Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 1 December 2025 – Friday, 12 December 2025

Virtual Hearing

Name of Registrant:	Stephanie Doreen Travis
NMC PIN:	92I3367E
Part(s) of the register:	Midwives part of the register RM: Midwife (05 July 1998)
Relevant Location:	Northwest Anglia and Milton Keynes
Type of case:	Misconduct
Panel members:	Oluwasola Falola (Chair, registrant member) Zoe Wernikowski (Registrant member) Shelley Hemsley (Lay member)
Legal Assessor:	Tracy Ayling KC
Hearings Coordinator:	Samara Baboolal
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter Represented by Mohsin Malik, Case Presenter (Friday, 12 December 2025)
Mrs Travis:	Present and represented by Adam Smith, counsel instructed by the Royal College of Nursing
No case to answer:	Charges 1(b), 5(b), 6(b)
Facts proved:	Charge 1(a), 1(c), 1(d), 1(e), Charge 3, Charge 4(a)(i), 4(a)(ii), 4(b)(i), 4(b)(ii), 4(b)(iii), Charge 5(a), Charge 6(d), Charge 7, Charge 8(a), 8(b)(i), 8(b)(ii), 8(b)(iii)

Facts not proved:	Charge 2, Charge 6(a), 6(c)
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (18 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge

‘That you, a registered midwife, whilst employed by the Northwest Anglia NHS Foundation Trust:

1. On 13 May 2020 you behaved in an unprofessional manner in the workplace in that you:
    a. behaved in an angry and/or abusive and/or aggressive manner towards Colleague A
    b. invaded Colleague A’s personal space
    c. shouted at Colleague A and/or shouted in Colleague A’s face
    d. swore in the presence of Colleague B
    e. spoke about Colleague A in a derogatory manner to Colleague B
2. Your conduct at charges 1(a) to (c) above was intended to intimidate and/or threaten Colleague A
3. Some or all of your conduct at charge 1 was done within the earshot of patients and/or other professional colleagues
4. On two unknown dates prior to 15 May 2020:
    a. at Patient A’s 12 week scan you:
        i. conducted the scan in a rough manner
        ii. responded in a rude manner when Patient A asked if she could video or photograph the scan
    b. at Patient A’s 20 week scan you:
        i. conducted the scan in a rough manner
        ii. when Patient A complained of pain/discomfort said words to the effect of ‘man up’
        iii. refused to write down the gender of Patient A’s baby

5. On 13 July 2020 during a meeting with colleagues you:
    a. Shouted
    b. stood up and threw papers towards your colleagues

Whilst employed by the Milton Keynes NHS Foundation Trust:

6. On 17 June 2022 you:
    a. shouted at Colleague C
    b. incorrectly stated that blood should not be taken from a patient as the patient was expecting twins
    c. said words to the effect that you were the sonographer/midwife and knew the policies whereas Colleague C knew nothing
    d. were rude to Colleague C
7. On an unknown date in early July 2022 you attempted to intimidate Colleague C following a complaint that Colleague C had raised against you
8. On 15 October 2022 you:
    a. were rude to Patient E
    b. made one or more inappropriate comments in that you:
        i. said that there was ‘too much’ of Patient E or words to that effect
        ii. said that you had ‘never scanned like this before’ or words to that effect
        iii. said ‘well thank god there is a heartbeat’ or words to that effect

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

Background

You were employed as a midwife and part-time sonographer at the Northwest Anglia NHS Foundation Trust (the Trust) from 2 October 2017 until 20 May 2021. A referral to the NMC was made by the Trust in relation to allegations that you made inappropriate comments about your line manager, and that you were aggressive towards her and shouted at her.

A patient complaint was received by the Trust in relation to you. Patient A alleged that she attended 12-week and 20-week scan appointments with you, where you lectured her following her request to record her scan, declined her request to write down the baby's gender, and roughly handled her.

On 4 January 2022, you commenced employment as an obstetric sonographer at Milton Keynes University Hospital NHS Foundation Trust. It is alleged that you shouted at Colleague C and incorrectly stated that a patient did not require a blood test. A patient also complained about your treatment of her during an appointment. Patient E alleged that, during an anomaly scan appointment, you were rude and unwelcoming and made offensive comments about her.

You were placed on an informal performance plan on 4 May 2023.

Decision and reasons on application to admit written statement of Ms 1 as hearsay evidence

The panel heard an application made by Mr Radley, under Rule 31, to allow the written statement of Colleague A/Ms 1 into evidence. Colleague A/Ms 1 was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, she did not attend today due to her health.

Mr Radley submitted that this statement sole and decisive in relation to an alleged incident which occurred between yourself and Colleague A/Ms 1 only. Mr Radley

submitted that there is evidence from other witnesses who can speak to the build up to this allegation and the aftermath.

Mr Radley submitted that Colleague A/Ms 1's statement is accurate and reflects the statement that she gave immediately after the alleged incident which formed part of the Trust's local investigation, which is contained within the exhibit bundle. He submitted that this contemporaneous statement was made following a conversation between Colleague A/Ms 1 and her manager at the Trust.

Mr Radley referred the panel to a medical letter from Colleague A/Ms 1's GP, dated 24 October 2025, which states her reason for non-attendance:

'[PRIVATE].'

Mr Radley submitted that Colleague A/Ms 1's attendance at this hearing would clearly have a detrimental impact on her health, in light of the above medical report.

Mr Radley submitted that reasonable attempts were made by the NMC to secure Colleague A/Ms 1 as a witness, including offering support mechanisms to facilitate her evidence. The NMC did not think it appropriate to apply for a Witness Summons.

In relation to the nature and extent of the challenge to the comments and the contents of Colleague A/Ms 1's written statement, Mr Radley accepted that there is clearly a challenge to this as you deny the allegations set out in the charges against you.

Mr Radley submitted that there is no suggestion of fabrication, and there is no reason for Colleague A/Ms 1 to fabricate her evidence. She was a senior nurse at the time, with 43 years of experience who is now retired with an unblemished record.

In relation to the seriousness of the charge, Mr Radley submitted that the charges relating to Colleague A/Ms 1's statement are very serious and could impact your career if found proved.

Mr Radley submitted that you were given sufficient notice to prepare for this application, namely, 26 November 2025.

Mr Radley invited the panel to adduce Colleague A/Ms 1's written statement into evidence. He submitted that the panel could place what weight it deemed appropriate on the evidence at a later stage.

Mr Smith, on your behalf, opposed the application.

Mr Smith submitted that insufficient notice of this hearsay application was provided, as you were informed that Colleague A/Ms 1 was not attending on the 26 November 2025, which Mr Smith submitted is less than a week. The charges themselves date back to 2020.

Mr Smith submitted that it would be unfair to you if Colleague A/Ms 1's statement were to be adduced as hearsay evidence.

Mr Smith submitted that there is a significant history between yourself and Colleague A/Ms 1, and there is some suggestion of fabrication, or in the least, exaggeration, of Colleague A/Ms 1's account. He submitted that this is exemplified by the allegation that you were invading Colleague A/Ms 1's personal space, where there is a dispute as to whether there was a couch in between the two of you at the time of this allegation. He submitted that there is very clear animosity towards you displayed by Colleague A/Ms 1.

Mr Smith submitted that this case relies heavily on details of what was said and the effects of this, and if Colleague A/Ms 1's statement were adduced as hearsay evidence, it would be unchallenged and untested. Mr Smith submitted that this is unfair to you.

Mr Smith submitted that these are very serious charges which would have a significant impact on your career if they were to be found proved. In addressing the nature and extent of the challenge, Mr Smith submitted that you deny the charges in this case.

Mr Smith submitted that, while Colleague A/Ms 1 provided a reason for her non-attendance at this hearing, her medical evidence is insufficient as it is more or less a report of what she had told her GP. He submitted that the NMC has attempted to put support in place to facilitate Colleague A/Ms 1's evidence and support her through these challenges, which she has declined.

Mr Smith submitted that this statement is the sole and decisive evidence in relation to several charges, including 1(a), 1(b), 1(c), 2 and 3. He submitted that only Colleague A/Ms 1 can speak to whether the alleged incidents amounted to intimidation, and the impact of your alleged words on her. He submitted that you would be unable to test Colleague A/Ms 1's account in cross examination, which would be unfair to you.

