, to improving yourself, by undertaking a Master's degree,

additional training and undertake the role of being involved in the faculty, which would have been a constant evolution of learning and training and updates in order to best inform new people coming through the practise how best to be midwives.

Ms Molyneux submitted that you have thoroughly engaged in these proceedings. You are somebody that has developed and considered her actions at length. She submitted to the panel that your witness statement is one of the most detailed witness statements that she has ever had from a registrant in a case. You have taken matters extremely seriously and have given it the attention to detail, importance and significance that is required and has worked very hard to do your best.

Ms Molyneux submitted that whilst there were some findings against you, the panel's observation was that there is no doubt about your sincerity, simply that quite often your answers would be generic, for example 'this is what I would have done'. Ms Molyneux explained to the panel that the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings, but to protect the public against the acts and emissions of those who are not fit to practise.

Ms Molyneux submitted that when looking at the test formulated in *Cohen*, it can be said that all the charges you have faced are all remediable and perhaps the most serious 'catastrophic' charge that you have faced of dishonesty was not found proved. You have also accepted many of the charges. Ms Molyneux submitted that there has been a significant amount of remediation and insight involved as you have set out in detail in your witness statement lots of elements of your practise that you have identified as to how to do things and understood what went wrong, to a large extent, in many of them regarding the charges that were found proved. You are now acutely aware of what expectations there were and what went wrong, and so you are somebody that is perfectly able to understand and remediate.

Ms Molyneux submitted that the fact that you have not been on a training course specifically for some of these charges to be relevant to needs to be looked at in the wider context of your experience and of your expertise, what was going on at that time and what lessons have been learned since then.

Ms Molyneux submitted that bearing in mind that the charges cover two shifts out of 15 years where things have gone wrong, the chances of repetition are exceptionally low. Should you wish to go back to practise, you would have to do a return to practise course in any event because of how long you have been out of practise. She submitted that the panel may be of the view that if there were any concerns with your practise that they would actually all be met and dealt with by the process of having to complete a return to practise programme. You are somebody that is highly educated, highly established, highly specialised and if she goes through a return to practise course, you would not be signed off until that course was completed.

Ms Molyneux submitted that when looking at public protection and public interest, you are safe to practise, you are competent to practise in the public interest as well. She submitted that these were one-off incidents which took place five years ago, where no harm was caused to Patient A and her baby. She submitted that taking this into account, the panel should consider whether fully informed members of the public, who would not only know about the circumstances of the charges and the case, your reputation, your professional career and all of the exceedingly glowing references that had been put forward on your behalf, still be so significantly concerned when this was a case where no harm was going on to be caused.

Ms Molyneux submitted that these were ‘2 blips’ in an otherwise excellent career that spanned over a decade, and the panel may be of the view that there is a public interest in keeping midwives like you in practise, in keeping that knowledge base within the profession. You are someone that has been involved in over 1000 births, somebody that has educated hundreds of trainee midwives, somebody that has worked tirelessly for the public. Whilst you did make mistakes, they were in a very specific set of circumstances.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches 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

4 Act in the best interests of people at all times
To achieve this, you must:
4.2 make sure that you get properly informed consent and document it before carrying out any action

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively
To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
To achieve this, you must:
9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.4 take account of your own personal safety as well as the safety of people in your care

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:
18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.3 keep to and promote recommended practice in relation to controlling and preventing infection

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.9 maintain the level of health you need to carry out your professional role

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted that you have accepted that the charges proved amount to misconduct and took this into account. The panel was of the view that as an experienced midwife and Delivery Suite Co-ordinator who was training student midwives, you should have been familiar with the Trust and National guidelines, and you should have followed those guidelines to ensure safety and to mitigate any risk to Patient A and her baby.

The panel determined that the facts found proved involved failures in fundamental aspects of midwifery practice, put Patient A and her baby at risk and affected Student A's perception of midwifery and learning experience. The panel was of the view that your actions were serious and fell short of the conduct and standards expected of all midwives and therefore amounted to misconduct.

