Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 7 April 2026 – Thursday, 16 April 2026

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

Name of Registrant:	**Susan Marie Squibb**
NMC PIN:	80J1005E
Part(s) of the register:	Registered Midwife RM – 20 July 2004 Registered Nurse – Adult RN1 – 22 November 1983
Relevant Location:	Peterborough
Type of case:	Misconduct
Panel members:	Konrad Chrzanowski (Chair, Lay member) Zoe Wernikowski (Registrant member) Alyson Young (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Ifeoma Okere (8 April 2026 – 16 April 2026) Hamizah Sukiman (7 April 2026 only)
Nursing and Midwifery Council:	Represented by Isabella Kirwan, Case Presenter
Mrs Squibb:	Present and unrepresented
Facts proved by admission:	Charges 1f (iii)
Facts proved:	Charge 1a, 1f (i), 1f (ii), 2a (iv)
Facts not proved:	Charge 1b, 1c, 1d, 1e, 1g, 2a (i), 2a (ii), 2a (iii), 2b

Fitness to practise:	**Impaired**
Sanction:	**Caution order (3 years)**
Interim order:	**No order**

Decision and reasons on adjourning the hearing on Day 1

At the outset of the hearing, Ms Kirwan, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the email correspondence between Mrs Squibb and the NMC, dated 7 April 2026. Within it, she wrote:

> *'I am very sorry that I have not been able to join the Teams enquiry today.*
> *My mother, who is [PRIVATE].*
> *Please accept my apologies.'*

Ms Kirwan explained to the panel that the NMC has sought to clarify Mrs Squibb's position, namely whether she does want to join the hearing more generally (and is unable to do so on 7 April 2026), or whether she is not joining outright. She submitted that Mrs Squibb does not excuse herself from the hearing in this correspondence, nor does she indicate she does not wish to attend the entirety of the hearing. She asked the panel to allow the NMC further time on Day 1 of the hearing to better ascertain Mrs Squibb's position, in fairness to her, and explore the possibilities of supporting Mrs Squibb's attendance (such as sitting at certain times of day, or commencing with the hearing on Day 2).

The panel accepted the advice of the legal assessor.

The panel bore in mind the correspondence it received from Mrs Squibb, detailing her difficult personal circumstances and inability to join the hearing today. The panel considered that Mrs Squibb did not indicate she is not attending the entirety of the hearing, and it determined that it would be fair to her to allow the NMC to explore possibilities of supporting her in attending the hearing, should she wish to do so.

The panel therefore adjourned the hearing until 09:00 on Day 2, subject to any response from Mrs Squibb in respect of her attendance.

NMC Opening of the case

Ms Kirwan opened the case.

This case concerns two separate and serious incidents in your practice as a midwife. The NMC's case is that both incidents raise concerns regarding your ability to recognise and respond appropriately to obstetric emergencies, as well as your clinical judgement, escalation, and record-keeping.

The first incident relates to events in 2018, when you were working a day shift on the delivery suite. At approximately 13:28, you assumed responsibility for Patient A, who had previously been under the care of another midwife. It is accepted that aspects of the care provided prior to delivery were in line with expected standards. However, concerns arise in relation to your management of Patient A following delivery of her baby.

The NMC's case is that you failed to recognise, appropriately escalate, and adequately document a postpartum haemorrhage. Patient A is said to have lost approximately 1.7 litres of blood, representing a significant and potentially life-threatening obstetric emergency.

It is alleged that you did not take immediate and appropriate action. In particular, rather than activating the emergency buzzer and commencing urgent clinical intervention, you left Patient A in the care of a student midwife while you went to obtain equipment. The NMC's position is that this represented a serious departure from expected practice in the context of an unfolding emergency.

It is further alleged that you failed to undertake appropriate observations, did not maintain adequate clinical records, and delayed the administration of Tranexamic Acid, a medication used to control bleeding. The NMC's case is that these omissions, taken together, demonstrate a failure to respond appropriately to a rapidly deteriorating clinical situation.

The second incident relates to events on 16 September 2016, when you were working within a home birth team and attended Patient B at home. A student midwife was present, and there was no second qualified midwife available.

Patient B required transfer to hospital due to blood loss, and you continued to provide care following that transfer. Concerns were subsequently identified by a local investigator, including alleged failures to adhere to trust and local guidelines, failures to escalate concerns, and a failure to recognise an obstetric emergency.

The NMC's case is that you failed to recognise a postpartum haemorrhage in Patient B's case. Although you documented blood loss on several occasions, it is alleged that you did not act on those observations or escalate appropriately. The NMC's position is that documentation without corresponding clinical action is insufficient, particularly in the context of potential haemorrhage.

It is further alleged that you failed to adequately monitor Patient B during labour. In particular, there were periods where the fetal heart rate was not recorded within required timeframes, namely exceeding 15 minutes in the first stage of labour and five minutes in the second stage. These are fundamental aspects of safe midwifery practice.

As with the first incident, concerns are also raised regarding the adequacy and accuracy of your documentation.

Taken together, the NMC will invite the panel to find that these matters represent serious departures from the standards expected of a registered midwife, with potential implications for patient safety.

These are the allegations the panel will be asked to determine.