Mr Smith submitted that placing weight on this statement would be insufficient to mitigate the unfairness to you, if it were adduced as evidence. He invited the panel to refuse the application.

The panel 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 legal assessor referred the panel to the principles set out in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin):

> '*(i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> *(v) whether there was a good reason for the non-attendance of the witnesses;*

(vi) whether the Respondent had taken reasonable steps to secure their attendance; and

(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.'

The panel was aware of the NMC guidance at DMA-6 and has taken it into account.

The panel determined that Colleague A/Ms 1's written statement is relevant to the charges against you, namely charges 1(a), 1(b), 1(c), 2, and 3.

The panel then considered whether Colleague A/Ms 1's statement was the sole or decisive evidence in support of charges 1(a), 1(b), 1(c), 2 and 3. The panel was of the view that Colleague A/Ms 1's statement is the sole or decisive evidence in relation to charges 1(a), 1(b), 1(c) and 2. No one else was present during the alleged incident between Colleague A/Ms 1 and you, and the door was allegedly shut. While there are witnesses to the build up to the incident and the aftermath, everything which occurred within these charges are unknown to others besides yourself and Colleague A/Ms 1.

The panel considered that the nature and extent of the challenge is extensive, and this cannot be rectified, as you are unable to challenge or test Colleague A/Ms 1's evidence in cross-examination. The panel is also unable to gain clarification around the impact that your alleged conduct in the charges would have had on Colleague A/Ms 1.

The panel was of the view that there is no suggestion that Colleague A/Ms 1 has fabricated her evidence. She was a senior nurse at the time and is now retired. Colleague A/Ms 1's initial email account was consistent with her subsequent accounts in both the local Trust investigation and the NMC investigation.

The panel considered that these are very serious charges, which if proved, could have a significant and adverse impact on your midwifery career.

The panel considered whether Colleague A/Ms 1 has provided a compelling reason for her non-attendance as a witness. It took into account the letter from Colleague A/Ms 1's GP [PRIVATE] and accepted that this may prevent her from attending to give evidence. However, the panel bore in mind that reasonable adjustments and support were offered to Colleague A/Ms 1 to facilitate her evidence through these medical challenges, which she declined.

The panel also considered whether the NMC has taken reasonable steps to secure Colleague A/Ms 1's attendance, including written and telephone correspondence. The panel was of the view that reasonable steps were taken by the NMC, including offering support and reasonable adjustments to Colleague A/Ms 1.

In relation to prior notice of this hearing, the panel was satisfied that sufficient time was given to yourself and your legal representation to prepare for this hearsay application. Notice that Colleague A/Ms 1 was not attending and that a hearsay application was going to be made by the NMC was provided to you and Mr Smith on 26 November 2025.

The panel determined not to accept Colleague A/Ms 1's written statement as evidence. It determined that it would be unfair to you to adduce evidence that is sole and decisive and cannot be challenged by you in cross-examination.

Application for no case to answer

Mr Smith made an application for no case to answer in respect of charges 1(a), 1(b), 2, 5(b), and 6(b). This application was made under Rule 24(7) of the NMC Fitness to Practise Rules 2004. He submitted that this application falls under both limbs of the Galbraith test (*R v Galbraith* [1981] 1 WLR 1039)

Mr Smith submitted that the evidence put before the panel by the NMC in relation to these charges is not present, or is tenuous and weak, and it would be inappropriate for them to go forward.

Mr Smith submitted that the NMC cannot rely on the evidence of Colleague A/Ms 1, as this was not accepted as hearsay evidence.

Mr Smith provided the following written submissions in relation to this application:

> *'It is submitted that there is insufficient evidence in relation to Charges 1(a), (b) and Charge 2. The evidence that the panel has heard thus far amounts to shouting being heard from inside the room where* [you] *and Colleague A/Ms 1 were arguing. The panel have heard evidence that both parties were arguing.*
>
> *In relation to Charge 1(a), it is therefore submitted that the panel has simply heard insufficient evidence regarding whether the shouting was angry, abusive or aggressive towards Colleague A/Ms 1, given that it was two ways. The NMC will likely rely on how Colleague A/Ms 1 appeared after the altercation, but it is submitted that there is no admissible evidence to suggest that her demeanour resulted from the Registrant's actions, as opposed to her own actions or from simply being engaged in a heated argument.*
>
> *It is submitted that evidence as to Charge 1(b) falls under the second limb of Galbraith/ DMA-6, in that there is some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the midwife. The witness 2 conceded that a description of the Registrant being "up in* [Colleague A/Ms 1]*'s face" was said for the first time during these proceedings, some 5 and a half years later. It is submitted that this evidence cannot be reliable, given the significant length of time that has passed. In her witness statement, Witness 2 did describe the Registrant getting in her face, and so realistically should have described the Registrant getting in Colleague A/Ms 1's face at the same time. This evidence is insufficient in determining that the Registrant was invading Colleague A/Ms 1's personal space.*
>
> *In relation to Charge 2, clearly no evidence has been put forward to suggest that the Registrants actions were intended to intimidate and/or threaten*

Colleague A/Ms 1. The evidence of the NMC at its highest only goes to two colleagues having an argument and shouting.

It is submitted that Witness 1 was clear in relation to Charge 5(b), where she accepted, per the exchange outlined above, that the Registrant never threw any papers, rather the papers were put down onto a desk. There is no evidence put forward to suggest otherwise, so it is submitted that Limb 1 of Galbraith is satisfied.

Finally, in relation to Charge 6(b) it is submitted that the height of Witness 7's' evidence upon clarification was that (a) the Registrant was asking for someone to clarify the procedure and (b) that the correct procedure in any case was that bloods would not be taken until an assessment from the antenatal team. It cannot be said therefore that the Registrant "incorrectly" stated that blood should not be taken from a patient as the patient was expecting twins. If anything, immediately taking bloods would not have been correct. It is submitted that here, too, Galbraith limb 1 is satisfied.

For the above reasons, the Panel is invited to dismiss Charges 1(a) and (b), Charge 2, Charge 5(b) and Charge 6(b). There is no case to answer in relation to these matters.'

Mr Radley did not challenge the application in respect of charge 5(b). However, he submitted that there is sufficient evidence before the panel in relation to charges 1(a), 1(b), 2, and 6(b) to proceed with the charges.

Mr Radley provided written submissions in relation to this application.

Mr Radley submitted that, in relation to charge 1(a), there is a case to answer as the evidence of Witness 1, Witness 2 and Witness 3 is relevant to this charge. He submitted that their evidence is '*consistent with their statements'* and that these witnesses '*all gave clear evidence even taking account of the passing of time'.*

Mr Radley submitted, in relation to charge 2, that your alleged behaviour in this charge was an outburst which caused staff *'and possibly patients to be distressed about what they saw or heard'.*

Mr Radley submitted, in relation to charge 5(b), Witness 1 was interviewing you with another colleague and a union representative at the time of this alleged incident. In her oral evidence, she stated that you threw the papers on the table, while the charge states that you *"stood up and threw papers towards your colleague".* Mr Radley submitted that it is for the '*panel to determine if the actions described in the evidence reflect the case as charged at 5(b).'*

In relation to charge 6(b), Mr Radley submitted that Colleague C/Witness 7's oral evidence is relevant to this charge. He submitted that Colleague C/Witness 7 *explained 'the process and what was said by* [you] *factually relying upon her statement'*. Mr Radley submitted that it is a matter for the panel to determine whether this statement was said or not at the facts stage of this case. He submitted that there '*is evidence that can be relied upon, and it was not so discredited during cross examination so as to be unreliable.'*

The panel accepted the advice of the legal assessor, who referred it to the NMC Guidance set out in DMA-6, and the three questions posed in the case of *Galbraith*, which stipulates:

1. There is no evidence; or
2. There is some evidence, but evidence which, taken at its highest, could not properly result in a fact being found proved against the nurse.
3. Where the evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability and where, on one possible view of the facts, there is evidence on which the panel could properly come to the conclusion that the allegation can be proved, then it should not allow the application.

<u>Charge 1(a)</u>

The panel determined that there is a case to answer in relation to this charge.

