Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 2 February 2026 – Thursday, 12 February 2026
Friday, 22 May 2026
Tuesday, 14 July 2026 – Thursday, 16 July 2026

Virtual Hearing

Name of Registrant:	**Tracy Anne Penny**
NMC PIN	19I2270E
Part(s) of the register:	Registered Midwife RM – 12 October 2019
Relevant Location:	Wigan
Type of case:	Lack of competence/Misconduct
Panel members:	Oluwasola Falola (Chair, Registrant member) Robin John Barber (Lay member) Helen Susannah Radice (Registrant member)
Legal Assessor:	Charlotte Mitchell-Dunn (2 February 2026 – 12 February 2026, 22 May 2026) Ian Ashford-Thom (14 July 2026 – 16 July 2026)
Hearings Coordinator:	Sabrina Khan
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mrs Penny:	Not present and not represented
Facts proved:	Charges 1a)i), 1aii), 1b)ii), 1c), 1d)i), 1d)ii), 1d)iii),1h), 1i), 1j)i), 1j)ii), 1j)iii), 1j)iv), 1j)v), 1k), 1l)i), 1l)ii) 1m)i), 1m)ii), 1miii), 1n)i), 1n)ii), 1n)iii), 1n)iv), 1n)v), 1n)vi), 1n)vii), 1o)i), 1o)ii),1o)iii), 1o)iv), 2a)i), 2aii), 2b)i), 2b)ii), 2b)iii), 2b)iv), 3, 4a), and 4b)
Facts not proved:	Charges 1b)i), 1b)iii), 1e)i), 1e)ii), 1f), 1g)i) and 1g)ii)
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Mr Kabasinskas, on behalf of the Nursing and Midwifery Council ('NMC'), made a request that this case be held partially in private on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined it would go into private session in [PRIVATE] as and when such issues are raised in order to protect her privacy and confidentiality.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Penny was not in attendance and that the Notice of Hearing letter had been sent to Mrs Penny's registered email address by secure email on 30 December 2025.

Mr Kabasinskas submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Penny's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Penny has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Penny

The panel next considered whether it should proceed in the absence of Mrs Penny. It had regard to Rule 21 and heard the submissions of Mr Kabasinskas who invited the panel to continue in the absence of Mrs Penny. He submitted that Mrs Penny had voluntarily absented herself.

Mr Kabasinskas referred the panel to the telephone conversation between the NMC Case Coordinator and Mrs Penny on 27 January 2026, where Mrs Penny acknowledged her agreed removal form and confirmed that the hearing can proceed in her absence if her application is refused. He submitted that the Mrs Penny's application for agreed removal has now been refused.

Mr Kabasinskas also referred the panel to the email from Mrs Penny which stated:

> '[PRIVATE].'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones (Anthony William)* [2006] UKHL 16.

The panel has decided to proceed in the absence of Mrs Penny. In reaching this decision, the panel has considered the submissions of Mr Kabasinskas, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Penny;
- Mrs Penny has informed the NMC that she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Six witnesses have agreed to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021 and 2023;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is disadvantage to Mrs Penny in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated to some extent. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the disadvantage is the consequence of Mrs Penny's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Penny. The panel will draw no adverse inference from Mrs Penny's absence in its findings of fact.

Details of charge

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:
    a) On 19 April 2021, you:
        i. prepared an incorrect dose of medication;
        ii. Prepared an injection for a baby with an incorrect size needle;
    b) Between 17 and 18 May 2021, you:
        i. did not escalate a deteriorating cardiotocography;
        ii. failed to follow “fresh eyes” protocol for hourly observations;
        iii. failed to document that a patient was on regular medication;
    c) On 9 August 2021, you administered medication to a patient without carrying out relevant medical safety checks;
    d) On 14 August 2021, you:
        i. did not interpret a deteriorating cardiotocography correctly;
        ii. did not escalate a deteriorating cardiotocography;
        iii. Altered observation stickers;
    e) On 20 August 2021, you:
        i. Did not escalate concerns following your difficulty in obtaining a heart rate;
        ii. In respect of the matter as charge 6) a) failed to complete relevant documentation;
    f) On 8 September 2021, you failed to escalate a patient’s raised blood pressure;
    g) On 16 September 2021, whilst under a supported practice plan, you:
        i. broke the waters of a high-risk patient with no instruction and under no supervision;
        ii. inappropriately increased a patient’s medication with no instruction and under no supervision;
    h) On 24 September 2021, while under a supported practice plan, you administered inappropriate medication to a patient;
    i) On 9 October 2021, you failed to escalate a patient who had started contracting regularly as instructed;
    j) On the 16 May 2023, you:

i. failed to recognise a suspicious cardiotocography;
ii. delayed escalating a suspicious cardiotocography;
iii. failed to recognise that a patient's regular blood pressured medication was due;
iv. increased the medication, syntocinon, 10 minutes early;
v. failed to follow "fresh eyes" protocol for hourly observations;

k) On 17 May 2023, in respect of Patient B, you failed to ensure hourly cardiotocography interpretations were carried out;

l) On 27 June 2023, in respect of Patient C, you:
i. used incorrect cardiotocography stickers;
ii. failed to ensure hourly cardiotocography interpretations were carried out;

m) On 30 June 2023, in respect of Patient D, you:
i. failed to carry out adequate observations;
ii. failed to accurately interpret their observations;
iii. failed to make accurate records in respect;

n) On 3 July 2023, in respect of Patient E, you:
i. broke the sterile field by handling equipment and examining them without first changing gloves;
ii. failed to accurately interpret their observations;
iii. failed to act on cardiotocography decelerations;
iv. failed to recognise that an episiotomy was required;
v. failed to identify and react when their baby was born floppy with no respiratory effort;
vi. failed to triple clamp the umbilical cord of their baby;
vii. failed to adequately record the events that occurred in respect of their labour;

o) On 5 July 2023, in respect of Patient F, you:
i. failed to adequately assess their risk;
ii. failed to escalate in respect of severely high blood pressure;
iii. failed to escalate in respect of an inability to pass urine;
iv. failed to keep a sufficient record of their observations;

2. Between 26 and 27 June 2022:

a) In respect of Patient A, you failed to:

i. complete adequate checks;
ii. to have and/or document a safe sleeping conversation.

b) In respect of Patient AA, you failed to:

i. complete a risk assessment;
ii. keep clear feeding records;
iii. complete a feeding chart;
iv. undertake blood glucose monitoring.

3. In respect of 2) b) iv) above, you completed blood glucose observation documentation
4. Your actions at charge 3 were dishonest in that:
    a) You knew the record you had created was inaccurate;
    b) You intended to mislead others that you had undertaken blood glucose monitoring

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in to charge 1 and, by reason of your misconduct in relation to charges 2-4.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas to amend the wording of charge 1e)ii).

The proposed amendment was to amend and correct the typographical error and 6a should be replaced with 1e)i). It was submitted by Mr Kabasinskas that the proposed amendment would correct the technical error and will not change the charge or case in any way.

"That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

e) On 20 August 2021, you:

i) …

*ii) In respect of the matter as charge ~~6)a)~~ **1e)i)** failed to complete relevant documentation;*

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in to charge 1 and, by reason of your misconduct in relation to charges 2-4."

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Penny and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Kabasinskas under Rule 31 to allow the written statement of Ms Dereszkiewicz into evidence. Ms Dereszkiewicz was not present at this hearing and, whilst the NMC had made efforts to secure her attendance, Ms Dereszkiewicz is unwell and has indicated that she is not able to participate in the hearing due to [PRIVATE].

Mr Kabasinskas submitted that the panel is entitled to admit hearsay evidence where it is relevant and where admission would be fair, and that both requirements are satisfied in this case.

By way of relevance, Mr Kabasinskas submitted that although Ms Dereszkiewicz is not a direct eyewitness to the clinical events underpinning the charges, her evidence nevertheless concerns matters that are in issue. He submitted that her statement addresses the investigation undertaken following the shift of 26–27 June 2022, the

meetings held as part of that investigation, the matters discussed during those meetings, and the explanations provided by Mrs Penny. He submitted that Ms Dereszkiewicz's evidence therefore provides context and contemporaneous documentation relating to the investigatory process and to what was said by Mrs Penny at the time. He submitted that it is relevant to charges 2, 3 and 4, particularly in respect of record keeping and the dishonesty allegation.

Turning to the legal framework, Mr Kabasinskas reminded the panel that admissibility is governed by Rule 31 and by the principles set out in the authority of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He submitted that hearsay should not be admitted as a matter of routine and that fairness remains the central consideration. He therefore addressed each of the relevant principles in turn.

First, Mr Kabasinskas submitted that the proposed hearsay evidence is neither sole nor decisive. He submitted that the panel would hear direct evidence from other witnesses who can speak to the clinical events themselves, including Patient AA's mother and nursing colleagues such as Ms Jones and Ms Stanford. He submitted that those witnesses would provide primary evidence about the care delivered and the incidence that occurred on the shift. He submitted that Ms Dereszkiewicz's evidence is limited to the investigation and what was said during meetings. He submitted that Ms Dereszkiewicz's evidence is therefore supplementary in nature and cannot properly be described as sole and decisive of the charges. He submitted that the absence of the opportunity to cross-examine Ms Dereszkiewicz could have been mitigated by Mrs Penny's ability to challenge other witnesses about the allegations that Ms Dereszkiewicz speaks to, had Mrs Penny attended the hearing.

Secondly, Mr Kabasinskas submitted that Mrs Penny's position, as reflected in the documentation before the panel, is not that the investigation meetings failed to take place or that the records have been fabricated. Instead, he argued, her challenge relates to the conclusions drawn from those meetings and her explanations for the clinical matters. He noted that the fact that the meetings occurred, and that certain matters were discussed, is not substantially in dispute. Mr Kabasinskas further submitted that the panel's task, particularly when considering dishonesty, is to assess Mrs Penny's state of mind and conduct, which is a matter for the panel's independent

assessment. In those circumstances, he submitted, that the inability to test the witness evidence orally does not result in significant prejudice.

Thirdly, Mr Kabasinskas submitted that there is no suggestion of Ms Dereszkiewicz's evidence being fabricated or unreliable. He submitted that the material consists of contemporaneous minutes, emails and investigation documents created in the ordinary course of professional duties. He submitted that such records carry inherent reliability. Moreover, he submitted that their contents broadly correspond with Mrs Penny's own account in places. He submitted that there is therefore no evidential basis to doubt their authenticity.

Fourthly, Mr Kabasinskas acknowledged the seriousness of the charges, particularly the allegation of dishonesty, which could have significant consequences for Mrs Penny's career. However, he submitted that seriousness does not of itself justify exclusion. Rather, he submitted, it requires careful balancing. Given that this evidence is documentary, corroborative and not decisive, he submitted that its admission remains fair and proportionate even in the context of serious allegations.

Fifthly, Mr Kabasinskas submitted that there is a good and cogent reason for the witness's non-attendance. The hearsay bundle demonstrates that Ms Dereszkiewicz previously engaged with the NMC and had indicated availability. He submitted that she subsequently informed the NMC that she is due to undergo major surgery, will be an inpatient and will be unavailable for a significant period of approximately fifteen weeks. He submitted that this is plainly a genuine medical reason beyond her control and constitutes a compelling explanation for her absence.

Sixthly, Mr Kabasinskas submitted that the NMC has taken all reasonable steps to secure attendance. He submitted that the NMC remained in contact with the witness and explored availability up to a late stage. He submitted that although a witness summons could theoretically be considered, it would be neither proportionate nor consistent with fairness to compel attendance [PRIVATE]. He therefore submitted that reasonable efforts have been exhausted.

Finally, Mr Kabasinskas submitted that while formal notice of reliance on hearsay was necessarily given at a relatively late stage due to the evolving medical situation, earlier notice would not realistically have changed matters. He submitted that Mrs Penny has had access to the documents themselves for some time and is aware of their contents. He submitted that there is therefore no meaningful procedural disadvantage.

Drawing the matters together, Mr Kabasinskas submitted that the evidence is relevant, reliable, documentary in nature, supported by other live witnesses, not sole or decisive, and that there is a clear and legitimate medical reason for the witness's absence despite reasonable steps having been taken. He submitted that any residual concerns can properly be addressed by the weight the panel chooses to attach to the evidence rather than by exclusion.

Accordingly, Mr Kabasinskas submitted that admission of the witness statement and exhibits would be fair and in the interests of justice, and he respectfully invited the panel to grant the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor referred the panel to the following cases, *NMC v Ogbonna* [2010] EWCA Civ 1216, *R (Bonhoffer) v GMC* [2012] IRLR 37, *Thorneycroft*, *El Karout v Nursing and Midwifery Council* [2019] EWHA 28 (Admin), and *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin).

The panel considered the application by the NMC to admit, as hearsay, the witness statement of Ms Dereszkiewicz together with the appended exhibits. The panel noted that the statement concerns Ms Dereszkiewicz's involvement in the investigation conducted on behalf of the Trust, including accounts of investigatory meetings and the documentation generated as part of that process.

The panel referred to Rule 31 and reminded itself that the central question is whether the proposed evidence is relevant and whether it is fair to admit it. The panel also took

into account the guidance in *Thorneycroft*, recognising that the admission of hearsay should not be treated as routine, and that a structured assessment of fairness is required, including consideration of the extent to which the statement may be sole or decisive, the nature and extent of any challenge, whether there is any reason to suspect fabrication, the seriousness of the allegation, the reason for the witness's non-attendance, the steps taken to secure attendance, and whether there has been adequate notice.

The panel first considered relevance. The panel concluded that the statement is relevant because it sets out the course of the Trust investigation, records what was said during investigatory meetings, and exhibits contemporaneous documentation. The panel was satisfied that the statement potentially bears upon factual issues arising in the case, including the circumstances surrounding the investigatory process and aspects of the documentary record.

The panel then considered whether the statement would be the sole or decisive evidence in relation to the charges. The panel concluded that it would not. The panel noted that other witnesses are to give live evidence, including witnesses with direct involvement in the events, and that the panel will be able to assess the factual particulars that Ms Dereszkiewicz provides evidence on, by considering the oral testimony and evidence of other witnesses.

The panel considered the nature and extent of any challenge that Mrs Penny might make to the contents of Ms Dereszkiewicz's statement. The panel noted that, Mrs Penny was not in attendance and had not provided representations and as such the nature and extent of her challenge to Ms Dereszkiewicz's evidence was unclear. The panel considered that whilst Mrs Penny, if she were in attendance at this hearing, may challenge Ms Dereszkiewicz's statement, there may be elements of Ms Dereszkiewicz's statement which she accepts.

The panel then considered whether there is any suggestion that Ms Dereszkiewicz had a reason to fabricate her account. The panel concluded that there is no such suggestion. The panel noted that Ms Dereszkiewicz's role was that of an investigator and that the statement is framed in a factual and objective manner, with reference to

documentary materials. The panel also noted that the statement appears broadly consistent with the sequence of events recorded elsewhere in the evidence. The panel found no basis on the evidence before it to conclude that there was any suggestion that Ms Dereszkiewicz had reasons to fabricate her evidence.

The panel took into account the seriousness of the allegations, in particular the dishonesty allegation, and recognised that an adverse finding could have significant consequences for Mrs Penny's professional career. The panel reminded itself that seriousness is an important factor within the fairness assessment but is not determinative of admissibility. The panel considered that the seriousness of the matter reinforces the need for careful scrutiny and appropriate weight, rather than requiring exclusion where the evidence is relevant and where other safeguards exist, including the availability of other live evidence. Further, the panel noted that its assessment of dishonesty would be based upon all of the evidence and surrounding circumstances as opposed to the sole evidence of Ms Dereszkiewicz.

The panel then considered whether there is a good reason for the witness's non-attendance. The panel noted that the NMC's information is that the witness is unwell, is due to undergo major surgery, and expects to be unavailable for a significant period following that surgery. The panel recognised that there is no independent medical evidence before it. However, the panel considered that it has no evidential basis to conclude that the witness is being untruthful [PRIVATE], and the communications with the NMC are consistent with an inability to attend. The panel therefore concluded that there is a good reason for non-attendance.

The panel considered the steps taken to secure the witness's attendance. The panel noted the documentary record of repeated email communications and a telephone call shortly before the hearing date, together with reminders to the witness of the obligation to cooperate. The panel was satisfied that the NMC took reasonable steps to secure attendance and pursued the matter up to a late stage. The panel also considered whether a summons should be sought to compel Ms Dereszkiewicz's attendance. The panel concluded that it was not necessary or proportionate in the circumstances, given Ms Dereszkiewicz's [PRIVATE].

The panel then considered whether Mrs Penny had prior notice that the statement might be admitted as hearsay. The panel accepted that Mrs Penny did not have prior notice due to the evolving nature of Ms Dereszkiewicz's [PRIVATE]. Considering the circumstances, the panel concluded that the absence of prior notice does not render admission of the hearsay evidence unfair.

Having regard to all of these factors, the panel concluded that it is fair to admit Ms Dereszkiewicz's witness statement and the appended exhibits as hearsay evidence.

The panel reminded itself that admissibility is separate from weight. The panel will bear firmly in mind that the statement has not been tested through cross-examination. The panel will therefore approach the hearsay material with appropriate caution when evaluating it alongside the live evidence and the documentary record. The panel makes no final determination on weight at this stage and will assess the evidence in the round when reaching its findings of fact.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms Dereszkiewicz but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reason of the panel to admit documents into evidence

Mr Kabasinskas submitted that he made an application to admit two documents into evidence. He submitted that the first document comprised images of certain machines. He reminded the panel that this document had been requested directly by the panel following references made to it by the witness during her oral evidence. He submitted that, as the document arose directly from the witness's evidence and pursuant to a panel direction, it was plainly relevant to the matters under consideration.

Mr Kabasinskas submitted that the panel was already familiar with the applicable test for admissibility, namely that evidence may be admitted provided it is relevant and fair. In relation to fairness, he acknowledged that the document had been submitted whilst Mrs Penny was not in attendance and that it had not been sent to Mrs Penny by the

NMC. He submitted that the panel might consider whether this gave rise to any potential unfairness.