Details of charge

That you, a registered midwife:

1. On 16 September 2016 in relation to Patient B**:**
    a) Failed to recognise and/or take appropriate action following an obstetric haemorrhage in that you did not escalate blood loss.
    b) Did not accurately measure the birthing pool temperature.
    c) Did not assess contractions at appropriate intervals, in that you did not assess contractions every 30 minutes in the first stage of labour and/or every 15 minutes in the second stage of labour.
    d) Did not monitor the fetal heart rate at appropriate intervals as you did not assess the fetal heart rate every 15 minutes in the first stage of labour every 5 minutes in the second stage of labour.
    e) Left them unattended with the placenta in-situ.
    f) Failed to maintain clear and accurate records in that you:
        i. Inadequately documented contractions;
        ii. Incorrectly documented the fetal heart rate as a range rather than as a value;
        iii. Did not record an APGAR score for their baby.
    g) Did not take an APGAR score for their baby.

2. On 21 February 2018, in relation to Patient A,
    a) Failed to recognise and/or take appropriate action following an obstetric postpartum haemorrhage in that you did not,
        i. use an emergency bell to escalate blood loss;
        ii. suture an episiotomy in a timely manner;
        iii. administer intravenous Tranexamic medication in a timely manner;
        iv. conduct clinical observations following the postpartum haemorrhage, or in the alternative, did not make a record of clinical observations.

b) Failed to maintain clear and accurate records in that you did not complete a post-partum haemorrhage pro-forma form.

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

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

During the course of the hearing, an application was raised by members of the panel that parts of this hearing should be held in private on the basis that proper exploration of your case may involve reference to sensitive matters relating to a family member's health.

The panel noted that neither Ms Kirwan nor you opposed this application.

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that, in accordance with Rule 19(1), hearings should ordinarily be held in public. However, under Rule 19(3), the panel may hold a hearing, or part of it, in private where it is satisfied that this is justified by the interests of any party or by the public interest.

The panel took into account the principle of open justice and the importance of maintaining public confidence in the regulatory process. However, the panel also recognised that there is a strong public interest in protecting the privacy and dignity of individuals where sensitive personal matters, such as health issues, are being discussed.

The panel noted that the application related specifically to matters concerning the health of a family member, which are inherently private and sensitive. The panel considered that public discussion of such matters could result in a disproportionate interference with you and your family member's right to privacy.

The panel therefore determined that it would be appropriate and proportionate to depart from the general principle of open justice only to the limited extent necessary.

Accordingly, the panel determined that those parts of the hearing which relate to your family member's health will be heard in private. The remainder of the hearing will be conducted in public.

The panel will consider whether to move into private session as and when such matters arise.

Decision and reasons on application to admit Ms Glenn's written statement and exhibits into evidence

Ms Kirwan, on behalf of the Nursing and Midwifery Council (NMC), made an application to admit the witness statement of Ms Glenn, together with its accompanying exhibits, into evidence. This application was made pursuant to Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ('the Rules').

Ms Kirwan submitted that Ms Glenn's witness statement and exhibits are highly relevant to Charge 2 in this case, which concerns your alleged failure to recognise and appropriately manage a postpartum haemorrhage. She directed the panel to specific parts of the evidence, including Ms Glenn's factual account dated 28 February 2018, her email dated 21 February 2018, and the investigation meeting notes dated 17 April 2018. She submitted that these documents address key aspects of the charge, including escalation of care, administration of medication, record keeping, and clinical decision-making during the incident.

Ms Kirwan submitted that Ms Glenn was not available to attend the hearing as she was out of the country on holiday and would not be available until a later date. She informed the panel that the NMC had taken steps to secure Ms Glenn's attendance, including inviting her to attend, but had been unable to do so. She further submitted that admitting the evidence would avoid the need for adjournment or the hearing becoming part-heard.

Ms Kirwan submitted that the evidence is not the sole or decisive evidence in respect of the charges. She informed the panel that it had already heard evidence from another witness regarding the same incident and would hear further evidence from Ms Emma

Smith. She submitted that Ms Glenn's evidence provides important context and may lend support to the oral evidence already received.

Ms Kirwan submitted that there would be no unfairness to you in admitting the evidence. She stated that you had been provided with the witness statement and exhibits and would have the opportunity to respond to the allegations in your own evidence. She reminded the panel that there is no absolute right to cross-examine a witness and that fairness must be considered in the round, including the interests of patients and the public and the NMC as a regulator.

You did not oppose the application.

The panel accepted the advice of the legal assessor. He reminded the panel that these are quasi-judicial proceedings and that the panel has an obligation to ensure that the hearing is fair. He referred the panel to the NMC Guidance, 'Evidence' (DMA-6), and to the principles derived from the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin*). He advised that the admissibility of hearsay evidence is governed by the principles of relevance and fairness, and that hearsay evidence is not inadmissible simply because it cannot be tested by cross-examination.

The panel noted that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, irrespective of whether it would be admissible in civil proceedings.

The panel first considered whether the evidence is relevant. The panel was satisfied that Ms Glenn's witness statement and accompanying exhibits are relevant to the proceedings. The panel noted that the evidence relates directly to the incident on 21 February 2018 and addresses matters central to Charge 2, including escalation, administration of medication, documentation, and clinical observations.

The panel then considered whether it would be fair to admit the evidence, having regard to the principles set out in Thorneycroft.

In relation to whether the evidence is sole or decisive, the panel noted that it had heard evidence from other witnesses which addressed the majority of the matters contained within Ms Glenn's evidence. The panel noted that the only aspect not directly covered by other witnesses relates to the alleged delay in the administration of tranexamic medication. However, the panel noted from your submissions that you did not deny a delay, but attributed it to the need to obtain the medication from another area of the maternity ward and to having received conflicting instructions from colleagues as to whether the medication should be administered intramuscularly or intravenously. In these circumstances, the panel determined that Ms Glenn's evidence is not sole or decisive.