The panel took into account the written statement of Witness 2, which stated:

> *'Miss Travis is ordinarily rather loud in their communication; however, they appeared loud and aggressive. This was particularly aimed at Colleague A/Ms 1. I note that both parties were initially raising their voices'.*

The panel also took into account that Witness 2 referred to this incident in her oral evidence.

The panel was aware that it was not able to hear from Colleague A/Ms 1 as a witness, however, it was of the view that limb three of the *Galbraith* test was applicable in relation to this charge, in that the strength or weakness of the evidence before the panel depends on the view to be taken of a witness' reliability.

The panel was of the view that there has been sufficient evidence provided that a properly directed panel could, if it were compelled to do so at this stage without hearing anything further, find this charge proved. 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 the evidence, in terms of whether the charge is found proved or otherwise, remains to be determined at the conclusion of all the evidence.

Charge 1(b)

The panel determined that there is no case to answer in relation to this charge.

The panel considered that the charge specifically outlines that Colleague A/Ms 1's personal space was invaded, and that it was neither able to hear from Colleague A/Ms 1 as a witness in this hearing, nor take into account her written statement.

Witness 2 gave evidence about this incident for the first time in her oral evidence when she said that you were in Colleague A/Ms 1's face. This incident was not

mentioned in either Witness 2's written statement or the notes of investigation carried out by the Trust at the time. Whilst the panel had no reason to believe that Witness 2 had fabricated her evidence, the panel had no information before it to suggest or support that you may have invaded her space, as per the wording of charge 2, which could be interpreted differently from being in someone's face, as described in oral evidence.

The panel therefore concluded that the only evidence before it that has some relevance to this charge did not sufficiently deal with this allegation, and limb two of the *Galbraith* test therefore applies.

The panel determined that there is some evidence to support this charge, but when taken at its highest, it could not properly support a finding of there being a case to answer.

Charge 2

The panel determined that there is a case to answer in relation to this charge.

The panel considered this charge in relation to charges 1(a) and 1(c) only, in light of its finding of no case to answer in relation to 1(b).

The panel took into account Witness 2 and Witness 3's oral evidence, both of which gave evidence as to whether your behaviour was intimidating. The panel has already accepted that there is sufficient evidence in relation to charge 1(a) and was of the view that there is ample evidence to suggest that there could be an intention to threaten or intimidate Colleague A/Ms 1.

The panel determined that limb three of the *Galbraith* test was applicable in relation to this charge, in that the strength or weakness of the evidence before the panel depends on the view to be taken of a witness' reliability.

The panel was of the view that there has been sufficient evidence provided that a properly directed panel could, if it were compelled to do so at this stage without

hearing anything further, find this charge proved. 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 the evidence, in terms of whether the charge is found proved or otherwise, remains to be determined at the conclusion of all the evidence

Charge 5(b)

The panel determined that there is no case to answer in relation to this charge. The panel took into account Witness 1's oral evidence and written statement and noted that there are some inconsistencies in her recollection of the incident. In her written statement and her oral evidence, Witness 1 said that you stood up and threw papers at her and the HR representative. However, in her interview at the local investigation and in cross-examination, Witness 1 said you slammed some papers down on the table. She conceded that the papers being slammed rather than thrown was more likely to be accurate, given that this was stated nearer in time to the incident.

The panel was very mindful of the specific wording of the charge, and although it has come to the conclusion that an incident has taken place in relation to papers, given the differences of the accounts provided by Witness 1, the evidence before the panel is unsatisfactory and would be insufficient to find this charge proved as worded. The panel therefore concluded that the only evidence before it that has some relevance to this charge did not sufficiently deal with this allegation, and limb two of the *Galbraith* test therefore applies.

As such, the panel determined that there is some evidence to support this charge, but when taken at its highest, it could not properly support a finding of there being a case to answer.

Charge 6(b)

The panel determined that there is no case to answer in relation to this charge.

The panel considered the wording of the charge, which outlines that you *'incorrectly stated'* that blood should not be taken from the unknown patient referred to in charge 6. The panel acknowledged that there was some evidence that a discussion on taking blood from patients with a twin pregnancy did occur, however there was no evidence before it that supports that anything stated by you was incorrect in relation to the unknown patient being examined.

The panel therefore determined that there is no evidence before it to properly support a finding of a case to answer in relation to this charge.

Decision and reasons on facts

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

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

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

- Witness 1: Head of Midwifery at Peterborough Hospital at the Trust
- Witness 2: Maternity Care Assistant at the Trust at the time of the allegations

- Witness 3: Consultant Midwife at the Trust. Previously Acute Service Lead at [PRIVATE] Hospital at the time of the allegations
- Patient A/Witness 4: Patient at the Trust
- Patient E/Witness 5: Patient at Milton Keynes University Hospital NHS Foundation Trust
- Witness 6: Associate Chief Nurse at Milton Keynes University Hospital NHS Foundation Trust
- Witness 7: Imaging Assistant at Milton Keynes Trust

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Smith on your behalf.

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

Charge 1

The panel first considered each sub charge individually, then considered the overall stem of charge one, whether you behaved in an unprofessional manner, as a whole.

Charge 1(a)

'On 13 May 2020 you behaved in an unprofessional manner in the workplace in that you: behaved in an angry and/or abusive and/or aggressive manner towards Colleague A.'

This charge is found proved.

In reaching this decision, the panel took into account the written statements and oral evidence of Witness 2 and Witness 3, the Trust investigation interview minutes dated 1 September 2020, and your oral evidence under oath.

Witness 2 in her oral evidence told the panel that she heard you shouting. In the Trust investigation interview minutes, Witness 2 stated:

'[You were] *shouting at Colleague A/Ms 1, and then started shouting at me 'she's lying.' Colleague A/Ms 1 stood in front of me as a guard, as [you] getting (sic) in my face, Colleague A/Ms 1 kept asking* [you] *to leave but* [you] *refused.'*

Witness 3, in her oral evidence, told the panel that both yourself and Colleague A/Ms 1 were raised in their communication, however you were more vocal and louder. Her written statement stated:

'Miss Travis is ordinarily rather loud in their communication; however, they appeared loud and aggressive. This was particularly aimed at [Colleague A/Ms 1]'

You told the panel that, whilst this incident occurred, in your view, you were interrupted by Colleague A/Ms 1 for no good reason. The panel was of the view that this interruption to speak with you was appropriate, as Colleague A/Ms 1 was addressing the concerns raised by Witness 2.

The panel preferred the accounts of Witness 2 and Witness 3. It was of the view that these witnesses had no reason to fabricate their evidence.

The panel accepted your explanation that there was a clique at the Trust at the time of the report, however, it took into account that Witness 2 was a new member of staff who raised this issue after her first conversation with you. The panel was of the view that there was no reason for Witness 2 to fabricate her account, as she was not part of any clique at the time of making the report.

The panel determined that by shouting at Colleague A/Ms 1 and calling her names, including a '*liar'*, you behaved in an angry, abusive and aggressive manner towards Colleague A/Ms 1.

As such, on the balance of probabilities, this charge is found proved.

Charge 1(c)

> *'On 13 May 2020 you behaved in an unprofessional manner in the workplace in that you shouted at Colleague A and/or shouted in Colleague A's face'*

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, the Trust investigation interview minutes, Witness 3's written statement and oral evidence, and your oral evidence. The panel also took into account that it did not hear evidence from Colleague A/Ms 1 at this hearing.

Witness 2, in the Trust investigation interview minutes, stated that you were shouting at Colleague A:

> '[You were] *shouting at Colleague A/Ms 1, and then started shouting at me 'she's lying.'*

The panel took into account that Witness 2's oral evidence was consistent with this account of the events. She told the panel that you were shouting at Colleague A/Ms 1 when she spoke to you about a conversation you had with Witness 2 around social

distancing at the Trust. The panel was of the view that Witness 2 is a reliable witness.

You told the panel, during the course of your oral evidence, that you were not shouting, but being '*assertive'.*

Witness 3, in her oral evidence, told the panel that she heard both yourself and Colleague A/Ms 1 shouting, and suggested that they were shouting at each other. She indicated that you were being more than assertive. The panel preferred Witness 3's evidence, as it was consistent with Witness 2's evidence, and reliable.

The panel concluded that there is sufficient evidence to support that you shouted at Colleague A/Ms 1, however, it did not have evidence before it to support that you shouted in Colleague A/Ms 1's face.

