

**Nursing and Midwifery Council
Fitness to Practise Committee**

Substantive Hearing

**Monday, 12 May 2025 – Tuesday 20 May 2025
Wednesday, 16 July 2025
Thursday, 2 October – Friday, 3 October 2025**

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

Wednesday 4 June 2025, Wednesday 20 August 2025
Virtual Hearing

Name of Registrant:	Pauline Ushuieonyia Okwo
NMC PIN:	05B0337E
Part(s) of the register:	Registered Midwife – 22 September 2011 Nurses Part of the Register-Sub Part 1 Registered Nurse – (Sub Part 1) Adult Nurse (level 1) - 11 September 2005
Relevant Location:	Sutton
Type of case:	Misconduct
Panel members:	Alisa Newman (Chair, lay member) Catherine Cooper (Registrant member) Dr. Fawzia Zaidi (Registrant member)
Legal Assessor:	Attracta Wilson (12 – 19 May 2025) Charles Parsley (20 May 2025) Attracta Wilson (4 June 2025, 16 July 2025) Georgina Goring (20 August 2025) Oliver Wise (2-3 October 2025)
Hearings Coordinator:	Ekaette Uwa (12 – 15 May 2025) Daisy Sims (16 May 2025) Ekaette Uwa (19 – 20 May 2025) Rodney Dennis (4 June 2025) Ekaette Uwa (16 July 2025) Daisy Sims (20 August 2025)

Ekaette Uwa (2-3 October 2025)

Nursing and Midwifery Council: Represented by Ben D'Alton, Case Presenter

Ms Okwo: Present and represented by Tope Adeyemi,
(instructed by Thompsons Solicitors)

Facts proved by way of admission: Charges 4 and 5

Offer of no evidence: 3a, 3b, 3c, 3d, 3e, 3f

Facts proved: 1a, 1b i), 1b ii), 1b iii), 2b, 2c, 6, 7a, 7b, 7c, 7d, 8a, 9

Facts not proved: 2a, 8b

Fitness to practise: Impaired

Sanction: **Suspension order with review
(three months)**

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

Decision and reasons on application to amend existing charge and add a new charge

The panel heard an application made by Mr D'Alton, on behalf of the Nursing and Midwifery Council (NMC), to amend the current schedule of charge in two respects:

- To amend charge 5, to reflect the correct date on which the incident occurred; and
- To add a new charge, charge 9, to reflect the alleged motivation underlying charge 7.

In respect of amending charge 5, Mr D'Alton applied to amend the date in charge 5 from 29 June 2020 to 26 June 2020 to correct what appears to be a typographical error. He submitted that the records confirm that you were caring for Patient E on 26 June 2020, which was the date of her labour as evidenced by Patient E's care notes.

Mr D'Alton further submitted that this amendment would not cause any procedural unfairness, nor change the substance of what is alleged and, in any case, is an admitted charge. He submitted that the proposed amendments would provide clarity and more accurately reflect the evidence.

The proposed amendment to the charge is as follows:

- 1) On ~~29~~ **26** June 2020, did not record the foetal heart rate on a partogram for Patient E and/ or Baby E.

Ms Adeyemi, on your behalf, did not oppose the application to amend Charge 5.

Mr D'Alton also made an application to add a new charge (charge 9). He submitted that this charge is brought following a further review of the facts underpinning charge 7 and is necessary to ensure that the motivations for charge 7 is properly captured. Mr D'Alton submitted that it is the NMC's position that the statement made to Colleague A, as set out

in charge 7, was racially motivated and/or demonstrate religious discrimination. He submitted that the new charge reflects the seriousness of the underlying conduct and would prevent under charging. He drew the panel's attention to *Lambert-Simpson v HCPC* [2023] EWHC 481(Admin) and *PSA v HCPC and Doree* [2017] EWCA Civ 319 to support his arguments.

Mr D'Alton further submitted that a failure to charge the motivation behind charge 7 would undermine the NMC's statutory objective of protecting the public.

The proposed new charge is as follows:

9) Your actions at charge 7 were racially motivated and/or displayed a discriminatory attitude based on religion.

Ms Adeyemi on your behalf opposed this application to add charge 9. She submitted that while it is accepted that the panel has the discretion to amend the charges at any stage before making findings of fact, the proposed amendment five years after the referral would be unjust and unfair.

Ms Adeyemi submitted that the charge introduces new and more serious allegations by asserting that the conduct at charge 7 was racially motivated and/or discriminatory based on religion. She argued that this changes the nature and gravity of the allegation considerably, imposing a greater burden on you at a very late stage in the proceedings.

Ms Adeyemi highlighted that the introduction of a racial or religious motivation to charge 7 was a recent development, against which you had not previously prepared. She further submitted that this would prevent you from gathering potentially relevant evidence to rebut the new element in the charge. This included obtaining character references, testimonials, or undertaking specific training, in light of your consistent proactivity in engaging with the proceedings and providing documentation in respect to your case.

Ms Adeyemi maintained that allowing the amendment at this stage would undermine fairness, especially in light of the time that has passed and the fact that the NMC already has eight charges before the panel which would be sufficient to hold you accountable. She submitted that this additional charge amounts to “shifting the goal post” four years after the original referral. She invited the panel to refuse the application.

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

The panel first addressed the proposed amendment to charge 5 and was satisfied that the amendment accurately reflects the date of the incident and does not cause any prejudice to you. The amendment to charge 5 was therefore granted.

Turning to the proposed addition of charge 9. The panel considered the submissions of both parties. It acknowledged that the introduction of this new charge makes the case more serious and has serious implications for your ability to understand and respond to the allegation against you.

The panel considered charge 7 and took into account that the suggested addition of charge 9 is linked to this charge. You have had notice of charge 7 which alleges inappropriate behaviour toward Colleague A, relative to her partner’s nationality and faith. The panel considered that the charges as currently drafted do not reflect the nature of the alleged comments or your alleged motivation in making them. Neither does it reflect the seriousness of the allegation. The panel considered that any unfairness to you in amending the charge sheet by the addition of charge 9 is mitigated by the fact that you have had notice of charge 7 from the outset.

The panel however, found that while regrettable that the NMC only sought to bring this charge at this late stage, it was required in the interest of justice and the overriding objective of public protection to ensure that the full nature of the alleged misconduct be properly set out. The panel was satisfied that any disadvantage to you could be mitigated

by allowing you sufficient time to respond, should that be necessary. The panel therefore granted the application to add charge 9.

Preliminary procedural question on application for hearsay

Before proceeding with the hearsay application, Mr D'Alton, on behalf of the NMC, sought the panel's guidance on whether it would consider deferring its decision on the hearsay application in relation to Charge 3 until later in the hearing. He stated that this was to allow the NMC further time to contact Patient D. Mr D'Alton submitted that no previous direct attempts had been made to contact Patient D, the person to whom the comments in charge 3 were allegedly directed at.

He noted that the NMC had not previously attempted to contact Patient D but was now seeking to do so. He stated that if the panel were minded to defer consideration of the hearsay application, this would allow the NMC the opportunity to reach out directly to Patient D before the close of its case.

Ms Adeyemi, on your behalf, opposed the proposal. She submitted that it would be procedurally inappropriate and prejudicial to the registrant to split the NMC's case in this way. She noted that the NMC had had ample time to prepare this matter and had not previously sought to secure Patient D's engagement. She also noted that Patient C was only available on a particular date, and that calling witnesses in two stages would be unworkable. Ms Adeyemi further submitted that it would be unfair to delay determination of the hearsay application, particularly given the seriousness of the allegation and the lack of any contemporaneous account from Patient D.

Having heard submissions, the panel determined that it would not defer consideration of the hearsay application. The panel considered that granting an overnight adjournment to explore the availability of Patient D would not be helpful or fair, given the delay in raising this issue and the potential prejudice to the registrant.