Decision and reasons on impairment

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

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. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

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

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

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

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

d) …

In relation to limb (a) of the test, the panel determined that you have in the past put patients at a risk of harm. The panel was satisfied that Patient A and her baby were placed at risk of harm whilst in your care, during Patient A's labour. You failed to follow fundamental elements of midwifery practise, namely, to wash your hands and wear gloves to minimise the risk of infection and during intimate contact. Furthermore, you did not auscultate the foetal heart rate at every 5 minutes in the second stage of labour.

In relation to limbs (b) and (c) of the test, the panel was satisfied that your proven misconduct involved breaches of the fundamental tenets of the midwifery profession, namely that you failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. The panel determined that, in so doing, you brought the profession into disrepute. The panel was of the view members of the public, expectant mothers and their families would be concerned about the level of care you could provide given your misconduct and question their safety whilst under the care of midwives. The panel further considered that it is also quite possible that an informed expectant mother could be reluctant to access the services of a midwife as a result.

The panel also noted that the test also requires it to consider what you are liable to do in the future in relation to these three limbs. In this regard, the panel considered your level of insight, steps taken to strengthen your practice and the risk of repetition.

The panel took into account your witness statement dated 4 February 2022. It considered that whilst you have made some admissions in relation to your record

keeping, you provided explanations for why certain things had happened at the time and sought to shift the blame onto others.

The panel also noted that your evidence was contradictory in nature in relation to your focus on patient care rather than student experience. It considered the following extracts from your witness statement:

> *‘ It is disappointing that Student A felt it acceptable to see Patient A as a means to test her knowledge and gain experience, rather than a labouring woman who was in pain and needed effective pain management’*
>
> *‘… The Midwife who was taking over from me for the night shift stated that she didn’t feel confident enough in a physiological 3rd stage to be left to do this by herself, so I stayed after my shift as a I felt this was a teaching opportunity for the Midwife, and Student A could then count the birth for her NMC numbers. It would be remiss of me to embrace a teaching opportunity and then undertake the one thing that you don’t want to do in a physiological 3rd stage… I was aware that Student A needed to get home. Had the placenta not been ready to deliver then I would have suggested the Midwife taking over the case carry on and asked Student A if she wished to stay with her. Unfortunately, NMC stipulations that students must witness the completion of the third stage of labour means that opportunities are lost as they take part in the birth of the baby, but are unable to be part of the third stage for a number of reasons. On this occasion the placenta was separated and situated behind the perineum at the entroitus so was delivered quickly, and Student A was able to witness the completion of the birth stages and therefore count the birth in her NMC numbers’* [*sic*]

The panel was of the view that it had no information before it which demonstrates that you have developed an understanding of how your actions could have potentially affected Patient A, your colleagues (in particular Student A) or how that might impact negatively on the reputation of the midwifery profession. The panel also took into account that through your witness statement and your oral evidence, you showed little remorse into how your actions made Patient A, colleagues and Student A feel.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your midwifery practice. The panel took into account the training you have undertaken in 2020-2022, including safeguarding, occupational health, recordkeeping, medication management and unconscious bias. However, the panel considered that apart from this, there is no evidence before it of significant relevant training you have undertaken to which is specific to the charges, for example managing the third stage of labour and prevention and control of infection.

The panel considered that it has no evidence of you having strengthened your clinical practice, given that you have not practised as a midwife since the regulatory concerns arose. The panel was of the view that there is a risk of repetition and 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 would be concerned if you were permitted to practise without restriction given the risk of repetition and your lack of remediation. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Kyriacou submitted that the sanction bid set out by the NMC at this stage is an 18-month conditions of practice order. She set out the aggravating and mitigating features of the case.

Ms Kyriacou submitted that in respect of the seriousness of the case, the panel has found that you placed a patient at risk of harm. The panel have also found that you breached a number of sections of the NMC Code, and that there remains a risk of harm to future expectant mothers due to the lack of remediation, strengthening of practice, insight and the risk of repetition.

