Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 24 August 2026 – Friday, 28 August 2026

Virtual Meeting

Name of registrant:	Louise Jane Leeson
NMC PIN:	23C0779E
Part(s) of the register:	Midwifery RM, Registered Midwife 16 October 2023
Relevant Location:	Norfolk
Type of case:	Lack of competence
Panel members:	Mary Idowu (Chair, Lay member) Zoe Wernikowski (Registrant member) Anita Kaur Mobberley (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Monsur Ali
Facts proved:	Charges 1(a)–1(e), 2, 3(a)–3(c), 5(a), 5(b)(ii)–5(b)(iv), 5(c), 5(d)(ii), 5(e) and 5(f), 6, 7, 8
Facts not proved:	Charges 5(b)(i) and 5(d)(i)
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

As this was a meeting**,** the panel noted that Ms Leeson was not in attendance and that the Notice of Meeting had been sent to Ms Leeson's registered email address by secure email on 22 June 2026.

The panel also noted that the Notice of Meeting had been sent to Ms Leeson's representative on the same day.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, dates and venue of the meeting.

In the light of all of the information available, the panel was satisfied that Ms Leeson has been served with notice of this meeting in accordance with the requirements of Rules 8 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, between 6 November 2023 and 6 August 2024 failed to demonstrate the standards of knowledge, skills and judgement required to practise without supervision as a band 5 midwife in that you:

1. On one or more occasion, while working under supervision, demonstrated poor medications practice in that:

a) On or around 26 February 2024, you prepared the incorrect dose of:

i. vitamin K;

ii. syntometrine.

b) On or around 31 May 2024, you attempted to increase the oxytocin when this was not clinically indicated.

c) On or around 25 June 2024 you prepared an IV pump for a 500ml bag but used a 1 litre bag.

d) On or around 30 June 2024 you:

i. prepared the incorrect dose of vitamin K;

ii. failed to check a patient's antibiotics when this was clinically indicated.

e) On or around 9 July 2024, you:

i. could not identify the marker for when to treat an infection;

ii. administered paracetamol without checking the patient records first;

iii. were unable to use Electronic Prescribing and Medicines Administration (EPMA) without intervention from your supervisor.

2. On one or more occasion, failed to prioritise and manage your workload effectively.

3. On one or more occasion, while working under supervision, you failed to correctly monitor cardiotocography [CTG] in that:

a) On or around 22 April 2024, you did not recognise and/or escalate a low fetal heart rate;

b) On or around 31 May 2024, you did not escalate a low fetal heart rate and/or suggest a change of position.

c) On or around 29 June 2024 were unable to:

i. identify the type of deceleration on the CTG;

ii. explain the definition of deceleration.

4. Failed the fetal monitoring assessment three times.

5. On one or more occasion, while working under supervision, you demonstrated poor record keeping in that you:

a) failed to complete the partogram without prompting on:

i. 24 May 2024

ii. 18 June 2024

iii. 25 June 2024

iv. 30 June 2024

b) failed to make any, or a complete, record of fluid balance, without prompting, on:

i. 7 May 2024

ii. 18 June 2024

iii. 25 June 2024

iv. 14 July 2024

c) failed to make any, or a complete, record of turn charts, without prompting on:

i. 18 June 2024

ii. 25 June 2024

d) failed to make any, or a complete, record of Pad changes, without prompting, on:

i. 24 April 2024

ii. 25 June 2024

e) On or around 18 June 2024 failed to record the fetal heart rate every 5 minutes during second stage of labour until prompted.

f) On or around 24 May 2024 failed to record the fetal heart rate every 15 minutes until prompted.

6. On one or more occasion, while working under supervision, you demonstrated poor infection control in that:

a) On or around 28 March 2024 you failed to maintain aseptic non-touch technique (ANTT) in relation to sterilisation of delivery instruments.

b) On or around 25 June 2024 you failed to maintain aseptic non-touch technique (ANTT) in relation to a catheter.

7. On one or more occasion, while working under supervision, you failed to manage and/or escalate one or more patients, in that on or around 9 May 2024 you failed to:

a) Identify a post-partum haemorrhage (PPH);

b) escalate the post-partum haemorrhage (PPH).

8. On one or more occasion, while working under supervision, you demonstrated poor patient care in that you:

a) failed to deliver adequate handover of care on:

i. 24 May 2024

ii. 18 June 2024

b) On or around 25 June 2024:

i. did not know which blood tests to arrange for a patient who had prolonged rupture of the membrane (PROM);
ii. failed to cannulate a patient correctly in that you failed to pull the needle back for a second flush back.

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC. The panel noted that there were no representations from Ms Leeson or representative.

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

Background

Ms Leeson was referred to the NMC on 7 August 2024 from Norfolk and Norwich University Hospitals NHS Foundation Trust ('the Trust'). Ms Leeson worked at the Trust as a Band 5 Midwife post qualification between 6 November 2023 and 6 August 2024.

The Trust alleged that there were ongoing concerns about Ms Leeson's competence and capability. Ms Leeson was dismissed on 6 August 2024 following a final probationary period review because she had failed to reach the necessary standard to work in a non-supervised capacity. Due to the Trust's ongoing concerns, Ms Leeson was working in a supernumerary capacity from 30 January 2024 until 6 August 2024. The Trust allege that they had put in place a very robust support network with feedback from all shifts by the midwife Ms Leeson was working with. The Trust further alleged that there were numerous near misses

which would have been causes for concern had Ms Leeson been working independently.

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

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

Charge 1

"On one or more occasion, while working under supervision, demonstrated poor medications practice in that:
a) On or around 26 February 2024, you prepared the incorrect dose of:
i. vitamin K;
ii. syntometrine."

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Joely Simeoni. In her witness statement dated 2 February 2025, she states:

'During this shift, whilst caring for the same patient, Ms Gass also drew up incorrect doses of syntometrine and Vitamin K. The syntometrine was for the patient (mother) and the Vitamin K was for the baby. Syntometrine, when used in the third stage of labour, can assist with the delivery of the placenta and reduce the risk of bleeding. Vitamin K is offered to all babies at birth to aid with blood clotting and reduce their risk of an internal bleed. Administering the incorrect dose of medication could lead to ineffective treatment or potential harm. I became aware that Ms Gass had drawn up both medications at two different times during the day which prompted me to verify them. I saw the medications on the desk, already drawn up into a syringe by Ms Gass. I cannot remember how long the Syntometrine was drawn up but I remember that the Vitamin K had been drawn up prior to the midwife's routine assessment of the newborn following birth. It was normal practice to

draw up this medication prior to this routine assessment as it is generally administered during this assessment.'

'Best practice dictates that medications are checked together when preparing and administering, so that errors are not made; Ms Gass had not asked me to verify these at the time she drew them up. I cannot find a policy which states that intramuscular injections should be double checked, but it is routine practice at the Trust for these medicines to be checked with a colleague to minimise risk of error. Our electronic prescribing system does not allow for an intramuscular medication to be given without two signatures being inputted.'

The panel also considered the contemporaneous evidence, including Feedback Log, which recorded medicines management concerns and referred to *'incorrect doses of syntometrine and vitamin K drawn up.'*

The panel considered that the contemporaneous documentation was consistent with Ms Simeoni's evidence and supported the allegation.

The panel noted that one of the feedback documents referred to the incident as having occurred in 2014. However, the witness evidence referred to the incident as occurring in 2024. The day and month were otherwise consistent. The panel was therefore satisfied that the reference to 2014 was an error.

Taking the evidence as a whole, the panel was satisfied, on the balance of probabilities, that Ms Leeson prepared incorrect doses of both vitamin K and syntometrine.

Accordingly, Charge 1(a) is found proved.

Charge 1(b)

> *"On or around 31 May 2024, you attempted to increase the oxytocin when this was not clinically indicated."*

This charge is found proved.

The panel considered Ms Simeoni's witness statement. In her written statement she states:

> *'The patient was on oxytocin, which is a hormone that helps to induce labour and bring on contractions. Ms Gass attempted to increase the oxytocin when the lady was already contracting four times every 10 minutes. I was present when Ms Gass wanted to increase the oxytocin, and I advised her that it was not safe to do so, as the woman was already contracting the recommended amount.'*
>
> *'If a patient is having four contractions every 10 minutes, we would not need to increase the oxytocin as per the policy in […] section 3.7.2 under 'Contractions'. and the 'Clinical Guideline for the Management of Oxytocin Infusion for Induction or Augmentation of Labour Following Amniotomy or Spontaneous Rupture of Membranes' policy which is […] when oxytocin infusion should be stopped or reduced. Ms Gass would be aware of this, as it is learnt throughout midwifery training and discussed on the fetal monitoring study day she completed in October 2023 […]. This should be routine knowledge for midwives.'*
>
> *'If too much oxytocin is given, the patient could contract too much and struggle by being in extreme pain and have no break between contractions to allow the body to relax and recover, and it could affect the baby's wellbeing as well. I spoke to Ms Gass at the time, I asked her how often the woman was contracting and whether she thought it was a good idea to increase the oxytocin when the woman is already contracting four times in 10 minutes. She reflected and realised that it was not a good idea to increase the oxytocin.'*

The panel also had regard to the policy, 'Joint Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling.'

The panel further considered the contemporaneous Feedback Log dated 31 May 2024:

> *'Attempted to increase the oxytocin when the lady was contracting 4:10 thus had to be prompted to review this before adapting infusion rates.'*

The panel considered that the contemporaneous feedback was consistent with Ms Simeoni's evidence. It demonstrated that Ms Leeson attempted to increase the oxytocin when the patient was already contracting at the recommended frequency and that she required prompting to reconsider this before altering the infusion rate.

The panel was therefore satisfied that the proposed increase in oxytocin was not clinically indicated.