As such, on the balance of probabilities, this charge is found proved in that you shouted at Colleague A/Ms 1.

Charge 1(d)

> *'On 13 May 2020 you behaved in an unprofessional manner in the workplace in that you swore in the presence of Colleague B.'*

This charge is found proved.

In making its decision, the panel took into account Witness 3's written statement and oral evidence, Witness 2's written statement, and your oral evidence.

The panel took into account Witness 3's statement:

> *'I asked* [Colleague A/Ms 1] *to leave the consultant room, as I felt that this would calm the situation down and allow me to speak with Miss Travis alone, which I thought would be of assistance as* [Colleague A/Ms 1] *remained shaken. Miss Travis was swearing.*

[…]
I attempted to calm Miss Travis down, who was shouting, confrontational and swore.'

Witness 3's oral evidence supported this account of events, that you were swearing following the confrontation with Colleague A/Ms 1. The panel was of the view that Witness 3 has no reason to fabricate this account and was a credible witness.

The panel took into account your oral evidence, in which you admitted that you did swear, and clarified that you said *"the 'S word'"*. The panel considered that the charge stipulates that you swore in the presence of Colleague B and does not specify what swear word was actually used.

As such, on the balance of probabilities, this charge is found proved.

Charge 1(e)

'On 13 May 2020 you behaved in an unprofessional manner in the workplace in that you spoke about Colleague A in a derogatory manner to Colleague B.'

This charge is found proved.

In making its decision, the panel took into account Witness 3's oral evidence and written statement, and your oral evidence.

The panel took into account Witness 3's written statement, which describes you referring to Colleague A/Ms 1 as a '*liar*' and '*mimicking her'*:

'Miss Travis referred to [Colleague A/Ms 1] *as a liar, mimicking* [Colleague A/Ms 1] *and their character.'*

In Witness 3's oral evidence, she told the panel that you were mimicking Colleague A/Ms 1's tone, voice, and mannerisms. She told the panel that this prompted her to ask you to leave.

This incident was also mentioned in the Trust Investigation Interview minutes with Witness 3:

> *'Stephanie was mimicking* [Colleague A/Ms 1]*, saying she had a clique, and that she was isolated within the team.'*

The panel was of the view that Witness 3's account was credible and reliable.

In your oral evidence, you told the panel that you *'couldn't "possibly" mimic* [Colleague A/Ms 1]*'.* The panel drew an inference from this, that this was a derogatory remark from you, considering that you did not say that you '*wouldn't'* mimic her, but that you *'couldn't'*, which has a negative connotation.

The panel took a specific note of the way in which you gave your evidence, in both Examination-In-Chief and cross-examination. The panel noted that the characterisation of you, by the witnesses it heard from, reflected your character and personality, as observed by the panel during your evidence. The panel came to the conclusion that this was far from assertiveness and concluded that you were likely capable of behaving in the manner described by the witnesses.

As such, on the balance of probabilities, this charge is found proved.

The panel then considered whether you behaved in an unprofessional manner in charges 1(a), 1(c), 1(d) and 1(e). The panel considered that, in relation to the charges found proved, these arose out of the same incident. It acknowledged that this was a difficult situation, having taken place during the COVID-19 pandemic, and this was a confrontation between colleagues. However, the panel considered that you did not take steps to de-escalate the confrontation. You were a registered professional in the workplace, and you should not have behaved in an abusive, aggressive, and angry manner towards your colleagues.

The panel considered that while this was a difficult and confrontational incident between a number of staff, it became out of hand when you became aggressive and loud.

The panel took into account that you admitted in your oral evidence that you had '*a meltdown'*.

As such, the panel determined that you behaved in an unprofessional manner in your conduct in charges 1(a), 1(c), 1(d), and 1(e).

Charge 2

> *'Your conduct at charges 1(a) to (c) above was intended to intimidate and/or threaten Colleague A.'*

This charge is NOT proved.

In making its decision, the panel took into account Witness 2 and Witness 3's oral evidence, and your oral evidence.

The panel took into account that your conduct in charges 1(a) and 1(c) appear to be a reaction, as opposed to a thought out and premeditated intention. It considered that you were on sick leave [PRIVATE] both prior to and after this incident.

The panel carefully considered that you explained that you felt you were being called a liar by Colleague A/Ms 1, suggesting that this was an emotional reaction you had in the moment.

The panel noted that it had ruled Colleague A/Ms 1's evidence as hearsay, and therefore inadmissible, and that it had no evidence before it to suggest that you were intentionally trying to intimidate or threaten Colleague A/Ms 1. It also noted that your intention in your conduct was not put to you in your evidence.

The panel acknowledged that the incident itself may have been seen as intimidating to your colleagues, specifically Colleague A/Ms 1. However, there is no evidence that this was your intention.

As such, the panel determined that the NMC has failed to discharge the burden of proof in relation to this charge and finds it not proved.

Charge 3

> *'Some or all of your conduct at charge 1 was done within the earshot of patients and/or other professional colleagues'*

This charge is found proved.

In making its decision, the panel took into account Witness 2's written statement and oral evidence, the Trust investigation interview minutes, and your oral evidence.

The panel carefully considered Witness 2's description of the layout of the area where the incident took place. She described the consulting room doors and its proximity to patients. Witness 2 explained that your voice and Colleague A/Ms 1's voice was raised.

The panel took into account the Trust investigation interview minutes with Witness 3:

> *'*[A midwife] *was working in the office opposite and she must have been able to hear.'*

The panel also took into account the Trust Summary of Investigation Meeting, which states:

> *'I went into the MDAU office, in there were* [four colleagues] *and* [Colleague A/Ms 1] – *they were all shaken.* [Colleague A/Ms 1] *stated that she was not coming back to work the next day if Stephanie was returning. The other three had all heard Stephanie shouting in front of patients, and also said they had moved* [Witness 2] *into another office.'*

In your oral evidence, you told the panel that other colleagues were present.

The panel was of the view that colleagues in particular would have heard this incident, and there is a real probability that patients in the area would have heard.

As such, on the balance of probabilities, this charge is found proved.

Charge 4(a)

'On two unknown dates prior to 15 May 2020 at Patient A's 12 week scan you:

i. conducted the scan in a rough manner

ii. responded in a rude manner when Patient A asked if she could video or photograph the scan'

This charge is found proved.

In making its decision, the panel took into account Patient A/Witness 4's written statement and oral evidence, Witness 1's written statement and oral evidence, your oral evidence, and a Trust email dated 15 May 2020 detailing Patient A/Witness 4's telephone complaint.

4(a)i:

The panel was of the view that Patient A/Witness 4 is a credible witness, and that there is no suggestion that her evidence has been fabricated.

The panel took into account that Patient A/Witness 4, in her oral evidence, explained that her scan was conducted in a very rough manner. She explained feeling uncomfortable throughout. The panel also took into account Patient A/Witness 4's written statement which recalls the scan being conducted in a rough manner:

'Whilst Miss Travis completed my 12 week scan, I felt that Miss Travis was particularly rough. By way of background, I had already had a private internal scan in the past, which I had as a direct point of comparison. I regarded the

scan as rough, as I felt Miss Travis was jerky and it felt as if someone had shoved something in me, as opposed to taking care of me.'

The panel noted that Patient A/Witness 4's oral evidence was consistent with her written statement.

The panel considered that Witness 1, in her oral evidence, did not mention a rough 12-week scan in the patient complaint, and there was no documentation of this being raised at the time. However, the panel took into account that Patient A/Witness 4 was able to clearly recall her 12-week scan in her oral evidence and had no reason to fabricate this. The panel considered that it was likely that she was prompted by the second scan also being conducted in a rough manner to formally make a complaint about both occasions.

The panel took into account your oral evidence, in which you stated that you did not recall this incident. However, the panel preferred Patient A/Witness 4's evidence.

It determined, on the balance of probabilities, that you conducted Patient A's 12-week scan in a rough manner.

