Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Order Review Hearing

Wednesday, 23 July 2025

Virtual Hearing

Name of Registrant:	**Parveen Kelly**
NMC PIN:	99I7519E
Part(s) of the register:	Registered Midwife RM Midwife (November 2002)
Relevant Location:	Oxfordshire
Type of case:	Lack of competence
Panel members:	Shaun Donnellan (Chair, Lay member) Karan Sheppard (Lay member) Sandra Abramsamadu (Registrant member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Karina Levy
Nursing and Midwifery Council:	Represented by Ms Naa-Adjeley Barnor, Case Presenter
Mrs Kelly:	Present and unrepresented
Order being reviewed:	Suspension order (6 Months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (12 months) to come into effect on 2 September 2025 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to extend the current suspension order.

This order will come into effect at the end of 2 September 2025 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the second review of a substantive suspension order originally imposed for a period of six months by a Fitness to Practise Committee panel on 1 August 2024. This was reviewed on 22 January 2025, and the reviewing panel imposed a further suspension for a period of six months.

The current order is due to expire at the end of 2 September 2025.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

> *"That you, between 27 August 2019 and 31 January 2020 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 6 midwife, in that you.*
>
> *1) Did not work to an adequate standard during your three week supernumerary period.*
>
> *2) Did not work to an adequate standard during your extended supernumerary period.*
>
> *3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;*
>
> > *a) Failed to pass a Fetal Monitoring Assessment in that you;*

i) Failed to pass a Continuous Electronic Fetal Monitoring Assessment.

ii) Failed to pass an Intermittent Auscultation test.

b) Failed to pass/complete the Passport to Practice.

c) Failed to pass a Band 6 progression form/assessment.

d) Failed to attend/pass training sessions regarding;

i) Cannulation and Venepuncture.

ii) Injectables.

e) Failed to undertake the pre-requisite E-learning sessions;

i) Venepuncture E-learning Package.

ii) Blood Transfusion E learning Package.

iii) Cannulation Video.

iv) Anaphylaxis Competency for 'Age 12 and over'.

v) Anaphylaxis Competency for 'All Ages'.

vi) Vascular Access Devices E-learning Package.

4) On 14 November 2019, during the third stage of labour for an unknown patient;

a) Attempted to deliver the placenta, before checking for;

i) The lengthening of the umbilical cord.

ii) Whether the uterus had taken on a globular shape.

iii) Whether the uterus had become firmer.

iv) Whether the uterus had risen in the abdomen.

v) A separation bleed.

b) Incorrectly attempted to pull on the umbilical cord before checking the uterus had contracted.

c) Incorrectly asked the unknown patient to bear down as you began to use the controlled cord traction method.

d) …

5) On or around 25 November 2019;

a) Were unable to demonstrate a full understanding of;

i) Delivering placenta using the controlled cord contraction method, in that you stopped applying traction after a brief pull.

ii) Completing Newborn Early Warning Score observation charts.

iii) The preparation of a birthing bed.

iv) Intravenous infusions during labour.

v) How to set up an Alaris pump for infusions.

6) On or around 26 November 2019;

a) Did not know that you needed to change the position of patients with epidurals every 1 hour.

b) Did not know that bladder care was at 2 hour intervals.

c) Did not know the guidelines for pyrexia in labour regarding a temperature of 37.5 degrees.

d) Considered conducting a vaginal examination for an unknown patient with a dense epidural block on her side, to avoid having to turn the patient.

e) Did not know how to turn a CTG machine off by the front button.

f) Were unfamiliar with how to get a woman onto clean sheets by turning her from side to side.

g) Did not know how perform intermittent catheterization.

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;

a) Were unsure about the loading dose of IV Benzylpenicillin.

b) Were unable to prepare a syntocinon infusion.

c) Were unable to set up syntocinon in an Alaris pump.

d) Did not document any of the care provided to an unknown patient in the clinical notes.

e) Did not keep up to date with the partogram.

f) …

8) On or around 4 December 2019 whilst caring for an unknown patient during labour;

a) Did not appropriately titrate the rate of syntocinon whilst the patient had been contracting 5-6:10 for 20 minutes.

b) …

9) …

10) …

11) …

12) On or around 4 January 2020 did not know how to connect a y-connector.

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;

a) Were unable to make a plan of care for a woman in labour.

b) Did not know how to read/use a CTG.

c) …

d) Failed to demonstrate basic knowledge relating to;

i) Suturing instruments.

ii) Suturing technique.

e) …

f) ….”

The original reviewing panel determined the following with regard to impairment:

“The panel considered whether Mrs Kelly’s fitness to practise remains impaired.

The panel noted that the original panel found that Mrs Kelly had insufficient insight. At this hearing, the panel had received no evidence from Mrs Kelly to demonstrate that she had reflected on her practice or that she had any insight into the issues identified.

The panel noted that Mrs Kelly resigned from her post in July 2020 and it appears that she has not practised as a midwife in this country for the last 4 and a half years. There was therefore no evidence before the panel of Mrs Kelly’s practice being strengthened.

The panel were of the view that some of the failings categorised by the previous panel as: 'Training, skills and comprehension', and specifically the: 'Failure to undertake the required e-learning modules/package' could have been remedied before the current review as this can be undertaken remotely and without working clinically. The panel found that there is no evidence that Mrs Kelly has tried to remedy the concerns in her practice.

The lack of competence relates to a number of fundamental areas of midwifery practice, which occurred over a significant period of time. The original panel determined that Mrs Kelly was liable to repeat matters of the kind found proved. Today's panel has received no new information and Mrs Kelly has not provided any of the evidence recommended by the previous panel. In light of this, this panel determined that Mrs Kelly is liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mrs Kelly's fitness to practise remains impaired."