The panel then considered the nature and extent of any challenge to the contents of the statement. The panel noted that you did not oppose the application and did not raise any challenge to the contents of the statement at this stage. The panel also noted that you will have the opportunity to respond to the allegations in your own evidence.

The panel next considered whether there is any suggestion that the witness had reason to fabricate her account. The panel noted that there is no evidence before it to suggest that Ms Glenn had any motive to fabricate her account. The panel also noted that the documents were created contemporaneously with the events in question, which supports their reliability.

The panel then considered the seriousness of the charges. The panel noted that the allegations are serious and relate to patient safety and clinical decision-making in an obstetric emergency. The panel bore in mind the potential impact of any adverse findings on your career. However, the panel also noted the public interest in ensuring that all relevant evidence is considered in determining serious allegations.

The panel went on to consider whether there is a good reason for the non-attendance of the witness. The panel noted that Ms Glenn had informed the NMC that she would be on holiday and unavailable to attend the hearing, and that she had provided alternative dates when she would be available. The panel noted that this communication took place prior to the hearing date being set.

The panel then considered whether the NMC had taken reasonable steps to secure the witness's attendance. The panel noted that the NMC had invited Ms Glenn to attend and had engaged in correspondence with her. The panel was satisfied that reasonable steps had been taken.

Finally, the panel considered whether you had prior notice that the witness statement would be relied upon. The panel noted that the statement and exhibits had been provided to you in advance. The panel also noted that you were made aware, on day 1 of the hearing, of the NMC's intention to make this application and therefore had the opportunity to respond.

Having considered all of the above, the panel determined that it would be fair and appropriate to admit Ms Glenn's witness statement and accompanying exhibits into evidence as hearsay.

The panel reminded itself that the weight to be attached to this evidence will be determined at a later stage and may be reduced to reflect the fact that the evidence has not been tested by cross-examination.

Accordingly, the application is granted.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you. You informed the panel that you made a full admission to Charge 1f(iii).

The panel therefore finds Charge 1f(iii) proved in its entirety, by way of your admission.

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 Ms Kirwan on behalf of the Nursing and Midwifery Council (NMC) and by you.

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: Esther Dorken; Band 7 Midwife
- Witness 2: Elizabeth (Liz) Ann Flemming; Midwife
- Witness 3: Emily Mondey; Midwife
- Witness 4: Nicola Griffin; Midwife
- Witness 5: Amanda Yvonne De'ath; Midwife
- Witness 6: Emma Smith (Bramell); Midwife

The panel also had regard to the written evidence of additional witnesses, including:

- Witness 7 Nicola Glenn; A midwife

The panel also heard evidence from you under affirmation.

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

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

Charge 1a

"That you, a registered midwife, on 16 September 2016, in relation to Patient B:

Failed to recognise and/or take appropriate action following an obstetric haemorrhage, in that you did not escalate blood loss."

This charge is found proved.

In reaching this decision, the panel considered whether you failed to recognise and/or take appropriate action following an obstetric haemorrhage.

The panel undertook a detailed review of the witness evidence and contemporaneous records, including the accounts of Ms Dorken, Ms Flemming, and Ms Mondey. It noted at the outset that there were inconsistencies in the sequence of events and observations made by witnesses entering the room at different times.

The panel had regard to the evidence describing the condition of the pool and the presence of blood and clots. In particular, it noted the description of *"significant clots which would suggest a large loss, not normal"*. The panel also noted that the blood loss was subsequently quantified at approximately 1100ml, which is consistent with a postpartum haemorrhage.

The panel carefully considered whether you recognised the haemorrhage. In doing so, it placed significant weight on your oral evidence. It noted that your evidence focused on the presence of a retained placenta and that you repeatedly referenced about your concern about the retained placenta, indicating that your clinical focus was directed towards that issue rather than the possibility of haemorrhage.

The panel therefore determined that, on your own account, you did not recognise, in a timely manner, that the situation amounted to an obstetric haemorrhage, but believed you were dealing with a retained placenta.

However, the panel then considered whether you recognised that there was a problem more generally. It noted that you did seek assistance and therefore accepted that you had recognised that there was a clinical concern requiring support.

The panel therefore made a clear distinction between recognising that something was wrong, and recognising the nature and severity of that concern as an obstetric haemorrhage.

The panel determined that while you did recognise that there was an issue requiring assistance, you failed to recognise the nature and severity of the situation as a haemorrhage.

The panel then turned to consider whether the action you took was appropriate. It noted that you sought assistance by attempting to locate a senior midwife. However, the panel determined that this did not amount to escalation in accordance with obstetric haemorrhage guidance. It noted that *"the appropriate action is to ring the bell"*.

The panel further considered that even in the absence of precise measurement, the clinical presentation should have prompted immediate escalation. It noted that Ms Mondey's factual account dated 23 September 2016 in which she stated ; *"I transferred the clots to a bed pan where I immediately realised the blood loss was over a litre as the bed pan was more than half full"*, and in these circumstances a midwife would be expected to exercise clinical judgement in identifying significant blood loss.

The panel also had regard to the applicable guidance and determined that there is a duty on the attending midwife to recognise haemorrhage and respond appropriately.

The panel also took into account your experience, including that you were *"used to doing home births in the community"*, and determined that you would be expected to recognise signs of significant blood loss in a range of settings.