However, Mr Kabasinskas submitted that, whilst the panel was not invited to draw any adverse inference from Mrs Penny's non-attendance, there were nevertheless consequences flowing from that non-attendance. He submitted that, had Mrs Penny been present, any issues arising from the document could have been addressed at that stage. He respectfully submitted that Mrs Penny's non-attendance should not operate as a procedural advantage or as a barrier to the admission of relevant evidence. He submitted that, aside from the issue of non-disclosure to Mrs Penny, there were no other grounds upon which it would be unfair to admit the document.

Turning to the second document, Mr Kabasinskas submitted that this consisted of meeting notes dated 29 June 2022, contained within a three-page document which had been sent to the NMC by the witness herself and had not been expressly requested by the NMC. He drew the panel's attention to exhibit KJ/15. He submitted that the first two pages of the newly provided document were identical to pages already before the panel, but that the document now included an additional page.

Mr Kabasinskas submitted that, whilst this was technically a new document, it could properly be interpreted as a missing page from a document already in the panel's possession. He accepted that the circumstances in which the document arose were not ideal. He submitted that the NMC could not clarify how the missing page came to be identified, as the witness remained under affirmation and could not be asked questions relating to her evidence at that stage. He submitted that the NMC's inference was that the witness may have realised that a page was missing and had sought to provide it, but he accepted that it was a matter entirely for the panel as to what weight, if any, was attached to that explanation.

Mr Kabasinskas submitted that the document was relevant, as it related to matters about which the witness had already given evidence, including issues concerning the machines. In relation to fairness, he again acknowledged that the document had not been disclosed to Mrs Penny. However, he submitted that the additional page largely

contained data, and that the witness had already given oral evidence relating to those figures and machines.

Mr Kabasinskas further submitted that the final discussion point contained within the document broadly reflected information already before the panel, including material contained in the bundle, namely an email correspondence which covered similar subject matter. He submitted that this existing evidence broadly corroborated the information contained in the final paragraph of the additional page.

Mr Kabasinskas submitted that, having regard to all the circumstances, the only potential unfairness arose from the fact that the document had not been disclosed to Mrs Penny, for the reasons he had already addressed. He submitted that there were no further grounds upon which it would be unfair to admit the document. He therefore invited the panel to admit both documents into evidence.

The panel accepted the advice of the legal assessor.

The panel considered an application made on behalf of the NMC to admit two documents into evidence.

In determining the application, the panel reminded itself of Rule 31, namely that the panel must consider whether the evidence is relevant, whether it would be fair to admit it, and whether its admission would cause injustice or undue prejudice. The panel further reminded itself that the threshold for admissibility is distinct from the question of what weight, if any, should ultimately be attached to the evidence.

Applying Rule 31, the panel was satisfied that both documents were relevant to the issues it was required to determine.

The panel noted that the document containing the images of the machines arose directly from matters referred to by the witness during her oral evidence and had been provided following a specific direction made by the panel. The panel was satisfied that the images were capable of assisting it in understanding the witness' evidence and the factual context of the allegations.

In relation to the meeting notes dated 29 June 2022, the panel noted that the document related to the same subject matter addressed in the witness' oral evidence, including issues concerning the machines and associated data. The panel further noted that the additional page appeared to form part of a document already in the panel's possession and could reasonably be viewed as completing or supplementing existing material. The panel therefore concluded that this document was also relevant.

The panel next considered whether admitting the documents would be fair and whether their admission would cause injustice or undue prejudice.

The panel acknowledged that the documents were introduced at a stage when Mrs Penny was not in attendance and that they had not been disclosed to Mrs Penny prior to the application. The panel considered this carefully and noted the NMC's submissions in respect of Mrs Penny's non-attendance. In all the circumstances it considered it would not be unfair to admit the documents.

In relation to the images of the machines, the panel attached weight to the fact that the document had been provided pursuant to a panel direction and was intended to assist the panel's understanding of evidence already given. The panel considered that the nature of the document was explanatory and did not introduce new allegations or issues.

In relation to the meeting notes, the panel accepted that the circumstances in which the additional page was provided were not ideal. However, the panel noted that the content of the page largely comprised data and discussion points which were consistent with, and reflective of, matters already addressed in the witness's evidence. The panel also noted that there was other documentary material before it which broadly covered similar ground.

The panel considered whether the admission of the documents would give rise to unfairness arising from Mrs Penny's non-attendance. The panel reminded itself that non-attendance does not preclude the admission of relevant evidence, and that fairness must be assessed in the round. The panel was satisfied that the admission of

the documents would not deprive Mrs Penny of a fair hearing, particularly as the panel retained the ability to control proceedings going forward and to ensure that any party had an opportunity to comment on the documents and challenge their reliability and weight.

Finally, consistent with the Rule 31, the panel emphasised that its decision related solely to admissibility. The panel made clear that it would determine what weight, if any, to attach to the documents at a later stage, having considered all the evidence as a whole.

For these reasons, the panel concluded that the documents were relevant, that their admission was fair, and that admitting them would not result in injustice or undue prejudice. The application was therefore granted, and both documents were admitted into evidence.

Decision and reason of the panel on witness availability

Mr Kabasinskas submitted that the NMC had been informed that Ms Jones was only available to give evidence on Wednesday morning, 11 February 2026, before 11:30, or alternatively, on any day the following week between 08:00 and 09:00.

Mr Kabasinskas submitted that Ms Jones remained under affirmation and that, in those circumstances, the NMC invited the panel to explore all available options to accommodate her evidence. He submitted that Ms Jones had been particularly helpful in assisting the panel, including returning to give further evidence and providing additional documentation. He submitted that it would be unfair to the witness if her evidence could not be completed within the allotted time, resulting in an adjournment while she remained under affirmation pending the resumption of the hearing.

Mr Kabasinskas submitted that he had consulted with the NMC and had been informed that it would accord with the NMC's values to accommodate the witness where possible. He therefore invited the panel to consider practical options, such as adjusting the start time of the hearing day or otherwise arranging the timetable, so far as it was within the panel's discretion, in order to allow the witness to complete her evidence.

Mr Kabasinskas emphasised that this was a careful and respectful invitation and that the panel was under no obligation to accept the suggestion. He further submitted that, should the witness resume her evidence the following week, the panel might consider asking the witness whether there was any further material she intended to refer to which had not already been adduced or exhibited, so that any further disclosure could be requested at one stage, thereby expediting the proceedings.

The panel accepted the advice of the legal assessor.

The panel considered the submissions made on behalf of the NMC in relation to the availability of Ms Jones. The panel noted that the witness remained under affirmation whilst other witnesses had been interposed in order to give their evidence. Ms Jones demonstrated a willingness to assist the proceedings, including by returning to give further evidence and by providing additional documentation.

The panel accepted the proposal advanced on behalf of the NMC and determined that the hearing would resume on Monday, 9 February 2026, at 08:00 in order to accommodate the witness and allow her to complete her evidence. In reaching this decision, the panel was satisfied that this arrangement was fair to the witness, proportionate, and consistent with the efficient conduct of the proceedings.

The panel further directed that the NMC's Hearings Coordinator liaise in advance of hearing her evidence to establish whether Ms Jones intended to refer to any additional documents not already adduced in evidence. The panel directed that, if so, details of any such documents should be identified and made available prior to the witness giving evidence on Monday at 08:00, in order to assist the panel and to avoid unnecessary delay.

Decision and reason of the panel to admit signed action plan

Mr Kabasinskas submitted that the panel had before it an unsigned version of the document which had been exhibited, and that the signed version was now available for

the panel's consideration. He submitted that the matter was entirely within the panel's discretion on whether to admit the signed version or not.

The panel accepted the advice of the legal assessor.

The panel noted that the signed version of the action plan was the same document that had already been exhibited before it, save for the signatures. The panel considered that the document was relevant as it formed part of the exhibits in this case and it was fair to admit it on the basis that its admission was not prejudicial to Mrs Penny.

Decision and reasons on application for hearing Patient A's evidence to be held wholly in private

Mr Kabasinskas made a request that this case be held wholly in private on the basis that proper exploration of Mrs Penny's case involves [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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

Having heard that there will be reference to [PRIVATE], the panel determined to hold the entirety of these parts of the hearing in private in order to protect Patient A's privacy and confidentiality.

Decision and reason on application for Patient A's special measures

Mr Kabasinskas submitted that the NMC sought special measures to facilitate the attendance and participation of Patient A.

Mr Kabasinskas explained that Patient A was currently overseas [PRIVATE]. As a result, he submitted, Patient A was unable to participate by video link.

Mr Kabasinskas submitted that Patient A had indicated that, subject to [PRIVATE], she would be able to give evidence later that day, at approximately 13:00. However, he submitted, given Patient A's location abroad and lack of internet access, the only feasible means by which she could participate in the hearing was by telephone. He confirmed that all alternative options had been explored and that, regrettably, there were no other practical arrangements available at that time.

Mr Kabasinskas emphasised that whether to permit participation by telephone was a matter entirely for the panel. In inviting the panel to grant the application, he referred to the NMC guidance document, '*Supporting People to Give Evidence in a Hearing*'. He highlighted that the guidance adopts a person-centred approach, emphasises the importance of supporting witnesses, and reflects the NMC's duties under the Equality Act. He noted that the guidance identifies a range of potential supporting measures, including flexibility around the manner in which evidence is given.

Mr Kabasinskas further submitted that timetabling was an important consideration. He submitted that the witness had asked how long her evidence was likely to take, and while it was difficult to give a precise estimate, Mr Kabasinskas had explored whether she might be able to make herself available for approximately one hour. He submitted that the witness had confirmed that, subject [PRIVATE], she would endeavour to do so. Mr Kabasinskas made clear that this was an indicative estimate only and not intended to pre-empt the panel's views. He invited the panel, when considering the application, to take into account the possibility of agreeing a time estimate or timetable, consistent with the guidance, which all parties would seek to adhere to. If additional time were required, the NMC would seek to liaise with the witness to determine whether this could be accommodated.

Mr Kabasinskas submitted that the panel was invited to grant special measures permitting Patient A to give evidence by telephone and to consider agreeing a realistic time estimate for her evidence.

The panel accepted the advice of the legal assessor.

The panel carefully considered the submissions made by Mr Kabasinskas and the NMC guidance, '*Supporting People to Give Evidence in a Hearing*'. The panel also took into account the circumstances outlined during the hearing in relation to the Patient A's availability and welfare.

The panel acknowledged that Patient A was [PRIVATE]. The panel noted that, as a result of these circumstances, the witness did not have access to appropriate facilities or a stable internet connection and was therefore unable to give evidence by video link.

The panel was satisfied that all reasonable alternatives had been explored and that participation by telephone was the only practicable means by which Patient A could give evidence at this stage of the hearing. The panel acknowledged that Patient A had indicated she would be available to give evidence at approximately 13:00, subject to [PRIVATE], and that this timing had been communicated to the panel.

In reaching its decision, the panel had regard to the importance of ensuring that witnesses are able to give their best possible evidence, particularly where that evidence is central to the matters under consideration. The panel considered that the evidence of Patient A was significant to the issues in the case and that it was in the interests of justice to facilitate her participation where possible.

The panel was satisfied that allowing the witness to give evidence by telephone was a necessary and proportionate measure, consistent with the person-centred approach set out in the NMC guidance and with the panel's duty to ensure fairness to all parties. The panel was also satisfied that this measure would not cause unfair prejudice to Mrs Penny and that appropriate safeguards could be maintained during the questioning of the witness.

The panel further considered the issue of timetabling. It noted the indication that Patient A might be available for approximately one hour and agreed that, so far as reasonably possible, the evidence should be managed efficiently and within a clear timeframe, whilst remaining flexible should circumstances require.

For these reasons, the panel granted the application to arrange special measures for Patient A.

Decision and reasons to amend the charge 1m)iii)

During the deliberations of the panel, the panel on its own volition amended charge 1 m)iii) to amend a typographical error. The proposed amendment is as follows:

"That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

m) On 30 June 2023, in respect of Patient D, you:

iii. failed to make accurate records ~~in respect~~;"

The panel accepted the advice of the legal assessor.

The panel was satisfied that there would be no prejudice to Mrs Penny and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

On 2 November 2022, the NMC received a referral from Wigan and Leigh Teaching Hospitals NHS Foundation Trust ('the Trust') about you, a registered midwife at the Trust.

The regulatory concerns were:

1. Failure to undertake patient assessments and observations in that you:

- failed to complete a risk assessment on Patient AA at the point of transfer to the ward
- failed to complete adequate checks on Patient A when feeding
- failed to undertake blood glucose monitoring on Patient AA as required.

2. Failure to keep clear and accurate records in that you:
   - failed to complete a feeding chart for Patient AA
   - failed to document the safe sleeping conversation with Patient A
   - failed to keep clear records of where, when, and how much Patient AA was fed.

3. Dishonesty in that you falsified documentation relating to Patient AA's blood glucose monitoring.

4. Lack of competence by failing to demonstrate the standards of knowledge, skill, and competence without supervision as a Registered Midwife, including in the following areas:
   - Risk assessing
   - Acting in emergency situations
   - Escalating concerns
   - Provision of care
   - Documentation
   - Observations.

These regulatory concerns relate to alleged incidents that are said to have taken place since November 2020 whilst Mrs Penny were working at the Trust as a Band 5 midwife.

On 18 May 2021, alleged concerns in respect of documentation, cardiotocography (CTG) interpretation, and a lack of escalation, were reported to the Trust's Practice Development Midwife. It was decided that Mrs Penny needed to be placed on an action plan, which commenced on 10 June 2021. Whilst Mrs Penny was on this action plan, it was alleged that similar concerns arose in August 2021.

Mrs Penny commenced supported practice again on 16 August 2021. A further concern arose on 20 August 2021 regarding Mrs Penny's alleged lack of escalation in respect of a CTG. A new action plan was put in place for her, which commenced on 1 September 2021. Whilst Mrs Penny was on her new action plan, further alleged concerns were raised about her midwifery practice between September and October 2021.

On 14 October 2021, a further review took place with the Trust, and it was agreed that Mrs Penny was to be placed on four more weeks of supervised practice and therefore, her action plan would be extended. During the further period of supported practice, no issues were identified. On 1 December 2021, Mrs Penny completed her action plan.

On a shift from 26 – 27 June 2022 where you were caring for Patient A, who was a gestational diabetic, and Patient AA, it is alleged that Mrs Penny:

- Failed to complete a risk assessment on Patient AA at the point of transfer to the ward;
- Failed to complete adequate checks on Patient A when feeding;
- Failed to undertake blood glucose monitoring on Patient AA as required;
- Failed to complete a feeding chart for Patient AA;
- Failed to document the safe sleeping conversation with Patient A;
- Failed to keep clear records of where, when, and how much Patient AA was fed.

On 19 July 2022, the Trust commenced an investigation into the concerns which had occurred over the night of 26 – 27 June 2022. Mrs Penny had investigatory meetings with the Trust on 29 July 2022, 1 August 2022, and 8 August 2022. Following the investigation, Mrs Penny was placed on an action plan, which was implemented on 27 February 2023.

During the implementation of the action plan, further alleged concerns were raised about Mrs Penny's clinical practice between May and July 2023. Mrs Penny was removed from clinical practice by the Trust following the concerns that were raised on 30 June, and 3 and 5 July 2023. On 2 January 2024, Mrs Penny resumed clinical

practice with her action plan ongoing. On 28 July 2024, Mrs Penny resigned from the Trust.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kabasinskas.

The panel has drawn no adverse inference from the non-attendance of Mrs Penny.

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 the panel will only find a fact proved if it is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Keeley Jones ('Ms Jones'): Practice Development Midwife at Royal Albert Edward Infirmary;

- Michelle Caslin ('Ms Caslin'): Preceptorship Lead Midwife at Royal Albert Edward Infirmary;

- Catherine Stanford ('Ms Stanford'): Divisional Director of Midwifery & Child Health, Surgical Division for Wrightington, the Trust, at Royal Albert Edward Infirmary;

- Amy Thornton ('Ms Thornton'): Midwife at Royal Albert Edward Infirmary;

- Alison Horton (‘Ms Horton’) Midwife and Practice Education Facilitator at Royal Albert Edward Infirmary;

- Patient A Patient A.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1 a)i)

“That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

a) On 19 April 2021, you:
   i) prepared an incorrect dose of medication”

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Ms Jones, the contemporaneous handwritten notes that was provided by Ms Jones during her oral evidence, and the signed action plan dated 10 June 2021, which is also provided by Ms Jones and signed by Mrs Penny.

The panel recognised the account in Ms Jones’ statement was, in part, not based on first-hand observation, but was escalated through other staff. However, the panel placed weight on Ms Jones’ oral testimony relating to the specific incident that led to the creation of the action plan. Ms Jones was clear in her evidence and non-evasive,

she confirmed that it was part of her role to obtain feedback from the staff group in regards to the junior member of staff and there was no reason to question the matters escalated to her by other staff. Ms Jones confirmed in her oral evidence that following the matters escalated to her by staff she audited the patient notes in order to confirm the concerns raised. Ms Jones then stated that she fed back to Mrs Penny the issues raised regarding preparing incorrect dose of medication through informal meetings and this was confirmed in a handwritten notes which she was able to show to the panel.

Furthermore, the panel interpreted Mrs Penny's signature on the action plan, as acknowledgement on Mrs Penny's behalf of the "*unsafe practice"* concerns, which included reference to incorrect protocol involving syntocinon/oxytocin infusion. The panel determined that this was an acknowledgement by Mrs Penny that she had prepared an incorrect dose of medication.

The panel determined that the contemporaneous handwritten notes supported the escalation of concerns.

Taking the evidence together, the panel was satisfied that on the balance of probabilities, it was more likely than not that Mrs Penny prepared an incorrect dose of medication on 19 April 2021.

Charge 1a)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

a) On 19 April 2021, you:
   ii) Prepared an injection for a baby with an incorrect size needle;

This charge is found proved.

In reaching this decision, the panel took into account both the oral and documentary evidence of Ms Jones including the handwritten notes.

The panel considered that for this allegation there were no patient notes, and the issue did not appear in the action plan.

However, the panel considered Ms Jones's handwritten notes provided contemporaneous evidence of the incident.