The original reviewing panel determined the following with regard to sanction:

"The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would protect the public and satisfy the public interest. The panel concluded that a suspension order would be the appropriate and proportionate response, and would also afford Mrs Kelly

adequate time to further develop her insight and take steps to strengthen their practice.

The panel determined to impose a suspension order for the period of 6 months, this duration reflecting the seriousness of the concerns and the lack of progress which Mrs Kelly has made in terms of demonstrating insight and strengthened practice. A period of 6 months would also provide Mrs Kelly with an opportunity to engage meaningfully with the NMC and provide reflections and evidence of insight and training as well as her future intentions.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 1 March 2025 in accordance with Article 30(1).

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

Any future panel reviewing this case would be assisted by:

- *Mrs Kelly's engagement and attendance at the substantive order review hearing.*
- *A detailed written reflective account which demonstrates Mrs Kelly's insight into the key issues identified in her clinical practice.*
- *Mrs Kelly's willingness to engage in retraining or a development programme in relation to the areas identified.*
- *A clear plan of action in respect of Mrs Kelly's midwifery practice."*

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has taken account of the submissions made by Ms Barnor on behalf of the NMC. She submitted that today is the second review of the order. At the substantive hearing which concluded on 1 August 2024, a panel of the Fitness to Practice Committee found several charges against you proved and that your fitness to practice was impaired by reason of your lack of competence. It should be noted that some of the charges laid were found not proved.

Ms Barnor submitted that there were four areas for improvement, electronic fetal monitoring, skills and drills, evidence of consolidation of clinical skills to include completion of the Band 6 progression assessments and fitness to practice to the satisfaction of your manager. The original panel determined that you remained impaired, similarly, they found that your acts amounted to a lack of competence, breached fundamental tenets of the profession and posed an ongoing risk to patient safety.

Ms Barnor stated that in consideration of whether you remain impaired, she invited the panel to consider the NMC's guidance, *'Standard reviews of substantive orders before they expire'*, *'REV-2A'* alongside the case of *Abrahaem V General Medical Council* [2008] EWHC 183 (Admin) which sets out that there is a persuasive burden on you to fully acknowledge why your past failings were serious and that they have been remedied. She submitted that it appears that there has been no change in circumstances since the original substantive hearing. You have not provided a detailed reflective piece nor any further training certifications.

Ms Barnor submitted that your position today remains the same as it was in the last review in January 2025 and encouraged the panel to determine that your fitness to practice

remains impaired and an appropriate sanction in this case should remain as a suspension order.

The panel heard and accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that the original reviewing panel found that you had insufficient insight. At this hearing you made submissions that were firmly based on your feelings of deficiencies that you felt were in the substantive hearing. The panel made it clear that it cannot go behind the decision of the previous panel and that this review was solely based on evidence of improvements in insight and strengthening of practice made since the last review. You acknowledged that you have not embarked on employment since the referral was made in 2020.

The legal assessor reiterated what the panel is here to do today and that this panel are unable to relitigate those matters.

The panel decided that your fitness to practice is still currently impaired. You have continued to focus primarily on past events rather than demonstrating how you are actively addressing the concerns raised and taking steps to ensure safe future practice. Without clear evidence of improvement and remediation, the panel concluded that there remains a risk of repetition of the previous failings, which would pose an ongoing risk to the public.

This panel was not provided with any evidence of insight and although the previous panel gave recommendations, albeit not binding, you have not provided any evidence of an action plan, reflective piece or undertaken any kind of employment where references could be provided. The panel recognised that, as a midwife with extensive experience and a wealth of knowledge, you have much to offer the profession. However, the panel noted that you have not yet been able to demonstrate sufficient insight into the issues identified.

This panel has acknowledged that you stated you have kept up to date, as you have a keen interest in women's health, but you were unable to provide proof of this and stated that you had already done so along with certificates of training to the previous review panel.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account that you have not undertaken any further training and/or development and although you have stated that you have no intention on returning to midwifery, this may change in the future.

The last reviewing panel determined that you were liable to repeat matters of the kind found proved. Today's panel have not received any new information to support your development of your fitness to practice. In light of this, this panel determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect the public and the wider public interest which includes maintaining confidence in the nursing profession and have upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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 a conditions of practice on your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public nor satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to your lack of competence.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on your previous failings. It considered that your need to gain a full understanding of how the failings of one midwife can impact upon the midwifery profession as a whole and not just the organisation that the individual midwife is working for. The panel concluded that a further 12-month suspension order would be the appropriate and proportionate response and would afford you adequate time to develop your insight and take steps to strengthen your practice.

The panel therefore determined that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of 12 months.

The panel decided to impose the suspension order for 12 months as it recognised that the previous imposition of 6-month suspension orders did not result in your developing insight while strengthening your practice. The panel determined that a 12-month suspension order will be sufficient for you to decide whether you wish to return to midwifery and will afford you sufficient time to develop and evidence the required insight and strengthening of practice.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 2 September 2025 in accordance with Article 30(1)

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

Any future panel reviewing this case would be assisted by:

- Provide a clear decision/plan regarding your future intentions so far as your midwifery practice is concerned
- Provide a detailed reflective piece including insight into the matters found proved
- Engage where possible with any appropriate training and courses both clinical and in relation to personal development and provide proof supporting this
- Provide evidence of any relevant work or voluntary positions with references/testimonials

This will be confirmed to you in writing.

That concludes this determination.