4(a)(ii):

The panel took into account the Trust email which details a telephone complaint received from Patient A/Witness 4. The email was addressed to Colleague A/Ms 1, and states:

'I had Patient A phone, asking to speak with you directly, however you wasn't (sic) in so I was able to take a message[…] Patient A attended her Anomaly scan with Stephanie over in the treatment centre […] Patient said that Stephanie had made the whole experience a bad one for her; because … was allowing ladies to record small snippets of their scan, Patient A kindly asked Stephanie if she was able to do this. Stephanie then proceeded into a rant saying how it becomes an unpleasant experience and puts a lot of pressure on the sonographer. This made Patient A feel very uncomfortable.'

The panel also took into account Patient A/Witness 4's written statement and oral evidence. In her written statement, Patient A/Witness 4 states:

> *'I felt that Miss Travis was rather rude. I asked Miss Travis whether I could take a photograph or a video of my scan. Miss Travis provided me with a lecture as to how this would damage them professionally, that it was inappropriate for me to have asked to take a photograph/video of the scan, and that this would allow someone to unfairly judge them.'*

Patient A/Witness 4's oral evidence was consistent with her written statement.

The panel accepted that you were following Trust policy at the time but was of the view that this could have been communicated in a compassionate and respectful manner to Patient A/Witness 4. The panel was of the view that it was more than likely that the manner in which you responded to Patient A/Witness 4 was rude.

As such, on the balance of probabilities, charge 4(a) is found proved in its entirety.

Charge 4(b)

'at Patient A's 20 week scan you:

i. conducted the scan in a rough manner

ii. when Patient A complained of pain/discomfort said words to the effect of 'man up'

iii. refused to write down the gender of Patient A's baby'

This charge is found proved.

In making its decision, the panel took into account Patient A/Witness 4's written statement and oral evidence, Witness 1's written statement and oral evidence, your oral evidence, and a Trust email dated 15 May 2020 detailing Patient A/Witness 4's telephone complaint.

4(b)(i):

The panel took into account Patient A/Witness 4's oral evidence, which was consistent with her written statement. Patient A/Witness 4 told the panel that, following her scan, she experienced bruising on her stomach. She showed this to her midwife, who then inquired whether Patient A/Witness 4's husband was *'being kind and caring'* with her.

Patient A/Witness 4, in her written statement, described the rough scan:

> *'During my 20 week scan, I also felt that Miss Travis was being rough. This is because Miss Travis pushed very hard into my stomach and kept pushing into my bottom aggressively. […] I was left with bruising to my stomach... I expect to be treated with common decency, not being physically hurt.'*

Patient A/Witness 4 said that she took photographs of the bruising, which have since been deleted as she did not want to keep those kinds of photos on her phone. She described it as unpleasant.

In Patient A/Witness 4's written statement, she outlined that she complained to the Trust after being left with bruising. She had a telephone call to discuss the concerns but did not receive a copy of her complaint. In her oral evidence, she was clear that she understood this to be a serious allegation which would have an impact on the professional, and as such would only share details with a person empowered to manage the complaint. The panel considered this to be a credible explanation, including the offer of photographs, and her reasons for not ultimately retaining them.

In your oral evidence, you deny conducting the scan in a rough manner. However, the panel was of the view that Patient A/Witness 4's evidence was credible and preferred her evidence.

It determined, on the balance of probabilities, that you conducted Patient A's 20-week scan in a rough manner.

4(b)(ii):

The panel took into account Patient A/Witness 4's oral evidence, which was consistent with her written statement.

In Patient A/Witness 4's written statement, she recalls being told words to the effect of '*man up'*, after expressing discomfort and pain during her scan:

> *'Miss Travis pushed very hard into my stomach and kept pushing into my bottom aggressively. I mentioned that this hurt, and Miss Travis had noted that I needed to 'man up' or they were going to finish the appointment. This is not the exact wording that Miss Travis used.'*

In your oral evidence, you deny conducting the scan in a rough manner and saying words to this effect to Patient A/Witness 4. However, the panel was of the view that Patient A/Witness 4's evidence was credible and preferred her evidence.

The panel determined, on the balance of probabilities, that you told Patient A/Witness 4 words to the effect of '*man up'.*

4(b)(iii):

The panel took into account Patient A/Witness 4's written statement and oral evidence, and your own oral evidence.

Patient A/Witness 4 stated in her written statement that:

> *'During a 20 week scan, you are informed of the gender of your baby. I had asked Miss Travis if they could write down the gender of my baby, in order for me to find out the gender with my husband. Miss Travis declined this, and stated that they either told me the gender now or I would not find out the gender of my baby.'*

Patient A/Witness 4's oral evidence was consistent with her written statement.

In your oral evidence, you accepted that you did not write down the gender, as this was against Trust policy.

The panel therefore determined, on the balance of probabilities, that you refused to write down the gender of Patient A's baby.

As such, on the balance of probabilities, charge 4(a) is found proved in its entirety.

Charge 5(a)

> *'On 13 July 2020 during a meeting with colleagues you shouted'*

This charge is found proved.

In making its decision, the panel took into account Witness 1's oral evidence and written statement, the Trust investigation findings report, and your oral evidence.

The panel took into account Witness 1's written statement, which states:

> *'I asked Miss Travis to please calm down. I thought that Miss travis might hit me, and I have never witnessed such behaviour. […] I personally would not wish to sit in a room with Miss Travis as she is a very angry character.'*

In Witness 1's oral evidence, she said that you were loud and angry, and that she has not been met with such behaviour before. She said that your voice was raised, and it was aggressive rather than assertive. The panel was of the view that Witness 1 was a reliable witness, and there was no suggestion that her evidence was fabricated.

The panel took into account the Trust investigation findings report:

> *'On 13 July 2020, Stephanie allegedly demonstrated aggressive and intimidating behaviours toward the Deputy Head of Midwifery and the HR*

Business Partner during a meeting to discuss the complaints arising from the alleged incident and patient complaints. These alleged behaviours were witnessed by the Trade Union Representative who was also present at this meeting. […] Witness 1 stated that Stephanie stood up […] and was pointing and shouting.'

The panel considered that you maintain, in your oral evidence, that you were not shouting, but being assertive. However, the panel was of the view that this incident likely went beyond being assertive.

As such, on the balance of probabilities, this charge is found proved.

Charge 6(a)

'On 17 June 2022 you shouted at Colleague C'

This charge is NOT proved.

In making its decision, the panel took into account your oral evidence and Colleague C/Witness 7's written statement and oral evidence.

The panel took into account that there were inconsistencies between Colleague C/ Witness 7's written statement and her oral evidence. Colleague C/ Witness 7 gave three different accounts of the incident, one of which was that you ignored her.

The panel also took into account your oral evidence, in which you said that you ignored Colleague C/Witness 7.

The panel preferred your evidence in relation to this charge. It was of the view that it was more likely that you ignored Colleague C/Witness 7 rather than shouted at her, and this is supported by her account that she was ignored by you.

As such, the panel determined that the NMC has failed to discharge the burden of proof in relation to this charge and finds it not proved.

Charge 6(c)

> *'On 17 June 2022 you said words to the effect that you were the sonographer/midwife and knew the policies whereas Colleague C knew nothing'*

This charge is NOT proved.

In making its decision, the panel took into account your oral evidence and Colleague C/Witness 7's written statement and oral evidence.

The panel took into account that there were inconsistencies between Colleague C/ Witness 7's written statement and her oral evidence. Colleague C/Witness 7 mentioned that she was completely ignored, and in another account, she said that you were checking the policy with another sonographer.

The panel also took into account your oral evidence, in which you said that you ignored Colleague C/Witness 7 and checked the policy with another sonographer. You said that you would not tell Colleague C/Witness 7 that you knew the policy, only to then check the policy with another sonographer.

The panel preferred your evidence in relation to this charge. It was of the view that it was more likely that you ignored Colleague C/Witness 7 and then checked the policy with another sonographer, rather than told her that you knew the policies and that Colleague C knew nothing, or words to that effect.

As such, the panel determined that the NMC has failed to discharge the burden of proof in relation to this charge and finds it not proved.

Charge 6(d)

‘On 17 June 2022 you were rude to Colleague C’

This charge is found proved.

The panel took into account your oral evidence and Colleague C/Witness 7’s oral evidence and written statement.

The panel accepted, in charges 6(a) and 6(c), that factually, you most likely ignored Colleague C/Witness 7.

The panel was of the view that ignoring a colleague who is attempting to help in the workplace is rude.