Accordingly, Charge 1(b) is found proved.

Charge 1(c)

> *"On or around 25 June 2024 you prepared an IV pump for a 500ml bag but used a 1 litre bag."*

This charge is found proved.

The panel considered Chloe Earl's witness statement. In her written statement she stated:

> *'Something we do very often in labour is to put up a Hartmann's solution, which is a bag of sterile water which is put up and administered via an intravenous ("IV") drip to the patient's cannula, to help keep them well hydrated in labour. This is fairly standard practice, especially on the Delivery Suite, but I remember when putting up the Hartmann's solution, I had to remind Ms Gass to ensure that the information inputted in the IV pump is the same as what is on the Hartmann's bag and the prescription chart. Ms Gass had told me before that she had done this and knew what to do. This is also standard practice and is something we would expect our student midwives to know how to do, and for it to be done correctly. On this instance, the bag was a litre and when putting it in the pump, Ms Gass put it through as a 500ml bag, meaning it would be administered to the patient at a different rate. The patient would therefore be getting the fluids at a slower rate (500mls over 6 hours compared to 1000mls over 6 hours), and as such not getting the fluids she needed. Ms Gass was not able to recognise this even when I had asked her if it was all correct. I had to*

specifically tell her to check the size of the bag, and the prescription chart, and even then still needed further prompting to realise what was incorrect. This happened once on this particular shift.'

The panel also considered Ms Earl's contemporaneous typed Feedback Log dated 25 June 2024, which states:

'When putting up Hartmanns solution required reminding to check information put in the pump is the same as what is on the bag and the drug chart.'

The panel further considered Ms Earl's handwritten contemporaneous note, which states:

'When putting up hartmanns, Louise needed reminded! Prompting to check information putting into pump is correct + matches the bag of fluids + prescription chart, as Louise was putting up 1L hartmanns but went to administer it as 500ml on the pump until encouraged to check. [sic]'

The panel placed particular weight on the contemporaneous typed and handwritten records, which directly addressed the incident. Those records were consistent with each other and clearly recorded that Ms Leeson was using a one-litre bag of Hartmann's solution but had set the pump to administer it as 500ml until she was prompted to check.

The panel was therefore satisfied that Ms Leeson prepared the IV pump on the basis of 500ml while using a one-litre bag.

Accordingly, Charge 1(c) is found proved.

Charge 1(d)

"On or around 30 June 2024 you:

i. prepared the incorrect dose of vitamin K;

ii. failed to check a patient's antibiotics when this was clinically indicated."

This charge is found proved.

In relation to vitamin K, the panel considered Ms Earl's witness statement. In her written statement she states:

> *'Vitamin K is given to babies when they are born. Some babies are born with deficiencies and Vitamin K is given as a precautionary measure as it does not cause them harm if they are not deficient, but can cause harm if deficient. This was something we do nearly every day and Ms Gass had been a little bit inconsistent, as she had previously said that she knew what the dose was and said it correctly, but on this occasion I had to tell her to double check the dose as she had prepared too much. Ms Gass looked at it and was unsure at first but then when I asked her to check again, she was able to see it was the wrong dose, however she had seemed very confident that it was correct prior to me asking her to check. There is a guideline on our intranet with the dose on there, which has not changed since Ms Gass was a student, and when giving intramuscular Vitamin K to a full term baby, it is always the same dose and is something we give very regularly on delivery suite as the majority of babies have it…'*

The panel also considered the Feedback Log dated 30 June 2024, which states:

> *'Louise when drawing up vitamin K thought the dose was 0.2mls and had to be reminded of the correct dose.'*

The panel also considered Ms Earl's contemporaneous handwritten notes, which state:

> *'When drawing up vitamin K, Louise thought the dosage was 0.2ml – had to remind Louise that the correct dose is 0.1ml.'*

The panel also had regard to the relevant safer practice policy Vitamin K Safer Practice Notice.

In relation to the patient's antibiotics, the panel considered Ms Earl's witness statement. In her written statement she stated:

> *'Ms Gass also did not check the patient's antibiotics for the pyrexia bundle. The pyrexia bundle is when the patient has a temperature and so needs bloods taken to determine if it is just a random temperature caused by labour, or if there is an infection, in which case we treat for sepsis. Either way the patient has a course of IV antibiotics, but depending on whether we are treating for pyrexia or sepsis will depend on what antibiotics are used and for how long. This ties into the previous shifts where I had concerns about Ms Gass checking EPMA, on 18 June 2024, and when I had to prompt her to check. I knew the antibiotics were due in the morning, (I'm unable to recall the specific time now), and waited until closer to that time, to the point they were due but Ms Gass had not remembered. Even when I was prompting her, when I asked her what was due or what she needed to check, she could not tell me and these antibiotics would not have been given if I had not told her.'*

The panel also considered the corresponding Feedback Log dated 30 June 2024, which stated:

> *'Louise didn't check when the patient's ABX [antibiotics] for pyrexia bundle were due until closer to them needing to be administered, of which I then prompted Louise to check when they're due.'*

The panel further considered the contemporaneous handwritten notes:

> *'Louise didn't check when the patients abx for pyrexia bundle were due until closer to when they were due of which I prompted her to check.'*

The evidence showed that Ms Leeson had prepared 0.2ml of vitamin K when the correct dose was 0.1ml and only recognised the error after being prompted.

The evidence also showed that Ms Leeson did not independently check when the patient's antibiotics were due. Despite prompting, she was unable to identify what needed to be checked and Ms Earl's evidence was that the antibiotics would not have been administered without her intervention.

The panel was therefore satisfied that both parts of Charge 1(d) were proved. Accordingly, Charge 1(d) is found proved.

Charge 1(e)

> *"On or around 9 July 2024, you:*
>
> *i. could not identify the marker for when to treat an infection;*
>
> *ii. administered paracetamol without checking the patient records first;*
>
> *iii. were unable to use Electronic Prescribing and Medicines Administration (EPMA) without intervention from your supervisor."*

This charge is found proved.

The panel considered Ms Earl's witness statement. In her written statement she stated:

> *'On this shift, we had a postnatal patient who had a C-Section in the early hours of the morning and had a Post-Partum Haemorrhage ("PPH") of 1.7 litres, meaning she bled more than we expected. She was on a sepsis bundle and was being treated for infection. Ms Gass did not know what the marker was for what we treat as an infection and what we do not. This was something we do very regularly. In order to treat for sepsis, the lactate must be two or above, as stated in our sepsis/pyrexia guideline but Ms Gass thought the lactate marker needed to be either four or five before we treat the infection, which was quite a significant difference. I exhibit a copy of our Guideline for Peripartum Pyrexia and Sepsis as Exhibit "CE16".There was a potential risk of missing appropriate antibiotics and not treating for the infection when patients needed to be, if Ms Gass did not know what the markers are. I had to explain this to her and she was okay about it and wrote it down….'*

‘The patient also asked for a paracetamol and Ms Gass gave it to her without checking the EPMA. When Ms Gass was going to document it, she noticed that the lady had paracetamol four hours prior and was not due another one. Due to the passage of time, and number of patients I care for, I am unable to recall the name of this particular patient, and as such am not able to provide their records. Paracetamol was prescribed for administration every six hours. Ms Gass stated that she would wait until it comes up in two hours’ time to chart it and said she will do it in two hours. I told her absolutely not and that it needed to be charted at the time she gave the paracetamol, because if something happens, there would be no evidence that it was given at that time. It is just standard practice to document drug administration when given to avoid things such as overdosing or giving medications too soon. This is outlined in the Medicines Management Quick reference Guide […] When I discussed this with her, she became very defensive and said she was not actually going to do that, so I asked her why she said that that was what she was going to do, and she just sighed and rolled her eyes.’

‘Ms Gass struggled to use EPMA on this shift and she was not able to remember how to find when drugs were previously given and needed to be prompted every time. Although Ms Gass has had a shift previously where little prompting was needed, it was something she could not remember to do despite using it every shift.’

The panel also considered the contemporaneous Feedback Log, which states:

‘Louise was not aware of an abnormal lactate value for pyrexia/sepsis. She is now aware of the importance of this information and how it the care that is provided.’

‘Louise administered paracetamol without it being prescribed and did not notice until midday. Made aware she should not administer medication without it being prescribed and charted.’

‘Louise struggled to us EPMA on certain areas however she has been shown and prompted about this on previous shifts.’

The panel also considered Ms Earl’s evidence alongside the Medicines Management Quick Reference Guide.

The panel accepted Ms Earl’s detailed account of the incident. It noted that Ms Leeson believed the lactate threshold for treating an infection was four or five when Ms Earl’s evidence was that the correct marker was two or above. The panel considered this to be a significant difference with the potential to delay appropriate treatment.

The panel was also satisfied that Ms Leeson administered paracetamol before checking EPMA and only subsequently discovered that the patient had received paracetamol four hours earlier and was not yet due another dose.

Finally, the panel considered Ms Earl’s evidence that Ms Leeson repeatedly required prompting to navigate EPMA and could not independently identify when medication had previously been administered.

Taking all of this evidence together, the panel was satisfied that each element of Charge 1(e) was proved.

Accordingly, Charge 1(e) is found proved.

Charge 2

“On one or more occasion, failed to prioritise and manage your workload effectively.”

This charge is found proved.