Drawing all of these matters together, the panel concluded that:

- you failed to recognise that the situation constituted an obstetric haemorrhage; and
- you failed to escalate the situation in accordance with guidance.

Charge 1b

"That you, a registered midwife, on 16 September 2016, in relation to Patient B:

Did not accurately measure the birthing pool temperature."

This charge is found NOT proved.

The panel considered whether you did not accurately measure the birthing pool temperature.

The panel had regard to the clinical records contained within the documentary evidence. It noted that at 11:20 am that Ms Dorken, a Band 7 midwife, was *"happy for patient B to enter the pool"*, indicating that there was senior clinical oversight at that stage.

The panel further noted that at 11:45, the pool temperature was recorded as 38.3°C, with a contemporaneous note stating, *"it doesn't feel like it"*. A further temperature of 36.7°C was recorded at 12:47.

The panel considered the applicable guidance and noted that *"it does not state that it has to be a pool-specific thermometer"* and that the requirement is that the temperature be checked rather than prescribing the exact method of measurement.

Having considered the documentary evidence and the guidance, the panel determined that there was sufficient evidence of temperature monitoring having taken place.

The panel therefore concluded that it could not be satisfied that the temperature was not accurately measured as alleged.

Charge 1c

"That you, a registered midwife, on 16 September 2016, in relation to Patient B,

Did not assess contractions every 30 minutes in the first stage of labour and/or every 15 minutes in the second stage of labour."

This charge is found NOT proved.

The panel considered whether you failed to assess contractions at appropriate intervals.

The panel had regard to the clinical records and noted multiple entries throughout the relevant period, including at 10:25, 10:45, 11:15 and 11:45, as recorded within the documentary evidence.

The panel acknowledged that not all of these entries have a frequency recorded. However, it determined that there is evidence in the patient notes that you were monitoring contractions throughout the period.

The panel further considered the overall clinical picture, including the rapid progression of labour, and determined that it was likely that you were actively monitoring contractions.

The panel accepted that while the documentation was incomplete, the evidence supported a finding that contractions were assessed.

The panel therefore concluded that it could not be satisfied that there was a failure to assess contractions.

Charge 1d

> "That you, a registered midwife, on 16 September 2016, in relation to Patient B:
>
> Did not monitor the fetal heart rate at appropriate intervals, in that you did not assess the fetal heart rate every 15 minutes in the first stage of labour and/or every 5 minutes in the second stage of labour."

This charge is found NOT proved.

In reaching its decision, the panel considered whether you failed to monitor the fetal heart rate at appropriate intervals.

The panel had regard to the clinical records and identified multiple entries recording fetal heart rate at the expected intervals.

The panel acknowledged that there were deficiencies in the clarity and format of documentation. However, it determined that monitoring had taken place.

The panel again distinguished between failure to monitor and failure to document, and concluded that the evidence did not establish that monitoring itself was inadequate.

Charge 1e

> "That you, a registered midwife, on 16 September 2016, in relation to Patient B:
>
> Left Patient B unattended with the placenta in situ."

This charge is found NOT proved.

The panel considered whether you left Patient B unattended with the placenta in situ.

The panel noted that there was contradictory evidence as to whether you were in or out of the room . It noted that Ms Flemming suggested that you were in the corridor, whereas you maintained that you remained in the doorway of the room.

The panel considered that being in a doorway could reasonably be interpreted as being either in or out of the room and therefore did not place determinative weight on that distinction.

The panel further noted that there was a student midwife present and that the student midwife would have been able to raise the alarm. It therefore concluded that Patient B was not left unattended in the room.

Charge 1f(i)

> "That you, a registered midwife, on 16 September 2016, in relation to Patient B:

Failed to maintain clear and accurate records, in that you inadequately documented contractions."

This charge is found proved.

In reaching its decision, the panel considered whether you inadequately documented contractions.

The panel noted that you accepted in your evidence that you didn't adequately record contractions. In your oral evidence, you stated; "*it's obvious from my records…my documentation let me down."*

The panel also had regard to the records and found that there was only one reference to contraction frequency and limited entries documenting the strength and duration of the contractions.

The panel determined that while contractions may have been assessed, the documentation was inadequate and fell below expected standards.

Charge 1f(ii)

"That you, a registered midwife, on 16 September 2016, in relation to Patient B:

Failed to maintain clear and accurate records, in that you incorrectly documented the fetal heart rate as a range rather than as a value."

This charge is found proved.

The panel considered whether you incorrectly documented the fetal heart rate as a range rather than a value.

The panel noted entries such as *"Pinard… and Sonicaid 116–120 bpm"* and considered whether this complied with the guidance.

The panel determined that although a clinician might interpret this entry as being Pinard 116,Sonicaid 120, as explained by you in your oral evidence, it did not meet the requirement to record a single value, and consequently the panel was satisfied that it was not sufficiently clear.

The panel therefore concluded that the documentation was not in accordance with the expected standard.

Charge 1g

> "That you, a registered midwife, on 16 September 2016, in relation to Patient B:
>
> Did not take an APGAR score for the baby."

This charge is found NOT proved.

In reaching its decision, the panel considered whether you failed to take an APGAR score.

The panel accepted your evidence in that APGAR assessment would be an automatic visual assessment conducted by the midwife at the birth and subsequently shortly after.

The panel further noted that there is no evidence to suggest you had not undertaken this assessment and that the only issue identified was the absence of documentation .

The panel therefore concluded that it could not be satisfied that the APGAR score was not taken.