The panel took into account an email correspondence from Ms 2, dated 15 August 2022:

> *‘Colleague C/Witness 7 feels that Stephanie has no respect for her or her role and found Stephanie’s behaviour to be rude. […] Stephanie then apologised if she was perceived as being rude to Colleague C/Witness 7.’*

During Colleague C/Witness 7’s cross examination, she was asked by Mr Smith whether you apologised for ignoring her, to which Colleague C/Witness 7 said that she does not remember being apologised to.

As such, on the balance of probabilities, this charge is found proved.

Charge 7

> *‘On an unknown date in early July 2022 you attempted to intimidate Colleague C following a complaint that Colleague C had raised against you’*

This charge is found proved.

In making its decision, the panel took into account your oral evidence, and Colleague C/Witness 7's oral evidence and written statement.

The panel heard Colleague C/Witness 7's oral evidence, in which she said that she did not expect that you would be informed of her complaint, however this complaint was supplied to you by Ms 2. She said that, following this complaint, after working with you again, you said: *'oh, so you're Colleague C. Ah. You're the one who did the complaint. Now I know who you are.'*

In her oral evidence, Colleague C/Witness 7 said that your tone of voice made her feel intimidated. She said that someone looking to find out who she was after she made a formal complaint is intimidating behaviour.

In your oral evidence, you admitted that you said this. However, you said that you did not say this in an intimidating manner, rather, a polite manner.

The panel preferred Colleague C/Witness 7's evidence in relation to this charge. It was of the view that the only reason you would say '*now I know who you are'* to someone who raised a formal complaint against you, is to intimidate them or make them feel intimidated. It also took into account the power imbalance between your role and hers, which would support that using these words would make a junior staff member feel intimidated.

As such, on the balance of probabilities, this charge is found proved.

Charge 8(a)

'On 15 October 2022 you were rude to Patient E.'

This charge is found proved.

In making its decision, the panel took into account Patient E/Witness 5's oral evidence and written statement, your oral evidence, and Witness 6's oral evidence and written statement.

The panel took into account that Patient E/Witness 5's oral evidence was clear and consistent with her written statement. There was no suggestion that her evidence was fabricated.

In Patient E/Witness 5's statement, she states:

> *'As soon as I entered the room, Miss Travis was directly rude to me. After taking one look at me, Miss Travis said 'well, I will do my best at this scan.' With pre-eclampsia comes swelling. I had swelling everywhere, including my feet and stomach. I was extremely uncomfortable and in a lot of pain.'*

The panel took into account Witness 6's evidence, who confirms that there was an investigation of a report made by Patient E/Witness 5 following the incident.

The panel noted that you denied being rude to Patient E/Witness 5. However, it preferred Patient E/Witness 5's evidence in relation to this charge. She was a vulnerable patient at the time and recalled the incident clearly and consistently during the course of her oral evidence.

As such, on the balance of probabilities, this charge is found proved.

Charge 8(b)

'On 15 October 2022 made one or more inappropriate comments in that you:

i. said that there was 'too much' of Patient E or words to that effect

ii. said that you had 'never scanned like this before' or words to that effect

iii. said 'well thank god there is a heartbeat' or words to that effect'

This charge is found proved.

In coming to its conclusion, the panel took into account Patient E/Witness 5's oral evidence and written statement, your oral evidence, and Witness 6's oral evidence

and written statement. This charge (i,ii,iii) relates to one incident of your involvement with Patient E on 15 October 2022.

The panel took into account Patient E/Witness 5's oral evidence, in which she said that she could not remember the exact words used, but that she will not forget the feeling she was left with. She said that, following this experience, she was left shocked and on the verge of tears.

The panel noted that Patient E/Witness 5's oral evidence was consistent with her written evidence, which states:

> *'During the scan, Miss Travis was huffing and puffing. Miss Travis was denoting that they could not do the scan properly, as 'there was too much of me'. Miss Travis called in a colleague to assist them and repeated that 'there was too much of me', and that they had 'never scanned like this before.''*

The panel took into account an email from Ms 2, relating to the complaint from Patient E and dated 17 November 2022:

> *'When she returned to the ward, she told the Radar reporter that the Sonographer was unable to scan the patient hand (sic) told her 'that in all my years of scanning I've never not been able to see and measure a baby'. She went on to say 'your stomach is too much, oedematous, and hard to be able to see the baby, but at least we can see a heartbeat. The sonographer reiterated that at least we can see a heartbeat. The patient was very distressed.'*

The panel noted that you denied making these comments to Patient E/Witness 5. It also took into account the oral evidence and written statement of Witness 6, whose statement states:

> *'On 15 October 2022, Patient E went for a scan […] The Radar was investigated by a Superintendent Sonographer. The limitations of the ultrasound were identified, and a second sonographer was called for a second*

attempt. Miss Travis stated that in an attempt to pacify Patient E's concerns, they had stated that at least there is a heartbeat. Miss Travis said that although their tone may have come across as unpleasant this is not how it was meant.'

However, the panel preferred Patient E/ Witness 5's evidence in relation to this charge. It was of the view that her evidence is consistent and credible.

The panel found that these comments were all inappropriate to make to such a vulnerable patient. Patient E/Witness 5 was in a vulnerable position, admitted with a serious complication and looking for reassurance in this scan. Instead, she was met with these comments.

The panel took into account that, in your oral evidence, you said that you could not remember interacting with Patient E/Witness 5, and that you may not have been the sonographer present. However, the evidence of the radar report, and your responses at the time, supported the panel's finding.

On the balance of probabilities, the panel found that you said that there was '*too much*' of Patient E/Witness 5, or words to that effect, that you *'have never scanned like this before*' or words to that effect, and '*thank god there is a heartbeat'*, or words to that effect.

As such, on the balance of probabilities, Charge 8(b) is found proved in its entirety.

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.

Following the submissions made by Mr Radley, you gave evidence under oath.

Over the course of your evidence at this stage, a Rule 19 application was made.

Decision and reasons on Rule 19 Application

Mr Smith made a request that this case be held partly in private on the basis that proper exploration of your case involves some reference to your health and private life. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Radley indicated that he supported the application.

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

The panel determined to go into private session in connection with your health and private life as and when such issues are raised in order to protect your privacy.

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.'* The panel had regard to the terms of the NMC Code of Conduct in making its decision.

Mr Radley invited the panel to take the view that the facts found proved amount to misconduct. He submitted that your actions in the charges found proved amounted to breaches of the fundamental tenets of the nursing profession.

Mr Radley identified the specific, relevant standards where your actions amounted to misconduct. He submitted that the concerns in the charges found proved are at the heart of a caring profession, namely your compassion and the manner in which you approached your duties, the language you used with colleagues, and swearing and angry exchanges taking place within the earshot of patients.

Mr Radley submitted that these charges amount to serious professional misconduct, as these issues relate to your role as a registered professional, and the impact that your conduct has had on your area of practice, namely on patient care and staff team relations.

Mr Smith submitted that your conduct in the charges found proved did not amount to serious misconduct.

Mr Smith invited the panel to consider the context around the charges found proved, and to evaluate whether the facts found proved are serious in that whether the swearing took place in private, and the context of any rude behaviour.

Submissions on impairment

Mr Radley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included

reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Radley invited the panel to make a finding of impairment.

Mr Radley submitted that breaches of the NMC Code involves breaching fundamental tenets of the profession. He submitted that the conduct in the charges found proved is serious, and a finding of impairment is required to mark the unacceptability of your behaviour, emphasise the importance of the fundamental tenets breached, and to reaffirm proper standards of behaviour.

Mr Radley acknowledged the steps you have taken to strengthen your practice and address the concerns, namely your reflective piece, testimonials, and portfolio of evidence of training.

Mr Radley, however, submitted that there is a risk of repetition in this case, and invited the panel to make a finding of impairment.

Mr Smith submitted that your practice is not currently impaired.

Mr Smith submitted that you have been practising unrestricted at your current workplace. He submitted that there has been no repetition of the conduct, and these were isolated incidents.

Mr Smith submitted that you had a previously unblemished record. He submitted that there is context behind the charges and personal circumstances at the time of the incidents.

Mr Smith submitted there is no risk of repetition. He submitted that you have engaged wholeheartedly in mediation communications courses, and you are supported by your current manager. He submitted that you have taken steps to recognise and address your failings in this matter.