The panel noted that the witness recollection of events may have faded, that there was no recorded statement from Patient D at the time, and that the NMC had had sufficient opportunity to investigate this issue in advance. The panel determined that it would hear and determine the hearsay application without further delay.

Decision and reasons on application to admit hearsay evidence

Mr D'Alton made an application under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 for the admission of hearsay evidence in relation to Charge 3. This charge concerns the alleged treatment of Patient D by the registrant between 16 and 17 May 2020.

The hearsay evidence in question comprised:

- Paragraphs 20–26 of the witness statement of Witness 1;
- Paragraph 7 of the witness statement of Colleague A;
- Colleague A's Exhibit 13 (excluding the second paragraph); and
- Paragraphs 9 -10 of Colleague A's Exhibit 4

Mr D'Alton submitted that while the statements contain hearsay, the evidence is relevant and should be admitted under Rule 31. He acknowledged that the account of Patient D, as presented through colleagues, would be the sole basis for Charge 3. He accepted that this evidence cannot be tested through cross-examination and that it is a serious allegation, which is denied by the registrant.

Mr D'Alton submitted that neither Witness 1 nor Colleague A had any reason to fabricate the content of their statements, and that the information attributed to Patient D was recorded in the normal course of events by colleagues performing their professional duties. He accepted that the NMC had only recently attempted to make direct contact with Patient D, and that she had previously declined to make a formal complaint. Nevertheless,

he submitted that the panel could, if necessary, adjourn the matter to allow for further time to contact Patient D.

He referred the panel to relevant case law including *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), *PSA v NMC and Jozi* [2015] EWHC 764 (Admin), *CRHCP v GMC and Ruscillo* [2004] EWCA CIV 1356, submitting that these authorities support his arguments on the panel's powers to admit hearsay evidence when it is fair and relevant, as well as its powers to adjourn proceedings to obtain further evidence, and its responsibilities to proactively manage cases. Mr D'Alton invited the panel to admit the evidence and determine the weight to attach to it during its deliberations on the facts.

Ms Adeyemi opposed the application on your behalf. She submitted that the hearsay evidence was wholly unreliable and should be excluded. She noted that the allegations in Charge 3 were serious and that the evidence in support was both double hearsay and uncorroborated. She submitted that the account of Patient D was passed to a colleague, who in turn relayed it to Witness 1.

Ms Adeyemi further submitted that neither Patient D nor Colleague B in Colleague A's exhibit 13 had provided a statement or been made available for cross-examination. She highlighted that no explanation had been provided for the absence of Colleague B, and that Patient D had declined to formalise her complaint at the local level.

Ms Adeyemi submitted that the evidence is fundamentally flawed. She submitted that it lacks clarity, is vague in its content, and contains no contemporaneous or signed record from Patient D. She further submitted that details may have been lost over time and that the serious nature of the allegation requires cogent and probative evidence. Ms Adeyemi submitted that without the ability to test the evidence or understand the tone or context in which comments were made, the registrant is placed at a significant disadvantage.

Ms Adeyemi submitted that this evidence represents the sole and decisive basis for charge 3 and that admitting it would amount to a denial of the registrant's right to a fair

hearing. She referred the panel to *Thorneycroft v NMC* and *El Karout v NMC* [2019] EWHC 28 (Admin) and urged the panel to reject the application.

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

The panel in considering the application, took into account, the submissions from both parties and the advice of the legal assessor.

The panel noted that the evidence relied upon consists of double hearsay as Patient D is said to have made a comment to a colleague who has not provided a statement and whose absence has not been explained. That colleague is then said to have shared the information with Witness 1. It noted that neither Patient D nor Colleague B have been made available for cross-examination, and there is no reliable, contemporaneous, or signed record apart from an email sent by Colleague B to Witness 1.

The panel noted that no effort had been made to contact Colleague B. The panel was concerned that no efforts were made to secure a statement from Colleague B at an earlier stage, and that only recently had attempts been made to contact Patient D.

The panel found that the hearsay evidence was the sole and decisive evidence in support of Charge 3. In such circumstances, the panel determined that admitting the evidence would be unfair to the registrant, particularly given the inability to test the evidence or explore its context. The panel considered that the public interest in a fair hearing and the registrant's right to respond to the allegations outweighed any benefit in admitting the material.

The panel therefore refused the application to admit the hearsay evidence under Rule 31. It directed that the relevant passages of the statements of Witnesses 1 and 2, and the identified exhibits, should be excluded from the evidence and will play no part in the panel's determination of the facts.

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

Mr D' Alton, on behalf of the NMC, made an application for parts of the hearing to be held in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', (the Rules).

Ms Adeyemi on your behalf did not oppose this 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.

Having heard that there will be [PRIVATE], the panel determined to go into private session as and when such issues are raised [PRIVATE].

Application to apply redactions to the case bundles

Mr D'Alton made an application to apply redactions to specific parts of the case bundles. He submitted that this application was to ensure that the material placed before the panel is fair, relevant, and within the scope of admissible evidence in light of the panel's decision on the hearsay application.

The requested redactions are as follows:

- 1) Witness statement of Witness 1 - paragraphs 12–13
- 2) Witness statement of Witness 1 - paragraph 14
- 3) Witness statement of Witness 1 - paragraph 52
- 4) Witness statement of Witness 1 – paragraph 74
- 5) Witness statement of Witness 2 - paragraph 7
- 6) Witness statement of Witness 2 - paragraph 22 – 25

7) Witness 1's exhibit titled '*email to colleagues summarising my concerns in relation to Patient A, dated 9 September 2020*' – Paragraph 5

Mr D'Alton submitted that paragraphs 12–13 of Witness 1's statement contained comments made by her in her capacity as midwifery matron for the Hospital, concerning your actions. He argued that these comments were pertinent to your role and responsibilities, and the degree to which the alleged actions were inconsistent with those duties. Mr D'Alton contended that this information was of significant importance for the hearing, given Witness 1's role as matron and your line manager. He submitted that, should the panel consider any of this evidence to extend beyond the witness's proper scope, the determination of the appropriate weight, if any to be attributed to that evidence would rest with the panel.

In relation to paragraph 14 of Witness 1's statement, Mr D'Alton submitted that the second sentence bears direct relevance to the charges and offers commentary on the risk to Patient C resulting from your alleged actions, as viewed from Witness 1's perspective in her capacity as your line manager and midwifery matron. He further submitted that, should the panel consider any portion of this evidence to extend beyond the permissible bounds of the witness's testimony, the determination of the appropriate weight, if any to be attributed to that evidence would lie within the panel's purview.

Concerning paragraph 52 of Witness 1's statement, Mr D'Alton argued that its content concerns matters you have admitted, thus precluding any unfairness in its admission. He addressed the hearsay issue in the first sentence by stating that it is not the sole and decisive evidence and emphasised that the witness's exhibits serve to corroborate the initial concerns brought forward by Mrs G.

With respect to paragraph 74 of Witness 1's statement, Mr D'Alton acknowledged that it fell within the same territory as paragraphs 12-14.

In respect of paragraph 7 of the witness statement of Witness 2, Mr D'Alton submitted that the first statement simply describes your relationship with the witness and constitutes relevant contextual information.

Mr D'Alton noted that paragraphs 22-25 of Witness 2's statements were within the witness's scope as a midwife who was also involved in the care of Patient C.

Regarding Paragraph 5 of Witness 1's exhibit named '*email to colleagues summarising my concerns in relation to Patient A, dated 9 September 2020*', Mr D'Alton argued that it involved matters you have admitted and would present no unfairness in its admission.