The entry in Ms Jones's handwritten notes dated 19 April 2021 stated:

> *"trying to give [Vitamin K] with a large needle"*

Ms Jones' statement described a subsequent discussion with Mrs Penny about the needle size in which Mrs Penny admitted the errors and provided the explanation that:

> *"…she had trained at another Trust and it had been a while since she had been on a delivery suite, so she was unfamiliar with the correct infusion policy, or that there were different sized needles."*

Ms Jones' oral testimony was consistent with her witness statement. In her oral evidence, Ms Jones clearly recalled the discussion she had with Mrs Penny and the acknowledgement on behalf of Mrs Penny that she lacked competence in this area.

The panel considered that in Ms Jones' role as a practice development midwife she would have been aware of what a band 5 registered midwife should know in regards to local policies and procedures. She was clear that Mrs Penny ought to have familiarised herself with local guidance on medicine preparation and administration as part of her role as a registered midwife working for the Trust. The panel accepted the evidence of Ms Jones in this regard.

On the balance of probabilities, and in light of Ms Jones' evidence that Mrs Penny accepted having made the error, the panel found the particular charge proved.

Charge 1b)i)

"That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

b) Between 17 and 18 May 2021, you:
    i. did not escalate a deteriorating cardiotocography"

This charge is found not proved.

The panel noted that Ms Jones had documented in her written evidence that during discussion with Mrs Penny, Mrs Penny alleged that she did escalate the deteriorating CTG to a registrar. The panel noted that it had no patient records, CTG traces, feedback form, and no written action plans to corroborate the allegations and considered those documents would have materially assisted the panel in reaching its decision.

The panel noted that without any further documentation Ms Jones's oral testimony alone was insufficient to uphold this allegation. The panel noted that Ms Jones' evidence in respect of this charge was second-hand ("*concerns escalated to me*") and the original first-hand witnesses were not before the panel on the basis that they could not be identified in any documentation provided.

Therefore, in the absence of the relevant supporting evidence, the panel was not satisfied that the NMC has discharged its burden of proof. This charge was found not proved.

Charge 1b)ii)

"That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

b) Between 17 and 18 May 2021, you:
   ii) failed to follow “fresh eyes” protocol for hourly observations”

This charge is found proved.

In reaching its decision on this charge, the panel again noted the absence of patient notes. However, the panel relied on Ms Jones’ account that Mrs Penny made an admission/acknowledgement in discussion that she did not know she was required to complete hourly “*fresh eyes*” assessments. In Ms Jones’ written statement she stated:

> *“Ms Penny told me that she remembered the day clearly. She said that she did not know that she had to do hourly fresh eyes assessments.”*

The panel also took account of Ms Jones’ contemporaneous handwritten notes and treated it as supporting the concern about one-hourly reviews. The handwritten notes stated:

> *“incorrect documentation-random review of CTG, not hourly.”*

The panel took account of Ms Jones’s oral testimony which was consistent with her handwritten notes which stated clearly that Mrs Penny had told her that she did not know that she had to undertake an hourly “fresh eyes” assessment. The panel gave weight to Ms Jones’s evidence and considered that her account was consistent and mirrored the contemporaneous handwritten note that she provided.

The panel was satisfied on the basis of Ms Jones’s evidence that the NMC has discharged its burden of proof that on the balance of probabilities Mrs Penny failed to follow the fresh eyes protocol for hourly observations.

Therefore, the panel was satisfied that this charge is found proved.

Charge 1b) iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

b) Between 17 and 18 May 2021, you:
   iii) failed to document that a patient was on regular medication;

This charge is found not proved.

The panel was of the view that this charge depended heavily on the patient records, which were not produced. The panel noted that there was no action plan, no clinical records, no incident report, no other witnesses to corroborate this specific allegation. The panel also noted that Ms Jones's account was not first-hand, and there was no admission by Mrs Penny identified for this specific matter. The panel considered this amounted to hearsay evidence which was sole and decisive and as such that it would not be fair to place weight upon it in the absence of any further evidence in respect of this matter.

The panel was not satisfied on the basis of Ms Jones' hearsay evidence that the NMC has discharged its burden of proof that on the balance of probabilities Mrs Penny failed to document that the patient was on regular medication.

The panel therefore found this charge not proved.

Charge 1c)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

c) On 9 August 2021, you administered medication to a patient without carrying out relevant medical safety checks;

This charge is found proved

The panel considered Mrs Penny's written reflection on medicines safety where she references her failure to carry out relevant medical safety checks prior to administering medication. The panel also took into consideration the action plan dated 1 September 2021 together with Ms Jones's written statement and oral testimony.

The action plan dated 1 September 2021 references unsafe practice and states:

> "*patient not wearing wristband, medication check not followed and student administering prostaglandin"*.

The panel noted that Ms Jones in her written evidence stated:

> *"On 9 August 2021, a concern arose. Ms Penny administered prostaglandin to a patient without carrying out the relevant medical safety checks. Prostaglandin in a medication for an induction of labour. The issue was that the patient did not have a wrist band on, so the correct checks could not be made before the prostaglandin was administered. This included Ms Penny not checking that it was the right patient who needed the medication."*

This was treated as consistent and supportive of the charge being proved. Taking together the credibility, consistency, and reliability of Ms Jones, in addition to the reflection of Mrs Penny which acknowledged failings in medicine safety in her reflective statement.

On the balance of probabilities, the panel therefore found it proved that Mrs Penny administered medication without relevant medical safety checks.

Charge 1d)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

d) On 14 August 2021, you:

i) did not interpret a deteriorating cardiotocography correctly;-

This charge is found proved

The panel had regard to the witness statement of Ms Jones which stated:

> *"On 14 August 2021, another concern arose. The main concerns on this date were poor documentation, a failure to escalate, and a poor CTG interpretation. Within the Unit, we have stickers that we put in a patient's notes to show our findings when we do a vaginal examination. Ms Penny documented her findings, went a spoke to a doctor, and then came back and changed the sticker to alter her findings. The changes that Ms Penny made were of her actual findings, being how far along the patient was in labour. There was also a deterioration in a patient's CTG, but Ms Penny did not interpret the CTG correctly, and she did not escalate it."*

The panel noted that the account in the statement of Ms Jones was not first-hand. However, in her oral evidence Ms Jones described concerns around CTG interpretation informing Mrs Penny's action plan.

The panel treated the action plan dated 1 September 2021, (created shortly after the date of incident) as significant corroboration that the concern existed and was being addressed as unsafe practice. The action plan described as including "*failure to recognise pathological CTG*" and remedial actions.

Therefore, the panel was satisfied that this charge was proved.

Charge 1d)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

d) On 14 August 2021, you:

ii) did not escalate a deteriorating cardiotocography;-

This charge is found proved

The panel noted its conclusions in respect of charge 1d)i) that Mrs Penny had failed to interpret a deteriorating cardiotocography correctly and considered that on the basis of this failure this would have resulted also in a failure to escalate the deteriorating cardiotocography. In these circumstances and in the absence of any evidence suggesting that escalation occurred, it found this charge was also proved on the balance of probabilities.

Charge 1d)iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

d) On 14 August 2021, you:

iii) Altered observation stickers;

This charge is found proved

The panel had regard to the witness statement of Ms Jones which stated:

"I spoke to Ms Penny about the concerns. In relation to the sticker where Ms Penny had changed her findings, she said that she changed it because the doctor told her that it was something different and that she wasn't sure so she

thought she would go back and change it. Ms Penny then went on to say that maybe she has a problem with numbers. I said to Ms Penny that she needs to me if that is the case. Ms Penny responded by saying 'I don't think I have a problem with numbers, I just made a mistake'."

The panel had regard to the action plan, dated 1 September 2021, which was treated as further corroboration that this issue was identified and addressed. The action plan referred to:

"Altering earlier VE sticker following examination by another member of staff."

Whilst the panel acknowledged that the action plan was not signed by Mrs Penny, the panel placed weight upon this evidence alongside the evidence of Ms Jones who described in her written statement discussing these concerns with Mrs Penny.

The panel was satisfied on the basis of Ms Jones' evidence that the NMC has discharged its burden of proof that on the balance of probabilities Mrs Penny altered observation stickers.

Accordingly, the panel therefore found this charge proved.

Charge 1e)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

e) On 20 August 2021, you:

i) Did not escalate concerns following your difficulty in obtaining a heart rate;

This charge is found not proved.

The panel took into account the witness statement of Ms Jones which stated:

> *"On 20 August 2021, a concern arose in respect of Ms Penny's lack of escalation in respect of a CTG. The same patient also had a fetal scalp electrode ("FSE"), which is a more accurate way of recording the fetal heart rate. It was not working, so Ms Penny needed to go back to the abdomen and put the transducer on again. Ms Penny did not do this, so there were periods of loss of contact with the fetal heart rate. Ms Penny should have escalated the fact that she was having trouble with the equipment and locating the fetal heart rate. She should have done this so that we could have tried to find a way of getting a clear picture of what was happening with the baby at that time. Ms Penny also failed to complete all of the relevant documentation for this."*

However, the panel was mindful that the evidence of Ms Jones was not first-hand evidence.

The panel acknowledged that the feedback from 20 August 2021, indicates that there was an issue relating to monitoring foetal heart rate:

> *"identify [reduced] FH- if FSE is not working to use CTG transducer".*

This evidence was framed as recommendations/guidance, not as a record that Mrs Penny failed to escalate concerns.

Whilst Ms Jones asserted that Mrs Penny had a duty to escalate concerns in her written statement, the panel determined that the oral evidence provided by Ms Jones did not establish that Mrs Penny had failed to escalate concerns. Ms Jones reiterated that she could not recall the specific details of the escalation failure. The panel considered that there was an absence of patient notes, CTG traces or first-hand evidence.

Taking all the evidence together the panel determined that the NMC has not discharged its burden in proving, on the balance of probabilities, that Mrs Penny did not escalate concerns as alleged. Therefore, this charge is found not proved.

Charge 1e)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

e) On 20 August 2021, you:

ii) In respect of the matter as charged in 1 e) i) failed to complete relevant documentation;

This charge is found not proved.

The panel had regard to the feedback dated 20 August 2021 which stated:

"emergency paperwork - to write notes if unable to document fully at the time of emergency."

Whilst Ms Jones asserted that Mrs Penny had failed to complete relevant documentation, this formed part of the concerns raised. However, the panel noted that this was hearsay evidence and there was no evidence of these concerns being recorded in any written feedback. The panel considered that there was an absence of patient notes or first-hand evidence and as such it could give limited weight to the hearsay evidence of Ms Jones.

In the circumstances and based on the absence of evidence the panel determined that the NMC has not discharged its burden of proving, on the balance of probabilities, that Mrs Penny failed to complete the relevant documentation.

Accordingly, the panel found this charge not proved.

Charge 1f)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

f) On 8 September 2021, you failed to escalate a patient's raised blood pressure;

This charge is found not proved.

The panel had regard to the witness statement of Ms Jones which stated:

> *"A concern arose on 8 September 2021, where Ms Penny failed to escalate a patient's raised blood pressure. This was something that Ms Penny should have known to escalate. When a patient has a blood pressure check, it is done electronically. If the reading shows a raised blood pressure, then it needs to be redone by checking the blood pressure manually. Ms Penny did not do this, and she did not escalate the raised blood pressure."*

The panel acknowledged that Ms Jones's statement recorded a concern escalated to her, but the account was not first-hand. However, the feedback document dated 8 September 2021 did not support the allegation that Mrs Penny failed to escalate a raised blood pressure. It read as: "aware to observe BP's - to use manual instead of automated", "recheck BPs and urine".

Furthermore, the feedback in the same document included positive remarks about Mrs Penny's care.

Ms Jones stated in oral evidence that she believed concerns existed regarding Mrs Penny's failure to escalate raised blood pressure. However, she acknowledged that this was not clearly reflected in the written feedback at the time, as staff often recorded concerns in a supportive or softer manner. As a result, the documentary evidence does not explicitly record a failure to escalate.

In the circumstances and based on the absence of evidence including patient notes/observations chart the panel determined that the NMC has not discharged its burden in proving, on the balance of probabilities, that Mrs Penny had failed to escalate high blood pressure readings.

The panel therefore concluded that the charge was not proved.

Charge 1g)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

g) On 16 September 2021, whilst under a supported practice plan, you:
   i) broke the waters of a high-risk patient with no instruction and under no supervision;

This charge is found not proved.

The panel was of the view that this charge contains a serious allegation, which was not supported by contemporaneous safety governance documentation (e.g., Datix, shift feedback forms, escalation records) and/or patient records.

The panel noted that no patient notes were provided.

Ms Jones gave evidence that the concern about breaking the water of a high risk patient without instruction or supervision was reported directly by the Band 7 midwife

supervising Mrs Penny. However, she did not witness the incident herself, and there was no formal contemporaneous documentation such as a feedback or incident report. The panel requested any Datix report in respect of this specific incident and Ms Jones was unable to obtain any.

The panel had regard to the witness statement of Ms Jones which stated:

> *"On 16 September 2021, a further concern arose. Ms Penny went into a patient's room without a doctor and without telling the midwife who she was working with, and she ruptured the patient's membranes on a patient who had polyhydramnios. This is an excess of fluid. For Ms Penny to do this, she was not looking at the full picture, as the patient could have had an emergency cord prolapse. At the time that Ms Penny did this, the midwife who she was working with did not know where she was. No harm was caused to the patient, but this was serious. This patient was high-risk, and even our senior midwives would not break the water of a high-risk patient such as this patient without a plan and without having theatre on standby. I do not think that a feedback form was completed for this shift, but it was common for midwifes who worked with Ms Penny to provide me with verbal feedback after their shift with Ms Penny."*
>
> *"…When I spoke to Ms Penny about the concerns she said that, in relation to the incident on 16 September 2021 where Ms Penny ruptured the patient's membranes, she said that she was in the room with a doctor. I do not know if the doctor was in the room with Ms Penny or not."*

In her oral testimony Ms Jones was unable to confirm whether a doctor was present or not, nor was she able to provide any patient notes or any further evidence that would support that Mrs Penny was not being instructed or supervised at the time of the incident.

Ms Jones' contemporaneous handwritten notes also included uncertainty (e.g., *query/"?*" about whether a doctor was present) and there was no independent corroboration. The handwritten notes provided by Ms Jones for the 16 September 2021

include the entry '*? Reg in room*' which suggests uncertainty regarding whether or not a doctor was present at the time of this alleged incident.

In the circumstances and based on the absence of evidence the panel determined that the NMC has not discharged its burden of proving, on the balance of probabilities, that Mrs Penny broke the waters of a high risk patient with no instruction and under no supervision.

Charge 1g)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

g) On 16 September 2021, whilst under a supported practice plan, you:
ii) inappropriately increased a patient's medication with no instruction and under no supervision;-

This charge is found not proved.

The panel noted that this charge was based on second-hand verbal reporting which was confirmed in Ms Jones's written statement that stated:

> *"…on 16 September 2021, Ms Penny went into the same patient and turned up to syntocinon on infusion despite the CTG being suspicious. This was discovered by the midwife that was working with Ms Penny on this shift. Ms Penny should not have done this. Instead, Ms Penny should have checked the CTG first to make sure that it was ok to turn up the infusion. As the CTG was suspicious, the infusion should not be turned up. Ms Penny should have also waited for the midwife that she was working with on this shift, but she did not wait."*

The panel also noted that there were no patient notes, no CTG/records, no Datix and no feedback form for the shift.

The panel further noted Mrs Penny's account as recorded in Ms Jones's written statement which stated that:

> *"When asking Ms Penny about turning up the infusion on 16 September 2021, she said that she asked the shift leader first, and the shift leader told her to turn up the infusion."*

This suggested that Mrs Penny may have informed the shift leader. Ms Jones was unable to confirm with certainty whether or not Mrs Penny informed the shift leader and received instruction from the shift leader to increase the medication. The panel did not receive any evidence from the shift leader in relation to this allegation.

In the circumstances and based on the absence of evidence the panel determined that the NMC has not discharged its burden of proving, on the balance of probabilities, that Mrs Penny inappropriately increased a patient's medication with no instruction and under no supervision.

On this basis, the panel found that this charge was not proved.

Charge 1h)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

h) On 24 September 2021, while under a supported practice plan, you administered inappropriate medication to a patient;

This charge is found proved.

The panel had regard to the witness statement of Ms Jones which stated:

> *"On 24 September 2021, there was a medication safety error which I was informed of by the midwife who worked with Ms Penny. Ms Penny administered prostaglandin to a high-risk patient without an obstetric review taking place first. The issue here was that prostaglandin can only be given without an obstetric review to low risk patients, and the patient who Ms Penny administered prostaglandin to was high risk."*

Ms Jones also stated that:

> *"In relation to the concern with administering prostaglandin to a high risk patient, Ms Penny said that the other midwife who she was working with was busy."*

The panel noted that in other instances Ms Jones recorded Mrs Penny denying matters, but in this instance, Mrs Penny did not deny administering the medication, instead offering an explanation that the other midwife was busy. The panel placed weight on the way Ms Jones consistently recorded Mrs Penny's responses and the subsequent action a practice development midwife would take to remediate the situation.

The panel acknowledged the evidential deficits namely, no patient notes, no Datix and no feedback form for this shift despite the seriousness of the charge.

However, the panel treated the evidence of Ms Jones as supporting evidence that the event occurred as described and concluded that it was more likely than not that inappropriate medication was administered in the circumstances alleged.

In the circumstances and based on the evidence before it the panel determined that the NMC has discharged its burden of proving, on the balance of probabilities, that Mrs Penny administered inappropriate medication to a patient while being under a supported practice plan.

Charge 1i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

i) On 9 October 2021, you failed to escalate a patient who had started contracting regularly as instructed;

This charge is found proved.

The panel had regard to Ms Jones' written statement that stated:

> *"On 9 October 2021, Ms Penny was working alongside myself. We were providing care to two patients. I had to go into theatre with one of the patients, so I asked Ms Penny to keep an eye on the other patient, and to let me know if anything changed. The patient that I asked Ms Penny to keep an eye on started contracting regularly. Ms Penny started the patient on gas and air, rather than escalating the patient to me. Ms Penny should have escalated the patient to me, because the patient was pre-term."*

The panel noted that the evidence of Ms Jones was first-hand and she was able to comment clearly in oral evidence on her observations as to Mrs Penny's work.