The panel considered Sherri Richardson's witness statement. In her written statement, she stated:

> *'It is Ms Gass' duty under the Code to prioritise people and preserve safety. Section 1.4 states to make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay. Ms Gass was unable to do things at the same time and could not prioritise effectively. She was slow in completing the records and unable to keep up with what needed to be prioritised. I cannot say that Ms Gass was taught to prioritise but it would have been part of Ms Gass' training to identify risk and prioritise what is the most at risk.'*

The panel also considered Chloe Earl's witness statement, which states:

> *'Ms Gass also required prompting in balancing intrapartum documentation and patient care needs. This goes back to the point above in that Ms Gass wanted to focus on improving her documentation skills and remembering to document all aspects of care being given, however when she was concentrating on the documentation side of things, she struggled to provide the expected care that needed to be provided. A lot of the time on Delivery Suite, one to one care requires balancing providing a lot of care, and also documenting that care. I had quite a lot of conversations with her to discuss the importance of balancing the care needs and documenting the care being provided, however this is something that Ms Gass really struggled to do.'*

The panel had regard to Ms Earl's contemporaneous Feedback Log dated 24 May 2024, which stated:

> *'A non systematic approach to handover of care and not utilising the SBAR tool to ensure all relevant information is communicated.'*

The panel also considered the Feedback Log dated 18 June 2024, which stated:

- *‘Plan of what is due at what times to facilitate keeping on top of tasks.*
- *Check EPMA at the beginning of the shift to know what is due.*
- *Did not document all aspects of care and forgot additional paperwork such as turn charts, fluid balance etc.*
- *Would not always finish tasks and get distracted performing something different.*
- *Did not document 5 minute FHR’s during second stage of labour.*
- *Missed information during handover of care.’*

The panel further considered Ms Simeoni’s contemporaneous Feedback Log as follows:

> *‘Unable to prioritise care effectively in 2nd stage of labour: went to take observations and complete fluid balance chart before escalating a suspicious CTG. Prioritised changing sheets, washing the patients and mobilisation over the immediate postnatal checks such as: checking the perineum and immediate postnatal maternal and neonatal observations which could have been delayed for some time.’*

The panel considered the evidence from the three witnesses and the contemporaneous records to be consistent in demonstrating a repeated difficulty in prioritising competing clinical demands.

The concern was not limited to one isolated task. The evidence showed difficulties in balancing documentation with direct patient care, completing tasks before moving on to others, recognising which clinical concerns required priority and ensuring that important information was communicated.

Of particular concern to the panel, was the contemporaneous record that Ms Leeson undertook observations and fluid balance documentation before escalating a suspicious CTG, and prioritised routine postnatal tasks over immediate maternal and neonatal observations.

The panel was therefore satisfied that Ms Leeson failed, on more than one occasion, to prioritise and manage her workload effectively.

Accordingly, Charge 2 is found proved.

Charge 3

"On one or more occasion, while working under supervision, you failed to correctly monitor cardiotocography [CTG] in that:"

a. *"On or around 22 April 2024, you did not recognise and/or escalate a low fetal heart rate."*

This charge is found proved.

The panel considered Ms Simeoni's witness statement:

> *'On one occasion, when I went in to a room to check in on Ms Gass, I observed that the baby's heart rate had dropped and Ms Gass had not escalated it as a concern. I do not recall the patient's name and therefore unable to provide a copy of the CTG trace. The concern of the heart rate dropping indicates that the baby is not tolerating the labour and could be at risk of harm. The risk is brain damage or in the worst instance, death. The baby's heart rates generally stay on one level (the baseline for that baby), but if it drops more than 20 beats below the baseline, then the baby and the mum need to be reviewed. In such circumstances, the CTG should be reviewed by the Delivery Suite Co-Ordinator and a senior doctor, as per the 'Joint Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling' guideline, section 3.7.5 […]. However, Ms Gass had not realised that this was a concern. From memory, I told Ms Gass that it should have been escalated to a Delivery Suite Co- Ordinator or a doctor. I cannot recall her response, the details of what occurred, or which staff were working. However, I do remember that I asked for the CTG to be*

reviewed by the Delivery Suite Co-ordinator and doctor on call for the Delivery Suite.'

The panel also considered Ms Simeoni's contemporaneous Feedback Log dated 22 April 2024:

'On one occasion when I did go into the room to check in on her, there had been a drop in baseline following a decel which she had not highlighted.'

The panel had regard to the Joint Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling which detailed the escalation pathways when there are concerns with the fetal heart rate.

The panel accepted Ms Simeoni's evidence that there had been a drop in the fetal heart rate which Ms Leeson had neither recognised as a concern nor escalated. Her account was supported by the contemporaneous feedback recorded on the same date.
The panel also took into account the potential seriousness of failing to recognise a significant change in the fetal heart rate, as explained by Ms Simeoni.

The panel was therefore satisfied that Ms Leeson did not recognise and/or appropriately escalate the low fetal heart rate.

Accordingly, Charge 3(a) is found proved.

Charge 3(b)

"On or around 31 May 2024, you did not escalate a low fetal heart rate and/or suggest a change of position."

This charge is found proved.

The panel considered Ms Simeoni's witness statement:

'I also recall that the fetal heart rate dropped by 20bpm for two minutes. This was a concern and usually if the heart rate does not come back up, we would need to change the position the lady was in, as turning onto a left lateral position usually helps resolve the heart rate concerns. This is the expectation as per the policy in Exhibit JS7 section 3.7.5. I remember Ms Gass making a joke that the baby was a boy and the heart rate would come up in a moment, but she did not take any action regarding the dropping fetal heart rate. I was assessing whether Ms Gass would change the position or escalate however she did not ask the patient to change position or escalate the concerns to the doctor or co-ordinator.'

The panel also considered Ms Simeoni's contemporaneous Feedback Log:

'A delay in escalation/care planning when the fetal heart rate dropped by 20bpm for 2 minutes and Louise had not asked the lady to change position or did not escalate concerns to midwife.'

The panel had regard to the Joint Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling. and, in particular, section 3.7.5:

'Actions to be taken in the event the CTG is assessed as suspicious or pathological:

Categorisation of a trace as suspicious or pathological does not necessarily mean delivery. If it is classified as suspicious or pathological, perform a full risk assessment, including a full set of maternal observations, taking into account the whole clinical picture, and document the findings, and start conservative measures to improve the fetal environment and reverse reversible causes of fetal hypoxia:

- *Excessive uterine activity. This is the most common cause for fetal hypoxia. Can be corrected by stopping oxytocin infusion, removing prostaglandins or administration of a Tocolytic, such as terbutaline (250mcg s/c).*

- *Aorto-caval compression. Can be a result of the mother being in the supine position, so can be corrected by changing maternal position, usually to her left lateral.'*

The panel considered that Ms Simeoni's evidence was clear and supported by her contemporaneous record. The fetal heart rate had dropped by 20 beats per minute for two minutes. Despite this, Ms Leeson did not ask the patient to change position and did not escalate the concern.

The panel noted that the relevant guideline required consideration of conservative measures to reverse potential causes of fetal hypoxia. The evidence also established that changing the patient's position was an appropriate response in the circumstances.
The panel was therefore satisfied that Ms Leeson failed to escalate the low fetal heart rate and failed to suggest the required change of position.

Accordingly, Charge 3(b) is found proved.

Charge 3(c)

"On or around 29 June 2024 were unable to:
i. identify the type of deceleration on the CTG;
ii. explain the definition of deceleration."

This charge is found proved.

The panel considered Ms Earl's witness statement:

'During this shift, Ms Gass was not able to identify the type of deceleration that happened in the CTG monitoring. Due to the passage of time, and number of patients I care for, I am unable to recall the name of this particular patient, and as such am not able to provide their records. When I was discussing this with Ms Gass, she was not able to tell me the definition of deceleration, despite on a previous shift (18 June 2024), she had been able to identify a prolonged deceleration. I had the conversation

with her that I felt that the shifts at this point were inconsistent. On one shift, her practice would improve and the next shift, we would seem to go back to square one. Ms Gass was quite defensive when I asked her if she could tell me what a deceleration was and I remember her saying "yes of course I know" but when I asked for the definition, she was not able to tell me what it was. When she tried to, it was incorrect. I remember she said if the baby's heart rate was down for one minute or more than then it is deceleration. Deceleration is classed as a drop of 15 beats for more than 15 seconds, so it was quite different to what she said. This is basic information we teach our first year student midwives so Ms Gass should definitely had known this, and she said that she had also had further CTG training with our fetal monitoring midwife by this point.'

The panel also considered Ms Earl's contemporaneous Feedback dated 29 June 2024:

- *'Unable to identify the type of decel on the CTG and what a definition of a deceleration was*
- *At the Dr ward round Louise did not mention why the preterm lady was admitted to delivery suite (CTG concerns) and the important of relaying this information.*
- *Louise left the room unattended to get some linen. During this time there was a prolonged decel on CTG. Reminded the importance of not leaving the room especially when there are CTG concerns.*
- *Reminded to document there was accelerations on the antenatal CTG trace as this impacts the overall classification.'*

The panel further considered Ms Earl's contemporaneous handwritten note:

'Louise wasn't able to identify what kind of decels were on the CTG + failed to describe the definition of a decel + characteristics.'

The panel noted that Ms Leeson had previously demonstrated some ability to identify a prolonged deceleration, but her performance was inconsistent. On the date in question,

she was unable to identify the type of deceleration present and gave an incorrect definition when asked to explain what constituted a deceleration.

The panel was therefore satisfied that both parts of Charge 3(c) were proved.

Accordingly, Charge 3(c) is found proved.

Charge 4

"Failed the fetal monitoring assessment three times."

This charge is found proved.

The panel considered the documentary evidence concerning Ms Leeson's fetal monitoring assessments.

In particular, the panel considered an email from Deirdre Foey to Ms Leeson dated 12 March 2024. The email recorded that Ms Leeson had failed the fetal monitoring assessment on three occasions:

'Dear Louise.

I have looked at your test results and see your result is 20/27.

This is not a pass.