Ms Adeyemi argued, on your behalf, that portions of Witness 1's and Colleague A's witness statements required redaction, as they strayed beyond the realm of factual witness evidence. She acknowledged that as midwives, the witnesses could offer evidence of their direct experiences and, at times, relevant second-hand information. However, she underscored that neither witness was qualified or called upon to give expert evidence at this proceeding, and their statements should be confined accordingly.

Concerning Witness 1, Ms Adeyemi submitted that while acknowledging her role as line manager and midwifery matron, it was inappropriate for her to provide evidence on a patient's feelings or to conclude whether the Code of Conduct had been breached. She argued that these statements were speculative and did not constitute admissible or first-hand factual evidence, adding that Patient C could testify directly about her emotional experience. Ms Adeyemi further highlighted a potential conflict of interest arising from Witness 1's managerial oversight over you.

Ms Adeyemi offered similar arguments with respect to Colleague A, submitting that Colleague A's comments on the expected duties of a midwife and whether your actions fulfilled those duties, were outside the scope of a factual witness. Ms Adeyemi insisted that Colleague A's role at this proceeding was to provide factual accounts of what she

observed, not to provide opinions or evaluative assessments of your behaviour or professional standards.

Ms Adeyemi also submitted that Witness 1's exhibit named '*email to colleagues summarising my concerns in relation to Patient A, dated 9 September 2020*' required redaction. Despite your acceptance of the factual basis of Charge 5, Ms Adeyemi pointed out that the exhibit contained material referencing additional, unaccepted matters. Therefore, she argued that the exhibit should be redacted to exclude these extraneous and disputed elements.

Ms Adeyemi concluded by emphasizing the need for the panel to exclude all inadmissible opinion, speculative or hearsay evidence. She reiterated that while witnesses could provide comprehensive accounts of their direct observations or experiences, they should not give evidence on matters of professional judgment, breaches of standards, hearsay or the emotional states of others.

The panel accepted the advice of the legal assessor.

The panel carefully considered the application for redactions to the witness statements of Witness 1 and Colleague A. The panel had regard to the submissions of the case presenter and Ms Adeyemi on your behalf.

Concerning paragraphs 12 and 13 of the Witness Statement of Witness 1, the panel has determined that these paragraphs contain opinion evidence concerning your professional responsibilities and whether your actions fell outside of them. The panel considers these matters to be outside the scope of a factual witness and to encroach upon the territory of expert opinion. Therefore, the panel directs that these paragraphs be redacted in their entirety, with the exception of the *phrase "Trust values as set out in the Trust's book of respect, attached as [Witness 1] Exhibit 4"*, which provides admissible factual context and is to be retained.

Regarding paragraph 14 of the Witness Statement of Witness 1, the panel has found that this paragraph contains further opinion evidence concerning patient safety and the alleged risk posed by your conduct. The panel has determined that these are matters for the panel to determine based on the entirety of the evidence presented, and not for a witness of fact to assert. Consequently, the panel directs that this paragraph be redacted in its entirety.

Concerning paragraph 52 of Witness Statement of Witness 1, the panel has noted that the initial sentence constitutes hearsay. However, the subsequent content is substantiated by the accompanying patient notes and is not the sole or decisive evidence. Therefore, the panel is satisfied that the fragment of the sentence “*I attach a screenshot from Patient E’s notes as [Witness 1] Exhibit “31”*”, may be retained, and the remaining part of the paragraph should be redacted.

With respect to paragraph 74 of the Witness Statement of Witness 1, the panel has determined that the comments made therein again venture into the realm of opinion and expert evidence. Consequently, the panel directs that the paragraph be redacted in its entirety, with the exception of the sentence “*I attach this policy as [Witness 1] Exhibit “42”*”, which provides admissible factual context and is to be retained.

With regards to paragraph 7 of the Witness statement of Colleague A, the panel determined that the majority of this paragraph consists of hearsay and opinion as to your professional role and duties. The panel noted that hearsay evidence is admissible subject to fairness and relevance. Bearing this in mind the panel accepts that it is appropriate to retain the first two sentences in the paragraph, “*I was never particularly friendly with the Midwife, but as colleagues we had always got on, and I had no issues with them. We would generally only have brief conversations in passing when working together or taking handovers*”. The panel considered that it provides relevant contextual information. The rest of the paragraph is to be redacted on the grounds of fairness.

Regarding paragraphs 22 through 25 of the Witness Statement of Colleague A, the panel has determined that these paragraphs contain opinion evidence concerning the expectations of a midwife and conclusions about your conduct. The panel considers these matters to fall outside the purview of a factual witness. Furthermore, the final sentence of paragraph 25, which refers back to paragraph 24, is deemed particularly speculative and inappropriate. Consequently, the panel directs that these paragraphs be redacted in their entirety, with the exception of the sentence *“I attach the Trust’s webpage setting out the values as [Colleague A] Exhibit 2’ paragraph 23.*

With regards to paragraph 5 of Witness 1’s exhibit named *‘email to colleagues summarising my concerns in relation to Patient A, dated 9 September 2020’*, the panel considers that this paragraph contains hearsay evidence, in that it records information given to Witness 1 by a third party who did not provide a witness statement, is not expected to give evidence and there is no information before the panel to indicate that they were contacted by the NMC to give evidence. The panel therefore determines that paragraph 5 should be redacted in full.

Details of charge (as amended)

That you, a registered midwife,

- 1) Between 30 April 2020 and 1 May 2020, in relation to Patient C, failed to:
 - a) assist and/ or seek assistance in response to their call bell being activated
 - b) treat them with respect and/ or kindness in that you:
 - i) Conducted a vaginal examination abruptly and/ or without care and sensitivity;
 - ii) Said to them they were “not coping with the pain and were being sensitive” or words to that effect;
 - iii) did not respect their decision to refuse opioids.

- 2) Between 7 May 2020 and 8 May 2020, in relation to Patient C failed to treat them with respect and/ or kindness in that you:
 - a) Said that it was a “nice day outside” or words to that effect in response to them attending hospital for Baby C’s Jaundice
 - b) Said that they “looked like a skater” or words to that effect,
 - c) Laughed at them.
- 3) Between 16 May 2020 and 17 May 2020, in relation to Patient D:
 - a) Failed to treat them with respect and/ or kindness,
 - b) Said “it’s God’s will” or words to that effect in response to them receiving news of a bereavement,
 - c) Talked about religion which they did not want to discuss,
 - d) Failed to provide re-assurance in response to them discussing a stillbirth,
 - e) Made comment about them eating “bad food” or words to that effect in response to discussing their gestational diabetes,
 - f) Made comment about their requirement for “discipline about her diet” or words to that effect in response to discussing their gestational diabetes.
- 4) Between 27 August 2020 and 28 August 2020, did not record the foetal heart rate on a partogram for Patient A and/ or Baby A.
- 5) On 26 June 2020, did not record the foetal heart rate on a partogram for Patient E and/ or Baby E.
- 6) On 26 June 2020, incorrectly transferred Patient E from the antenatal ward to the labour ward.

- 7) Between 30 January 2021 and 31 January 2021, in relation to Colleague A:
 - a) Asked if their partner was “English this time” or words to that effect,
 - b) Asked why they did not prefer “English boys or men of [their] own colour” or words to that effect,
 - c) Said that their partner would make them take up the Muslim faith,
 - d) Said that their partner would make them change their name to “Fatima”.
- 8) Between 30 January 2021 and 31 January 2021, in relation to Patient B:
 - a) Told them to “shush” or words to that effect,
 - b) Slapped their leg and/ or thigh.
- 9) Your actions at charge 7 were racially motivated and/or displayed a discriminatory attitude based on religion.