The panel also considered that the timeline provided by Ms Jones corroborated her written and oral evidence. The timeline references the following, *"Incident poor communication/escalation…around labouring woman."*

The panel took account of the typed notes of Ms Jones that stated:

> *"…the 2nd lady was contracting regularly and using Entonox which wasn't communicated by Tracy."*

The panel determined that Ms Jones's oral testimony was consistent with her written evidence, taken together, the panel was satisfied on the balance of probabilities that Mrs Penny failed to escalate the patient as instructed and therefore this charge was found proved.

Charge 1j)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

j) On the 16 May 2023, you:
   i. failed to recognise a suspicious cardiotocography;

This charge is found proved.

The panel had regard to the direct evidence from Ms Thornton which stated:

> *"Around the time that Ms Penny was delaying fresh eyes from 25 – 45 minutes, the CTG was suspicious...*
>
> *Ms Penny did not recognise that the CTG was suspicious. I had to point that out to her. Ms Penny was delayed in acting upon the suspicious CTG as she was more interested in other things like chatting to the patient and making sure the patient was comfortable. Ms Penny was not interpreting the CTG, so I told her that she needed to stop what she was doing and look at the CTG.*
>
> *When a CTG is suspicious, a midwife should take conservative measures. This includes getting the patient to change position, reduce or turn off the syntocinon infusion if the patient is having the infusion, and get a registrar to come and view the CTG. I had to tell Ms Penny*

that she needed to take those measures and action them."

This strongly suggests that Mrs Penny did not recognise that the CTG was suspicious until it was pointed out by Ms Thornton.

The panel also took account of the feedback form provided by Ms Thornton on the same day as the incident which stated:

"…When our CTG was classified as suspicious, Tracy delayed acting upon this and again had to be prompted to do conservative management…"

In Ms Thornton's oral testimony she stated that Mrs Penny failed to carry out timely fresh eyes CTG reviews, did not act promptly on a suspicious CTG trace and failed to escalate concerns appropriately. She further states that Mrs Penny required prompting and did not escalate independently, and these concerns were recorded in her feedback.

Additionally, the panel took account of the Witness statement of Ms Caslin which stated:

"During the shift on 16 May 2023, a CTG was classified as suspicious, but Ms Penny delayed acting on this and, again, she had to be prompted to act on this."

The panel further had regard to the meeting notes, MC11 which includes Mrs Penny's account of the incident and the issue being considered at the meeting.

"Tracy denied that she did not act on the CTG – she states that she had previously spoken to the registrar who was not himself concerns. When it became suspicious again, she was about to leave the room to speak with the doctor again when the midwife came into the room asking her what her plan was with the ctg."

The panel acknowledged that there were no patient records, but found the allegation was supported by a combination of first-hand witness account, contemporaneous

feedback documentation, and the subsequent meeting record showing the concern was raised and discussed.

In the circumstances and based on the evidence before the panel provided by two witnesses, the panel determined that the NMC has discharged its burden of proving, on the balance of probabilities, that Mrs Penny failed to recognise a suspicious cardiotocography.

Therefore, the panel found this charge proved.

Charge 1j)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

j) On the 16 May 2023, you:
ii. delayed escalating a suspicious cardiotography;

This charge is found proved.

The panel determined that based on the same evidence that the panel relied upon to prove charge 1j)i), charge 1j)ii) was also found proved.

Charge 1j)iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

j) On the 16 May 2023, you:

iii. failed to recognise that a patient's regular blood pressure medication was due;

This charge is found proved.

The panel considered the witness statement of Ms Thornton which stated:

> *"…Ms Penny also did not notice that a regular medication was due for the patient's blood pressure. I cannot recall what the exact medication was, but I think it may have been labetalol. I had to prompt Ms Penny to notice that the medication was due. However, I cannot recall how often the medication was due.*
>
> *Ms Penny would have known that the medication was due as it would have been a part of the patient's care plan and prescribed on the drug board for that particular patient.*
>
> *As the patient was hypertensive, the patient not having the medication as prescribed could result in other problems. This could include the patient having a stroke."*

The panel also had regard to the feedback form provided by Ms Thornton to Mrs Penny which stated:

> *"…it was not recognised that a regular medication was due for the woman's BP…"*

The panel considered Ms Thornton's oral testimony that Mrs Penny failed to recognise that the patient's blood pressure medication was due and required prompting to administer it. She included this concern in a feedback and linked it to broader issues of clinical awareness and escalation.

The panel was satisfied that Mrs Penny had a professional duty to recognise prescribed regular medication as part of the care plan and to act accordingly.

In the circumstances and based on the evidence before the panel provided by two witnesses, the panel determined that the NMC has discharged its burden of proving, on the balance of probabilities, that Mrs Penny failed to recognise that a patient's regular blood pressure medication was due.

Accordingly, the panel found this charge as proved.

Charge 1j)iv)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

j) On the 16 May 2023, you:

iv. increased the medication, syntocinon, 10 minutes early;

This charge is found proved.

The panel found there was clear evidence that the infusion was increased earlier than the 30-minute interval required by the guidance. This was confirmed by the witness statement of Ms Thornton which stated that:

> *"…Ms Penny also increased the syntocinon infusion after 20 minutes, although it should be increased after 30 minutes and only if appropriate…*
> *…Ms Penny should not have increased the syntocinon infusion for the patient because by increasing it after 20 minutes, the patient is not getting the full effect of the drug as it has not been left for 30 minutes as it should be.*
> *Increasing syntocinon too soon can lead to fetal distress…"*

The panel had regard to the feedback form of Ms Thornton which stated:

> *"…Tracy increased the syntocinon infusion after twenty minutes although the policies and guidelines state after 30 minutes if appropriate..."*

The panel accepted the contemporaneous feedback and witness statement as consistent that the increase occurred at 20 minutes (or otherwise earlier than 30 minutes).

The panel further took into account the meeting notes with Ms Caslin which contained an explanation that Mrs Penny believed that the infusion started earlier (15 vs 20 minutes), but the panel treated that as supporting that the infusion was increased too early in any event, i.e. consistent with the stated charge.

Ms Thornton in her oral testimony explained the correct standard that the syntocinon should be increased every 30 minutes per guideline but Mrs Penny increased the infusion after about 20 minutes instead of waiting 30 minutes. Ms Thornton intervened at the time and instructed Mrs Penny to correct the rate. Ms Thornton further confirmed that Mrs Penny did not recognise the error independently and this formed part of her concern about Mrs Penny's adherence to protocol and need for supervision.

The panel referred to the guidance document for the administration of an oxytocin infusion which stated, "*increase every 30 minutes"*, to establish the standard expected of Mrs Penny.

In the circumstances and based on the evidence before the panel provided by two witnesses, the panel determined that the NMC has discharged its burden of proving, on the balance of probabilities, that Mrs Penny increased the medication, syntocinon, 10 minutes early.

The panel found this charge proved.

Charge 1j)v)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

j) On the 16 May 2023, you:

v. failed to follow “fresh eyes” protocol for hourly observations;

This charge is found proved.

In reaching its decision the panel had regard to the witness statement of Ms Thornton which stated:

> *“…Ms Penny delayed fresh eyes from 20 – 45 minutes. Fresh eyes are to take place every hour. The idea of fresh eyes is to get another midwife to come and look at the patient's cardiotocography ("CTG"), which monitors the fetal heart. It should be the shift supervisor that does the fresh eyes every hour. I would expect Ms Penny to have known that fresh eyes were to be carried out every hour as it is something that midwives learn as students. Therefore, I would even expect a third-year midwifery student to know that.”*

This was confirmed in Ms Thornton’s oral testimony also where she stated the protocol for hourly observation particularly for CTG requires a *“fresh eyes”* review every hour with another midwife and escalation of any concerns.

Ms Thornton stated that Mrs Penny failed to carry out these reviews on time, did not act promptly on a suspicious CTG, and did not escalate concerns appropriately.

The panel also took account of the witness statement of Ms Caslin which stated:

“It was reported by the midwives that worked with Ms Penny on 16 May 2023 that, on a few occasions, fresh eyes were delayed from 20-45 minutes, and Ms Penny had to be prompted to complete these. Allegedly, when Ms Penny was asked by the shift co-ordinator when the fresh eyes were due, she replied 'now', despite the fact that it was already overdue.”

The panel also had regard to the feedback following the shift from Ms Thornton which stated:

“On a few occasions fresh eyes were delayed from 20-45 minutes which had to be prompted to be completed.”

The panel further had regard to the feedback provided by the delivery suite coordinator who stated that:

“I was approached by mw AT who informed me that she had prompted TP to request I perform a ‘fresh eyes’ which was due 15 mins previous. It was only 30 minutes later that TP asked me to perform this check. When I asked her when it was due, she replied “now”. It was in fact 45 minutes late. I feel she tried to deceive me and when I pointed this out, she acted surprised and didn’t seem happy that I signed it at a later time (the true time which I signed it).”

The panel also noted that the meeting notes with Ms Caslin recorded that Mrs Penny was in agreement that fresh eyes had been delayed and this was not acceptable.

Therefore, the panel was satisfied that the “fresh eyes” protocol required hourly review by an appropriate colleague and that delays of 20–45 minutes occurred.

In the circumstances and based on the evidence before the panel provided by two witnesses, the panel determined that the NMC has discharged its burden of proving, on the balance of probabilities, that Mrs Penny failed to follow “fresh eyes” protocol for hourly observations. The panel therefore found this charge proved.

Charge 1k)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

k) On 17 May 2023, in respect of Patient B, you failed to ensure hourly cardiotocography interpretations were carried out;

This charge is found proved.

The panel had regard to the evidence of Ms Caslin which stated:

> *"…I noticed that the antenatal CTG interpretation was missing at 08:00 within Patient B's notes. Hourly reviews of CTGs are required, regardless of whether the patient is an antenatal patient or intrapartum in labour. Where the patient is on continuous fetal monitoring, there is a review every hour where a sticker which asks the midwife questions to classify the CTG is to be used. Evidence of the antenatal CTG interpretation should have been in Patient B's notes between the entry at 07:45 and the entry at 08:45.*
>
> *The antenatal CTG interpretation sticker is missing again at 15:00 just prior to the transfer of Patient B. This should have been documented before the entry at 15:15 on page 2 of Patient B's notes.*
>
> *…During my conversation with Ms Penny, she agreed that she did not classify the CTG as she was not aware of the stickers. I told Ms Penny that, although I appreciated that the CTG stickers were quite new at the time within the Trust, hourly classifications of a CTG was not so it still needed to be done. Prior to the stickers being used, we used an acronym to assist with classifying CTGs, and that same acronym is the one used on the stickers, so it was not unfamiliar to Ms Penny.*

Therefore, I would have expected Ms Penny to know that she needed to document the CTG interpretations and to have classified the CTG within Patient B's notes. I also expected Ms Penny to have done that as it is a part of the Greater Manchester and Eastern Cheshire ("GMEC") guidelines which are specific for all midwives within the GMEC area."

The panel also had regard to Patient B's notes and the GMEC's Fetal Monitoring in Labour including Fetal Blood Sampling Guideline that was relied upon by Ms Caslin.

The panel took into account the notes from a meeting with Ms Caslin held on 19 May 2023 which stated that regarding the shift on 17 May 2023 Mrs Penny agreed that she did not classify the antenatal CTG as she was not aware of the stickers.

Taking all the evidence together the panel accepted Ms Caslin's evidence in that the CTG interpretations were missing at required times (notably between 08:00 and 15:00) and that these interpretations should have been documented while the patient was on continuous monitoring.

The panel acknowledged that Mrs Penny was not directly observed and that some documentation appeared incomplete or missing. However, the panel placed weight on Ms Caslin's senior role and expertise and her structured documentary audit identifying absent CTG interpretations.

Therefore, on the balance of probabilities, the panel found that Mrs Penny failed to carry out hourly required CTG interpretations and found the charge as proved.

Charge 1l)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement

required to practise without supervision as a band 5 midwife in that:

l) On 27 June 2023, in respect of Patient C, you:

i. used incorrect cardiotocography stickers;

This charge is found proved.

In reaching its decision the panel treated Ms Caslin's evidence as reliable and authoritative.

The panel took account of the witness statement of Ms Caslin which stated:

> *"…From my review, I saw that, at 12:10 on 27 June 2023, Ms Penny used an antenatal sticker despite the patient contracting 3-4:10 and cx 4cm effaced and central. The antenatal sticker can be seen on page 1 of Patient C's notes for the entry at 12:10. Ms Penny also uses another antenatal sticker underneath that entry on page 1 of Patient C's notes."*

The panel also had regard to Patient C's notes that confirms that Patient C was contracting (3–4 contractions) and therefore required intrapartum, not antenatal, CTG stickers. The panel noted that the documentary evidence clearly showed antenatal stickers were used despite the patient being in labour.

Therefore, on the balance of probability the panel found that Ms Penny used the incorrect cardiotocography stickers.

Charge 1l)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement

required to practise without supervision as a band 5 midwife in that:

l) On 27 June 2023, in respect of Patient C, you:

ii. failed to ensure hourly cardiotocography interpretations were carried out;

This charge is found proved.

The panel had regard to the evidence of Ms Caslin which stated:

> *"From Patient C's notes, I could also see that fresh eyes was performed at 14:55, but that there had not been a CTG review between 13:00 and the one at 14:55. Fresh eyes reviews must take place every hour as per the GMEC guidelines and local guidelines, so Ms Penny had missed the assessment which should have taken place at 14:00, being one hour after the CTG review at 13:00."*

This was also confirmed in Patient C's notes.

The panel found a clear gap between CTG reviews (from approximately 12:30/13:00 until 14:55), during which a required hourly review should have taken place. The panel was satisfied there was no documented hourly review.

With the evidence before it, the panel concluded that there was a clear duty to carry out hourly CTG interpretations and there was a failure to carry these out. Therefore, on the balance of probabilities this charge is found proved.

Charge 1m)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

m) On 30 June 2023, in respect of Patient D, you:

i. failed to carry out adequate observations;

This charge is found proved.

The panel was satisfied that, in this context, “observations” included fetal observations via CTG.

The panel accepted the evidence of Ms Caslin who stated in her witness statement that:

> *“From my review, I considered that there was good documentation throughout the care provided during labour, but I noted CTG review errors.*
>
> *In Patient D’s notes at 07:45, I saw x1 deceleration on the CTG. The deceleration can be seen on page 4 of Patient D’s notes, which is page 2 of the CTG, between 07:10 and 07:20. In Patient D’s written notes at 08:00 on page 1, the antenatal CTG sticker has ‘no’ circled for the decelerations section. Whilst I agree with the classification of the CTG as being ‘normal’ as there were also reassuring features, the deceleration should have been noted by circling ‘yes’..”*

In her oral testimony, Ms Caslin stated:

> *‘On the antenatal sticker it wasn’t documented that there was any decelerations, which it should have been’*

Patient D’s CTG traces, notes and stickers corroborated with Ms Caslin’s statement. The evidence demonstrated:

- clear decelerations on the CTG between 07:10–07:20;
- failure to record or classify these appropriately at the 08:00 review;

In Ms Caslin's oral testimony she explained where decelerations appeared, why they mattered and why sticker documentation was inaccurate. Most importantly, she physically identified the deceleration on the CTG trace. This is objective evidence and not dependant on memory, therefore the panel gave weight to Ms Caslin's testimony.

Therefore, based on the evidence before it, the panel found this charge proved.

Charge 1m)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

m) On 30 June 2023, in respect of Patient D, you:

ii. failed to accurately interpret their observations;

This charge is found proved.

The panel had regard to Ms Caslin's statement which stated:

> "*Upon my review, I also noticed that at 12:00, fresh eyes took place and variable decelerations were documented. This can be seen within the fresh eyes sticker on page 8 of Patient D's notes. Despite the variable decelerations, Ms Penny classified the CTG as 'normal', when it should have been classified as suspicious. It should have been classified as suspicious due to the fact that the fresh eyes that took place a;t 11:00 stated the same as there were also variable decelerations at that time. According to the fresh eyes criteria on the fresh eyes stickers, the ongoing variable decelerations meant that the CTG met the criteria to be classified as suspicious."*

This was corroborated in Ms Caslin's oral testimony when she stated that the decelerations are, *'still continuing and they are over 90 minutes, so at that point it should have been suspicious, not normal'*. Therefore, normal categorisation was inappropriate.

The panel was of the view that the continued misclassification of CTGs as "*normal*" when variable decelerations persisted amounted to failure in interpreting the observations accurately. Therefore, this charge is found as proved.

Charge 1m)iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

m) On 30 June 2023, in respect of Patient D, you:

iii. failed to make accurate records;

This charge is found proved.

The panel found records were inaccurate/incomplete because the CTG findings were mis recorded; expected documentation (including neonatal attendance details) was missing.

This was confirmed by the witness statement of Ms Caslin which stated:

"*Although it is not included within Patient D's notes, Patient D's MEOWS chart was completed fully at 07:50, but no further documentation of four hourly observations was added by Ms Penny. Patient D's partogram can be seen on page 14 of Patient D's notes. I*

expected to see Patient D's observations recorded on the partogram, but not all observations have been included. Whilst there has been hourly blood pressure readings because of the epidural and the material pulse was recorded every half an hour, there should have been a full set of observations at 12:30. This is because a full set of observations were done at 08:30, which can be seen across the top of box 1 of the partogram, so another full set needed to be completed again four hours later at 12:30. However, the top of box 5 on the partogram does not have a full set of observations documented for 12:30.

Finally in relation to Ms Penny's notes for Patient D, I noticed that Ms Penny did not include the names of neonatal doctors and the times of arrival within Patient D's notes."

This was corroborated in Ms Caslin's oral testimony where she stated:

'We do maternal observations every four hours…we do mum's blood pressure, temperature, pulse rates, just to check that she is not developing anything that we need to be aware of and that she is coping with labour just as well as baby is.'

The panel also had regard to Patient D's records, where it found that complete partogram entries and neonatal doctor names and times of arrival was absent as stated by Ms Caslin.