I disagree about question 18 and think that you have not understood the question if you disagree with the answer.

Variable decelerations are normal and there are no concerning features but I want to go over each question with you.

I think we need to get together to go through the assessment next week .

When are you free next week between Monday Tuesday or Thursday please ?

I am quite concerned about your ctg interpretation.

This is a core vital part of your role to understand this I order to be able to give safe labour care.

I suggest take some time to go through the scenarios on the K2 package that I showed you yesterday evening and I will print out your results ,we can go through them next week.

This is the 4 th time that you have completed the same fetal monitoring assessment, and passed only once.

We must get to the bottom of what you don't understand.

I have included a summary below of results

13/11/23 20/27 - failed

16/10/23 20/27 - failed

2/12/23 27/27 - passed

12/03/23 20/27-failed'

The panel noted that the email clearly set out the dates and outcomes of the four assessments. Three assessments resulted in scores of 20/27 and were recorded as failed, while the assessment dated 2 December 2023 was passed with a score of 27/27.
The panel also took account of the concern expressed in the email about Ms Leeson's CTG interpretation and the description of fetal monitoring as a core and vital part of the role required for safe labour care.

The panel considered the email to be reliable documentary evidence that Ms Leeson had failed the fetal monitoring assessment three times.

Accordingly, Charge 4 is found proved.

Charge 5

> *"On one or more occasion, while working under supervision, you demonstrated poor record keeping in that you:"*
>
> *a. "failed to complete the partogram without prompting on:*
> *i. 24 May 2024;*
> *ii. 18 June 2024;*
> *iii. 25 June 2024;*
> *iv. 30 June 2024."*

This charge is found proved.

In relation to 24 May 2024, the panel considered Ms Earl's witness statement:

> *'This was the next shift where Ms Gass and I worked together. During this shift, Ms Gass needed a lot of prompting to document the baby's heart rate every 15 minutes, which was something we had discussed on the previous shift on 28 March 2024 in terms of the partogram. It is really important to document baby's heart rate in the partogram, and write it longhand in the written notes as well. There were a lot of occasions however I cannot recall how many times specifically when I was looking at Ms Gass' documentation and I was having to ask her to go back to put in the baby's heart rate because it was missed or forgotten. I recall her saying "Yes of course, I do remember" and she realised that she knew it was something she needed to do when I reminded her. It never came as a shock to her, but did subsequently forget to do it over again even after being reminded, and despite the fact that this is basic knowledge we would expect of a first year student midwife…..'*

The panel also considered the contemporaneous typed Feedback Log:

> *'Required prompting to document 15 minute FHR during labour'*

The panel further considered Ms Earl's contemporaneous handwritten notes dated 24 May 2024:

> *'Today was a bit disjointed day however Louise was keen to get involved + help + practise tasks. It was clear today that Louise 's communication with families have improved + Louise is more confident in this area. Louise practised how to use ICE – chasing blood results + was able to do this no help. Louise also was more independent with documentation, and was able to provide emotional support to a labourer during break relief.'*

The panel recognised that the handwritten record contained positive observations, including that Ms Leeson had become more independent with some aspects of documentation. However, the panel considered that these positive comments did not undermine the more specific evidence that she continued to require prompting to document the fetal heart rate within the partogram.

In relation to 18 June 2024, the panel considered Ms Earl's witness statement:

> *'As with the previous shifts, Ms Gass was not aware on how to fill out a partogram, which continued to be an ongoing occurrence throughout the time I worked with her and I had to have a conversation with her about it every shift. Either Ms Gass was forgetting to do it or doing it incorrectly. She was inputting incorrect information and I recall her saying that it was how she always did it, which was incorrect because we had already had this conversation on previous shifts where I had shown her how to do it correctly, so she should have been aware of how to do it correctly. This aspect of care and documentation is what we would expect a first year student midwife to know how to do correctly, therefore as Ms Gass was a fully qualified midwife this is something that she should have known how to do.'*

The panel also considered the typed contemporaneous Feedback Log dated 18 June 2024:

> *'Was not aware of how to fill out a partogram.'*

The panel also noted that the handwritten form referred to further information on the back of the page, but the back of that page had not been provided. The panel therefore considered the evidence available to it, including Ms Earl's detailed witness statement and the contemporaneous typed material.

In relation to 25 June 2024, the panel considered Ms Earl's witness statement:

> *'During this shift, Ms Gass again needed prompting to commence the partogram. We were caring for a patient in labour so were therefore 1:1 with just that one patient. Once Ms Gass started, she was able to do this correctly but needed reminding for it to be commenced in the first place.'*

The panel also considered the contemporaneous feedback:

> *'Required prompting to commence the partogram but then maintained this accurately.'*

The panel further considered the handwritten note:

> *'Louise Need prompting to commence partogram, was able to complete correctly with some help but overall better than previously.'(sic)*

The panel took into account that Ms Leeson was said to have performed better than previously and was able to maintain the partogram once it had been commenced. However, the allegation concerned whether prompting was required. The evidence clearly recorded that Ms Leeson required prompting to begin the partogram.

In relation to 30 June 2024, the panel considered Ms Earl's witness statement:

'As with previous shifts, Ms Gass did not commence the partogram, and once prompted to start it, was unable to keep on top of the partogram throughout the shift and I had to remind her of its importance multiple times.'

The panel also took into account the contemporaneous Feedback Log:

'Unable to keep on top of the partogram today and reminded of its importance.'

Further:

'Louise wasn't able to keep up to date with partogram today, however reiterated how important it is.'

The panel also had regard to Ms Richardson's evidence concerning the record-keeping policies which Ms Leeson would have been made aware of. Ms Richardson stated in her written statement:

'It is Ms Gass' duty under the Code Section 10 to keep clear and accurate records relevant to your practice. Section 10.1 states to complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event. Ms Gass would have been made aware of the record-keeping policy at the Trust...'

The panel considered the evidence across all four dates. Although there were occasions when Ms Leeson demonstrated improvement, there remained repeated instances where she either failed to commence the partogram, completed it incorrectly or required prompting to keep it up to date.

The panel was therefore satisfied that Ms Leeson failed to complete the partogram without prompting on each of the four dates alleged.

Accordingly, Charge 5(a) is found proved.

Charge 5(b)

"failed to make any, or a complete, record of fluid balance, without prompting, on:

i. 7 May 2024;

ii. 18 June 2024;

iii. 25 June 2024;

iv. 14 July 2024."

Charge 5(b)(i) is found not proved. Charges 5(b)(ii), 5(b)(iii) and 5(b)(iv) are found proved.

In relation to 7 May 2024, the panel carefully reviewed the evidence before it but was unable to identify any evidence which supported the allegation that Ms Leeson failed to make any, or a complete, fluid balance record without prompting on that date.

The panel was therefore not satisfied that the NMC had discharged its burden of proof in relation to Charge 5(b)(i).

In relation to 18 June 2024, the panel considered Ms Earl's witness statement:

'At the beginning of the shift, I told Ms Gass to keep on top off documenting on the turn chart and fluid balance chart and Ms Gass agreed that she was aware of the task, however these records were not completed as expected during the shift….'

'As far as I recall, Ms Gass completed half of the fluid balance chart (documenting fluids patient had been drinking),but did not the document the urine the patient was passing. Due to the passage of time, and number of patients I care for, I am unable to recall the name of this particular patient, and as such am not able to provide their records. Due to this, we were not able to calculate the fluid balance and assess whether what the patient was taking in was in par with what was coming out. It is important

in labour to keep up to date with fluid balance, so we are aware the kidneys are working well and making sure there is no retention or obstruction. However, we are unable to measure it accurately with only half of the information needed.'

The panel also considered the contemporaneous typed Feedback Log dated 18 June 2024:

'Did not document all aspects of care and forgot additional paperwork such as turn charts, fluid balance etc.'

The handwritten feedback referred to the back of the page, which was not available. The panel therefore relied on the contemporaneous typed record, which expressly referred to the fluid balance documentation.

The panel was satisfied that the evidence demonstrated that Ms Leeson did not complete the fluid balance documentation without prompting on 18 June 2024.
In relation to 25 June 2024, the panel considered Ms Earl's witness statement:

'As with the shift on 18 June 2024, I again had to prompt Ms Gass about completing the turn chart and the fluid balance chart, as she was not filling out the charts at all during this shift, and is aware that if it is not documented then 'we didn't do it'.'

The panel also considered the contemporaneous Feedback Log. It noted that the handwritten note from the day referred to the back of the form, but it was not provided. The panel therefore relied on the typed version, which states:

'Remember to document on the turn chart/ performing aspects of the fluid balance such as output but not in its entirety such as input. To remember to check pressure areas and to complete the turn chart.'

The panel also considered Ms Earl's handwritten note:

‘Louise had filled in output on fluid balance chart but needed prompting to fill in input. Lousie had forgotten to document on TURNS chart, therefore reminded of importance of skin integrity.’

The panel considered that these records demonstrated that Ms Leeson had completed only part of the fluid balance chart and required prompting to record the remaining information.

In relation to 14 July 2024, the panel considered Ms Simeoni’s witness statement:

‘Ms Gass also did not update the fluid balance chart which details what fluids go into the patients. I exhibit a copy of the Bladder care and Fluid Balance, Antenatal, Intrapartum and Postnatal as Exhibit “JS16”; page 5 of “procedures” highlights that fluid balance should be monitored from admission, throughout labour and in the postnatal period to monitor voiding function. I cannot recall the patient name, and therefore I cannot provide a copy of this record. It is difficult to assess improvement in Ms Gass’ practice because there were some days where she would have difficulties and some days where she would do something better. Ms Gass would forget what she was taught and was very inconsistent with what she could and could not do. It was never one issue that we could solve.’