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

Decision and reasons on application to offer no evidence in respect of Charge 3

Following the panel’s decision to reject the application to admit hearsay evidence in respect of Patient D, Mr D’Alton made an application under the NMC’s guidance *Offering No Evidence* (DMA – 3) to offer no evidence in respect of charge 3.

Mr D’Alton submitted that the Case Examiners’ decision to refer charge 3 was based on evidence now deemed inadmissible following the panel’s ruling. He highlighted that the hearsay evidence constituted the sole and decisive evidence supporting this charge, and without it, the NMC has no further admissible evidence available. He noted that if the application were refused, the NMC would need to seek an adjournment to attempt to

secure additional evidence, which the panel had already indicated in its decision on the hearsay application would not be appropriate as it would cause further delay.

Ms Adeyemi, on your behalf, did not oppose the application.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel considered the NMC's guidance document Offering No Evidence (DMA-3) which states that "offering no evidence because there isn't enough evidence to prove the facts, so that there's no longer a realistic prospect, will only be appropriate if:

- the state of the evidence has changed since case examiners made a finding of case to answer
- it has become apparent that the case examiners' decision was made on an incorrect basis
- the charge relies on the evidence of a witness who cannot attend a hearing, and an application to rely on their statement as hearsay evidence has been rejected
- the case was referred directly to the Fitness to Practise Committee, and since then, our investigation has shown that it is no longer in the public interest to continue with the allegation or part of the allegation."

The panel determined that criteria 1 and 3 were satisfied in this case. The panel then went on to consider whether any further lines of enquiry could realistically yield admissible evidence. It noted that the incident relating to charge 3 occurred over five years ago and that Patient D had declined to formalise a complaint at the local level. The panel

concluded that there was no indication that Patient D would now be willing or available to engage with these proceedings.

Given the absence of admissible evidence to support the charge and no realistic prospect of securing further material evidence, the panel determined it appropriate to grant the NMC's application in respect of Charge 3.

Background

The charges arose whilst you were employed as a midwife by St Helier University Hospital ("the Hospital"). The Hospital is part of Epsom and St Helier University NHS Trust ("the Trust").

The regulatory concerns relate to a referral made by Patient C in December 2020. Patient C was admitted to the Hospital on 29 April 2020 to induce labour for her first child ("Baby C"). The induction took place over several days and during this time Patient C alleges that she experienced a significant lack of compassionate respectful care from you, leading to her being traumatised. This was compounded by the fact that her husband was unable to attend the induction of labour due to Covid 19 restrictions in place at the time.

On the night of 30 April 2020, Patient C reports calling for assistance due to pain she was experiencing. It is alleged that you responded after approximately 30 minutes, turned off her call bell, and informed her that you would ask her assigned midwife to attend to her, before leaving the room.

Patient C alleges that following this, you remained in the hallway engaging in non-clinical conversation with a colleague/s and did not arrange for another midwife to attend to her. When you returned, you stated you would carry out a vaginal examination. Patient C states that when she attempted to guide you through the examination to manage her discomfort and asked you to stop, you responded rudely.

It is further alleged that you told Patient C she was being “too sensitive” and proceeded to bring her Pethidine despite her having refused this medication. It is alleged that you did not return to attend to Patient C for the remainder of that night.

Baby C was subsequently born on 2 May 2020. Following discharge, Patient C contacted the postnatal advice line with concerns that Baby C was jaundiced and was advised to attend Accident and Emergency.

Upon returning to the hospital, Baby C was admitted overnight for observation. It is alleged that the following morning, you questioned why Patient C had returned to the hospital, her decision to call the advice line and commented that it was a nice day, suggesting she should be outside enjoying the weather instead. When Patient C became tearful, you allegedly instructed her to pack her belongings as they would be discharged after review by a doctor.

Patient C reports feeling distressed and unable to leave her room. It is further alleged that you subsequently reprimanded Patient C in a public area for standing in the corridor with her baby and made an inappropriate comment about her appearance.

Patient C raised her concerns with the Hospital on 9 May 2020. Witness 1 responded on 22 May 2020, informing Patient C that you had been given an opportunity to reflect on the incidents. Further concerns were subsequently raised by Colleague C, on 29 June 2020. These concerns relate to the inappropriate transfer of Patient E, who was in advanced labour, and your alleged failure to adequately document the delivery of Baby E.

On 1 February 2021, additional concerns were raised by Colleague A, a midwife. These included that you had made inappropriate comments about her personal life, instructed a labouring patient (Patient B) to “shush”, and slapped the patient on the leg. As a result of these allegations, the Hospital placed you on non-clinical duties.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Adeyemi, who informed the panel that you made full admissions to charges 4 and 5.

The panel therefore finds charge 4 and 5 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr D'Alton on behalf of the NMC and by Ms Adeyemi on your behalf. The panel noted that submissions are not evidence.

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: Midwifery Matron for Inpatient Services at the Hospital;
- Colleague A: Midwife employed by the Hospital;
- Patient C: Patient C.

The panel also heard evidence from you under oath.

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

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

Charge 1a

That you, a registered midwife.

- 1) Between 30 April 2020 and 1 May 2020, in relation to Patient C, failed to:
 - a) assist and/or seek assistance in response to their call bell being activated

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it.

The panel first considered whether you were on duty at the time the call bell from Patient C was activated, and whether you had assumed any responsibility in responding to that call.

The panel accepted your account that you were coming on shift at the time the call bell was activated. This was consistent with Patient C's own evidence and with the contemporaneous clinical notes. The panel was therefore satisfied that you were not yet on duty when the call bell was first activated and that there was no evidence before the panel to contradict this position.

The panel found it concerning that the call bell went unanswered for some time but considered that you acted appropriately in responding before your shift began.

The panel found that by turning off Patient C's call bell, you assumed a duty to assist and/or seek assistance. It also noted and is not in dispute that you told Patient C that you would seek assistance.

Next the panel considered whether, having attended the call bell, you failed to seek assistance for Patient C. It had particular regard to Patient C's evidence where she stated that:

"After the Midwife left, having told me they were going to get a midwife to do an examination, they immediately stood just on the other side of the ward door, in the corridor, talking to another colleague about the last few days of their private life. I could not see the Midwife but could hear them on the other side of the door. I believe this conversation went on for around 30 minutes and could clearly hear that it related to their private life."

The panel also considered your evidence very carefully. It noted that you dispute Patient C's account. You informed the panel that having spoken to Patient C you asked a midwife to attend to her whilst you went to get changed into your uniform. You denied having a conversation beyond a short greeting with a colleague.

The panel compared the evidence of Patient C with your evidence. The panel noted that Patient C's evidence was detailed and supported by contemporaneous records completed by her close to the time of the alleged incident. Patient C's oral and written evidence was consistent with her contemporaneous records and remained consistent when tested under cross-examination.

The panel considered your evidence and the response to Patient C's complaint that you provided at the time. In your response, you stated that you talked to a colleague outside Patient C's room before you started your shift, which the panel considered to be consistent with Patient C's account.

"Patient said I was standing and talking to another person yes this was with another staff before the start of my shift."

In your oral evidence you said that you only exchanged a passing greeting with your colleague away from Patient C's bed. The panel considered that your evidence in this regard has changed over time and that your contemporaneous response is more likely to be accurate. Having accepted your contemporaneous response, as the more accurate record the panel was satisfied that on the balance of probabilities you had a conversation with a colleague outside Patient C's room which the panel regard as more consistent with Patient C's account of a lack of response to a call bell.

Further, when compared to Patient C's contemporaneous record your response is lacking in detail, and the panel also noted that the midwife you claim you asked to attend to Patient C has never been identified by you. Patient C has been clear and consistent that there was an unbroken chain of events from you answering the call bell to having a protracted personal conversation with a colleague in the corridor around 2 meters from the bed.