Taken together, this constituted a failure to make accurate records. Hence, this charge is found proved.

Charge 1n)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement

required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:

i. broke the sterile field by handling equipment and examining them without first changing gloves;

This charge is found proved.

In reaching its decision the panel had regard to evidence of Ms Horton, which stated that Mrs Penny had opened sterile packages without changing gloves, thereby breaking sterility. In her written statement, Ms Horton stated:

> *"During the second stage of labour, Ms Penny was wearing sterile gloves as the baby's head was crowning. However, I then noticed that Ms Penny was continuing to open packages of items that she needed, and she did not change her sterile gloves. This meant that Ms Penny was breaking the sterile field.*
>
> *My concern here is an area that is open to interpretation and it was something that concerned me due to the way that I practice and how I was taught as a midwife. When a patient is labouring and delivering their baby, if there is any form of internal examination, then the midwife needs to be wearing sterile gloves. Even though Ms Penny was not doing an internal examination, I was taught that there needs to be a sterile field in case the patient needs suturing following delivery. Therefore, anytime I put gloves on, I would not touch anything else, and I put a blue sheet down when the patient is delivering so I can place my hands on it. Although Ms Penny put the gloves on and had the blue sheet out, she was opening packets, breaking the sterile field."*

This account was corroborated by the contemporaneous feedback provided by Ms Horton, following the shift.

In her oral testimony, Ms Horton was asked whether this was a competence expectation for all Band 5 midwives and she replied, *'I believe so, yes'*.

The panel accepted Ms Horton's expertise and found on the balance of probabilities, this charge is proved.

Charge 1n)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:
   ii. failed to accurately interpret their observations;

This charge is found proved.

The panel had regard to evidence of Ms Horton, where she stated that late decelerations were present but misclassified as variable. She also stated that Mrs Penny did not independently recognise or escalate the concern. Ms Horton directly observed the failure and escalated it herself. In her written witness statement, Ms Horton stated:

> *"Whilst encouraging active pushing, the cardiotocography ("CTG") which monitors the baby's heartrate, was showing late decelerations. At times, those decelerations were late to recover. On the CTG, it records the contractions and the baby's heart rate. When the baby's heart rate drops after a contraction, as it did for this baby, it is classed as a late deceleration. A deceleration is when the baby's heart rate drops, so on the CTG it shows the heart rate coming down in a 'v' shape on the graph.*
>
> *I had to point out the late decelerations to Ms Penny and discuss the CTG with her. Ms Penny did not escalate the CTG, so I escalated it as required.*
>
> *When a contraction happens, a baby's heart rate can drop as it is reacting to the contraction. However, it is a cause for a concern when the baby's heart rate*

drops after the contraction, as the compromise to the baby, being the contraction, has ended, so there should be nothing for the baby's heart rate to react to. Therefore, when the decelerations are late to recover, it can indicate fetal distress and/or fetal compromise.

…Ms Penny should have noticed the late decelerations and she should have escalated it to a doctor, rather than me noticing them and escalating the patient. I would expect a student midwife to notice decelerations and to escalate accordingly, which is why I expected Ms Penny to do that as a band 5 midwife. After one or two decelerations, I said to Ms Penny that I was not happy with the monitor and it was at that time that I requested a review from a doctor. Ms Penny said 'yeah ok fine', so she understood that it was needed, but she did not recognise anything herself.."

This was corroborated by Ms Horton in her oral testimony when she stated:

"So once the contraction had ended, the CTG would reflect the fact that the baby potentially was distressed because the heart rate was still low following the contraction and that's what she failed to recognise."

This account was corroborated by the contemporaneous feedback provided by Ms Horton following the shift.

The panel noted that this information was confirmed via the CTG traces and the patient notes.

In addition, the panel also noted that a corroborative review was done by Ms Caslin to confirm this. Ms Caslin in her written statement stated:

"At 08:00, Ms Penny classified the CTG as normal on the fresh eyes sticker. This was despite the fact there were variable decelerations identified on the CTG both at 08:00 and on the previous CTG at 07:00. Therefore, this was the same scenario as it was for Patient E in that the ongoing variable decelerations meant that the CTG met the criteria to be classified as suspicious. The

decelerations can be seen on page 9 of Patient E's notes, which is page 3 of the CTG, from 07:50 onwards. The decelerations are obvious, though not massively concerning.

…There can be risks associated with classifying a suspicious CTG as normal instead of suspicious and therefore not seeking a registrar review as leaving a suspicious CTG for a long time risk puts the baby at risk of acidosis. Whilst decelerations are acceptable to an extent, a baby can quickly become very tired and decompensate."

Taken all the evidence together, the panel found this charge as proved.

Charge 1n)iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:

iii. failed to act on cardiotocography decelerations;

This charge is found proved.

The panel relied upon the evidence of Ms Horton who stated in her written evidence that:

***"**By not noticing or not escalating such decelerations means that the fetus could be compromised which can ultimately lead to death. If a patient has late decelerations like Patient E had, and they are actively pushing, a doctor needs to look at it and act upon it."*

This was again corroborated by the contemporaneous feedback by Ms Horton.

Ms Caslin in her written statement stated that:

> *"…There can be risks associated with classifying a suspicious CTG as normal instead of suspicious and therefore not seeking a registrar review as leaving a suspicious CTG for a long time risk puts the baby at risk of acidosis. Whilst decelerations are acceptable to an extent, a baby can quickly become very tired and decompensate."*

Therefore, on the balance of probabilities, the panel found this charge as proved.

Charge 1n)iv)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:
   iv. failed to recognise that an episiotomy was required;

This charge is found proved.

The panel accepted the evidence of Ms Horton who stated that an episiotomy was required and that this was not recognised by Mrs Penny and that a registrar was ultimately required to intervene to confirm that an episiotomy was required. In her written evidence Ms Horton stated:

> *"As the baby's head was crowning, there were late decelerations and the patient had a contraction, I asked Ms Penny if there was a need for an episiotomy, to which she said 'no'. An episiotomy is where we infiltrate the skin with local anaesthetic before cutting the bottom of the vagina to the left hand side past the anus and at an angle to open up the vaginal space.*

After the Patient E's next contraction, I asked Ms Penny if there was enough room or if it was a tight space around the baby's head. Ms Penny said that there was enough room, indicating that an episiotomy was not needed. I could see from where I was stood that there was not a lot of space around the baby's head. When a baby's head is crowning, it means you can see the top of the baby's head and it is possible at that point to visually see if there is enough space for the baby to be delivered.

Patient E was losing control because of the pain she was in and, because of the late decelerations as well, it was necessary to assess if an episiotomy was needed to help the patient along. This is because we do not want to cut a patient unless we really have to. I believed it was necessary as I could see that the skin was tight around the baby's head.

When the registrar was present, the registrar and I decided that an episiotomy was needed, and then Ms Penny quickly changed her mind and said she agreed. I am not sure if it would have made a difference, but perhaps the episiotomy should have been done earlier. This would have allowed for the head to be delivered quicker.

Once the baby was delivered, she was born in poor condition. I would not be able to accurately say whether the poor condition of the baby was as a result of Ms Penny's actions."

This was corroborated in the oral testimony of Ms Horton where she stated:

"I feel like it was needed to be assessed and she assessed incorrectly…the skin was too tight to the baby's head, there was minimal space and I feel that potentially she could have torn a lot worse if we hadn't performed an episiotomy."

This account was corroborated by the contemporaneous account of Ms Horton following the shift.

The panel accepted this as a failure of recognition and found that this charge was hence proved.

Charge 1n)v)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:

v. failed to identify and react when their baby was born floppy with no respiratory effort;

This charge is found proved.

The panel accepted Ms Horton's evidence that Mrs Penny did not respond as would be expected to a Patient E's baby which was born in poor condition. In her written statement Ms Horton stated:

> *"The baby was white floppy with no respiratory effort. I asked Ms Penny to clamp and cut the cord as soon as possible. I then prepared for the baby to commence resuscitation with the paediatrician SHO. Once resuscitation commenced, it became apparent that we needed more assistance. I pulled the emergency buzzer.*
>
> *It was obvious that the baby was born in poor condition and it was obvious that the baby needed urgent resuscitation, but Ms Penny did not recognise the importance of it. Instead, Ms Penny was giving congratulations to the family and saying well done. Whilst that was good of her to do, she needed to act quickly due to the poor condition of the baby. I encouraged Ms Penny to clamp and cut the cord and assess the baby rapidly."*

In her oral testimony Ms Horton stated:

“So for me I don’t feel she responded quickly enough for the medical state of the baby.”

This account was corroborated by the contemporaneous feedback provided by Ms Horton following the shift.

The panel was satisfied that this demonstrated a failure to identify the baby’s compromised state.

The written evidence was corroborated by the detailed oral evidence of Ms Horton and the panel placed significant weight on the tested oral evidence. The panel was therefore satisfied that the charge was found proved.

Charge 1n)vi)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:
   vi. failed to triple clamp the umbilical cord of their baby;

This charge is found proved.

The panel noted that triple clamping was required to preserve cord gases given the baby’s condition. Ms Horton explained this was standard practice taught to midwives, but Mrs Penny failed to do so and required prompting. This was supported by her written statement and her contemporaneous feedback. In her written statement, Ms Horton stated that:

“Whenever a baby is born in a poor condition, it is always a given that the cord needs to be clamped in a certain way. Usually, the cord needs to be clamped

right by the baby's abdomen and then another clamp is put on the cord with a space to cut in between. Routinely, in a situation like the situation we were in, a third clamp is put on the cord, allowing blood to be stored between the clamps. This enables the midwife to obtain cord gases from the cord. The results inform staff of the condition of the baby in utero.

When the paediatric registrar arrived, he asked for cord gases as soon as possible. When a baby is born in poor condition, cord gases can give us a lot of information about the condition of the baby. Cord gases are taken from the cord which gives a venous sample and arterial sample. This can help to see whether, for example, the baby was acidotic or not. The result should be 7.25 or above, and anything below is considered to be a concern.

I asked Ms Penny to obtain the cord gases and the obstetrics registrar was assisting her. The obstetrics registrar then realised that the cord had been double clamped, so no cord bloods could be obtained. Ms Penny had not put a third clamp on the cord, so the cord gases could not be obtained.
As cord gases could not be obtained, it meant that we had to bleed the baby. That is not an ideal situation when the baby needs resuscitation.

Ms Penny should have known to put the third clamp on the cord to allow for cord gases to be obtained. I did not explicitly tell Ms Penny that she needed to do that, but that is because, at the stage she was in in her career, it was a given that it needed to be done and I should not have needed to remind her. It is good practice to clamp the cord in that way when the baby is in bad condition, and it is taught to midwives when they are students."

Therefore, based on the Ms Horton's statement and her oral testimony, the panel found this charge is proved.

Charge 1n)vii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

n) On 3 July 2023, in respect of Patient E, you:

vii. failed to adequately record the events that occurred in respect of their labour;

This charge is found proved.

In reaching its decision the panel had regard to the evidence of Ms Horton who confirmed that Mrs Penny's documentation in respect of labour was brief and incomplete, particularly given the neonatal emergency. Ms Horton also stated that she herself had to complete retrospective notes for Patient E. The panel had sight of this note. The panel noted that the contemporaneous feedback from Ms Horton supported her evidence. This was also corroborated by Ms Caslin, who was a senior independent reviewer.

In her oral testimony, Ms Horton stated:

> *"When you read the documentation that she gave, she was very vague in what she wrote."*

Therefore, the panel was satisfied that on the balance of probabilities this charge was found to be proved.

Charge 1o)i)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

o) On 5 July 2023, in respect of Patient F, you:

i. failed to adequately assess their risk;

This charge is found proved.

The panel accepted the evidence of Ms Caslin who stated that Patient F had pre-eclampsia and was therefore a high-risk patient. In her written evidence Ms Caslin stated:

> *"…Upon review of Patient F's notes, I noticed that Patient F's MEOWS chart was completed at 13:05, but there were no further observations completed on the MEOWS despite Patient F having a diagnosis of pre-eclampsia ("PET").*
>
> *… The next observations are not until 20:15.*
>
> *When a patient has PET, it should be documented. If the PET is severe, they will be treated with high dependency unit ("HDU") care. That was not the case for Patient F, so it was important that their observations were documented in the MEOWS chart. There are some observations recorded in Patient F's written notes, but it should also be in the MEOWS chart and the patient is to be escalated if there is any deviation from the norm."*

The panel took account of Patient F's MEOWS chart that showed an entry at 13:05 and no further entries until 20:15, representing a significant gap in documented observations.

The panel also took into account Patient F's clinical notes and determined that although some observations (including blood pressure) were recorded elsewhere in the notes, the absence of contemporaneous MEOWS charting undermined the effective assessment of risk and escalation triggers.

The panel concluded that Mrs Penny failed to adequately assess Patient F's risk on the balance of probabilities and therefore this charge is found proved.

Charge 1o)ii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

o) On 5 July 2023, in respect of Patient F, you:

ii. failed to escalate in respect of severely high blood pressure;

This charge is found proved.

The panel had regard to the evidence of Ms Caslin who stated in her written statement that:

> ***"****Patient F had an epidural sited at 16:00. Following this, there were times when Patient F's blood pressure readings were severely high but there was no documentation to suggest that the patient had been escalated. It should have been escalated because it was known at Patient F had PET so it needed to be controlled. It was important that Patient F's blood pressure did not become dangerously high as it would put Patient F at risk of life changing conditions, such as a stroke."*

Ms Caslin's statement was supported by Patient F's notes that recorded Patient F's blood pressure of 151/106.

The panel accepted Ms Caslin's evidence and was satisfied that the recorded blood pressure constituted severe hypertension requiring escalation.

The panel expressly did not rely on the hypertension guideline provided, as it noted that, it related to antenatal/postnatal management and was not applicable to intrapartum care.

The panel noted that there was no evidence of escalation by Mrs Penny in the records. Therefore, the panel relied on Ms Caslin's expertise and concluded that due to Mrs Penny's failure to escalate Patient F in respect of her blood pressure, Mrs Penny exposed the patient to life-changing risks such as stroke.

The panel concluded that on the balance of probabilities this charge was found proved.

Charge 1o) iii)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

o) On 5 July 2023, in respect of Patient F, you:

iii. failed to escalate in respect of an inability to pass urine;

This charge is found proved.

The panel took account of the evidence of Ms Caslin. In her written statement Ms Caslin stated:

> *"My final concern related to Ms Penny's documented regarding Patient F's passing of urine. With every labouring woman, we are taught bladder care is crucial and their output is maintained but that is especially important for someone with PET. This is because they are at risk of pulmonary oedema so we want to make sure they are not going into fluid retention which is a sign of their kidneys not working properly.*

Whilst it was documented that Patient F was unable to pass urine, there was no escalation of the patient."

The panel noted that entries at approximately 13:50, 14:20 and 15:30 in Patient F's notes supports Ms Caslin's statement.

The panel concluded that Patient F experienced repeated inability to pass urine. While catheterisation was eventually performed, the panel accepted Ms Caslin's evidence that, given the context of pre-eclampsia, repeated urinary retention and low urine output should have been escalated due to risks including fluid overload and pulmonary oedema.

The panel acknowledged that Mrs Penny did not escalate the matter although escalation was required in respect of Patient F, who was a high-risk patient.

Accordingly, the panel found this charge proved.

Charge 1o)iv)

That you, a registered midwife:

1. Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 midwife in that:

o) On 5 July 2023, in respect of Patient F, you:

iv. failed to keep a sufficient record of their observations;

This charge is found proved.

The panel noted that Ms Caslin in her evidence has repeatedly provided examples of how Mrs Penny failed to keep records of her observations in respect of Patient F. In her written statement, Ms Caslin stated:

"When a patient has PET, it should be documented. If the PET is severe, they will be treated with high dependency unit ("HDU") care. That was not the case for Patient F, so it was important that their observations were documented in the MEOWS chart. There are some observations recorded in Patient F's written notes, but it should also be in the MEOWS chart and the patient is to be escalated if there is any deviation from the norm.

Patient F had an epidural sited at 16:00. Following this, there were times when Patient F's blood pressure readings were severely high but there was no documentation to suggest that the patient had been escalated…

…It was clear that Patient F had not been escalated as if she had been and a doctor had reviewed Patient F, there would be documentation within Patient F's notes from the doctor.

…My final concern related to Ms Penny's documented regarding Patient F's passing of urine…."

Patient F's MEOWS chart and clinical records supports Ms Caslin's evidence.

Taking all the evidence into account, the panel determined that observation records were incomplete, MEOWS charting was inadequate and documentation did not sufficiently reflect Patient F's risk status.

The panel was satisfied with the evidence put before it and therefore, this charge was found proved.

Charge 2)a)i)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

a) In respect of Patient A, you failed to:

i) complete adequate checks;

This charge is found proved.

In reaching its decision the panel had regard to the evidence of Ms Jones and Ms Stanford.

The evidence of Ms Jones demonstrates that Mrs Penny failed to perform required clinical monitoring of a high-risk neonate, failed to initiate appropriate feeding documentation, and failed to maintain accurate and complete records concerning both blood glucose monitoring and safe sleeping arrangements, thereby compromising established neonatal safety safeguards.

> *"During the shift from 26 – 27 June 2022, Ms Penny also failed to complete*
>
> *adequate checks on Patient A when she was feeding Patient AA. It was discovered that Ms Penny had failed to do this as there was nothing documented in Patient AA's feeding chart, or any narrative in Patient A or Patient AA's notes relating to the preferences for feeding, for example. I understand a copy of Patient AA's blank feeding chart is produced at* ***Exhibit KJ/14****. The first entry in Patient AA's postnatal notes made by Ms Penny was at 23:45 on 26 June 2022, though 06:00 is crossed out, so I did consider whether she started writing her notes for the night shift at*
>
> *06:00 on 27 June 2022.*
>
> *If Ms Penny had been observing Patient AA being breast fed, then she should have documented, for example, whether Patient AA was appropriately attached to the nipple. Position should also be discussed with the mother, and it should be documented whether it is felt that the mother needs any support. Nothing of this nature was documented in Patient A or Patient AA's notes. I do not think that Patient AA was Patient A's first baby, so she was experienced. However, these types of assessments and discussions still need to take place."*

However, in her oral testimony, Ms Stanford accepted that in Patient AA's postnatal notes, there were references to breast feeding.