The panel also considered Ms Simeoni’s contemporaneous Feedback Log dated 14 July 2024:

‘Missed fluid balance chart’

The panel further had regard to ‘Bladder care and Fluid Balance, Antenatal, Intrapartum and Postnatal’ Guideline which details the importance of maintaining an accurate fluid balance.

The panel considered the witness evidence and contemporaneous records to be consistent. It was satisfied that the allegation was proved in relation to 18 June, 25 June and 14 July 2024, but there was insufficient evidence in relation to 7 May 2024.

Accordingly, Charge 5(b)(i) is found not proved and Charges 5(b)(ii), 5(b)(iii) and 5(b)(iv) are found proved.

Charge 5(c)

> *"failed to make any, or a complete, record of turn charts, without prompting on:*
>
> *i. 18 June 2024;*
>
> *ii. 25 June 2024."*

This charge is found proved.

In relation to 18 June 2024, the panel considered Ms Earl's written witness statement:

> *'At the beginning of the shift, I told Ms Gass to keep on top off documenting on the turn chart and fluid balance chart and Ms Gass agreed that she was aware of the task, however these records were not completed as expected during the shift. For example, if a patient has an epidural and as such is not able to mobilise, it is important to check her pressure areas so she does not develop any pressure sores. This has to be done every couple of hours as stated in our Waterlow chart, […] and which is provided for each patient in our admission pack. If a patient scores above 10, depending on their mobility, then we need to check their skin and pressure areas every two hours. It is also written on our repositioning chart, that if depending on their score, how often we should be checking/repositioning but Ms Gass did not complete these checks independently and did not document anything without being reminded. […] Ms Gass did not remember to check the pressure areas at all, I left it to see if she would remember throughout the shift, however she failed to do this. I ended up asking Ms Gass after it had gone past the time of it being due if she could remember what she had not done and what needed to be completed, but she was not able to tell me. Once I had reminded her she would do it, however she would then forget again by the time it was due again, despite having a list of what was due and at what times. Once the*

pressure areas had been checked, Ms Gass was not going to document it in either the longhand notes or the reposition chat, until she asked me if there was something she was missing in the notes, at which time I reminded her to document that we had checked the patient's pressure areas and that everything was intact / there were no concerns. This was a regular occurrence that Ms Gass would forget to document aspects of care given.'

The panel also considered the contemporaneous typed Feedback Log:

'Did not document all aspects of care and forgot additional paperwork such as turn charts, fluid balance etc.'

As previously noted, the handwritten version referred to information on the back of the form which had not been provided. The panel therefore relied on the contemporaneous typed record.

In relation to 25 June 2024, the panel considered Ms Earl's witness statement:

'As with the shift on 18 June 2024, I again had to prompt Ms Gass about completing the turn chart and the fluid balance chart, as she was not filling out the charts at all during this shift, and is aware that if it is not documented then 'we didn't do it'.'

The panel also considered the contemporaneous Feedback Log:

'Remember to document on the turn chart/ performing aspects of the fluid balance such as output but not in its entirety such as input. To remember to check pressure areas and to complete the turn chart.'

The panel further considered the contemporaneous handwritten note:

‘Louise had filled in output on fluid balance chart but needed prompting to fill in input. Lousie had forgotten to document on TURNS chart, therefore reminded of importance of skin integrity.’

The panel considered the evidence from both dates to be clear. On 18 June 2024, Ms Leeson did not complete the relevant additional documentation despite being reminded at the beginning of the shift. On 25 June 2024, she again required prompting and the handwritten record specifically stated that she had forgotten to document on the turn chart.

The panel was therefore satisfied that Ms Leeson failed to make a complete record of the turn charts without prompting on both dates.

Accordingly, Charge 5(c) is found proved.

Charge 5(d)

“failed to make any, or a complete, record of Pad changes, without prompting, on:
i. 24 April 2024;
ii. 25 June 2024.”

Charge 5(d)(i) is found not proved. Charge 5(d)(ii) is found proved.

In relation to 24 April 2024, the panel carefully reviewed the evidence but was unable to identify any material which supported the allegation. It was therefore not satisfied that the NMC had discharged its burden of proof in relation to that date.

In relation to 25 June 2024, the panel considered Ms Earl’s witness statement:

‘I also had to prompt Ms Gass to complete and document pad changes and the liquor colour, which is basic patient hygiene care. This is standard procedure when repositioning and checking the patient’s pressure areas, and is something we had already discussed on previous shifts. Liquor colour refers to the colour of the woman’s waters (amniotic fluid) and it is really important to monitor this as when there are changes it can change

the plan of care we provide. Liquor colour is expected to be clear or a little bit pink but it is important to be aware if it, for example, changes to a red, green or brown colour. Ms Gass forgot to document this in the notes. Due to the passage of time, and number of patients I care for, I am unable to recall the name of this particular patient, and as such am not able to provide their records. I had to have a conversation with Ms Gass to remind her that this needs to be completed, and to always document it throughout the labour as per our Waterlow chart...'

The panel also considered the contemporaneous Feedback Log:

'Remember to document pad changes and liquor colour.'

The panel further considered Ms Earl's handwritten note:

'Remember MP [maternal pulse] when commenting full picture on CTG every 30 minutes and remember to document pad changes / liquor colour as Louise needed prompting with this.'

The panel considered that Ms Earl's witness evidence was supported by both the typed and contemporaneous handwritten records. Those records specifically referred to the need to document pad changes and liquor colour and recorded that Ms Leeson required prompting to do so.

The panel was therefore satisfied that Charge 5(d)(ii) was proved, but found no evidence capable of establishing Charge 5(d)(i).

Accordingly, Charge 5(d)(i) is found not proved and Charge 5(d)(ii) is found proved.

Charge 5(e)

"On or around 18 June 2024 failed to record the fetal heart rate every 5 minutes during second stage of labour until prompted."

This charge is found proved.

The panel considered Ms Earl's witness statement:

> *'Ms Gass also did not document the five minute fetal heart rate during the second stage of labour. This is something we teach our first year students during training and Ms Gass would have been aware of this. When the patient is fully dilated (meaning their cervix is 10cm dilated) and pushing, it is important to increase how often we document the fetal heartrate, from every 15 minutes to every five minutes, as it is more common for babies to become distressed during this stage of labour (the second stage). As such it is important we are observing clearly and documenting everything so we are aware if there have been any changes or concerns arising. This is highlighted in our intrapartum guideline […] for the second stage. When asking Ms Gass what we need to increase observing once the patient entered the second stage of labour she was unable to tell me. Once I had reminded her what we needed to do, she lacked understanding of this and said she would have forgotten. Throughout the second stage I had to remind her multiple times to document every five minutes. I frequently discussed with Ms Gass the importance of this.'*

The panel also considered the contemporaneous typed Feedback Log dated 18 June 2024:

> *'Did not document 5 minute FHR's during second stage of labour.'*

The handwritten Feedback Note did not contain the same level of detail and referred to information on the back of the page which was not available. The panel therefore relied on the contemporaneous typed record.

The panel also had regard to the Joint Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling which details how regularly the fetal heart rate should be monitored and recorded during the different stages of labour.

The panel considered Ms Earl's evidence to be clear and directly supported by the contemporaneous feedback. Her evidence was that Ms Leeson did not know that monitoring needed to increase to every five minutes in the second stage and required repeated prompting throughout that stage.

The panel was therefore satisfied that Ms Leeson failed to record the fetal heart rate every five minutes during the second stage of labour until prompted.

Accordingly, Charge 5(e) is found proved.

Charge 5(f)

> *"On or around 24 May 2024 failed to record the fetal heart rate every 15 minutes until prompted."*

This charge is found proved.

The panel considered Ms Earl's witness statement:

> *'This was the next shift where Ms Gass and I worked together. During this shift, Ms Gass needed a lot of prompting to document the baby's heart rate every 15 minutes, which was something we had discussed on the previous shift on 28 March 2024 in terms of the partogram. It is really important to document baby's heart rate in the partogram, and write it longhand in the written notes as well. There were a lot of occasions however I cannot recall how many times specifically when I was looking at Ms Gass' documentation and I was having to ask her to go back to put in the baby's heart rate because it was missed or forgotten. I recall her saying "Yes of course, I do remember" and she realised that she knew it was something she needed to do when I reminded her. It never came as a shock to her, but did subsequently forget to do it over again even after being reminded, and despite the fact that this is basic knowledge we would expect of a first year student midwife.'*

The panel also considered the Feedback Log dated 24 May 2024:

> *'Required prompting to document 15 minute FHR during labour'*

The panel further considered the contemporaneous handwritten Feedback notes under the heading *"Support required to achieve outstanding objectives":*

> *'Today was a bit disjointed day however Louise was keen to get involved + help + practise tasks. It was clear today that Louise 's communication with families have improved + Louise is more confident in this area. Louise practised how to use ICE – chasing blood results + was able to do this no help. Louise also was more independent with documentation, and was able to provide emotional support to a labourer during break relief. Louise used E3 and gathered a good + through history of a high risk + complex lady.'*

The panel took into account the positive aspects recorded in the handwritten feedback. However, it considered that these did not contradict the specific witness evidence and contemporaneous feedback that Ms Leeson required repeated prompting to document the fetal heart rate every 15 minutes.

The panel was therefore satisfied that the allegation was proved.

Accordingly, Charge 5(f) is found proved.

Charge 6

"On one or more occasion, while working under supervision, you demonstrated poor infection control in that:

a. *On or around 28 March 2024 you failed to maintain aseptic non-touch technique (ANTT) in relation to sterilisation of delivery instruments."*

This charge is found proved.