The panel noted that you did return to Patient C after some time, however it did not consider that this constituted providing assistance to Patient C in response to her call bell being activated due to the lapse of time.

Having carefully considered the evidence as a whole and for reasons given above, the panel preferred the evidence of Patient C over your evidence and on the balance of probabilities is satisfied that you failed to assist and/or seek assistance in response to Patient C's call bell being activated.

In light of these findings, the panel determined that charge 1(a) is proved.

Charge 1b(i)

That you, a registered midwife,

- 1) Between 30 April 2020 and 1 May 2020, in relation to Patient C, failed to:
 - b) treat them with respect and/ or kindness in that you:

- i) Conducted a vaginal examination abruptly and/ or without care and sensitivity;

This charge is found proved.

The panel considered the evidence in relation to this charge.

Patient C gave clear and consistent evidence. Patient C made a written complaint at the time of the alleged incidents, and this was before the panel. The panel noted that Patient C's written complaint was consistent with her subsequent statement and her live evidence. Patient C's account of the vaginal examination conducted by you was that you conducted the examination abruptly "*without explanation, reassurance care and consideration*" and ignored her request for you to be patient and to allow her to guide you through the examination because she was very sore and uncomfortable following the previous examination.

The panel considered your evidence. You initially told the panel that you did not undertake the vaginal examination due to Patient C's discomfort, however when the panel requested and received the vaginal examination documentation, it was evident from the detail from your contemporaneous clinical documentation that a fuller examination had taken place.

The panel considered Patient C's written and oral evidence in the round and paid particular regard to her contemporaneous written record completed. The panel considered that Patient C's oral evidence was consistent with her contemporaneous record. Your live evidence contradicted both your response to the complaint letter and your clinical records and therefore the panel considered your evidence was unreliable compared to the evidence of Patient C.

The panel concluded that Patient C had a reasonable expectation that the examination would be conducted with care and compassion and be patient led. This expectation was informed by the approach of other midwives during earlier examinations.

Having considered the evidence as a whole, the panel was satisfied that as a registered midwife you had a duty to treat Patient C with respect and/or kindness when carrying out a vaginal examination. The panel was also satisfied that on the balance of probabilities you failed to treat Patient C with respect and/or kindness in that you conducted a vaginal examination abruptly and/ or without care, compassion and sensitivity.

Accordingly, the panel finds this charge proved.

Charge 1b(ii)

That you, a registered midwife,

- 1) Between 30 April 2020 and 1 May 2020, in relation to Patient C, failed to:
 - b) treat them with respect and/or kindness in that you:
 - ii) Said to them they were *“not coping with the pain and were being sensitive”* or words to that effect;

This charge is found proved.

The panel considered the NMC evidence including Patient C’s complaint written at the relevant time and her oral and written evidence. The panel also carefully considered the response you provided to Patient C’s complaint at the time and your oral evidence.

Patient C in her complaint stated, *“she told me that I was being sensitive and that I would need to have the pethidine injection, and that I really need to consider pain relief for when I’m in active labour”*.

Patient C maintained this position in her oral evidence and her evidence remained consistent with tested under cross-examination.

The panel considered your evidence. In response to Patient C's complaint, you *stated "I explained to the patient that it normal to be sensitive after balloon and Prostin and so many examinations, I did not know she misunderstood me."*

You maintained this position throughout your oral evidence.

The panel proceeded to consider the evidence as a whole in relation to this charge and the entire care episode and it is not in dispute that you used the word "*sensitive*". What is in dispute is the context in which the word was used.

In evaluating the evidence, the panel had regard to your accounts and Patient C's accounts, both from the local investigation and at this hearing.

The panel first considered whether you made these comments as alleged by Patient C. It was of the view that Patient C maintained consistently, both during the local investigation and in her live evidence that you made those comments. The panel found her account to be clear, credible and consistent with the broader context of her labour experience. It was of the view that during the vaginal examination, Patient C experienced pain to the extent that she asked you to stop. Taking all the above factors into account, the panel found that it was more likely than not, that you made the comments as alleged in response to the pain that Patient C experienced during vaginal examinations. It was also satisfied that in making the comments, you failed to show kindness and respect to Patient C.

The panel, therefore, finds this charge proved.

Charge 1b(iii)

That you a registered midwife,

- 1) Between 30 April 2020 and 1 May 2020, in relation to Patient C, failed to:
 - b) treat them with respect and/ or kindness in that you:
 - iii) did not respect their decision to refuse opioids.

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it. It had particular regard to the initial complaint by Patient C in an email dated 9 May 2020, her subsequent statement, as well as her live evidence given at this hearing. The panel also considered your response to the complaints and your live evidence.

Firstly, the panel considered whether you had a duty to respect Patient C's decision to refuse opioids. It was satisfied that you did have a duty to discuss, listen and respond to her preferences and to respect her decisions about her own care.

The panel accepted Patient C's account that she had always been clear that she did not want opioid pain relief, and this decision was included in her birth plan.

The panel also considered Patient C's evidence that following her vaginal examination, you told her that she needed an injection for pain relief and that you returned to her bed with a needle in your hand.

You do not dispute attending Patient C's bedside with a pethidine injection, albeit you say it was on a tray, and you were with a colleague. In your live evidence, you described a fulsome discussion with Patient C about pethidine before you conducted a vaginal examination on her, and that following that discussion she said she "would like to have it".

The panel has carefully considered these accounts, and it has determined that, on the balance of probabilities, you did not engage in a full discussion with Patient C about pain relief options to obtain her informed consent for an opioid injection before drawing up the injection and bringing it to her bedside. Had you done so, the panel find it highly likely that Patient C would have articulated her very clear decision that she did not want opioids.

Having considered the evidence overall, the panel determined that your actions overall lacked kindness and respect, and that on the balance of probabilities you did not respect Patient C's decision to refuse opioids.

Therefore, the panel finds this charge proved.

Charge 2a)

- 2) Between 7 May 2020 and 8 May 2020, in relation to Patient C failed to treat them with respect and/ or kindness in that you:
 - a) Said that it was a "*nice day outside*" or words to that effect in response to them attending hospital for Baby C's Jaundice

This charge is found NOT proved.

In reaching its decision the panel took into account all the evidence before it. It had particular regard to the live evidence given at this hearing.

The panel considered whether, between 7 May 2020 and 8 May 2020, you said to Patient C that it was a "*nice day outside*" or words to that effect, in response to her attending hospital for Baby C's jaundice and if so, whether this amounted to a failure to treat her with respect and/or kindness.

It is not in contention that you said "*nice day outside*" or words to that effect. However, there is no evidence to support a finding that in saying so you failed to treat Patient C with kindness and/or respect.

Accordingly, the panel finds this charge not proved.

Charge 2b)

- 2) Between 7 May 2020 and 8 May 2020, in relation to Patient C failed to treat them with respect and/ or kindness in that you:
 - b) Said that they "*looked like a skater*" or words to that effect,

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it. It had particular regard to Patient C's clinical notes dated 8 May 2020 as well as the email from Witness 1 to Patient C dated 25 May 2020.

The panel considered whether you said to Patient C that they "*looked like a skater*" or words to that effect, and whether this amounted to a failure to treat the patient with respect and/or kindness.

The panel had sight of Patient C's clinical notes in which it was recorded that her care had been taken over by your colleague as Patient C was unhappy with you. It also had further regard to the email by Witness 1 to Patient C stating:

"...I also discussed with MW Okwo the comment that she made about your attire when you were walking up the corridor. MW Okwo felt that she made this remark in a humorous way but has now reflected that this was inappropriate, and she regrets any distress or offence she caused you..."

While you denied making the comment, the panel accepted Patient C's live evidence, in which she recalled asking you what you meant by the comment, to which you responded by referencing her clothing and laughed. The panel considered that this is supported by the email of Witness 1 to Patient C.