Ms Stanford in her oral testimony also stated that in order to complete adequate checks for Patient A she would have expected more detail. She stated:

> *"So mum was diabetic. So this was on first admission to the ward. So then there is nothing else about mum in that documentation overnight. Had she been up to the toilet? Had she passed urine? Was her loss okay? Was there any issues? Did she need any analgesia overnight? Did she sleep?"*

Additionally, Ms Stanford's evidence established the expected standard of postnatal checks, particularly where feeding and fatigue were present. In her written statement, Ms Stanford stated that if Mrs Penny had been observing Patient AA during breastfeeding, she should have documented an assessment of attachment to the nipple, positioning, and whether Patient A required any support, yet no such assessment or discussion was recorded in either Patient A's or Patient AA's notes. Although Patient AA was not Patient A's first baby and she was therefore experienced, Ms Stanford emphasised that proper assessment and documentation are still required in all cases. She explained that while feeding charts are not mandatory for every baby, they are required where risk factors are present, and because Patient A was a gestational diabetic, Patient AA was a baby requiring additional support; accordingly, a feeding chart should have been completed. Ms Stanford stated that Mrs Penny would have known this from her training and experience on the postnatal ward, where feeding charts form part of routine midwifery care. Although in some circumstances a feeding chart may be dispensed with if feeds are comprehensively documented in the baby's notes, Mrs Penny did neither. Ms Stanford further stressed that adequate and frequent checks during feeding are essential, particularly because a mother may be sleepy and at risk of falling asleep while feeding, and that such checks must be both carried out and properly documented.

Patient A, who was Patient A gave live evidence and supported the evidence of Ms Jones and Ms Stanford.

After considering all the evidence, the panel accepted that, only minimal checks were documented; no MEOWS or equivalent structured observations were completed; and that Patient A recalled no further checks after delivery.

The panel therefore concluded that adequate checks were not completed and found this charge as proved.

Charge 2)a)ii)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

    a) In respect of Patient A, you failed to:

        ii) to have and/or document a safe sleeping conversation.

This charge is found proved.

The panel again considered the evidence of Ms Jones and Ms Stanford. In addition, it also had regard to Patient A's postnatal notes.

Ms Jones' evidence confirmed that although Mrs Penny indicated that Patient A had fallen asleep in bed with Patient AA, Mrs Penny failed to document that the baby had been in bed with the mother and did not complete or record a safe sleep discussion, as evidenced by the unticked safe sleep assessment box in the postnatal notes.

This was supported by the evidence of Ms Stanford, who in her written evidence stated:

> *"There were also concerns raised that Ms Penny did not document the safe sleeping conversation that she had with Patient A. However, it is difficult for me to say whether this was an issue that was a cause for concern, as it was a night shift that Ms penny was on, and the safe sleep conversation with mothers*

should take place as early as possible, but it must have taken place by the time the mother and their baby leave the hospital to go home. The purpose of the safe sleeping conversation is to reduce the risk of cot death. Therefore, the temperature of the room, the position of the baby, what the baby is dressed in are areas that a midwife will speak to a mother about."

Patient A's postnatal notes confirmed this.

The panel determined that the safe-sleep discussion box was not completed. It noted that the baby was documented as being in bed with a fatigued mother and that Mrs Penny acknowledged forgetting to document the discussion according to Ms Jones.

While Ms Stanford suggested timing flexibility, the panel placed greater weight on local protocol following a recent incident and Ms Jones's evidence that documentation was mandatory.

Therefore, the panel found the charge as proved.

Charge 2)b)i)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

    b) In respect of Patient AA, you failed to:

i) complete a risk assessment;

This charge is found proved.

The panel took account of the evidence from Ms Stanford who stated in her written statement that:

> *"During Ms Penny's shift, she also failed to complete a risk assessment on Patient AA at the point that Patient AA was transferred to the Ward. This is evident within Patient AA's postnatal notes on pages 1 – 3, where the sections such baby care, baby alerts, key to risk, first baby assessment and personalised care plan have not been filled out.*
>
> *When Patient AA was transferred to the Ward, Ms Penny should have checked Patient AA over to see if see if any additional support was needed, documented a care plan and completed the risk assessment. This was particularly important given that Patient A was diabetic, so a care plan needed to be formulated. By not doing, Ms Penny did not undertake the appropriate observation."*

Patient AA's postnatal notes supported Ms Stanford's evidence.

The panel noted that multiple sections of the neonatal risk assessment were blank, including baby alerts, first-baby assessment and personalised care plan.

Given maternal gestational diabetes, the panel was satisfied a neonatal risk assessment was required, and this was not carried out by Mrs Penny.

Therefore, the charge was found proved.

Charge 2)b)ii)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

b) In respect of Patient AA, you failed to:

ii) keep clear feeding records;

This charge is found proved.

The panel had regard to the evidence of Ms Jones and 4. They also took account the blank feeding chart and the hypoglycaemia guidance to make a decision.

Ms Jones in her written evidence stated:

> *'When Ms Penny was providing care to Patient A on 26 – 27 June 2022, she should have also commenced a feeding chart for Patient A and Patient AA . It is standard practice for a midwife to start a feeding chart when a patient has gestational diabetes, like Patient A did. Ms Penny did not commence a feeding chart, and Patient AA's feeding chart was blank…*
> *…As Patient A was a gestational diabetic, was classified as an 'at risk/high risk' baby…*
> *…Where this is the case, a feeding chart should always be completed. This is common knowledge for midwives…*
> *…During this conversation, Ms Penny said that Patient AA had been taken away from Patient A and given a top up with artificial milk. If a breast-feeding baby is given artificial milk, this should be documented within a specific document***.'**

Ms Stanford in her written evidence stated:

> *'During the shift from 26 – 27 June 2022, Ms Penny also failed to complete adequate checks on Patient A when she was feeding Patient AA. It was discovered that Ms Penny had failed to do this as there was nothing documented in Patient AA's feeding chart, or any narrative in Patient A or Patient AA 's notes relating to the preferences for feeding, for example…The first entry in Patient AA's postnatal notes made by Ms Penny was at 23:45 on 26 June 2022, though 06:00 is crossed out, so I did consider whether she started writing her notes for the night shift at 06:00 on 27 June 2022.'*

Taken all the evidence together, the panel noted that Patient AA was an infant of a diabetic mother and therefore high risk. It determined that a feeding chart should have been commenced in respect of Patient AA which was not done and that feeding records were inconsistent and unclear.

The panel noted that although some feeding was documented, records were fragmented and contradictory.

Therefore, the panel found this charge as proved.

Charge 2)b)iii)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

    b) In respect of Patient AA, you failed to:

iii) complete a feeding chart;

This charge is found proved.

In reaching its decision the panel relied on the same evidential factors as charge 2b)ii) namely evidence of Ms Jones, Ms Stanford, the blank feeding chart and the hypoglycaemia guidance.

For the reasons already set out in relation to charge 2b)ii), and on the basis of those same findings of fact, the panel is satisfied that the elements of charge 2b)iii) are established on the balance of probabilities. No additional or distinct evidential findings are required to reach this conclusion.

Therefore, this charge is found as proved.

Charge 2)b)iv)

That you, a registered midwife:

2. Between 26 and 27 June 2022:

b) In respect of Patient AA, you failed to:

iv) undertake blood glucose monitoring.

This charge is found proved.

As stated earlier, Ms Jones in her written evidence stated that Patient AA was classified as an “at risk/high risk” neonate because Patient A was a gestational diabetic, and under the Trust’s Neonatal Guideline: Hypoglycaemia such babies were required to undergo two

pre-feed blood glucose monitoring checks prior to discharge. She stated that although Mrs Penny documented that she had taken blood glucose readings of 2.7 at 23:45 on 26 June 2022 and 2.8 at 04:00 on 27 June 2022, Patient A reported that no overnight monitoring had taken place. When Patient AA's foot was examined, there was only one heel-prick wound, attributable to a later check carried out by another colleague on the morning of 27 June, whereas there should have been three wounds corresponding to the two recorded overnight checks and the subsequent morning test. Ms Jones stated that an audit of all blood sampling machines across the ward and delivery suite revealed no readings matching those recorded by Mrs Penny, and laboratory assurance confirmed that partial deletion of readings was not possible.

Ms Stanford's evidence corroborated Ms Jones's evidence.

In addition, the panel took account of the neonatal monitoring chart and the postnatal notes which confirmed this.

Ms Jones also provided photographic documents of the blood glucose machine audits that supported Ms Jones's evidence.

In addition, Patient A, in her oral evidence confirmed that no blood glucose testing for Patient AA was done overnight.

The panel accepted compelling cumulative evidence that blood glucose monitoring was not carried out, including:

- only one heel-prick mark present despite two documented readings;
- absence of corresponding machine records at the relevant times;
- evidence that machine entries could not be selectively deleted;

- Patient A’s credible evidence that no testing occurred overnight.

Therefore, the panel determined that this charge was proved on the balance of probabilities.

Charge 3)

That you, a registered midwife:

3. In respect of 2) b) iv) above, you completed blood glucose observation documentation.

This charge is found proved.

The panel had already found proved charge 2b)iv) that Mrs Penny did not undertake blood glucose monitoring for Patient AA.

The panel was satisfied that blood glucose readings of 2.7 and 2.8 were nevertheless recorded in two separate documents and that those entries were made by Mrs Penny. This was supported by the neonatal monitoring chart, the postnatal notes and the evidence of Ms Jones who stated in her written statement that:

> *"I then checked Patient AA's notes and I saw that Ms Penny had documented that the blood monitoring checks had been completed…*
>
> *On this chart, the row which says 'date' has time entries of 23:45*
>
> *and 04:00 as the times which Ms Penny carried out the blood monitoring checks.*
>
> *At the bottom of the chart in the second row from the bottom, Ms Penny*

has recorded the blood sugar reading for 23:45 as 2.7, and the blood sugar reading for 04:00 as 2.8…

On the last page of Patient AA's notes, an entry at the top of the page has been made by Ms Penny where the date and time reads '26/6/22' and '23:45'. Within this entry, it also reads that Patient AA's blood sugar reading was 2.7. The entry below for '27/06/22' at 04:00 also reads that Patient AA's blood sugar reading was 2.8."

The panel concluded that, as a matter of fact, Mrs Penny completed blood glucose observation documentation despite not having undertaken the monitoring.

Therefore, this charge is found proved.

Charge 4)a)

That you, a registered midwife:

4. Your actions at charge 3 were dishonest in that:
    a. You knew the record you had created was inaccurate;

In reaching its decision the panel took account of the fact that charge 2b)iv) and charge 3 were already found proved.

In addition, the panel carefully examined Mrs Penny's changing accounts across multiple investigatory meeting records. The panel noted that Mrs Penny initially asserted that she had undertaken the monitoring but later claimed that she had done the monitoring but could not remember the results. The panel also noted that Mrs Penny gave subsequent explanations that she panicked, believed the results were "normal", and wrote values she

thought were correct and eventually she acknowledged that she recorded inaccurate information at a disciplinary hearing on 11 October 2022. The panel noted that these explanations evolved only after contrary evidence such as machine audits and the absence of heel-prick marks was put to Mrs Penny.

Moreover, the panel also noted that Ms Jones suggested that Mrs Penny might have made an admission that she did not conduct blood monitoring checks on Patient A. Ms Jones stated in her written statement that:

> *“I teach a human factors course, and Ms Penny came along to one of the dates as a part of the actions that she required to take as a result of the allegations. When I saw Ms Penny, said 'maybe I did forget' in respect of the blood monitoring checks that Patient A said were not performed.”*

In contrast, the panel noted that Ms Stanford’s account of the conversation between her and Mrs Penny with regards to the matter was conflicting. Ms Stanford in her written statement stated:

> *“I asked Ms Penny to explain the events from her perspective. Ms Penny said to me that she had completed the blood monitoring checks, and that she did not know why the mum would have said that she had not completed these. Ms Penny provided a clear explanation about conversations with Patient A and what Patient A looked like. Ms Penny's account seemed very reasonable”.*

Having already found that the monitoring did not occur, the panel concluded that Mrs Penny must have known she was recording results not derived from an actual test.

The panel therefore found that, at the time the entries were made, Mrs Penny knew the records were inaccurate.

Applying the Ivey test which is derived from the case of *Ivey v Genting Casinos* [2017] UKSC 67, the panel was of the view that an honest course of action would have been to not record blood glucose testing results which Mrs Penny knew to be false, escalate the matter and arrange accurate blood glucose testing as soon as possible.

The panel next considered whether ordinary decent people would regard deliberately recording fabricated clinical results as dishonest. The panel concluded that ordinary decent people would reach this conclusion.

Accordingly, the panel found that charge 4a) was proved.

Charge 4)b)

That you, a registered midwife:

4. Your actions at charge 3 were dishonest in that:

    b. You intended to mislead others that you had undertaken blood glucose monitoring.

This charge is found proved.

The panel determined that Mrs Penny recorded specific numerical values for blood glucose monitoring (2.7, 2.8) at defined times between 26 June 2022 and 27 June 2022. It noted that Mrs Penny told Ms Stanford that she had completed the blood glucose monitoring. It also noted that the documentation created the clear impression that required monitoring had occurred.

Having found charge 4a) as proved the panel was satisfied that Mrs Penny had deliberately and intentionally falsified the record.

The panel rejected the suggestion that this was merely careless or incompetent documentation. This is because the entries made by Mrs Penny were precise, they aligned with what would be expected if monitoring had been performed and they were relied upon by others reviewing the notes.

The panel was of the view that ordinary decent people would regard recording invented clinical results, thereby conveying that a high-risk baby had been monitored when they had not, as dishonest conduct intended to mislead.

Therefore, on the balance of probabilities, the panel found charge 4b) as 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/or misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired.

Submissions on lack of competence

Mr Kabasinskas submitted that the panel should consider the NMC's guidance on lack of competence (FtP-2B), which provides that a lack of competence usually involves an unacceptably low standard of professional performance, judged against a fair sample of a registrant's work, demonstrating deficiencies in knowledge, skill or judgment which could place patients at risk. He submitted that the appropriate standard against which Mrs Penny should be assessed was that of a reasonable Band 5 registered midwife, rather than any higher or more demanding standard.

Mr Kabasinskas referred the panel to *Holton v General Medical Council* [2006] EWHC 2960 (Admin). He submitted that the assessment of competence is an objective exercise. Personal matters, such as inadequate education, insufficient training or personality, are irrelevant when determining whether professional performance was deficient. By contrast, external factors, such as workload pressures, lack of resources or professional isolation caused by the working environment, may properly be taken into account when assessing competence.

Mr Kabasinskas submitted that the facts found proved demonstrated that Mrs Penny's competence fell below the standard expected of a Band 5 registered midwife. He submitted that the concerns were numerous, widespread and related to fundamental aspects of midwifery practice, including:

- medication administration;
- compliance with clinical protocols;
- interpretation and escalation of CTG findings;
- application of observation stickers;
- carrying out CTGs appropriately;
- undertaking and interpreting observations;
- record keeping;
- infection prevention and control;

- recognising when an episiotomy was required;
- identifying a baby's condition at birth;
- umbilical cord clamping;
- risk assessments;
- escalation of maternal blood pressure and urinary concerns.

Mr Kabasinskas submitted that these failings represented fundamental clinical skills expected of every practising midwife and occurred despite extensive support having been provided, including supervision, supported practice, action plans, regular feedback, formal training and reflective exercises.

Mr Kabasinskas submitted that the evidence satisfied the three-stage approach to determining lack of competence:

1. Awareness of concerns – Mrs Penny had been made aware of concerns regarding her competence from April 2021 onwards through numerous meetings and discussions.
2. Opportunity to improve – Mrs Penny had been given significant opportunities to improve through action plans, supervision and support.
3. Further assessment – Despite these opportunities, Ms Thornton’s witness statement confirmed that Mrs Penny had not completed her action plan by January 2024, although it had been due for completion on 20 August 2023. He submitted that Mrs Penny only resumed clinical practice on 2 January 2024 and remained subject to the action plan.

Accordingly, Mr Kabasinskas submitted that all three stages were clearly established.

Mr Kabasinskas further submitted that Mrs Penny's conduct breached numerous provisions of The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (‘the Code’), including paragraphs 1.2, 1.4, 8.1–8.6, 9.2, 10.1–10.3, 13.1–

13.2 and 19.1–19.4, relating to delivering fundamental care, communication, record keeping, recognising deterioration, escalation, patient safety and infection prevention.

Mr Kabasinskas submitted that the evidence demonstrated that Mrs Penny's professional performance was objectively below the standard expected of a registered Band 5 midwife and therefore amounted to a lack of competence.

Submissions on misconduct

Mr Kabasinskas submitted that whether the facts amounted to misconduct was ultimately a matter for the panel's professional judgment. He reminded the panel of the definition of misconduct established in *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, namely conduct involving an act or omission falling short of what would be proper in the circumstances. He further relied upon *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), submitting that the shortcoming must be serious and that the seriousness should be given its proper weight. He submitted that negligent conduct may amount to serious professional misconduct where the negligence is sufficiently serious.

Mr Kabasinskas submitted that the appropriate benchmark for determining what was proper in the circumstances was the Code, to which Mrs Penny was subject throughout the relevant period.

In relation to the misconduct charges, he submitted that the following provisions of the Code were engaged:

- Charge 2a): paragraphs 1.2, 3.1, 10.1, 13.4, 19.1 and 19.2;
- Charge 2b): paragraphs 1.2, 1.4, 3.1, 10.1, 10.2, 17.1, 19.1 and 19.2;
- Charge 3: paragraph 10.3;
- Charge 4: paragraphs 20.1 and 20.2, insofar as they concern honesty and integrity.

Mr Kabasinskas referred the panel *to Professional Standards Authority v General Medical Council and Onyekpe* [2023] EWHC 2391 (Admin), submitting that particular regard should be had to the vulnerability of the individual affected when assessing seriousness. He submitted that this was especially relevant to Charge 2b), as Patient AA was a newborn baby and therefore particularly vulnerable.