The panel considered Ms Earl's written witness statement:

> *'During the shift, I also had concerns about Ms Gass' infection control. We use the aseptic non-touch technique ("ANTT") which is a standard procedure that is taught while on placement (prior to qualification) through skills sessions. ANTT procedure is in place to avoid contamination and reduce infection risk. We have training on this on our E-Learning, there is a specific course on ANTT which you are updated on regularly. I am not aware of whether Ms Gass completed this particular E-Learning course, however, we have mandatory training every year which includes time to complete our E-Learning Courses. The first time this training is done is when you are new to the Trust so I suspect Ms Gass would have completed the course. Throughout the delivery of a baby, we have a delivery pack and a pack of delivery instruments that we use as part of the delivery. When a midwife is delivering a baby, it is important to maintain the sterile field. This means making sure that the swabs, delivery pack and instruments are maintained sterile in order to reduce the risk of infection. During this shift, Ms Gass touched the sterile field twice, and I had point it out to her each time. Ms Gass' response on both occasions was that she forgot it needed to stay sterile. I did not really feel at that time that she understood the risks, as she sort of brushed it off. We had a further discussion about this after the delivery, at which time I still felt she still lacked understanding of the importance of this.'*

The panel noted Ms Earl's evidence explaining the purpose of ANTT and the importance of maintaining the sterile field to reduce the risk of infection. It also noted her clear evidence that Ms Leeson touched the sterile field twice and required this to be pointed out to her on both occasions.

The panel also considered the contemporaneous Feedback Log dated 28 March 2024:

> *'Areas of development*
>
> *Maintaining sterilisation of delivery instruments.'*

The panel considered Ms Earl's evidence to be clear and supported by the contemporaneous feedback. It was satisfied that Ms Leeson did not maintain the sterile field and thereby failed to maintain ANTT in relation to the delivery instruments.

Accordingly, Charge 6(a) is found proved.

Charge 6(b)

> *"On or around 25 June 2024 you failed to maintain aseptic non-touch technique (ANTT) in relation to a catheter."*

This charge is found proved.

The panel considered Ms Earl's witness statement:

> *'During this shift, I also had issues again with Ms Gass' ANTT for a Suprapubic Catheter insertion ("SRC"). It is a sterile technique for inserting a catheter into the patient's bladder. It is important to keep the field sterile to reduce the risk of infection. Ms Gass started to cross contaminate by touching sterile things such as the catheter and the cotton wool with non-sterile hands and putting the outer packaging onto the sterile field, and also putting things such as the catheter onto the trolley underneath, which is a non-sterile field. Therefore, I had to prompt her about the ANTT prior to inserting the catheter. Ms Gass said that she forgot but again as this is standard practice that she would have been aware of, she should know the importance of this. I also had previous conversations with Ms Gass about ANTT and sterile fields. [sic]'*

The panel also considered the contemporaneous Feedback Log:

> *'Required reminding of correct ANTT for inserting an SRC [self retaining catheter]'* The panel also considered Ms Earl's handwritten

contemporaneous note: *'Louise needed reminded of clean hand, dirty hand when inserting SPC [sic] but is aware of importance of this now.'*

The panel considered that Ms Earl's account contained specific examples of cross-contamination, including touching sterile equipment with non-sterile hands and placing packaging and equipment inappropriately within the sterile field.

Her account was supported by both the contemporaneous typed and handwritten records, which recorded that Ms Leeson required reminding about the correct ANTT procedure.

The panel was therefore satisfied that Ms Leeson failed to maintain ANTT in relation to the catheter.

Accordingly, Charge 6(b) is found proved.

Charge 7

"On one or more occasion, while working under supervision, you failed to manage and/or escalate one or more patients, in that on or around 9 May 2024 you failed to:

a) Identify a post-partum haemorrhage (PPH);

b) escalate the post-partum haemorrhage (PPH)."

This charge is found proved.

The panel considered Ms Richardson's written witness statement dated 25 April 2025, which states:

'A meeting was held with Ms Gass, Ms Sayer and Ms Simeoni following a shift on 9 May 2024. We called Ms Gass straight in to the office and spoke to her about an incident whereby a postpartum haemorrhage ("PPH") was not properly escalated.'

'On 9 May 2024, Ms Gass did not escalate a PPH appropriately. The average blood loss postpartum is 500 millilitres ("mls"). I asked Ms Gass

what the average was and she said it was 650mls. The patient had lost more than a litre and she did not follow the escalation process. She did not do anything and the patient bled a lot without any input from the doctor. The haemorrhage was identified by the midwife (I do not know their name) Ms Gass handed the care to and the midwife was shocked and escalated the issue to the coordinator (Nicki Bridges). Fortunately, there was no harm caused to the patient. This was quite dangerous and it prompted us to meet with Ms Gass straightaway. She accepted that she did not know what a PPH was and also accepted that she did not manage it appropriately.'

'When haemorrhaging occurs, certain procedures are done such as getting all the documents and senior midwives involved, drugs, fluid interventions, and vaginal examination depending on where the blood loss is coming from but in this case Ms Gass just handed the patient's care over. She did not recognise that it was a PPH. I would have expected her to know PPH that it was 500mls as this is part of her midwifery training as a student. However, Ms Gass thought it was 650mls. Ms Gass would have had a competency signed off for PPH during her midwifery training. Ms Gass would have been signed on for PPH as this assessment is part of modules covered by a student midwife, therefore Ms Gass would not have qualified as a midwife without successfully completing the assessment. I am unable to provide a copy of the assessment completed by Ms Gass but the midwifery school attended by Ms Gass would have a copy of this (I cannot confirm the name of the school). Ms Gass would also have had an oral exam at the end of her midwifery training, where PPH was one of the things that would have been questioned. Ms Gass completed the PROMPT which is a multi-professional maternity emergencies training day on 7 December 2023 which deals with emergency drills and skills and would have covered PPH [Feedback from the Fatal Competency Assessment].'

The panel noted Ms Richardson's evidence that concerns were raised immediately following the shift because a PPH had not been identified or appropriately escalated. Her

evidence was that the patient had lost more than one litre of blood, yet Ms Leeson did not follow the escalation process.

The panel also noted that the haemorrhage was identified by the midwife who subsequently took over the patient's care and that it was that midwife who escalated the matter to the coordinator.

The panel further considered the contemporaneous Support Log dated 10 May 2024:

> *'Concerns raised from late shift on 9/5/24 – PPH not recognised or escalated appropriately. Missed documentation. Reflected on this care with Louise and concerns highlighted. Louise to write a reflection on this care.'*

The panel also considered the contemporaneous email dated 9 May 2024:

> *'In short:*
> *NVB @ 1803*
> *1807 – large gush and trickling (no amount documented)*
> *P&M delivered….*
> *Care taken over by RMR Harvey. Not informed that perineal inspection was not done until adter(sic) RM Gass had written her notes. Checked and sutured in room by RM Harvey…*
>
> *My concern is that the continuing bleeding was not documented as being escalated (certainly none of the obstetric team were aware at handover – both the exiting day team and entering night team)…*
>
> *This is really concerning as Louise has only just come off supernumerary status. Can this please be investigated more thoroughly and discussed with Louise at the first available opportunity?'*

The panel had regard to the Major Obstetric Emergency Guideline which details the steps to be taken and escalation pathways in the event of a PPH.

The panel considered the witness and documentary evidence to be consistent. The contemporaneous Support Log expressly recorded that the PPH had not been recognised or escalated appropriately, which supported Ms Richardson's detailed account.

The panel also took into account Ms Richardson's evidence that Ms Leeson accepted that she did not know what a PPH was and that she had not managed it appropriately.
The panel was therefore satisfied that Ms Leeson failed both to identify the PPH and to escalate it appropriately.

Accordingly, Charge 7 is found proved.

Charge 8

> *"On one or more occasion, while working under supervision, you demonstrated poor patient care in that you:*
>
> *a. failed to deliver adequate handover of care on:*
> *i. 24 May 2024;*
> *ii. 18 June 2024."*

This charge is found proved.

In relation to 24 May 2024, the panel considered Ms Earl's witness statement:

> *'When we were handing over the care to a different midwife at the end of the shift, whose name I am unable to recall, Ms Gass' handover was very disjointed. She would explain one point, but not completely, before going on to a different point, then going back to the first point. We use the SBAR tool which stands for 'Situation, Background, Assessment, and Recommendation'. On the SBAR paper which we fill out when handing over care it has 'situation, background, assessment, and recommendation' written on it in order to help allow these important factors not to be missed.[…] Whenever you hand over, it is always in front of you, for guidance. This allows you to explain what the situations is, the background*

of care being provided, the assessment of where we have got to in terms of care at that time, and the recommendation of what needs to be done/what is due. It is very important to use the SBAR tool when doing a handover of care to ensure a systematic approach, and so all basis of care are covered. Ms Gass' handover was very unclear, so I gave her some tips on how I personally find handover useful to see if it would help her find it easier to follow. Ms Gass really appreciated it and I could tell it was something she wanted to work on, however, unfortunately, I subsequently had to have the same conversation with her during the majority of shifts we had together, as vital information was regularly missed, which in turn alters the plan of care for the patient.'

The panel also considered the contemporaneous Feedback Log dated 24 May 2024:

'A non systematic approach to handover of care and not utilising the SBAR tool to ensure all relevant information is communicated.'

The panel further considered the contemporaneous handwritten note:

'Today was a bit disjointed day however Louise was keen to get involved + help + practise tasks. It was clear today that Louise 's communication with families have improved + Louise is more confident in this area. Louise practised how to use ICE – chasing blood results + was able to do this no help. Louise also was more independent with documentation, and was able to provide emotional support to a labourer during break relief. Louise used E3 and gathered a good + through history of a high risk + complex lady.'