The panel was therefore satisfied on the balance of probabilities that you said that she "*looked like a skater*" or words to that effect, and that in making the comment you failed to treat Patient C with kindness and respect.

Accordingly, the panel finds the charge proved.

Charge 2c)

2) Between 7 May 2020 and 8 May 2020, in relation to Patient C failed to treat them with respect and/ or kindness in that you:

c) Laughed at them.

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it, and its findings in relation to charge 2b. It considered the email written by Witness 1 to Patient C, recording Witness 1's discussion with you, in which it was said that you made the remark in a humorous way. Taking this evidence and Patient C's account into consideration, the panel was satisfied on the balance of probabilities that you laughed at Patient C in the context of remarks about her clothing and in so doing failed to treat her with respect and kindness.

Therefore, the panel finds this charge proved.

Charge 6)

On 26 June 2020, incorrectly transferred Patient E from the antenatal ward to the labour ward.

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it. It considered your live evidence, Witness 1's testimony, and Patient E's clinical notes.

The panel accepted your evidence that at the time of the transfer, the antenatal ward was busy with at least two patients contracting and that the labour ward was not busy. The panel also heard that there were emergency birth packs available for births on the antenatal ward. The panel noted that you made the decision to transfer Patient E upstairs to labour ward instead of waiting for help or managing the delivery on the ante-natal ward.

The panel noted that immediately prior to transfer Patient E was in active labour and feeling the urge to push. It noted that Patient E had a previous quick delivery. It took into account your entry in Patient E's clinical note where you wrote "*by the time we entered into the room, the baby head was already delivered*". The panel considered that on the balance of probabilities your decision to transfer Patient E was based on your clinical judgement at a time when you were under pressure. Nevertheless, the panel determined that on the balance of probabilities you incorrectly transferred Patient E from the ante-natal ward to the labour ward in that at the time of transfer she was about to give birth.

Consequently, the panel finds this charge proved.

Charge 7a)

7) Between 30 January 2021 and 31 January 2021, in relation to Colleague A:

a) Asked if their partner was "*English this time*" or words to that effect,

This charge is found proved.

The panel considered whether, between 30 January 2021 and 31 January 2021, you asked Colleague A if their partner was "*English this time*" or words to that effect.

In reaching this decision, the panel considered all the evidence before it. It considered Colleague A's contemporaneous complaint email to Witness 1, dated 2 February 2021 where she stated:

"...Has your boyfriend come back to you".. I asked her what she meant by this and explained I had broken up with my ex but do have a new partner. She then proceeded to ask me "and is he English?"

The panel noted that in Colleague A's written statements she simply records that you asked her whether her new partner was English.

It also considered the account given by you at the local investigation interview notes, where it is recorded that you said “*I asked her where he was from...*” The panel considered this to be broadly consistent with Colleague A’s written statement, where she states “*the midwife then asked me whether my new partner was English...*”

The panel therefore determined on the balance of probabilities that you asked Colleague A if their partner was “English this time” or words to that effect.

Given these findings, the panel finds this charge proved.

Charge 7b)

7) Between 30 January 2021 and 31 January 2021, in relation to Colleague A:

- b) Asked why they did not prefer “*English boys or men of [their] own colour*” or words to that effect

This charge is found proved.

The panel considered whether, between 30 January 2021 and 31 January 2021, you asked Colleague A why they did not prefer “English boys or men of [their] own colour” or words to that effect.

In reaching this decision, the panel considered all the evidence before it. It had regard to Colleague A’s contemporaneous complaint email to Witness 1, dated 2 February 2021, her witness statement and oral evidence.

The panel noted that Colleague A’s witness statement and oral evidence is supported by the contemporaneous complaint email she sent to Witness 1 on February 2, 2021, and there is consistency throughout Colleague A’s evidence.

The panel noted your denial of this charge, but bearing in mind that Colleague A's evidence is supported by a contemporaneous record, it is satisfied on the balance of probabilities that you asked Colleague A why they did not prefer "*English boys or men of [their] own colour*" or words to that effect.

Accordingly, this charge is proved.

Charge 7c) & 7d)

7) Between 30 January 2021 and 31 January 2021, in relation to Colleague A:

- c) Said that their partner would make them take up the Muslim faith
- d) Said that their partner would make them change their name to "Fatima".

These charges are found proved.

Given the similarity of the allegations, which arise out of the same conversation, the panel considered charges 7c and 7d together.

In reaching its decision, the panel considered all the evidence before it. It had regard to Colleague A's contemporaneous complaint email to Witness 1, dated 2 February 2021 where she stated:

"...So he will have you change your religion to be a Muslim and will have you being called Fatima".

The panel also noted your response during the local investigation interview and live evidence in which you said:

"...I asked if he was a Muslim if he was half Iranian and she said no. I said OK, because when they marry our girls they change their names to either Fatima or Adina..."

“...The words I used were “when they marry our girls they will change their names to either Fatima or Amina...”

“... It happened to me, my first cousin was a Christian and she married a Muslim, and they changed her name to Amina.”

“...they marry our girls, and they change their names to either Fatima or Adina. To our girls in Nigeria, they do.”

The panel first considered Colleague A’s clear and consistent evidence, which is supported by a contemporaneous record. Colleague A’s evidence has remained unchanged overtime. You deny the wording you used but concede that there was a conversation relating to changing names and religion when marrying into the Muslim faith.

The panel is satisfied that a conversation took place between you and Colleague A, during which the religion and ethnicity of Colleague A’s partner was discussed. There is contradictory evidence as to whether the alleged comments were made in relation to Colleague A and her partner personally or in the context of your own family experience.

The panel considered that following the conversation Colleague A made her complaint on the grounds that you stated that their partner would make her take up the Muslim faith and change her name to Fatima. The panel was satisfied on the balance of probabilities that Colleague A’s complaint recorded in writing at the time was made in the context of her recollection of the comments being made with specific reference to her and her partner.

Therefore, the panel finds both charges proved.

Charge 8a)

- 8) Between 30 January 2021 and 31 January 2021, in relation to Patient B:
 - a) Told them to “shush” or words to that effect

This charge is found proved.

The panel considered whether, between 30 January 2021 and 31 January 2021, you told Patient B to “shush” or used words to that effect.

In reaching this decision, the panel took into account all the evidence before it, including your live evidence and the contemporaneous evidence of Colleague A.

The panel reviewed Colleague A’s account from the disciplinary record stating:

“...so to her it may not have been something unusual to happen for her. But it made me feel really uncomfortable, telling someone to shush when they’re in pain.”

It also considered the Disciplinary Investigations Initial Assessment form, detailing your line manager’s outline of a meeting with you as follows:

“An informal fact finding meeting was held with her line manager ... to establish her view of the incident as described by the midwife who reported the incident. During this meeting ... stated that she did shush the woman and asked her to be quieter in some way...”

The panel noted the contradiction between the investigation notes where you were noted to have stated:

“...I did not shush her.”

It also noted the Disciplinary Investigations Initial Assessment Pro-Forma where you were said to have admitted telling the patient to shush.

Based on the information presented, the panel concluded it was more likely than not that you told Patient B to shush or words to that effect.

Given the panel's findings, this charge is proved.

Charge 8b)

8) Between 30 January 2021 and 31 January 2021, in relation to Patient B:

b) Slapped their leg and/or thigh.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, including Witness 1's Exhibit 40 (The Investigation Report and appendices, dated 14 April 2021), your live evidence and the evidence of Colleague A. The panel also noted that there was no evidence from Patient B and Patient B did not raise a complaint in relation to the alleged incident.

The panel considered whether, between 30 January 2021 and 31 January 2021, you slapped Patient B on the leg and/or thigh.