Charge 2ai)

> "That you, a registered midwife, on 21 February 2018, in relation to Patient A,

Failed to recognise and/or take appropriate action following an obstetric postpartum haemorrhage, in that you did not use an emergency bell to escalate blood loss."

This charge is found NOT proved.

In reaching this decision, the panel took into account whether you failed to escalate blood loss by not using the emergency bell.

The panel had regard to the evidence relating to the sequence of events and the escalation of care. It noted that you did not activate the emergency bell and that this was not in dispute.

The panel then considered whether this amounted to a failure to take appropriate action.

The panel had regard to the relevant postpartum haemorrhage guidance, which states that in cases of major haemorrhage, staff should *"summon help using the emergency bell in the room".*

The panel considered the factual circumstances at the time the haemorrhage was recognised. It noted that by the time the blood loss had been assessed and the situation clarified:

- there were two Band 7 midwives present; and
- the specialist registrar was already in the room.

The panel therefore considered whether the use of the emergency bell would have resulted in any additional or different support.

The panel determined that by the time the haemorrhage was confirmed, there were two Band 7 midwives and the registrar in the room and that this constituted an appropriate and sufficient level of escalation in the circumstances.

The panel therefore concluded that the use of the emergency bell would not have provided any additional support because there was already a multidisciplinary team in the room.

The panel also considered that, as senior clinicians were present, responsibility for escalation and clinical decision-making had appropriately transferred to a more senior midwife.

The panel therefore concluded that, although you did not use the emergency bell, this did not amount to a failure to take appropriate action in the circumstances.

Charge 2a (ii)

> "That you, a registered midwife, on 21 February 2018, in relation to Patient A,
>
> Failed to recognise and/or take appropriate action following an obstetric postpartum haemorrhage, in that you did not suture an episiotomy in a timely manner."

This charge is found NOT proved.

In reaching its decision, the panel considered whether you failed to suture an episiotomy in a timely manner.

The panel had regard to the evidence relating to the management of the episiotomy and the involvement of other clinicians.

The panel noted that the initial assessment of the perineum identified that the bleeding was coming from the episiotomy site and that immediate steps were taken, including the application of pressure.

The panel further noted that a more senior midwife attended and assessed the situation, recognising that it was a more complicated tear and that suturing would require appropriate expertise. It noted that Mrs De'ath stated in her investigative meeting on the 16 April 2018; *"SS told me the lady needed suturing and she was not happy to do it, so I said I would do it…"*

The panel noted, in her oral evidence, Mrs De'ath further stated; *"Sue had accessed this [tear] and felt it was beyond her capabilities. Sue had previously been in the community so*

may have been less confident." It also noted that in her oral evidence, Mrs De'ath stated that she did not witness anything out of the ordinary in this incident.

The panel considered that the suturing was subsequently undertaken by a second Band 7 midwife, and that the involvement of a more experienced clinician was appropriate in the circumstances.

The panel also noted evidence that any delay in suturing was influenced by factors including clinical complexity.

The panel therefore determined that the timing of suturing was clinically appropriate and that responsibility for suturing had appropriately transferred to a more senior clinician.

Charge 2a(iii)

> "That you, a registered midwife, on 21 February 2018, in relation to Patient A,
>
> Failed to recognise and/or take appropriate action following an obstetric postpartum haemorrhage, in that you did not administer intravenous Tranexamic Acid in a timely manner."

This charge is found NOT proved.

In reaching the decision, the panel considered whether you failed to administer intravenous Tranexamic Acid in a timely manner.

The panel had regard to the clinical records and noted that Tranexamic Acid was administered shortly after the haemorrhage was identified.

The panel noted that the timing of administration was within a very short timeframe, for example in the K2 record, the panel noted that the Tranexamic Acid was requested at 18:22 and was given at 18:25.

In addition, the panel also heard evidence from you and Ms Smith that Tranexamic Acid was not kept in the delivery room but located in another room down the corridor.

The panel considered the definition of “timely” in this context and determined that such a short interval could not reasonably be characterised as a delay.

The panel also considered that the administration of medication was part of a broader, team-based response and could not be attributed solely to you.

The panel therefore concluded that there was no failure in this regard.

Charge 2a(iv)

> “That you, a registered midwife, on 21 February 2018, in relation to Patient A,
>
> Failed to recognise and/or take appropriate action following an obstetric postpartum haemorrhage, in that you did not conduct clinical observations, or in the alternative did not record them.”

This charge is found proved.

In reaching its decision, the panel considered whether you failed to conduct or record clinical observations following the haemorrhage.

The panel had regard to the clinical records and your own evidence.

The panel noted that you accepted that further observations should have been undertaken and that *“in an ideal world, yes, I should have done more”* .

The panel further noted that while some observations were recorded, they were not undertaken at the frequency expected following a postpartum haemorrhage.

The panel considered that appropriate post-haemorrhage care requires regular and frequent monitoring and that this is a fundamental aspect of patient safety.

The panel therefore determined that you failed to undertake, or in the alternative failed to adequately record, appropriate clinical observations following the haemorrhage.

Charge 2b

> "That you, a registered midwife, on 21 February 2018, in relation to Patient A,
>
> Failed to maintain clear and accurate records, in that you did not complete a postpartum haemorrhage pro-forma."

This charge is found NOT proved.

The panel considered whether you failed to complete a postpartum haemorrhage pro-forma.

The panel had regard to the evidence relating to the documentation of the incident.

The panel noted that the pro-forma itself was not present within the records. However, the panel considered whether the absence of the pro-forma meant that the relevant information had not been recorded.