Ms Kyriacou submitted that a caution order would not be appropriate in this case. She submitted that a caution order is for cases that do not fall into the category of having a risk of harm to the public, which the panel have found in this instance and often those cases at the less serious end of the scale.

Ms Kyriacou submitted that a conditions of practice order is appropriate in this case. She submitted that there are appropriate, workable and measurable conditions which could be imposed, which would suffice to protect the public and act as a proportionate restriction on your midwifery practise. She submitted that the key consideration for the panel before making this order is whether the conditions put in place will be sufficient to protect patients or service users, and if necessary, address any concerns about public confidence, proper professional standards and conduct.

Ms Kyriacou submitted that a conditions of practice order is also appropriate because as per the NMC guidance, in considering relevant factors, the following factors are apparent in this case, namely no evidence of harmful deep-seated personality or attitudinal problems, there are identifiable areas of the registrant's practise which require further training and assessment, there is no evidence of general incompetence. She submitted that your potential and willingness to respond positively to retraining remains to be seen at this stage because the panel have not heard or seen from you that you would be willing to receive further midwifery training or retraining. Ms Kyriacou further submitted that patients would not be put in danger either directly or indirectly as a result of the conditions.

Ms Kyriacou submitted that as long as the conditions are sufficiently robust, patients can be properly protected and not put at risk of harm during the period that they are enforced. She submitted that this comes down to the nature of the conditions and that conditions can be created that can be monitored and assessed. The conditions must be relevant, proportionate, workable and measurable.

Ms Kyriacou set out for the panel proposed conditions of practice that are in line with the current interim conditions of practice order, which has been in place since 2019. She submitted that these conditions of practice would be the appropriate, proportionate and workable conditions to address the risk in this case.

Ms Kyriacou submitted that if the panel do not think that those conditions are sufficient to protect the public, workable, or if you are not willing to comply with those conditions, the panel must move to consider the next most serious sanction of suspension. She submitted that it is the NMC's application however that these are robust and stringent conditions which, if you were to return to midwifery practise, would be appropriate to manage the risk in this case, to address the public interest concerns, but primarily would be sufficient to protect the public. Ms Kyriacou submitted that a conditions of practice order formulated in similar terms to the current interim conditions of practice would ensure that you are supervised by a midwife who is physically present, and working alongside you and that a personal development plan to address the main concerns would be created.

Ms Molyneux submitted that she is in agreement with the NMC that the correct disposal of this case is a conditions of practice order, but that she disagrees with most of the submissions made by the NMC. She submitted that the panel have been presented with a series of wholly unworkable and disproportionate conditions over a period of time that are completely out of step with the mischief and seriousness of this case. She submitted that the proposed conditions by the NMC are tantamount to a suspension which is what NMC panels are told should not happen.

Ms Molyneux set out that the proposed series of conditions of practise were put in place by an interim order panel in 2019, when every charge was taken at its highest and the risk of harm and dishonesty were set out to be realistic and high. She submitted that years ‘down the line’, the position is not the same today as it was when the interim order panel imposed those initial conditions in 2019. Ms Molyneux submitted that it would be wrong and disproportionate to simply copy and paste those interim conditions of practice to create substantive conditions of practice.

Ms Molyneux submitted that the deficiencies in practise that the panel have found, and the lack of insight are remediable. She submitted that they are not at the most serious end of the spectrum. This was a case where the incidents took place over two days in the context of an exemplary career and practice. Further, no actual harm was caused to patients. Ms Molyneux submitted that these are important factors to bear in mind and given the panel’s findings, these are areas that can be dealt with very swiftly as you are more than capable of adopting changes in your practise and developing insight.

Ms Molyneux submitted that the conditions of practice order should be more akin to the length of about six months, as that would give you time to undertake training, undertake reflective exercises, develop insight and should be in a position to present to a reviewing panel what changes there have been. She submitted that six months would allow there to be a reasonable amount of time, considering you do have a full-time job and other commitments. Ms Molyneux explained that either way, you would also be required to complete a return to practise course should you chose to return to midwifery, as you have been out of practice for so long.