Mr Kabasinskas also referred the panel to the NMC guidance on misconduct, which states that serious professional misconduct is more likely to arise where the conduct occurs during the provision of professional care.

Mr Kabasinskas submitted that Mrs Penny's conduct, in each of the charges found proved, fell seriously below the standards expected of a registered midwife and therefore amounted to misconduct.

Submissions on impairment

Mr Kabasinskas submitted that the panel should apply the updated NMC guidance on impairment, which poses the critical question:

> *'Can this midwife practise safely and effectively without restriction?'*

He submitted that the panel should consider both the nature of the concerns and the wider public interest.

Mr Kabasinskas referred the panel to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), submitting that impairment requires consideration not only of current risk to the public but also the need to uphold professional standards and maintain public confidence in the profession.

He further referred to paragraph 76 of Grant, adopting the modified Dame Janet Smith test, and submitted that all four limbs were engaged.

Limb A – Risk of Harm

Mr Kabasinskas submitted that Mrs Penny's lack of competence demonstrated an inability to provide safe care in relation to fundamental midwifery skills and clinical judgment. Although no actual physical harm resulted from the competence concerns, he submitted that this was only because colleagues intervened and provided support. Accordingly, there remained a clear potential for patient harm.

In relation to Charges 2, 3 and 4, Mr Kabasinskas submitted that Mrs Penny's omissions placed Patient AA, a newborn baby, at risk of harm. He further submitted that Patient A, the baby's mother, had given evidence that she continued to experience the psychological consequences of Mrs Penny's omissions, demonstrating that harm had been suffered.

Limb B – Bringing the Profession into Disrepute

Mr Kabasinskas submitted that Mrs Penny's lack of competence, misconduct and dishonest conduct had brought the profession into disrepute.

Limb C – Breach of Fundamental Tenets

Mr Kabasinskas submitted that the concerns involved fundamental midwifery skills. Unless remedied, Mrs Penny remained liable to repeat those failings and therefore to breach the fundamental tenets of the profession in the future.

Limb D – Dishonesty

Mr Kabasinskas submitted that Mrs Penny had acted dishonestly and remained liable to act dishonestly in the future.

Mr Kabasinskas reminded the panel that impairment must be assessed as at the date of the hearing. He referred the panel to *Cohen v General Medical Council* [2008] EWHC 581*,* submitting that three questions should be considered.

(1) Are the concerns remediable?

Mr Kabasinskas referred to the NMC guidance FtP-16A and submitted that whilst deficiencies in clinical competence may generally be capable of remediation, dishonesty presents an attitudinal concern which is among the most serious and difficult forms of misconduct to remedy.

(2) Have the concerns been remedied?

Mr Kabasinskas referred the Panel to Mrs Penny's written response to the regulatory concerns contained within the exhibits bundle. He accepted that Mrs Penny had acknowledged responsibility, reflected upon the events and described steps she believed she should have taken. However, he submitted that:

- she failed to demonstrate sufficient understanding of the impact of her actions upon those receiving care;
- she did not adequately address the risks created by her conduct;
- in relation to dishonesty, her acceptance was qualified;
- she sought to explain the dishonesty by suggesting she had confused patients, which the NMC submitted appeared to minimise her conduct;
- she had altered her explanation during the local investigation;
- she demonstrated insufficient insight into why she should not have entered information into patient records when uncertain of the facts.

Mr Kabasinskas therefore submitted that Mrs Penny's insight remained insufficient.

Although Mrs Penny stated that she had completed a number of training courses, he submitted that there was no documentary evidence before the panel verifying those courses and no evidence of strengthened practice or current safe clinical practice.

(3) Is repetition highly unlikely?

Mr Kabasinskas submitted that there remained insufficient insight, no evidence of strengthened practice and no evidence of current safe practice. Accordingly, he submitted that there remained a continuing risk to public safety.

Mr Kabasinskas submitted that Mrs Penny's continuing deficiencies in competence created an ongoing risk that members of the public could be exposed to unsafe care. He submitted that restrictions upon her practice remained necessary in order to protect the public.

Mr Kabasinskas submitted that impairment was also required on wider public interest grounds.

In relation to the competence concerns, he submitted that the public is entitled to expect that registered midwives possess the necessary competence to provide safe maternity care. Allowing a midwife whose competence remained deficient to practise unrestricted would undermine public confidence in the profession. He further submitted that honesty is a fundamental tenet of the nursing and midwifery profession. Mrs Penny's dishonest conduct demonstrated attitudinal concerns regarding her professionalism, making a finding of impairment necessary to uphold proper professional standards and maintain public confidence in the profession.

Accordingly, Mr Kabasinskas invited the panel to find that Mrs Penny's fitness to practise was currently impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor who referred the panel to the cases of *Grant, Cohen* and *Nandi v General Medical Council*.

Decision and reasons on lack of competence

The panel considered whether the facts found proved under charge 1 amounted to a lack of competence. It had regard to the submissions made on behalf of the NMC, the legal advice it had received and the guidance on the fitness to practise.

The panel recognised that a lack of competence ordinarily involves an unacceptably low standard of professional performance, demonstrated through a fair sample of a registrant's work. The panel assessed Mrs Penny's performance objectively against the standard reasonably expected of a Band 5 registered midwife. It did not apply any higher or more demanding standard.

The panel considered that the facts found proved under charge 1 concerned numerous, repeated and wide-ranging deficiencies across fundamental areas of midwifery practice. These included:

- the safe administration and management of medication;
- compliance with relevant clinical policies and protocols;
- the performance, interpretation and escalation of cardiotocography ("CTG");
- the recognition and escalation of abnormal clinical observations;
- maternal and neonatal assessment;
- infection prevention and control;
- labour ward management;
- risk assessment;
- cord clamping;
- recognition of a baby's condition at birth;
- professional judgment; and
- the completion of clear, accurate and contemporaneous clinical records.

The panel considered the evidence of the witnesses who had directly supervised and assessed Mrs Penny in clinical practice. It attached significant weight to the evidence of Ms Jones, Ms Caslin, Ms Thornton and Ms Horton, which it considered to be fair, balanced and supported by contemporaneous documentary evidence.

The panel noted that the witnesses described repeated occasions on which Mrs Penny required prompting in relation to routine and fundamental aspects of midwifery practice. The evidence demonstrated deficiencies in Mrs Penny's ability to recognise and appropriately escalate clinical concerns, interpret CTG traces, document maternal and neonatal observations, comply with induction and escalation protocols, administer medication safely and manage patients independently.

The panel noted, in particular, evidence that Mrs Penny failed to recognise when blood pressure medication was due, did not correctly follow the relevant escalation protocol and required regular prompting in relation to CTG management, interpretation and escalation. The panel also took account of the evidence that colleagues would not have felt comfortable leaving Mrs Penny to care for patients without supervision.

The panel considered the evidence relating to failures to recognise abnormal findings, delays in escalation, inadequate assessment of clinical urgency and deficiencies in documentation. It also considered the concerns relating to delivery management, cord clamping and record keeping.

The panel found Ms Caslin's evidence particularly persuasive because it was derived substantially from objective documentary material, including CTG traces, patient records and observation charts. That evidence demonstrated repeated failures in documentation, escalation and the recognition of clinical risk.

The panel acknowledged that a newly qualified Band 5 midwife may initially require support and supervision. However, it considered that Mrs Penny's shortcomings extended

significantly beyond matters attributable to inexperience. They were not isolated errors, momentary lapses or failings arising during a single difficult shift. Rather, they constituted a persistent pattern of deficient professional performance across multiple clinical areas over a prolonged period.

The panel applied the three-stage approach identified in the submissions of Mr Kabasinskas.

First, the panel was satisfied that Mrs Penny had been made aware of the concerns regarding her competence. Concerns had been raised with her from April 2021 onwards through regular discussions, meetings, feedback and formal performance processes.

Second, the panel was satisfied that Mrs Penny had been given a proper and extensive opportunity to improve. The Trust had implemented numerous remedial measures, including action plans, enhanced supervision, supported practice, educational support, reflective discussions, competency reviews, regular meetings and performance management.

Third, the panel considered whether Mrs Penny's practice had been further assessed and whether she had demonstrated sufficient improvement. The panel noted that Mrs Penny's action plan was due to have been completed by 20 August 2023. However, the evidence of Ms Caslin was that it remained incomplete when her witness statement was finalised in January 2024. The panel noted that Mrs Penny had resumed clinical practice on 2 January 2024 but remained subject to the action plan. The panel considered that the evidence did not demonstrate sustained improvement despite the extensive support provided.

The panel was therefore satisfied that all three stages had been established. Mrs Penny had been informed of the concerns, had been provided with extensive opportunities and support to improve, and had nevertheless failed to demonstrate sustained improvement when her practice was reassessed.

The panel determined that Mrs Penny's conduct breached the following provisions of the Code:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work cooperatively

To achieve this, you must:

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 health and care professionals and staff
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

10.1 complete 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
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)
19.3 keep to and promote recommended practice in relation to controlling and preventing infection
19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public'

The panel *considered* that these provisions went to fundamental aspects of safe and effective midwifery practice.

The panel was satisfied that the facts found proved disclosed a fair sample of Mrs Penny's work over a substantial period. They demonstrated repeated and persistent shortcomings across multiple areas of practice and was below the standard that one would expect of the average registered nurse acting in Mrs Penny's role.

The panel therefore determined that the facts found proved under charge 1 demonstrated a lack of competence.

Decision and reasons on misconduct

The panel next considered whether the facts found proved under charges 2, 3 and 4 amounted to misconduct.

The panel bore in mind that misconduct must represent a serious departure from the standards expected of a registered professional. It considered Mrs Penny's conduct by reference to the standards set out in the NMC Code and exercised its own professional judgment.

Charge 2a)

Charge 2a) concerned Mrs Penny's failures in relation to Patient A, including the failure to complete adequate checks and the failure to undertake and/or document a safe-sleeping conversation.

The panel considered that these omissions related directly to the safety of Patient A and her baby, Patient AA. Mrs Penny was responsible for ensuring that the necessary checks were completed and that appropriate advice was provided and documented. Her failure to do so created a foreseeable risk of harm.

The panel also considered Mrs Penny's explanation that the ward was busy and that she was working the third of three consecutive night shifts. The panel recognised that workload and fatigue may provide relevant context. However, Mrs Penny remained professionally responsible for assessing whether she could practise safely, prioritising essential clinical tasks and escalating or seeking assistance where she was unable to complete them.

The panel determined that Mrs Penny's conduct in relation to charge 2a) breached the following provisions of the Code:

'***1 Treat people as individuals and uphold their dignity***
To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

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

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.4 take account of your own personal safety as well as the safety of people in your care

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures'

The panel considered that the failures under charge 2a were sufficiently serious to amount to misconduct.

Charge 2b)

Charge 2b) concerned the failure to complete a risk assessment, a failure to keep clear feeding records, a failure to complete a feeding charts and a failure to undertake and accurately record blood glucose monitoring in respect of Patient AA, a newborn baby.

The panel considered the objective audit evidence relating to the blood glucose monitoring machines. Although Mrs Penny maintained that the checks had been undertaken, the audit was unable to identify corresponding blood glucose readings for Patient AA. The panel noted that the audit process had successfully matched readings for other babies and that there was no evidence that records could have been deleted from the machines.

The panel also considered the evidence of Patient A, who stated that Mrs Penny attended to assist with feeding but did not observe Mrs Penny undertake the required blood glucose monitoring.

The panel considered the risk assessment, feeding documentation and monitoring to be clinically important because Patient AA was a newborn baby who required additional

protection and vigilance. The failure to undertake the risk assessment, feeding documentation and monitoring exposed Patient AA to a risk of harm.

The panel further considered that Mrs Penny recorded that blood glucose monitoring had taken place when the objective audit evidence demonstrated that corresponding readings could not be identified. Every registered midwife is under a fundamental obligation to maintain accurate clinical records. Such records are essential to patient safety, continuity of care and informed clinical decision-making.

The panel determined that Mrs Penny's conduct in relation to charge 2b) breached the following provisions of the Code:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *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*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*
>
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> ***10 Keep clear and accurate records relevant to your practice***
> ***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> *To achieve this, you must:*

10.1 complete 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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
To achieve this, you must:

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures'

The panel considered that Mrs Penny's failure to undertake the required risk assessment, feeding records, feeding charts and blood glucose monitoring, represented a serious

departure from the standards expected of a registered midwife. Her conduct therefore amounted to misconduct.

Charge 3

Charge 3 concerned the completion of an inaccurate clinical record.

The panel considered that the maintenance of accurate records is a fundamental professional obligation. Clinical records must provide a reliable account of the care that has been delivered. Subsequent healthcare professionals must be able to rely upon those records when making decisions about ongoing treatment and care.

The panel was of the view that by recording clinical care that had not taken place, Mrs Penny created a false and misleading account of Patient AA's care. This had the potential to mislead other professionals and to compromise the continuity and safety of care.

The panel determined that Mrs Penny's conduct breached the following within the Code:

> ***'10 Keep clear and accurate records relevant to your practice***
> ***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> *To achieve this, you must:*
>
> *10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements'*

The panel considered that the deliberate creation of an inaccurate clinical record constituted a serious abuse of professional trust and amounted to misconduct.

Charge **4**

Charge 4 concerned dishonesty.

The panel had found that Mrs Penny knowingly made an inaccurate clinical entry and intended that entry to be accepted as an accurate record of care. The panel considered that honesty and integrity are fundamental requirements of registered nursing and midwifery practice.

Mrs Penny's conduct breached the following provisions of the Code:

> ***'20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
>
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

The panel considered that dishonest conduct involving a clinical record was particularly serious because healthcare professionals, patients and the public must be able to trust the accuracy of records created by registered professionals.

The panel determined that Mrs Penny's dishonesty represented a serious departure from the standards expected of a registered midwife and amounted to misconduct.

The panel concluded that Mrs Penny's failures to complete essential checks, undertake blood glucose monitoring, protect a vulnerable newborn baby and maintain accurate clinical records were serious.

The panel also considered the deliberate creation of an inaccurate clinical record and the associated dishonesty to be fundamentally incompatible with the standards expected of a registered midwife.

The panel therefore determined that the facts found proved under charges 2, 3 and 4 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next considered whether Mrs Penny's fitness to practise was currently impaired by reason of her lack of competence and misconduct.

The panel had regard to the NMC's guidance on impairment and exercised its own independent professional judgment. The panel recognised that impairment is a forward-looking exercise. The purpose is not to punish the registrant for past failings but to determine whether she is currently fit to practise safely, effectively and without restriction.

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

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

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

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered whether Mrs Penny had in the past acted, or was liable in the future to act, to put patients at an unwarranted risk of harm. The panel found this limb engaged.

Mrs Penny's lack of competence concerned fundamental areas of midwifery practice, including clinical assessment, CTG interpretation, escalation, medication management, record keeping and professional judgment. Her failures created a real risk that

deterioration or clinical concerns would not be recognised or acted upon appropriately. Although the competence failings did not result in identified physical harm, the panel considered that this was substantially due to the intervention, prompting and supervision provided by colleagues. The potential for serious harm was nevertheless present.

In relation to charges 2, 3 and 4, Mrs Penny's failure to undertake blood glucose monitoring placed Patient AA, a vulnerable newborn baby, at risk of harm. The panel also took account of the evidence that Patient A continued to suffer psychological effects arising from the events.

The panel considered whether Mrs Penny had in the past brought, or was liable in the future to bring, the profession into disrepute. The panel found this limb engaged.

Mrs Penny's widespread clinical failings, her inaccurate recording of care and her dishonesty were capable of seriously undermining the reputation of the nursing and midwifery professions.

The panel considered whether Mrs Penny had in the past breached, or was liable in the future to breach, fundamental tenets of the profession. The panel found this limb engaged.

The safe assessment of patients, recognition and escalation of clinical risk, administration of medication, maintenance of accurate records, adherence to clinical protocols and protection of vulnerable patients are fundamental tenets of midwifery practice. Mrs Penny's conduct breached those tenets.

In the absence of sufficient remediation and insight, the panel considered that there remained a risk that Mrs Penny would breach those fundamental tenets again.

The panel considered whether Mrs Penny had acted dishonestly in the past or was liable to act dishonestly in the future. The panel had found that Mrs Penny acted dishonestly by creating an inaccurate clinical record.

The panel therefore found the past-looking element of this limb engaged. In considering future risk, the panel had regard to the limited evidence of insight and remediation relating to the dishonesty.

The panel therefore determined that all four limbs of the Dame Janet Smith test were engaged.

Regarding insight, the panel considered Mrs Penny's written response to the regulatory concerns. It noted that Mrs Penny had acknowledged that she was accountable for her actions, had reflected upon certain events and had identified some of the steps she should have taken. She had also referred to having undertaken training.

However, the panel considered that Mrs Penny's insight remained limited. Mrs Penny did not adequately address the impact of her conduct upon the patients in her care or demonstrate a sufficiently developed understanding of the risks created by her actions.

In relation to the dishonesty, the panel considered that Mrs Penny had not provided a satisfactory explanation or demonstrated sufficient insight into why she should not have entered information into a clinical record when she was uncertain whether the care had been provided.

The panel noted that Mrs Penny had suggested that she had confused patients. It considered that this explanation had the potential to minimise her conduct. It also took account of the fact that Mrs Penny's explanation had changed during the local investigation.

The panel had limited documentary evidence confirming the training Mrs Penny said that she had completed. Nor did it have:

- evidence that Mrs Penny had completed targeted remediation;

- updated competency assessments;
- recent reflective work addressing the specific concerns;
- testimonials from employers or colleagues;
- evidence of strengthened practice; or
- evidence of recent safe and unrestricted clinical practice.

The panel also noted that extensive remedial support had previously been provided by the Trust, including action plans, enhanced supervision, educational support, reflective discussions, meetings with senior midwives, additional monitoring and competency assessments. Despite those interventions, significant concerns persisted.

The panel therefore determined that Mrs Penny had not demonstrated sufficient insight or remediation.

The panel considered whether the concerns were capable of remediation. It accepted that clinical deficiencies are generally capable of remediation through targeted training, supervision, reflection, competency assessment and the development of insight.