Mr Smith submitted that there was no indication that any rough handling of patients was deliberately done by you. He submitted that you have been practising as a sonographer for an extensive period of time without concerns.

The panel accepted the advice of the legal assessor, who referred to, (amongst other authorities):*Roylance v GMC* (No. 2) [2000] 1 AC 311; *General Medical Council v Meadow* [2007] QB 462 (Admin);*Cohen v General Medical Council* [2008] EWHC 581 (Admin); and *CHRE v Nursing and Midwifery Council & Grant* [2011] EWHC 927.

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.

Charge 1

The panel determined that your conduct in this charge amounted to serious misconduct.

Having found that this amounted to angry, aggressive, and abusive behaviour toward Colleague A/Ms 1, involving swearing and shouting, the panel considered this to be a serious falling short of the conduct expected of a registered midwife.

Basic professionalism is expected within the workplace, and the members of the department and senior staff became involved in this incident for a number of hours, potentially disrupting the service provided to patients, because you would not calm down.

The panel therefore determined that serious misconduct was established in relation to this charge.

Charge 3

The panel determined that your conduct in this charge amounted to serious misconduct.

Having found that your angry, aggressive, and abusive behaviour towards Colleague A/Ms 1, involving shouting and swearing, was likely within earshot of patients and professional colleagues, the panel considered this to be a serious falling short of the conduct expected of a registered midwife.

The panel considered that during the COVID-19 Pandemic, it was important that professionals maintain an unflustered and confident appearance, and an ability to deal with difficult situations. By shouting and swearing in proximity to and within earshot of patients, you showed that the situation was not under control, which could have put patients at risk of losing trust in the profession.

The panel therefore determined that serious misconduct was established in relation to this charge.

Charge 4(a)

The panel determined that your conduct in this charge amounted to serious misconduct.

Having found that you conducted Patient A/Witness 4's 12-week scan in a rough manner and responded in a rude manner when she asked to video or photograph the scan, the panel considered this to be a serious falling short of the conduct expected of a registered nurse.

Patient A/Witness 4 sought care and reassurance during her pregnancy. This was an internal scan, which is very intimate, and it was conducted in a rough manner leaving Patient A/Witness 4 feeling as if she was not being taken care of. Furthermore, due to her pregnancy occurring during the Covid-19 pandemic, she could not have her husband present for support.

Instead of communicating with Patient A/Witness 4 in a polite and respectful manner, you were rude to her and made her feel uncomfortable. She described your conduct as one that made '*the whole experience a bad one for her.'* The panel was of the view that this fell short of caring and compassionate care.

The panel therefore determined that serious misconduct was established in relation to this charge.

Charge 4(b)

The panel determined that your conduct in this charge amounted to serious misconduct.

Having found that you conducted Patient A/Witness 4's 20-week scan in a rough manner and told her words to the effect of *'man up'* when she expressed discomfort and pain, the panel considered this to be a serious falling short of the conduct expected of a registered midwife.

Patient A/Witness 4 sought care and reassurance during her pregnancy. You conducted the 20-week scan in such a rough manner that she experienced bruising to her stomach following the scan. Patient A/Witness 4 said that she expected '*to be treated with common decency, not being physically hurt.'* When she expressed that she was experiencing discomfort and pain, you told her to '*man up'* or words to that effect, or else you would finish the appointment. The panel was of the view that this fell short of caring and compassionate care.

The panel did not find that your conduct in charge 4(b)(iii) amounted to misconduct.

While the panel found that factually, you refused to write down the gender of the baby, it was satisfied that you were adhering to Trust policy. The panel was of the view that this was not a serious departure from the NMC Code.

The panel therefore determined that serious misconduct was established in relation 4(b)(i) and 4(b)(ii) only.

Charge 5(a)

The panel determined that your conduct in this charge amounted to misconduct.

Having found that you shouted during a meeting with colleagues on 13 July 2020, the panel considered this to be a falling short of the conduct expected of a registered midwife.

The panel was of the view that your behaviour, namely shouting at your colleagues, was aggressive, and fell short of professional conduct within the workplace setting.

The panel therefore determined that misconduct, but not serious misconduct, was established in relation to this charge.

Charge 6(d)

The panel determined that this charge did not amount to misconduct.

The panel was of the view that, while ignoring colleagues not particularly polite or professional, it does not meet the threshold of '*sufficiently serious misconduct'.*

The panel was of the view that this did not amount to a serious departure from the NMC Code.

Charge 7

The panel determined that your conduct in this charge amounted to misconduct.

Having found that you attempted to intimidate Colleague C/ Witness 7, following a complaint that she raised against you, the panel considered this to be a falling short of the conduct expected of a registered midwife.

The panel took into account that your conduct had an impact on your colleague and made her feel intimidated. This could have led to her feeling undermined and impacted the quality of her work and patient care. Treating colleagues in an intimidating way could lead to staff disengagement. However, because this was said on only one occasion and there were no further intimidatory actions by you, the panel considered that this did not amount to serious misconduct.

The panel therefore determined that there was misconduct, but not serious misconduct, in relation to this charge.

Charge 8

The panel determined that your conduct in this charge amounted to serious misconduct.

Having found that you were rude to Patient E/ Witness 5 and made three inappropriate comments to Patient E/Witness 5, the panel considered this to be a serious falling short of the conduct expected of a registered midwife.

The panel took into account that Patient E/Witness 5 was a very vulnerable patient who was admitted with serious complications. She was admitted to the hospital seeking care and compassion. Your comments and behaviour towards her made her feel distressed and upset. Your comments were so serious that a memo had to be sent out to sonographers at the Trust, reminding them to be mindful of their communication with patients.

The panel had regard to the impact that your conduct had on Patient E/Witness 5, which was significant. She expressed that she wanted to go home, and this could have resulted in harm given the seriousness of her condition. The panel was of the view that your conduct in this charge was beyond unprofessional and fell short of caring and compassionate care.

The panel therefore determined that serious misconduct was established in relation to this charge.

The panel was of the view that your actions in charges 1(in its entirety), 3, 4(a), 4(b)(i), 4(b)(ii), and 8 (in its entirety) did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

- ***1.1*** *treat people with kindness, respect and compassion*
- ***1.2*** *make sure you deliver the fundamentals of care effectively*
- ***8.1*** *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
- ***8.5*** *work with colleagues to preserve the safety of those receiving care*
- ***9.3*** *deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times*
- ***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*
- ***20.5*** *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your rude, unprofessional, intimidating, bullying, aggressive and angry behaviour, as well as your lack of compassion and care for two vulnerable patients as identified in the charges found proved, was very serious and breached fundamental tenets of the midwifery profession and professional standards expected of a registered midwife.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* DMA-1 in which the following is stated:

> *'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. To justify that trust, midwives must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *...’*

The panel was of the view that your actions put patients at risk of harm. You conducted two scans on Patient A/Witness 4 in a rough, uncaring manner, which caused her both physical harm in the form of bruising, as well as emotional harm. In relation to Patient E/Witness 5, this patient was very vulnerable and experiencing serious medical complications during her pregnancy. She experienced emotional harm and distress as a result of your conduct and was placed at an unwarranted risk of harm.

The panel determined that your actions in the past brought the midwifery profession into disrepute. Your behaviour in relation to charge 1 took place within the earshot of patients. This incident took place during COVID-19, and hearing such behaviour including shouting and swearing, could have alarmed patients. This conduct also had the potential to impact your colleagues and their ability to work and provide patient

care. The panel also took into account the possibility of Patient A/Witness 4 and Patient E/Witness 5 telling others about their negative experiences while seeking care.

The panel took into account that key aspects of the serious misconduct in this case are focussed on your failure to provide caring and compassionate care to vulnerable patients, and your failure to promote professionalism in the workplace and in your interactions with your colleagues. The panel determined that you breached several fundamental tenets of the nursing profession through your conduct towards your colleagues and your patients.

The panel was of the view that the misconduct identified could be remediable with the right training and support. When considering whether it has been remedied by you, the panel took into account that you have produced some reflective pieces and provided evidence of training. You have also provided positive testimonies which speak to your ability to practise safely and professionally.

However, the panel was of the view that, while you have demonstrated some developing insight, it was not satisfied that this has been fully developed. In your evidence, you were still deflective, and you framed the situation as circumstantial as opposed to taking responsibility for your conduct.