The panel noted that Colleague A stated in her evidence that she witnessed you slap Patient B. However, the panel also noted that Colleague D who was also present at the time of the incident stated at the local investigation that:

"I didn't see PO hit the patient, I was at the head of the bed the patient was clearly labouring. I haven't been able to establish whether PO was on or off break at this point."

The panel took account of your consistent denial of this allegation, which you maintained during the local investigation, stating:

"I did not touch that woman... With Covid you are not allowed to touch the patient, if they are sleeping and I need to wake them up I have to tap the bed to wake them up."

You reiterated in your live evidence before the panel, asserting that no such contact occurred.

The panel noted that there are conflicting accounts from Colleagues A and D. It took into account that no complaint was made by Patient B and the panel did not have any account from her of the alleged incident. Colleagues A and D were both present at the relevant time. Colleague D's account supports your consistent denial of the incident. Therefore, the panel cannot be satisfied on the balance of probabilities that you slapped Patient B's leg and/thigh.

Accordingly, the panel finds this charge not proved.

Charge 9)

Your actions at charge 7 were racially motivated and/or displayed a discriminatory attitude based on religion.

This charge is found proved.

The panel had regard to its finding in relation to Charge 7. It considered the comments made and likely purpose behind them. It considered whether they were made in a way that showed hostility or a discriminatory attitude towards a racial group.

It took into account your explanation as follows:

"...It happened to me, my first cousin was a Christian and she married a Muslim, and they changed her name to Amina."

The panel considered that you made the comments with direct reference to the ethnicity and your assumption as to the religion of Colleague A's partner. It considered that the comment that Colleague A's partner would make her take up the Muslim faith and change her name to Fatima demonstrated a racial purpose in that it directly and unequivocally

referred to race and religion. The panel also considered that the comments made demonstrated a discriminatory attitude to members of the Muslim faith.

The panel considered whether there could be any alternative, non-discriminatory explanation or motivation for your comments. It found that the remarks collectively revealed stereotypical assumptions based on race and religion. The panel was unable to identify any other plausible motivation for the comments other than one grounded in racial discrimination.

While the panel acknowledged that you may not have intended to offend, it concluded that the effect and underlying nature of your remarks were on the balance of probabilities racially motivated and demonstrated a discriminatory attitude based on religion.

The panel, therefore, finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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.

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

- Colleague E: Midwife at St Helier Hospital
- Colleague F: Digital Midwife at St Helier Hospital

The panel also heard evidence from you under affirmation.

Submissions on misconduct

Mr D'Alton invited the panel to take the view that the facts found proved amount to misconduct.

Mr D'Alton submitted that the specific, relevant standards where your actions amounted to misconduct were sections 1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 4.2, 7.1, 7.2, 8.2, 10.1, 19.1, 19.4, 20.1, 20.2, 20.3, 20.5, and 20.7.

Mr D'Alton submitted that your collective actions and comments as found proved had a negative impact on patients and fell below the standards expected of a professional in your position.

Ms Adeyemi informed the panel that you accept your actions and respect the panel's decision on facts. She submitted that you have reflected on the concerns and have taken steps to address them. She submitted that it was for the panel to determine misconduct.

Submissions on impairment

Mr D'Alton moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need

to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) (Grant).

Mr D'Alton urged the panel to consider the 4 questions in the case of Grant at the forefront of its mind when determining your impairment. He submitted that in this case the first 3 limbs are engaged.

Mr D'Alton submitted that you have caused significant distress to a patient through your conduct and placed a patient at risk of harm both physically and psychologically. He reminded the panel of the clear impact your conduct had on Patient C when she gave evidence [PRIVATE].

Mr D'Alton submitted that although you have shown some insight, it is still developing. Mr D'Alton stated that you minimise your actions and your reflection does not go into details on the specific allegations and impact although you have expanded on this in oral evidence. He submitted that you seem reluctant to directly confront your failings and that the root cause of these concerns has not been addressed.

Mr D'Alton submitted that in terms of the racially motivated and discriminatory comments made towards Colleague A, your solution is to no longer comment in such circumstances. He submitted that this does not address the discriminatory nature of the conduct found proved.

Ms Adeyemi reminded the panel that in circumstances where a registrant has denied the allegations, this should not amount to lack of insight. She urged the panel to have a holistic view of the circumstances of this case by looking at the actions you have undertaken, your positive references and the fact that you have worked nearly five years since the concerns were first identified with no record of any new incident. She submitted that this shows you are no longer impaired

Ms Adeyemi referred the panel to the case bundles and your oral evidence and submitted that your insight occurred at an early stage during the local investigation and that you have achieved much growth since the incidents occurred.

Ms Adeyemi submitted that you have built on your earlier reflection and demonstrated in evidence that you now ensure that the message you are trying to pass across to patients and colleagues is received as intended.

In relation to the charges of racially motivated and discriminatory comments, Ms Adeyemi stated that you have commented on how discrimination may impact the wellbeing of patients and colleagues and have maintained that with Colleague A you did not intend to cause offence. She submitted that Colleague A had admitted in evidence that she did not take offence nor did she feel that you intended to cause offence.

Ms Adeyemi referred the panel to the testimonies of Colleagues E and F attesting to your attitude, commitment, dedication, compassion, support, empathetic care and positive behaviour towards colleagues and patients. She submitted that the recurring theme from your references indicate your professionalism and it is clear that you are a role model who has mentored these people from when they were students.

In relation to remediation, Ms Adeyemi submitted that you have undertaken courses in order to understand and address the concerns identified and now request feedback from colleagues to prevent such incidents from recurring.

Ms Adeyemi submitted that you currently work in a patient facing role where you conduct examinations, record-keeping, patient transfers and sustain communication with patients and colleagues with no repetition of the allegations found proved. She submitted that this demonstrates your practice of the learning and insight you have developed since the incidents.

Ms Adeyemi submitted that matters of discrimination and treating people with disrespect would grieve members of the public. However, in this circumstance, she stated that you have been held to account, have taken steps to remediate and have worked without incident during the intervening years. She submitted that whilst the public interest is engaged, there would be no expectation of a finding of impairment and members of the public would be satisfied with no finding of impairment given your current growth and development.

The panel accepted the advice of the legal assessor which included reference to Grant.

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered midwife, and that your actions amounted to a breach of the Code. Specifically:

1) Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively
- 1.3 avoid making assumptions and recognise diversity and individual choice
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

2) Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.3 encourage and empower people to share in decisions about their

treatment and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

4) Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action.

10) Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.

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

20) Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.7 make sure you do not express your personal beliefs (including political,

religious or moral benefits) to people in an inappropriate way.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel found that your conduct at charges 4, 5, 6 and 8a were not serious enough to amount to misconduct.

The panel was of the view that it is incumbent on midwives caring for women and babies at a vulnerable time in their lives to treat them with respect and dignity as well as show kindness and compassion in delivering care to them to avoid the risk of them coming to physical, emotional or psychological harm through the midwife's conduct or omissions.

The panel determined that your conduct towards Patient C as found proved did cause her physical pain, significant and long-lasting emotional and psychological harm.

In relation to Patient C, the panel determined that your actions as found proved in charges 1 and 2 amounted to serious misconduct and caused her physical, emotional and psychological harm in that you failed to treat her with dignity, respect and kindness. The panel was satisfied that these actions fell far short of the standards expected of a registered midwife, represented a clear breach of the Code, and undermined the trust and confidence that patients are entitled to place in those providing their care.

In relation to Colleague A, the panel considered the conduct at charges 7 and 9 to be particularly serious. It was of the view that making racially motivated and discriminatory remarks about Colleague A's partner, religion and identity, displayed an attitude that was wholly incompatible with the values of the profession and your regulator. The panel found that such behaviour had the potential to cause significant personal and professional harm to Colleague A and risked creating a hostile and unsafe working environment.