The panel recognised the positive comments contained in the handwritten note, particularly in relation to Ms Leeson's communication with families and her willingness to become involved. However, these matters did not address the specific concern regarding the quality of her handover.

The panel considered Ms Earl's evidence that the handover was disjointed and unclear and that Ms Leeson did not use the SBAR structure effectively. This was directly supported by the contemporaneous Feedback Log.

In relation to 18 June 2024, the panel considered Ms Earl's witness statement:

> *'Ms Gass also missed providing information during the handover of care to the next midwife, however, I cannot recall the specific information that was missed. I remember needing to prompt her regarding the missed information and I had to go back and fill in the gaps of the things that she had not said. Ms Gass was aware of the importance of providing all the information during a handover, and was aware this is vital for patient safety, however she continued to miss important information. Ms Gass would have been aware of this as she knows that incorrect or lack of information will alter the plan and care needs of this patient.'*

The panel also considered the contemporaneous typed Feedback Log, which states:

> *'Missed information during handover of care.'*

The handwritten Feedback Log did not contain the same level of detail and the panel therefore relied on the contemporaneous typed record.

The panel considered that the evidence relating to both dates demonstrated similar concerns. Ms Leeson's handover was not systematic on 24 May 2024 and relevant information was omitted on 18 June 2024, requiring Ms Earl to intervene and complete the handover.

The panel was therefore satisfied that Ms Leeson failed to deliver an adequate handover of care on both dates.

Accordingly, Charge 8(a) is found proved.

Charge 8(b)

"On or around 25 June 2024:

i. did not know which blood tests to arrange for a patient who had prolonged rupture of the membrane (PROM);

ii. failed to cannulate a patient correctly in that you failed to pull the needle back for a second flush back."

This charge is found proved.

In relation to the blood tests required for a patient with PROM, the panel considered Ms Earl's witness statement:

'Ms Gass was unaware of what bloods to take for patients who had a prolonged rupture of the membrane ("PROM"). This meant the patient's waters had been broken for more than 24 hours. When this is the case, the risk of infection to mother and baby is higher, so we often take a blood test called the C-Reactive Protein ("CRP") test which checks for infection levels and infection markers. When I was discussing the blood test to Ms Gass, she did not know which blood test was needed to be taken and did not know what CRP was. This is something that would have been taught to Ms Gass throughout her training and placements as this is something that is very common to do and we end up taking bloods a lot on the Delivery Suite. Ms Gass wrote it down in her note pad and said that she would remember to do it, but when it was required later on the safe shift, Ms Gass forgot what we needed to test for and what it meant and did not look at the notes she had earlier made. If there are concerns, sometimes we need to take this blood test more than once and for different reasons such as PROM (as stated above), or if the patient has a temperature or showing signs of infection.'

The panel also considered the contemporaneous Feedback Log:

'Unaware of what bloods to take for ladies who are PROM (CRP), made aware of this.'

The panel further considered Ms Earl's contemporaneous handwritten note:

> *'Louise was unaware of what bloods to check for when taking bloods for Prom (CRP) however, is ware of this now.'*

The panel considered that Ms Earl's witness evidence was directly supported by both contemporaneous records. It was satisfied that Ms Leeson did not know that a CRP test was required in the circumstances and did not understand what CRP was.

In relation to cannulation, the panel considered Ms Earl's witness statement:

> *'I had to remind Ms Gass the correct Inferior Vena Cava ("IVC") technique when inserting a cannula. When inserting a cannula, you get a flush back of blood, and pull the needle back for a second flush back before pushing in the cannula tube/removing the needle at the same time and securing it in place. The second flush back is done to ensure that the needle is definitely in the right place. When completing the second flash back there will be blood that comes up into the tube to confirm that the needle is in the vein. To insert the cannula, you push the tube in and take the needle out so the rest of the needle is not being pushed into the patient. This is taught on the IVC and venepuncture study day which all newly qualified midwives attend at the very beginning of qualifying. I am unable to confirm whether Ms Gass attended this training. IVC technique is practiced on a fake arm at the study day. It is then required for the newly qualified midwives to have inserted at least five cannulations appropriately and correctly on real patients following this study day. I am aware that Ms Gass completed some cannulations on real patients, however I am not aware of how many. I cannot recall how many were signed off in her pack. I do recall Ms Gass stating that she had forgotten to get them all signed so I do not believe they were all in her book. However, this is a skill that Ms Gass had stated she felt comfortable and confident in. [sic]'*

The panel considered it helpful to take account of Ms Earl's explanation of the correct cannulation technique. However, it did not place reliance on the additional material

concerning the study day or whether Ms Leeson had subsequently been signed off, as Ms Earl was unable to confirm those matters.

The panel then considered the following section of Ms Earl's written statement:

> *'However in this instance, when I was watching Ms Gass insert the cannula, she got the first flush back but did not try to get the second flush back before inserting the cannula. Ms Gass failed to remove the needle from the plastic tube and therefore ended up inserting the rest of the needle into the patient which caused them extreme discomfort and distress. The patient's hand became very swollen, or what we call 'tissued', as a result. Ms Gass became very flustered and did not know what to do and I had to step in and take over. The patient was crying and screaming "ow", was not able to sit still and was very distressed. I had to take over because Ms Gass stood up and moved away without actioning or rectifying it. I removed the IVC and torniquet and applied pressure to the tissued area.'*

The panel further considered the contemporaneous Feedback Log:

> *'Required reminding of correct IVC technique as did not wait for the second pushback before inserting the cannula. As a result the vein tissued.'*

The panel also considered the contemporaneous handwritten note:

> *'Louise needs more help with cannulation, as attempted IVC on our patient today but forgot about getting second flash back + proceeded to insert full cannula into vein after first flash back which resulted in discomfort for patient + vein to tissue. Louise is aware tissuing can't be helped sometimes but is aware of importance of making sure to have both flash backs + then to advance.'*

The panel considered Ms Earl's evidence to be detailed and supported by both the contemporaneous typed and handwritten records. The records specifically confirmed that Ms Leeson did not obtain the second flashback before proceeding with the cannulation and that the vein subsequently tissued.

The panel was therefore satisfied that Ms Leeson did not know which blood tests were required for a patient with PROM and that she failed to cannulate the patient correctly in the manner alleged.

Accordingly, Charge 8(b) is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Ms Leeson's 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 suitability to remain on the register unrestricted

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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Ms Leeson's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

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

The NMC identified the specific, relevant standards where they alleged Ms Leeson's actions amounted to a lack of competence. They invited the panel to assess Ms Leeson's competency using a three stage process:

- Is there evidence that Ms Leeson was made aware of the issues around their competence?
- Is there evidence that they were given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Ms Leeson's competence at the time was below the standard expected of a registered midwife.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Leeson's fitness to practise impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'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

2.1 work in partnership with people to make sure you deliver care effectively

6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time 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
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance.'

The panel bore in mind, when reaching its decision, that Ms Leeson should be judged by the standards of the reasonable average Band 5 registered midwife and not by any higher or more demanding standard.

The panel first considered whether the facts found proved amounted to a lack of competence. The panel was satisfied that Ms Leeson had been assessed on a fair sample of her professional work. The concerns arose over several months and covered a wide

range of important areas of midwifery practice, including medicines management, fetal monitoring, record keeping, prioritising care, infection control, handover and escalation.

The panel took into account that Ms Leeson was a newly qualified midwife and that she had been working under supervision. However, she had received a significant level of support over a prolonged period and, despite this, similar concerns continued to arise. The panel noted that there were some signs of improvements from the Feedback Logs, but these were inconsistent and not sustained.

The panel noted that there was reference to aspects of Ms Leeson's health and family life which may have had an impact on her practice. No evidence has been submitted to assist the panel in relation to this, so the panel could give it no weight.

The panel considered some of the proved charges to be particularly serious, including the failure to recognise and escalate a post-partum haemorrhage and the failure to appropriately escalate concerns about a low fetal heart rate. These failures had the potential to place mothers and their babies at risk of serious harm.

The panel also took into account an email from Ms Leeson dated 27 February 2024, which showed that she had a positive relationship with colleagues and those who supported her and appreciated the support being provided:

> *'Hi Joely*
> *I just wanted to send a quick email to let you know how grateful I am that you were there yesterday. I really appreciate all the help and support. I also wanted to apologise for my emotional outburst, […] I'm sure I would have felt very positive about how I am learning every day. Thank-you! […]*
> *best wishes*
> *Louise'*

The panel considered that the concerns did not arise because support was unavailable or because Ms Leeson had a poor relationship with those supervising her. Rather, despite that support, the evidence showed repeated and wide-ranging deficiencies in her knowledge and clinical skills.

The panel considered that the pattern of concerns, the number of charges found proved and the potential risk to patients demonstrated more than isolated mistakes or errors. It was satisfied that Ms Leeson was not practising at the standard required of a registered midwife during the relevant period.

The panel did not consider the concerns to amount to misconduct. It considered that they arose from deficiencies in Ms Leeson's professional knowledge and skills.

Taking into account its reasons in its findings of the facts, the panel has concluded that Ms Leeson's practice was below the standard that one would expect of the average registered midwife acting in Ms Leeson's role.

In all the circumstances, the panel determined that Ms Leeson's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Ms Leeson's fitness to practise is currently impaired.

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

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

> *'In determining whether a practitioner's fitness to practise is impaired… 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/their fitness to practise is impaired in the sense that S/He/They:

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 determined that the first three limbs were engaged. It did not consider the fourth limb to be engaged, as there was no finding of dishonesty.

The panel was satisfied that Ms Leeson's lack of competence had placed patients at an unwarranted risk of harm. It considered that some of the most serious examples were her failure to recognise and escalate a post-partum haemorrhage and her failure to appropriately recognise and escalate concerns about a low fetal heart rate. The panel noted that, on a number of occasions, actual harm may only have been avoided because Ms Leeson was working under close supervision and another midwife was able to intervene.