While your training relates to improving how you provide transvaginal scans, the panel did not have evidence of training relating to your communication style and skills when working with patients in particular. Your reflection addressed technical aspects of patient care but did not address the interpersonal elements of providing good patient care.

The panel also took into account that the misconduct relates to two sets of charges that took place at two different trusts, demonstrating a pattern of repetition from 2020 to 2022. Whilst the panel accepted that there were factors in 2020 which may have exacerbated your behaviour, including the Covid-19 pandemic, your bereavement, and your isolation within the team, it noted that the incidents in 2022 occurred when

there were no such mitigating factors. The panel was of the view that there is an indication of behavioural and attitudinal issues.

The panel accepted that you are taking medication [PRIVATE] and that you are under the care of your GP. However, while this is being managed to an extent, the panel was not confident that you would not repeat conduct of the nature in the charges found proved if you were under similar stressful conditions. The panel was not satisfied that the risk of repetition was “highly unlikely” as per the case of *Cohen* as cited above.

The panel determined that limbs a, b and c of the *Grant* test are engaged, and that you are liable in the future to put patients at risk of harm, bring the profession into disrepute, and breach the fundamental tenets of the nursing profession.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required, as public confidence in the nursing profession would be seriously undermined if a nurse with charges relating to rude, angry, aggressive, abusive, unprofessional behaviour, and a lack of compassion and care for two vulnerable patients, were allowed to practise without a finding of impairment. It determined that a finding of impairment is necessary to maintain public confidence in the nursing profession and the NMC as regulator and uphold proper standards of professional conduct.

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.

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

Submissions on sanction

Mr Malik on behalf of the NMC, informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months with a review if it found your fitness to practise currently impaired.

Mr Malik submitted that there are attitudinal concerns, a lack of insight into your behaviour, and limited remediation, and remorse.

In terms of mitigation, Mr Malik submitted that you have some developing insight.

Mr Malik submitted that there is a significant risk of repetition and a risk of harm to the public.

Mr Malik submitted that conditions of practice would not be appropriate, as there are no areas of practice in need of assessment or training. He submitted that this case relates to some attitudinal concerns, which may be difficult to remediate.

Mr Malik submitted that, as your insight is still developing, a period of temporary removal from the NMC Register is required to protect the public and maintain public confidence in the nursing profession. He submitted that that a suspension order of 12 months with a review is the appropriate and proportionate order in this case.

Mr Malik submitted that a strike off order would be disproportionate in light of your subsequent period of clinical practice without repetition. He submitted that this suggests that you are capable of practising safely and effectively.

Mr Smith submitted that a suspension order for a period of three to six months is appropriate and proportionate. He submitted that this would give you the time necessary to reflect and remedy your impaired practice.

Mr Smith submitted that a strike off order would be disproportionate in these circumstances.

Mr Smith submitted that a short period of suspension is proportionate, as a longer period would risk '*atrophying'* your current clinical skills and practice.

Mr Smith submitted that there are no aggravating features and submitted that the rough handling of Patient A was not deliberate, and was a genuine mistake. He referred the panel to the positive feedback and testimonials that you have provided.

Mr Smith submitted that there are mitigating features in this case, including personal factors. He submitted that you have undertaken training courses on communication, and you acknowledge that more can be done.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor, who referred it to the NMC Sanction Guidance SAN-1.

Having found that 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:

- Conduct which put patients put at risk of suffering harm
- Actual emotional harm caused to Patient A/Witness 4 and Patient E/Witness 5
- Conduct which was repeated at two different trusts
- Lack of insight into conduct specifically in relation to your communication with patients

The panel also took into account the following mitigating features:

- Evidence of relevant training courses completed
- Positive testimonials
- Developing insight specifically in relation to your communication with your colleagues
- Personal mitigation during 2020, including your health and bereavement

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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 carefully considered that the misconduct in this case is serious and indicate that there may be some attitudinal and behavioural concerns. However, referring to its determination on impairment of fitness to practise, the panel was not satisfied that these attitudinal concerns were deep-seated and incapable of being remediated. It bore in mind that you have demonstrated an ability to practise safely for three years without restrictions since the incidents in the charges found proved, and that you are managing your health conditions [PRIVATE], and feeling supported by your current managers.

The panel determined that the risk of repetition and harm in this case stems from your inability to practise under stressful circumstances. It took into account that your

insight needs further developing in relation to your compassion and communication with patients and your colleagues.

The panel acknowledged that you have undertaken and successfully completed training courses in relation to practical elements of patient care, including transvaginal scans and Effective Communication in the Workplace, dated 1 February 2025. It took account of the testimonial provided by the Superintendent Sonographer at Milton Keynes University Hospital, dated 17 November 2025:

> *'One of the qualities that stands out about Stephanie is her enthusiasm for continuous professional development. She has shown a keen interest in enhancing her skills in Gynaecology, particularly regarding her Transvaginal Scanning skills. This focus has not only improved her clinical competence but has also had a positive impact on her confidence in working with patients*
>
> *[…]*
>
> *During the last 6 months, Stephanie has also been undertaking a skills refresher in gynaecological ultrasound.'*

However, the panel noted that you have not yet demonstrated a strengthening of your interpersonal communication with patients.

The panel considered imposing a suspension order for a period of three to six months, however, it was not satisfied that temporarily suspending you from practising would address and remediate the concerns it has identified. While a short period of suspension would allow you time to develop your insight and reflection, address the attitudinal concerns, and undertake further training, it would not necessarily address or strengthen your ability to communicate with disparate and/or vulnerable patients and colleagues while under stress.

The panel was satisfied that appropriate and practical conditions could be formulated to address the concerns, namely your ability to perform under and manage stress, your communication with colleagues and patients, compassion in the workplace, and

your reflection and insight. The panel was satisfied that a conditions of practice order would sufficiently protect the public and meet the public interest.

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 otherwise unblemished career 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 continue to practise as a midwife.

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

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of your case, as you have demonstrated an ability to practise safely without concern since the incidents, and you have demonstrated a willingness to undertake further training and remediate the concerns.

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.

In making this decision, the panel carefully considered the submissions of Mr Malik in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a suspension order would not fully address the concerns, for the reason outlined above.

The panel concluded that a strike off order would be disproportionate in light of the circumstances of this case.

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 must limit your practice to Milton Keynes NHS Foundation Trust. You must not undertake agency work.

2. You must work with your supervisor to develop a Personal Development Plan (PDP) to address the following:

    a) Communication with patients and colleagues
    b) Compassionate leadership and practice in your role
    c) Development of your emotional intelligence
    d) Managing your behaviour when working under stress

3. You must send a copy of this PDP to your NMC Case Officer.

4. You must meet with your line manager, mentor, supervisor, or a member of staff appointed by your line manager, once a month to undertake a supervised practice session. A record of this supervised session must be sent to the NMC by your line manager, mentor, or supervisor prior to any review.

5. You must raise any challenging situations you have encountered within the workplace with your manager, mentor or supervisor as soon as practicable.

6. You must undertake additional learning and training, with a particular focus on appropriate communication with colleagues and patients.

7. You must produce a written reflection or reflections addressing:

a) Communication with patients and colleagues
b) Compassionate leadership and practice in your role
c) Development of your emotional intelligence
d) Managing your behaviour when working under stress

8. You must send up-to-date copies of this written reflection or these written reflections to your NMC Case Officer prior to any review.

9. You must keep the NMC 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.

10. You must keep the NMC 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.

11. 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.

12. 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.

13. 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

This conditions of practice order is for a period of 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:

- A copy of your Personal Development Plan and evidence of completion
- Line Manager records of supervised sessions
- Copies of your written reflections
- Testimonials/feedback if received from patients and/or colleagues/professionals
- Details of courses and/or training you have undertaken

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 Mr Malik and Mr Smith.

Mr Malik invited the panel to impose an 18-month interim conditions of practice order in order to cover any period of appeal. He submitted that an interim conditions of practice order would protect the public and meet the public interest during any appeal period.

Mr Smith submitted that an interim order is not necessary. He submitted that you have been working without restriction for an extended period of time with no further concerns.

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, in order to protect the public and meet the public interest during any 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.

This will be confirmed to you in writing.

That concludes this determination.