In these circumstances, 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 found, your fitness to practise is currently impaired.

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

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

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”

If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

At paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d)'*

The panel first considered whether any of the limbs of the Grant test were engaged as to your past conduct. The panel was of the view that your misconduct in your behaviour towards Patient C and Colleague A breached the fundamental tenets of the profession and brought the profession into disrepute. By failing to respond appropriately to a patient in need, carrying out an examination without sensitivity, disregarding her refusal of pain relief, calling her a skater and laughing at her, you failed to uphold the values of dignity, respect and compassion which are central to the profession.

The panel also found that the racially motivated and discriminatory comments directed towards Colleague A were particularly serious. It considered that the profession relies on the public's trust that midwives will act without prejudice and treat patients and colleagues with fairness, kindness and respect.

The panel found that your misconduct constituted a serious breach of fundamental tenets of the midwifery profession, in that you failed to practise kindly, preserve safety and promote professionalism and trust. It determined that you failed to uphold the standards and values of the midwifery profession, thereby bringing the reputation of the midwifery profession into disrepute.

The panel therefore concluded that limbs a, b and c of the Grant test are engaged in respect of your past conduct.

In considering insight, the panel acknowledged that you had shown some early insight during the local investigation. It took account of the positive references provided on your behalf, your reflections, the courses you have undertaken, your apologies and the fact that you have been practising in a people-facing role and there has been no record of any concerns since the last incident. However, the panel considered that whilst you have acknowledged some of the panel's findings, you have not demonstrated full insight into your failings. The panel considered that you were unable to clearly articulate how learning from those courses related to the allegations found proved. The panel remained concerned that you did not demonstrate a full understanding of the impact of your conduct on Patient C preferring to focus on record keeping and the perception of Patient C rather than being accountable for your actions and how you made her feel.

The reflection document which you produced at an early stage in this hearing showed very little insight; whereas your later written reflection and the evidence which you gave orally to the panel at this stage of the proceedings showed that your level of insight had improved but was not complete.

In relation to your racially motivated and discriminatory comments, the panel was of the view that your comments as charged and found proved went beyond poor communication and raised concerns as to attitude towards those from different ethnic and religious backgrounds. You have undertaken some relevant training on communication, discrimination, equality and diversity. After careful consideration, the panel was satisfied that you had demonstrated sufficient understanding and remediation to address the discriminatory aspects of your conduct.

The panel accepted that the misconduct in this case is, in principle capable of remediation. However, given the limited nature of insight shown in relation to the impact of your actions on Patient C found proved, the panel determined that there remains a risk of repetition of the type of incident which occurred with Patient C. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 also required. It concluded that public confidence in the profession would be seriously undermined if a finding of impairment were not made, particularly in respect of racially motivated or discriminatory behaviour. The panel was satisfied that a finding of impairment is required to uphold proper professional standards and to promote and maintain confidence in the profession. It therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

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

Submissions on sanction

Mr D'Alton submitted that the panel should make a striking-off order. He submitted that this is a serious case where you caused physical, psychological and emotional harm to a patient and made racially motivated and discriminatory comments towards a colleague.

Mr D'Alton submitted that the key aggravating factors in this case include:

- Still developing insight
- The conduct caused both physical pain and long-lasting emotional and psychological harm to a patient
- The conduct includes discriminatory and racially motivated conduct
- The conduct appears to show underlying attitudinal concerns.

Mr D'Alton submitted that the mitigating features in this case include:

- Partial admissions
- Work done in remediation.

He stated that this case is far too serious for an order of no further action to be appropriate. Similarly, a caution order would be disproportionate given the seriousness of your failings and the potential damage to public confidence in the profession.

Mr D'Alton further submitted that a conditions of practice order is also inappropriate, as it would be impossible to formulate workable and realistic conditions to address the concerns in this case.

The NMC considered a suspension order would be appropriate in circumstances of a single instance of misconduct. He submitted that this is not a case involving a single instance of misconduct. He submitted that there were significant gaps in your insight and that this presents a significant risk of repetition. He concluded that the misconduct in this case is fundamentally incompatible with continued registration.

Ms Adeyemi highlighted that sanctions are not designed to be punitive but to safeguard patients and urged the panel to consider a sanction that achieves the overarching objective with the least impact on you.

Ms Adeyemi submitted that the mitigating features include:

- Your engagement with the proceedings
- You have demonstrated some insight and reflected on your conduct
- You have undertaken steps from the outset to remediate the concerns
- You have had no previous or subsequent regulatory concerns.

Ms Adeyemi submitted that a suspension order, given the facts of the case, would be disproportionate and would only serve to punish you. She submitted that the real concern is in relation to your understanding of the impact of your actions on Patient C.

Ms Adeyemi submitted that a conditions of practice order could achieve the objective of ensuring public protection as you have demonstrated a willingness to strengthen your practice. She submitted that given the work that you have already done it would be unnecessary for such an order to last longer than three months.

Turning to a caution order, Ms Adeyemi submitted that this would be the most appropriate order in this circumstance given your positive record and the fact that you are appreciated by all the patients you care for. She concluded by reminding the panel of the positive references it had received on your behalf and submitted that the risk you pose to the public has been addressed.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the NMC Sanctions Guidance (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:

- The physical, psychological and long-lasting emotional harm caused to a patient
- The nature of the racial and discriminatory behaviour found proved.

The panel also took into account the following mitigating features:

- Your early admissions to some of the charges
- Your expression of remorse and a desire to apologise
- The steps you have undertaken to mitigate repetition with regard to communication techniques and Equality, Diversity and Inclusion training (EDI)
- You have been working in a patient-facing role undertaking many the duties called into question from the charges proved for the past five years
- You have had no concerns prior to or after the incidents
- Written and oral testimony from colleagues attesting to your professionalism and good character.

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 interest 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 is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of your misconduct nor satisfy the public interest element.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *...; and*
- *...*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order. In particular, the panel considered that a striking-off order would be disproportionate in this case, and given the on-going steps you have taken to address your failings.

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

The panel acknowledged the hardship such an order will inevitably cause you, both financially and in terms of your professional reputation. It also took into account the considerable number of testimonies from your colleagues which attest to your good work as a midwife and your good character as a colleague. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

In making this decision, the panel carefully considered the submissions of Mr D'Alton in relation to the sanction that the NMC was seeking in this case and the submissions of Ms Adeyemi on your behalf.

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

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

Any future panel reviewing this case would be assisted by:

- Your attendance at a future review
- An updated reflective piece on the impact of your misconduct particularly in relation to Patient C
- References from any paid or unpaid work undertaken during the period of your suspension.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr D'Alton. He submitted that an interim suspension order for a period of 18 months was required on the grounds of public protection and public interest. He sought that order on the basis that one was required because the panel had found that a substantive suspension order should be made partly on public protection grounds.

The panel also took into account the submissions made by Ms Adeyemi. She submitted that there is no need for an interim order in the circumstances of this case. She reminded the panel that there was no interim order currently in place and that you had worked as a midwife for several years since the events of this case. Imposing an order would be

disproportionate, and you might be suspended for a long time if you appealed. She therefore invited the panel not to impose an interim order.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

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 it should impose a limited interim conditions of practice order in order to meet the public protection consideration pending any appeal. It would be disproportionate and unjustifiable to hold that it was necessary to impose an interim suspension order for the next month or for the appeal period when you have practised satisfactorily for over 4 years.

The only necessary condition, which reflects your current professional practice is :

- 1) you may not work as a nurse/midwife except by working for your current employer (St Helier Hospital) in your current role.

The length of the interim conditions of practice order is 18 months, in order to cover the period which, it may take for an appeal to be heard.

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

That concludes this determination.