The panel noted that the clinical records (K2 notes) contained detailed information, including:

- timings of events
- interventions undertaken
- medications administered
- the condition of the patient

The panel determined that the information required for the pro-forma is evidenced on the K2 notes and that the relevant details had been documented, albeit not on the pro-forma itself.

The panel heard evidence from you and Ms Smith that the pro-forma system was not always consistently used and that information may have been recorded contemporaneously on paper and later transferred into electronic notes.

The panel therefore considered that, although the pro-forma itself was not completed or retained, the essential information had been recorded elsewhere.

The panel concluded that it could not be satisfied that there was a failure to maintain clear and accurate records.

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 safely and effectively without restriction.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Kirwan submitted that the facts found proved amount to serious professional misconduct. She reminded the panel that misconduct is defined in Roylance v General Medical Council (No. 2) as *"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances."*

Ms Kirwan submitted that not all breaches of the Code will amount to misconduct and that regulatory action should only be taken where there is evidence of serious professional misconduct, particularly where there is a risk of harm to patients or a loss of public confidence.

In relation to Charge 1a, Ms Kirwan submitted that although you recognised that there was an issue, you failed to recognise the nature and severity of the situation as an obstetric haemorrhage and failed to escalate appropriately. She referred the panel to the factual account that the blood loss was *"over a litre and the bedpan was more than half full"*, submitting that a midwife should have exercised clinical judgement to identify significant blood loss and escalate immediately.

In relation to Charges 1f(i), 1f (ii) and 1f(iii), Ms Kirwan submitted that your documentation was inadequate and fell below expected standards.

In relation to Charge 2a(iv), Ms Kirwan submitted that you failed to undertake appropriate and sufficiently frequent clinical observations following a postpartum haemorrhage. She relied on your own evidence that *"in an ideal world… [you] should have done more"* and the panel's finding that *"appropriate post haemorrhage care requires regular and frequent monitoring,"* which it described as *"a fundamental aspect of patient safety."*

Ms Kirwan submitted that your actions breached provisions of the Code, including:

- **Section 6**, in particular **6.2** (requirement to maintain the knowledge and skills needed for safe and effective practice)
- **Section 10** (requirement to keep clear and accurate records)
- **Section 16** (requirement to act without delay if there is a risk to patient safety)

She submitted that, taken together, the charges found proved represent a serious departure from good professional practice and amount to misconduct.

You did not make substantive submissions on misconduct.

Submissions on impairment

Ms Kirwan 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)

Ms Kirwan submitted that the first three limbs of the Grant test are engaged. She submitted that you have in the past acted in a way which placed patients at unwarranted risk of harm and that you remain liable to do so in the future. She further submitted that your actions brought the midwifery profession into disrepute and breached fundamental tenets of the profession.

Ms Kirwan submitted that your conduct was serious and occurred on two separate occasions in similar circumstances, and was therefore not an isolated incident. She submitted that your actions posed a real risk of harm to patients, and that in one instance the failure to escalate resulted in significant blood loss.

Ms Kirwan submitted that you have not demonstrated sufficient remediation. She noted that you have not practised since 2018, have not addressed the concerns, and have not demonstrated improved practice. She submitted that the panel cannot therefore be satisfied that there is no risk of repetition.

Ms Kirwan submitted that a finding of impairment is also required in the public interest to maintain confidence in the profession and uphold proper standards.

In response, you stated: *"I don't think so… I think this has gone on long enough."* You explained that you had been unable to demonstrate remediation because you had not been able to practise, describing this as a *"catch 22"* situation due to your inability to complete revalidation.

You asked the panel, following legal advice, whether your character reference had been taken into consideration, and the panel confirmed that it had.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No. 2) [2000] 1 AC 311 (PC)*, *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*, and *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)*.

Decision and reasons on misconduct

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

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

The panel considered the provisions of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*. The panel determined that the following provisions were engaged:

Specifically:

*'**1**. Treat people as individuals and uphold their dignity",*
***1.2**. make sure you deliver the fundamentals of care effectively*
***1.4.** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

***6.2**. Maintain the knowledge and skills you need for safe and effective practice.*

***10**. Keep clear and accurate records relevant to your practice.*

***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*

***13.1**. Accurately assess signs of normal or worsening physical and mental health in the person receiving care.*

***16**. Act without delay if you believe that there is a risk to patient safety or public protection.*

***19.1.** take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

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

In reaching its decision on misconduct, the panel accepted the advice of the legal assessor and had regard to the authorities of *Roylance v General Medical Council (No. 2) [2000] 1 AC 311 (PC)*, *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*, and *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)*.

The panel adopted the definition of misconduct in *Roylance*, namely that misconduct is *"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances."* The panel bore in mind that not every breach of the Code will amount to misconduct, and that the conduct must be sufficiently serious to warrant a finding of misconduct.

The panel had regard to the context in which the events took place. It acknowledged that you were working in a pressurised clinical environment where multiple factors required simultaneous consideration. The panel recognised that you did take some action, including seeking additional assistance, and that you were not inactive. However, the panel determined that this did not amount to appropriate escalation of a suspected haemorrhage.

In relation to Charge 1a, the panel determined that you failed to recognise the nature and severity of the blood loss as a haemorrhage and failed to escalate appropriately. The panel noted that the significant blood loss was only fully identified when another midwife attended. The panel considered that this failure exposed the patient to a risk of harm. The panel also considered that, whilst you had identified a clinical issue, your focus on the retained placenta meant that the haemorrhage was not appropriately prioritised. The panel noted that you were fortunate in that another practitioner identified the severity of the blood loss.