The panel also considered the wider pattern of concerns. These included failures in record keeping, medicines management, infection control, handover, prioritising care and fetal monitoring. Some of these concerns, when considered alone, may have appeared less serious. However, the panel considered them collectively and noted that they covered a wide range of basic and important areas of midwifery practice. The patients concerned were also particularly vulnerable, including women in labour and unborn or newborn babies.

The panel considered that these failings had brought, and were capable of bringing, the midwifery profession into disrepute. It considered that a well-informed member of the public would be concerned to learn that a registered midwife had demonstrated such wide-ranging competency concerns, particularly after receiving a significant and robust level of support throughout the whole period.

The panel was also satisfied that Ms Leeson had breached fundamental tenets of the midwifery profession. In particular, her practice had failed to meet the requirements to practise effectively, preserve safety and promote professionalism and trust. The panel considered that these concerns related to fundamental aspects of midwifery care rather than highly specialised or unusual skills.

The panel next considered Ms Leeson's insight and whether she had taken steps to strengthen her practice. It had received no information from Ms Leeson or her representative and had no evidence demonstrating any insight, relevant training, continuing professional development or other steps taken to address the concerns. The panel noted that there had been some limited improvement recorded in the Feedback Logs during the period of supervision. However, the improvements had had not been consistent and the concerns remained wide-ranging.

The panel considered that the concerns were, in principle, capable of remediation because they related mainly to knowledge, understanding and clinical skills rather than a deep-seated attitudinal issue. However, Ms Leeson had already received a significant amount of support over a prolonged period of time and the concerns had continued. Further, the panel had received no current evidence to show that the deficiencies had since been addressed. It therefore considered that there remained a significant risk of repetition.

The panel therefore determined that a finding of current impairment was necessary on the grounds of public protection.

The panel also considered the wider public interest. It 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, to maintain public confidence in the nursing and midwifery professions and to uphold proper professional standards.

The panel considered that a member of the public, knowing the full circumstances of the case, would be concerned if Ms Leeson were permitted to practise unrestricted without evidence that the serious and wide-ranging deficiencies in her practice had been addressed, and to not find current impairment would undermine the public trust in the midwifery profession and the NMC as the regulator. In the panel's view, a finding of impairment was therefore also required to maintain public confidence in the profession and to uphold proper professional standards.

Having regard to all of the above, the panel was satisfied that Ms Leeson's 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 12 months. The effect of this order is that the NMC register will show that Ms Leeson's registration has been suspended.

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

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in their Statement of Case, the NMC had advised Ms Leeson that it would seek the imposition of a conditions of practice order for a period of two years if it found Ms Leeson's fitness to practise currently impaired.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The large number of concerns and the wide ranging nature of those concerns;
- The pattern of concerns over a prolonged period of time;
- The repetition of similar concerns within relatively short periods of time which continued despite Ms Leeson receiving significant and robust support from the Trust over a prolonged period;
- The vulnerability of the patients for whom Ms Leeson was caring, including women in labour and newborn babies;
- The risk of serious harm arising from some of the concerns;
- The absence of Ms Leeson's insight into the concerns identified;
- There was no evidence of reflection, further training, continuing professional development or other steps taken by Ms Leeson to strengthen her practice; and
- Ms Leeson had not attended the hearing, completed the case management form or otherwise meaningfully engaged with the regulatory process.

The panel also took into account the following mitigating features:

- Ms Leeson appeared to have had good relationships with her patients and there was evidence regarding her positive communication with them;

- While working under supervision, Ms Leeson demonstrated a willingness to learn and improve her practice; and
- There was some information about personal and family difficulties during the relevant period, although the information available to the panel was limited.

The panel had regard to its previous findings on impairment in coming to this decision. It bore in mind that its primary purpose was to protect the public and maintain public confidence in the midwifery profession and the NMC as its regulators. The panel had found significant public protection concerns arising from Ms Leeson's lack of competence. These included failures relating to fetal monitoring, escalation of a post-partum haemorrhage, medicines management, record keeping, infection control, handover and prioritising patient care.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness and wide-ranging nature of the concerns. Taking no action would not protect the public from the risk of repetition and would not maintain public confidence in the midwifery profession.

The panel therefore decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case and the public protection issues identified, an order that does not restrict Ms Leeson's 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 this case was not at the lower end of the spectrum. The concerns were numerous, repeated and covered several important areas of midwifery practice. Some of the failures had the potential to result in serious harm. The panel therefore considered that a caution order would not provide sufficient public protection. 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 Ms Leeson's registration would be a sufficient and appropriate response.

The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel did not identify any deep-seated personality or attitudinal concerns. It also considered that there were areas of Ms Leeson's practice which could, in principle, be addressed through further training and assessment.

However, the panel was concerned about the number and range of those areas. They included CTG monitoring, obstetric emergencies, medicines management, record keeping, infection control, handover and other important aspects of midwifery practice. The panel considered that these were not narrow or isolated concerns but covered a wide range of important areas of practice.

The panel also took into account that the Trust had already provided Ms Leeson with a significant amount of support and supervision over a prolonged period. Despite this, the concerns continued and similar errors were repeated.

The panel acknowledged that, while Ms Leeson was being supervised, there was evidence that she was willing to learn and at times responded positively to support. However, the panel had received no current information to demonstrate that this remained the case. There was also no evidence before the panel of current insight, reflection, retraining or other steps taken to address the concerns.

The panel also noted that neither Ms Leeson nor her representative had meaningfully engaged with the NMC during these proceedings.

In a letter from the NMC dated 22 June 2026 to Ms Leeson, the decision of the referring panel was quoted which stated:

> *'The panel considered that Ms Leeson has not engaged with the NMC and does not appear to dispute the charges. Further, the panel noted that Ms Leeson has set out her current intention not to return to work as a midwife in the near future.'*

The panel considered this is relevant when assessing whether Ms Leeson was likely to engage with and comply with a conditions of practice order.

The panel considered whether conditions could be put in place which would protect patients. It considered that conditions would have to be extensive and would, in effect, require Ms Leeson to return to a level of very close supervision similar to that which had already been provided by the Trust.

Given the wide ranging concerns, the amount of support already provided, Ms Leeson's lack of current engagement and the absence of evidence of current insight or strengthened practice, the panel was not satisfied that practical and workable conditions could be formulated which would adequately address the risks identified.

The panel therefore concluded that a conditions of practice order would not be sufficient or appropriate.

The panel then went on to considered whether a suspension order would be an appropriate sanction.

The SG state key things to weigh up before imposing this order include (but not limited to):

- *Whether the risk posed to the public, or to people receiving care, can only be managed by temporary removal from the Register?*
- *Will suspension be sufficient to protect people using services, public confidence in the profession, or professional standards?*
- *Is it realistic that the professional could return to unrestricted practice in the future, even if it is not appropriate for them to do so now?*
- *What would the registrant need to do in order to be fit to practise in the future? Is it realistic that they will be able to do this?*

The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *The charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *While it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *There is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *What went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *Despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.*

The panel considered the third bullet point above to be particularly relevant in this case. It had already found that there remained a risk to patient safety and that conditions of practice would not be workable or sufficient to address that risk.

The panel also considered that Ms Leeson's difficulties related to her knowledge, understanding and clinical skills. The panel therefore considered that the concerns were, in principle, capable of remediation.

Importantly, the panel had no evidence that the concerns had yet been remedied. There was no evidence of current insight, further training or continuing professional development. Ms Leeson had also not engaged with her regulator to demonstrate a willingness to address the concerns at the present time. The panel therefore concluded that at present there was no realistic possibility of Ms Leeson returning to unrestricted practice.

The panel was satisfied that a suspension order was necessary to protect the public and to maintain public confidence in the midwifery profession. It considered that suspension was the only appropriate sanction which would adequately address the risks identified.

As this is a lack of competence case, the panel noted that a striking-off order was not available to it at this stage. The panel concluded that a suspension order was the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Ms Leeson. However, this is outweighed by the need to protect the public and the wider public interest in this case.

The panel considered that this order is necessary to mark the seriousness of the concerns, maintain public confidence in the profession, and uphold proper professional standards.

The panel determined that a suspension order for a period of 12 months was appropriate and proportionate. In determining on this period, the panel took into account the seriousness and wide-ranging nature of the facts found proved, the risk to particularly vulnerable patients, the repeated concerns despite significant support and the absence of current evidence of insight or strengthened practice.

The panel considered that 12 months would provide Ms Leeson with sufficient time to reflect on the concerns, developed insight and, should she wish to return to midwifery practice, take meaningful steps to address the deficiencies identified. The panel considered that a shorter period would not be appropriate given the number and seriousness of the concerns and the work that would be required before Ms Leeson could safely return to unrestricted practice.

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:

- A reflective piece which properly addresses the lack of competence identified by this panel in its determination;
- Evidence of any training which Ms Leeson may have undertaken which addresses the lack of competence identified by this panel. In particular, evidence of relevant training or continuing professional development in the areas identified in this determination, including fetal monitoring, obstetric emergencies, medicines management, record keeping and infection control;
- Ms Leeson's engagement with the NMC, including her attendance at the next review of this order; and
- Testimonials from any caring role, paid or unpaid, which Ms Leeson may have undertaken during her period of suspension.

This decision will be confirmed to Ms Leeson in writing.

Interim order

As the substantive 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 is in Ms Leeson's own interests until the substantive suspension order takes effect.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be a suspension order, as to do otherwise would be incompatible with its earlier findings. The interim suspension order will be for a period of 18 months to cover the appeal period and any appeal.

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

That concludes this determination.