Ms Molyneux set out to the panel her suggestions for workable, proportionate and appropriate conditions of practice.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Patient A and her baby were placed at a risk of harm
- Your limited insight into your failings
- Attitudinal concerns
- Elements of shifting blame onto others
- Your lack of remorse
- Your lack of acceptance of what you did wrong
- You not accepting Trust and National Guidance in relation to the way care should be delivered

The panel also took into account the following mitigating features:

- [PRIVATE]
- Lack of support following your reduction in role from Band 7 to a Band 6

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate, nor in the public interest, to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel 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, you have had an unblemished career of 15 years as a

midwife. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a midwife.

The panel was of the view that a conditions of practice order would be the least restrictive order to demonstrate your ability to practise safety, effectively and kindly. It noted that you have been subject to an interim conditions of practice order since 2019 and have chosen not to engage with the interim conditions and return to midwifery practice. Notwithstanding that, the panel was still of the view that a conditions of practice order remains workable and sufficient to adequately mitigate the risk in this case, and therefore most appropriate. The panel was of the view that adaptations to the current interim conditions of practice would make them easier to achieve.

The panel recognised that as a result of you not having practised as a midwife for 5 years, you have to undertake a return to practise course.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because the public protection and public interest concerns as well as the level of risk in this case, would be appropriately managed and met with the imposition of conditions of practice.

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. You will send the NMC a report 14 days in advance of the next NMC hearing or meeting from either:
    - Your supervising midwife or clinical mentor
    - Your line manager.

2. You must limit your midwifery practice to a single NHS employer.

3. You must ensure that you are supervised by a registered midwife any time you are working. Your supervision must consist of:

    - Working at all times on the same shift as, but not always directly observed by, a registered midwife of band 6 or above and directly observed in the second and third stages of labour until assessed as competent.

4. You must work with your supervising midwife to create a personal development plan (PDP). Your PDP must address the concerns identified below:
    - Management of the second and third stage of labour to include monitoring maternal and foetal wellbeing
    - Informed consent
    - Prevention and control of infection
    - Medicines management
    - Managing and assessing risk

    You must:
    - Send your case officer a copy of your PDP 14 days before the next substantive review of this order.

- Send your case officer a report from your supervising midwife or clinical mentor or line manager every six months.

This report must show your progress towards achieving the aims set out in your PDP. Your supervising midwife could also review your completion of return to practise documents to evidence this.

5. You must engage with your supervising midwife on a frequent basis to ensure that you are making progress towards aims set in your personal development plan (PDP), which include:

   a. Meeting with your supervising midwife at least 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:
   a. Telling your case officer within seven days of accepting or leaving any employment.
   b. Giving your case officer your employer's contact details.

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

8. You must immediately give a copy of these conditions to:
   a. Any organisation or person you work for.
   b. Any employers you apply to for work (at the time of application).

c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

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:
   a. Any current or future employer.
   b. Any educational establishment.
   c. Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months. The panel was of the view that 18 months would be sufficient time for you to complete a return to practise programme and commence employment as a midwife. The panel is aware that you can request an early review should you be able to achieve the outcomes of your conditions of practice before the end of the 18 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC and attendance at a future hearing

- Up-to-date references from midwifery employers
- An up-to-date reflective piece, following a recognised model, detailing how your actions impacted your colleagues, Patient A, the wider public interest and the reputation of the midwifery profession
- Evidence of training in informed consent and management of the second and third stages of labour and how you have embedded what you have learnt into your clinical practice.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own 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 Ms Kyriacou. She submitted that the NMC make an application for an interim conditions of practice order for a period of 18 months to essentially mirror the substantive order. She submitted that the reason for the application is because the substantive order does not come into effect until the end of the appeal period, which is 28 days.

Ms Kyriacou submitted that it is fair, proportionate and necessary to have an interim order to mirror the terms of the substantive order for public protection, as the panel have found that the public are at risk, but also in the public interest as it would be of concern if the registrant were allowed to practise for a period of time without an order in place.

Ms Molyneux made no submissions in respect of an interim 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 the 28-day 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 you are sent the decision of this hearing in writing.

That concludes this determination.