In relation to Charges 1f(i), 1f(ii), and1f(iii), the panel determined that your record keeping was inadequate. The panel considered that accurate and complete records are essential to ensure continuity of care and to enable subsequent practitioners to have a full understanding of the patient's condition. The panel determined that your failure to maintain adequate records placed patients at risk.

In relation to Charge 2a(iv), the panel determined that, whilst some observations were undertaken, these were not carried out with the required frequency following a postpartum haemorrhage. The panel accepted that you acknowledged that further observations should have been taken and you stated in your oral evidence that you; *"could have done better".* The panel determined that this amounted to a failure to provide appropriate post-haemorrhage care, which it considered to be a fundamental aspect of patient safety.

The panel determined that your actions breached these fundamental provisions of the Code.

Taking all matters into account, the panel concluded that your failings, particularly in failing to recognise and appropriately escalate a haemorrhage and in failing to undertake adequate observations and record keeping, fell seriously short of the standards expected of a registered midwife. The panel determined that these failings exposed patients to a risk of harm.

The panel therefore determined that the facts found proved amount to serious professional misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)*. in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *….'*

In reaching its decision on impairment, the panel had regard to the need to protect the public and the wider public interest. It accepted the advice of the legal assessor and applied the test set out in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant*

The panel considered the first three limbs of the Grant test.

The panel determined that your misconduct placed patients at unwarranted risk of harm. In particular, the failure to recognise and escalate a haemorrhage and the failure to undertake appropriate observations had the potential to result in serious harm to vulnerable patients.

The panel considered the risk of repetition. It noted that there were two incidents, separated by a period of two years, involving similar concerns.

The panel considered whether your failings were capable of remediation. It determined that they were, in principle, remediable. However, the panel noted that you have not practised since 2018 and have not demonstrated any remediation, or strengthened practice. The panel determined that there is no evidence before it of significant remediation. The panel accepted that this is a consequence of your inability to work in the profession in the interim period and your stated and carefully reasoned decision that you no longer wish to work in the profession.

The panel did note in your submission dated 30 April 2022, that you admitted many of the charges and made comments that indicate a good degree of insight. For example at paragraph 13 "*I now recognise that if I was involved in a similar incident in the future, I would pull the emergency bell to escalate concerns in order to maintain patient safety."* In paragraph 16, "*if the situation arose again, I would have prepared for suturing straight away and allocated the student to undertake initial baby cares."*

These insights and similar comments were repeated by you throughout the hearing giving the panel confidence that the risk of repetition is low.

The panel considered your insight in the context of a 14 year career in the profession, with no previous regulatory concerns. In addition, the panel had sight of numerous positive of testimonials from colleagues and previous patients, for example *"I have witnessed her decision making and escalation when there were potential safety concerns in antenatal care and intrapartum care at home births and her decisions and escalation was appropriate…"* The panel was therefore further reassured that the risk of repetition is low.

Accordingly, the panel determined that your fitness to practise is not currently impaired on the grounds of public protection.

The panel went on to consider the public interest. It determined that your misconduct represents a departure from the standards expected of a registered midwife. The panel considered that your actions brought the profession into disrepute.

The panel determined that a finding of impairment is required to uphold proper standards and to maintain public confidence in the profession and in the NMC as a regulator. The panel considered that a well-informed member of the public would be concerned if a midwife who had failed to recognise and appropriately respond to a haemorrhage, were permitted to practise without this being marked by a finding of impairment.

The panel therefore finds that your fitness to practise is currently impaired by reason of your misconduct on public interest grounds only.

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

Sanction

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Kirwan submitted that the appropriate and proportionate sanction in this case is a striking-off order.

Ms Kirwan began by reminding the panel of the seriousness of the findings. She submitted that this case involves a pattern of misconduct, including failures in clinical judgement, failure to recognise and appropriately respond to a postpartum haemorrhage, and failures in record keeping. Ms Kirwan submitted that these concerns placed patients at a real risk of serious harm and involved fundamental aspects of midwifery practice.

Ms Kirwan referred the panel to its findings on the facts and misconduct, in particular the failure to recognise the nature and severity of blood loss and to escalate appropriately. She submitted that the panel had found that the situation was serious and that harm was only avoided due to the intervention of another practitioner. Ms Kirwan further submitted that the failures in record keeping undermined continuity of care and posed a risk to patient safety.

Ms Kirwan submitted that these actions amount to breaches of the fundamental tenets of the profession and engage serious concerns regarding patient safety. She submitted that this is therefore a serious case requiring a restrictive sanction.

Turning to the available sanctions, Ms Kirwan invited the panel to consider them in ascending order.

Ms Kirwan submitted that taking no further action would be wholly inappropriate given the seriousness of the concerns, the clinical nature of the misconduct, and the risk of harm posed to patients.

Ms Kirwan further submitted that a caution order would not be appropriate, as the concerns are not at the lower end of the spectrum. She submitted that the misconduct involved repeated clinical failings which had the potential to cause serious harm, and that the concerns have not been fully addressed.

Ms Kirwan submitted that a conditions of practice order would also not be appropriate. While the concerns relate to clinical practice, she submitted that the repetition of similar failings and the registrant's circumstances render conditions neither workable nor proportionate. Ms Kirwan informed the panel that you have indicated that you have not practised since 2018 and do not intend to return to midwifery practice. In those circumstances, she submitted that any conditions imposed would not be capable of being complied with and would serve no useful purpose.

Ms Kirwan then addressed the issue of a suspension order. She referred the panel to the NMC's Sanctions Guidance (SAN-2d) and submitted that suspension is only appropriate where there is a realistic prospect of the registrant returning to safe and effective practice. She submitted that, in this case, you have indicated that you do not intend to return to practice and have not practised since 2018. Ms Kirwan further submitted that there is limited evidence of remediation and that you would be unable to demonstrate strengthened practice.

Ms Kirwan submitted that, in those circumstances, a suspension order would not be appropriate or proportionate, as it would likely result in a cycle of reviews without any realistic prospect of remediation. She submitted that it is neither in the public interest nor in your own interests to be kept in such a position.

Ms Kirwan therefore submitted that a striking-off order is the appropriate sanction in this case. She referred the panel to the NMC's Sanctions Guidance (SAN-2e) and submitted that, in the absence of any lesser sanction being appropriate, striking off is necessary to protect the public and maintain public confidence in the profession.

Ms Kirwan submitted that the concerns in this case raise serious issues about patient safety and professional standards. She acknowledged that there is no evidence of deep-seated attitudinal concerns, but submitted that the seriousness of the misconduct, the repetition of failings, the limited insight, and the lack of any realistic prospect of remediation justify the imposition of a striking-off order.

Ms Kirwan submitted that public confidence in the profession would be undermined if a lesser sanction were imposed in a case involving repeated clinical failings which placed patients at risk of serious harm.

You informed the panel that you have not practised since 2018 and that you were unable to revalidate. You explained that you had applied for a role as a community midwife prior to the NMC referral but were unsuccessful, and that you have not returned to practice since that time.

You told the panel that, due to your age, you do not consider that returning to midwifery practice is realistic. However, you indicated that you may consider a return to nursing practice if it were possible to do so.

You expressed concern about the impact of any sanction on your ability to undertake a return to practice course in the future.

When asked by the panel whether you had any comments on the sanction proposed by the NMC, you stated that you found the prospect of being struck off upsetting but did not make further submissions on sanction.

The panel sought clarification from you regarding your future intentions. You confirmed that you have not worked since 2018 and that you do not intend to return to midwifery practice. You indicated that you may consider returning to nursing practice if you were able to do so, but were uncertain whether this would be possible in light of the ongoing proceedings.

The panel also explored whether your inability to return to practice was due solely to your personal circumstances or whether it was influenced by the ongoing NMC proceedings.

You confirmed that the existence of these proceedings had affected your ability to pursue a return to practice course.

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. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Potential harm caused to a patient

The panel also took into account the following mitigating features:

- Shown insight in relation to these concerns

The panel took into account that whilst it had noted that there is now a low risk of harm to the public posed by you, your fitness to practise remains impaired and that this impairment must be marked by a sanction. The panel determined that your actions were unacceptable and fell below the standards expected of a registered midwife. However, the panel recognised that, notwithstanding the seriousness of your misconduct, the risk you now pose to the public is low.

The panel also took into account that you have shown insight into your misconduct throughout these proceedings. The panel noted your admissions and your engagement with the NMC. In addition, the panel had regard to the numerous positive testimonials provided, which it considered supportive of your insight and professional conduct. The

panel was satisfied that you have shown sufficient insight and that the risk of repetition is low. The panel therefore considered that your misconduct is highly unlikely to be repeated.

The panel then 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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel had regard to the NMC Guidance on *'Caution order' (Reference: SAN-2b) Last Updated: 28/01/2026) in which the following is set out:*

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel noted that you have shown insight into your conduct. It also noted that you made some early admissions to the charges and have engaged with the NMC since referral. The panel also noted that there have been no adverse findings in relation to your practice either before or since these incidents.

The panel then considered whether a conditions of practice order would be appropriate. The panel determined that a conditions of practice order is not applicable in this case. It noted that you have not practised since 2018 and concluded that it is unable to formulate conditions that would be relevant, proportionate, workable, and measurable.

In reaching this decision, the panel had regard to the NMC's Sanctions Guidance (SAN-1) on Sanctions for charges related to upholding public confidence in the profession or upholding proper professional standards, in particular the third paragraph, which states:

'Where the Committee has found impairment to uphold public confidence and professional standards, it is unlikely that a conditions of practice order will be an appropriate sanction...'

The panel also had regard to the guidance that conditions of practice will only be appropriate where they can be formulated to address the concerns in a way that is practical and capable of being complied with.

The panel determined that these criteria are not met in this case. It concluded that a conditions of practice order would serve no useful purpose, would not be proportionate, and is not necessary to protect the public or satisfy the wider public interest.

The panel concluded that no useful purpose would be served by a conditions of practice order. It is not necessary to protect the public and would not assist your return to midwifery practice.

The panel has decided that a caution order would adequately meet the public interest. For the next three years, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction.

Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of three years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered midwife.

In making this decision, the panel carefully considered the submissions of Ms Kirwan in relation to the sanction that the NMC was seeking in this case. However, the panel determined that a striking-off order is not appropriate in the circumstances as it would be

wholly disproportionate and would go beyond what is necessary to maintain public confidence in the profession, and uphold proper professional standards.

The panel considered that your misconduct, whilst serious, is not fundamentally incompatible with continued registration. It noted that you have demonstrated insight into your conduct and that the risk of repetition is low. The panel also took into account that there is no evidence of persistent or deliberate misconduct, nor any indication of deep-seated attitudinal concerns.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.