However, the panel considered that the concerns in this case were not isolated or confined to one area of practice. They involved CTG interpretation, clinical assessment, recognition of risk, escalation, medication management, documentation, professional judgment, adherence to protocols and record keeping. They represented a broad pattern of deficient professional performance demonstrated over a significant period.

The panel further considered that dishonesty is more difficult to remediate because it may indicate an underlying attitudinal concern.

The panel therefore determined that the clinical concerns were, in principle, remediable, but that the dishonesty was more difficult to remediate and required compelling evidence of insight and attitudinal change.

The panel considered whether repetition was highly unlikely. Given the breadth and persistence of the clinical concerns, the incomplete action plan, the absence of evidence of strengthened practice and the limited insight demonstrated, the panel could not conclude that repetition was highly unlikely.

The panel considered that there remained a real risk that Mrs Penny would repeat the clinical failings and again place patients at risk.

In relation to dishonesty, the panel considered that Mrs Penny's limited insight and the absence of persuasive evidence of attitudinal remediation meant that a risk of repetition also remained.

The panel noted that Mrs Penny's deficiencies concerned fundamental areas of clinical practice and had continued despite extensive support and supervision. There was no reliable evidence that the concerns had been fully remediated or that Mrs Penny was now capable of safe and effective unrestricted practice.

The panel determined that a finding of impairment was necessary on the grounds of public protection to protect patients from the risk of future harm.

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

Members of the public are entitled to expect a registered Band 5 midwife to recognise clinical deterioration, interpret and escalate CTG concerns, maintain accurate clinical records, administer medication safely, comply with established protocols, act with integrity and place patient safety at the centre of her practice. Mrs Penny's conduct departed significantly from those expectations.

The panel considered that public confidence in the profession would be seriously undermined if no finding of impairment were made in respect of a registrant who had demonstrated persistent failings across multiple areas of clinical practice and had deliberately created an inaccurate clinical record.

The panel also determined that a finding of impairment was required to declare and uphold proper professional standards. Failure to make such a finding would risk sending the wrong message to the profession and the public regarding the importance of patient safety, accurate documentation, medication management, escalation of concerns, honesty and professional accountability.

Therefore, the panel also finds that Mrs Penny's fitness to practise is impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Penny's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Penny off the register. The effect of this order is that the NMC register will show that Mrs Penny has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor who referred the panel to the cases of *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Holton v GMC* [2006] EWHC 2960 (Admin). The legal assessor also referred the panel to Article 29 (6) of the 2001 Nursing

and Midwifery Order, and advised the panel that it has no power, in the present circumstances, to impose a striking off order in respect of the finding of lack of competence.

Submissions on sanction

Mr Kabasinskas submitted that the panel should first have regard to the NMC guidance titled "*The Purpose and Approach to Sanctions*" (SAN-1). He reminded the panel that the purpose of any sanction is not to punish Mrs Penny, but to protect the public, maintain public confidence in the nursing and midwifery professions, and uphold proper professional standards.

Mr Kabasinskas submitted that, when determining the appropriate sanction, the panel should consider the available sanctions in ascending order, beginning with the least restrictive option. In doing so, the panel should have regard to the reasons why Mrs Penny's fitness to practise had been found impaired, together with the relevant aggravating and mitigating factors.

Mr Kabasinskas submitted that the following aggravating features were present.

Firstly, he submitted that there had been an abuse of Mrs Penny's position of trust, particularly having regard to the panel's findings in respect of the misconduct charges.

Secondly, whilst the misconduct occurred during a single shift, Mr Kabasinskas submitted that the panel had found numerous failings, demonstrating a pattern of misconduct when all of the charges were considered collectively.

Thirdly, he submitted that Mrs Penny's conduct deliberately or recklessly placed patients at risk of suffering harm. He acknowledged that it would ultimately be for the panel to determine whether her conduct was deliberate or reckless.

Fourthly, Mr Kabasinskas submitted that Mrs Penny's failure to attend the hearing and engage fully with the fitness to practise proceedings without good reason amounted to an aggravating factor. Whilst Mrs Penny had engaged with the NMC to some extent during the investigation, she had failed to attend the substantive hearing. He submitted that, under the updated sanctions guidance, a failure to engage without good reason may properly be regarded as an aggravating feature.

Mr Kabasinskas further submitted that Mrs Penny had demonstrated limited insight. He referred the panel to the Sanctions Guidance, which states that an absence of insight, or only very limited insight, is likely to constitute a significant aggravating factor because it is difficult for a professional to address concerns unless they properly understand what occurred and why it was wrong. He reminded the panel that, where particularly serious concerns have been found proved, insight may carry less weight. He also observed that the same feature should not be treated as both an aggravating and a mitigating factor, leaving it to the panel to determine the appropriate weight to attach to Mrs Penny's level of insight.

Finally, Mr Kabasinskas submitted that the vulnerability of the patients receiving care, particularly the involvement of a newborn baby, constituted a further aggravating feature.

Turning to mitigation, Mr Kabasinskas submitted that Mrs Penny had provided certain matters of personal mitigation within her written responses to the NMC. He submitted that these matters were of a private nature and, because the hearing was taking place in public, he did not propose to set them out in detail. Nevertheless, he invited the panel to consider them when determining sanction.

Mr Kabasinskas also reminded the panel of Mrs Penny's explanation regarding the level of support available to her within the workplace, inviting the panel to consider that explanation insofar as it considered it relevant.

Mr Kabasinskas submitted that the appropriate and proportionate sanction in this case was a striking-off order. He reminded the panel that Mrs Penny had been notified, in the original Notice of Hearing dated 30 December 2025, that a striking-off order was available as a potential sanction. Although certain charges had not ultimately been found proved, he submitted that this did not materially reduce the overall seriousness of the case, particularly as the remaining findings included both lack of competence and serious misconduct involving dishonesty.

Mr Kabasinskas submitted that taking no further action or imposing a caution order would be wholly inappropriate. He submitted that the seriousness of the findings alone rendered those outcomes insufficient. Furthermore, the evidence demonstrated that Mrs Penny had repeated the same clinical errors despite receiving significant support, supervision and development opportunities, thereby placing patients at risk of serious harm.

Mr Kabasinskas submitted that a conditions of practice order would also be inappropriate. He reminded the panel that it had already found that Mrs Penny had received extensive support, supervision, action plans and developmental opportunities, none of which had resulted in sustained improvement. Accordingly, even if the case concerned clinical competence alone, he submitted that conditions of practice would not be workable. More importantly, however, the case also involved serious misconduct, including dishonesty. Mr Kabasinskas submitted that conditions of practice are generally unsuitable where dishonesty has been found proved because such concerns relate to professional attitude and integrity rather than deficiencies in clinical competence alone.

Mr Kabasinskas further referred the panel to the Sanctions Guidance for Highest Risk Cases (SAN-4) dealing with dishonesty. He submitted that honesty is central to professional practice because of the exceptional degree of trust placed in registered professionals. Accordingly, allegations of dishonesty will almost always place a professional at risk of being struck off, although the seriousness of the particular dishonest conduct must always be assessed.

Mr Kabasinskas submitted that one of the factors identified within the guidance as favouring strike-off was engaged in this case, namely dishonesty involving a direct risk to people receiving care. He submitted that this was particularly relevant to the findings under charges 2 and 4.

Mr Kabasinskas reminded the panel that this was a hybrid case, involving findings of both lack of competence and misconduct. He accepted that, where impairment is found solely upon lack of competence, a striking-off order is generally unavailable. However, he submitted that where a case involves both lack of competence and serious misconduct, including dishonesty, a striking-off order remains available. In support of that proposition, he referred the panel to *Okafor v Nursing and Midwifery Council* [2015] EWHC 1872 (Admin). He submitted that the Court confirmed that, in such hybrid cases, a striking-off order is imposed by reason of the misconduct, including dishonesty, rather than the lack of competence itself.

Mr Kabasinskas submitted that the panel should nevertheless consider a suspension order before deciding whether strike-off was required. He referred the panel to the sanctions guidance relating to suspension (SAN-2D), which explains that suspension is generally appropriate where the concerns are very serious but are not fundamentally incompatible with continued registration.

Mr Kabasinskas submitted that the panel had already found Mrs Penny's impairment to be very serious. However, he submitted that the misconduct, and particularly the dishonesty, was fundamentally incompatible with remaining a registered professional. He further submitted that the guidance requires the panel to consider whether the risks to the public can be adequately managed by temporary removal from the Register. Whilst suspension represents temporary removal, Mr Kabasinskas submitted that the NMC's position was that removal from the Register was indeed necessary. The remaining question for the panel was whether that removal should be temporary or permanent.

Mr Kabasinskas submitted that a suspension order would not adequately protect the public, maintain public confidence or uphold professional standards in light of the seriousness of the findings, particularly the dishonest conduct.

Mr Kabasinskas also invited the panel to consider whether it was realistic that Mrs Penny could return to unrestricted practice following a period of suspension. He submitted that there was no evidence before the panel suggesting that Mrs Penny would be capable of returning safely to unrestricted practice in the future. Mrs Penny had not attended the hearing, had not engaged with the proceedings and had provided no evidence demonstrating how she intended to address the concerns identified by the panel.

Mr Kabasinskas reminded the panel that, in its impairment decision, it had already identified two significant concerns:

- Mrs Penny's lack of competence had placed patients at risk of harm; and
- Mrs Penny had failed to demonstrate meaningful insight into her dishonest conduct or explain why she now understood it to have been wrong and why it would not be repeated.

Mr Kabasinskas submitted that the panel therefore had no evidential basis upon which to conclude that Mrs Penny would realistically be capable of addressing those concerns during a period of suspension.

Mr Kabasinskas referred the panel to the NMC guidance "*Deciding Between Suspension and Strike-Off*" (SAN-3). He reminded the panel that suspension orders are ordinarily subject to review before expiry and may subsequently be extended. However, he submitted that it would not be appropriate to suspend a registrant merely to provide a final opportunity for engagement where there was no evidence that engagement was likely.

The guidance requires consideration of:

- Whether public confidence would be maintained if Mrs Penny returned to unrestricted practice following a period of suspension;
- Whether Mrs Penny's insight and attitude were realistically capable of improving during the suspension period; and
- Whether it was likely that Mrs Penny would use the suspension period to address the concerns.

Mr Kabasinskas submitted that these considerations weighed strongly against suspension. Mrs Penny had not engaged with the hearing, and there was nothing before the panel to suggest that she would reflect upon the findings, develop meaningful insight or take steps to remediate her practice. He further reminded the panel that professionals are under an obligation to cooperate with their regulator. Where a registrant fails to engage with the fitness to practise process, the guidance indicates that it will not usually be appropriate to impose a suspension order merely to provide a further opportunity to engage or demonstrate insight.

Finally, Mr Kabasinskas submitted that a striking-off order was the only sanction capable of satisfying the overarching objective. He referred the panel to the Sanctions Guidance, which provides that strike-off is likely to be appropriate where a professional's actions are fundamentally incompatible with continued registration.

Mr Kabasinskas submitted that honesty is central to professional practice and that Mrs Penny's dishonest conduct was fundamentally incompatible with remaining a registered midwife.

He invited the panel to consider the following questions identified within the guidance:

- Whether the findings raised fundamental questions regarding Mrs Penny's professionalism;
- Whether public confidence could be maintained if Mrs Penny remained on the Register;

- Whether any realistic degree of future insight or reflection would adequately protect the public and uphold professional standards; and
- Whether there was any realistic prospect that Mrs Penny would, following suspension, develop sufficient insight and strengthen her practice so as to reduce the risks identified.

Mr Kabasinskas submitted that the answers to each of those questions favoured permanent removal from the Register. He submitted that Mrs Penny's professionalism had been fundamentally called into question, public confidence could not be maintained without removal, her current insight remained very limited, and there was no evidence before the panel indicating that meaningful remediation was realistically achievable.

Accordingly, Mr Kabasinskas submitted that, having considered all available sanctions in ascending order, the only appropriate and proportionate sanction was a striking-off order.

Decision and reasons on sanction

Having found Mrs Penny’s fitness to practise currently impaired by reason of lack of competence and misconduct, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- An abuse of the position of trust held by Mrs Penny as a registered midwife;
- Repeated clinical failings across a broad range of fundamental midwifery competencies;
- Deficiencies occurring over a prolonged period rather than as isolated incidents;
- Repeated failures affecting patient safety and clinical risk management;

- Repeated failures to recognise, assess and escalate clinical concerns;
- Repeated deficiencies in medicines management
- Repeated deficiencies in record keeping;
- The persistence of concerns despite extensive support, supervision, action plans, educational input and opportunities for remediation;
- Mrs Penny's failure to demonstrate sustained improvement despite those interventions;
- A pattern of misconduct during the relevant shift;
- Reckless conduct which placed patients at risk of harm;
- Dishonesty involving the creation of inaccurate clinical records;
- Conduct which had the potential to mislead colleagues and compromise continuity of care;
- The vulnerability of Patient AA, who was a newborn baby;
- Mrs Penny's limited insight into the seriousness of the concerns;
- The absence of persuasive evidence of remediation;
- Mrs Penny's failure to attend the hearing and engage fully with the fitness to practise proceedings; and
- The combination of both persistent lack of competence and serious misconduct.

The panel considered the dishonesty particularly serious. Accurate clinical records are fundamental to safe professional practice. Healthcare professionals must be able to rely upon records when making decisions about ongoing care. Mrs Penny's dishonest creation of inaccurate clinical records represented a significant breach of professional trust and integrity and exposed a vulnerable patient to a risk of harm.

The panel considered whether Mrs Penny's conduct had been deliberate or reckless. It did not find that Mrs Penny had maliciously intended to cause physical harm. However, it determined that her conduct was reckless. She knowingly created an inaccurate record of clinical care, thereby disregarding the obvious risk that the record could mislead other professionals and compromise patient safety.

The panel did not treat the existence of internal disciplinary processes as a separate aggravating factor. It had not examined the full circumstances of those processes and considered that it would be inappropriate to place independent weight upon them.

The panel also took into account the mitigating factors. The panel considered the personal mitigation provided by Mrs Penny within her written responses. This included private personal circumstances, including [PRIVATE], which the panel did not consider it necessary or appropriate to set out in detail in a public determination.

The panel also considered Mrs Penny's explanations regarding the pressures within the clinical environment and the level of support available to her at certain times. It noted that Mrs Penny was relatively newly qualified during part of the relevant period and had engaged with some aspects of the Trust's support and performance-management processes.

The panel considered that the above two matters carried limited weight.

Mrs Penny had been provided with extensive support and adjustments over a prolonged period. Notwithstanding that support, significant concerns persisted. Further, although workload pressures and a demanding clinical environment may provide context for an omission or error, they could not justify the dishonest creation of a clinical record.

The panel did not regard the absence of an intention to cause physical harm as a mitigating factor. Registered professionals are expected not to cause harm, and compliance with that basic obligation does not amount to mitigation.

Having carefully balanced all relevant matters, the panel concluded that the mitigating factors carried limited weight when viewed against the breadth, persistence and seriousness of the findings.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It concluded that such an outcome would be wholly insufficient given the seriousness of the findings, the current impairment

identified and the ongoing risks to the public and to public confidence in the profession. Taking no further action would fail to protect the public, uphold proper professional standards or maintain public confidence in the nursing and midwifery professions. The panel therefore determined that taking no further action would be inappropriate.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

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

The panel considered that Mrs Penny's actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety.

The panel reminded itself that a caution order may be appropriate where concerns are isolated, limited in nature, unlikely to be repeated and where a registrant has demonstrated sufficient insight. The circumstances of this case were fundamentally different. The concerns were neither isolated nor minor. They involved repeated failings across multiple areas of clinical practice, persistent deficiencies despite prolonged support and serious dishonesty. The panel had also found current impairment and a continuing risk of repetition.

A caution order would provide no meaningful public protection and would fail to reflect the seriousness of the findings. It would also be insufficient to maintain public confidence in the profession or uphold proper professional standards. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel therefore rejected a caution order.

The panel next considered whether to place a conditions of practice order on Mrs Penny's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on '*Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026).

The panel accepted that many of the clinical failings identified were, in principle, capable of remediation and that isolated clinical deficiencies may potentially be addressed through workable and measurable conditions. However, the panel could not formulate conditions that would adequately address the full breadth of concerns in this case.

The panel was of the view that Mrs Penny had already been provided with extensive support, supervision, action planning, educational input, competency assessments and opportunities for remediation over a significant period. Despite those measures, concerns continued to arise. The evidence demonstrated that Mrs Penny struggled to transfer knowledge into clinical practice and continued to require substantial prompting and supervision in fundamental areas of midwifery care. The panel had no confidence that further conditions would succeed where previous structured and extensive support had not resulted in sustained improvement.

More importantly, conditions could not adequately address the dishonesty found proved. The panel considered that dishonesty is attitudinal in nature. Conditions may be capable of addressing deficiencies in knowledge or skill, but they cannot adequately address a finding that a professional deliberately created an inaccurate clinical record. The public is entitled to expect complete honesty and integrity from registered professionals. The panel was also concerned by the absence of persuasive evidence of developed insight, meaningful reflection, remediation or attitudinal change in relation to the dishonesty.

The panel therefore concluded that there are no relevant, proportionate, workable or measurable conditions that would provide adequate public protection and would sufficiently address the wider public interest considerations arising in this case.

It determined that a conditions of practice order would be neither sufficient nor appropriate and will be unable to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'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.'

Whilst the panel acknowledged that, had this case concerned clinical competence alone, a suspension order may have represented a proportionate response. The clinical failings were serious, and temporary removal from the Register may potentially have provided public protection while allowing Mrs Penny an opportunity to remediate.

However, this case went significantly beyond clinical competence. It involved serious misconduct and dishonesty. The dishonesty concerned the creation of inaccurate clinical records which purported to document clinical observations that had not been undertaken. This was not merely poor or incomplete documentation. It went to the heart of professional integrity, accountability and trustworthiness.

The panel was particularly concerned that the dishonest conduct occurred in a clinical setting and related directly to patient care. The inaccurate record had the potential to mislead other healthcare professionals, compromise continuity of care and expose Patient AA to harm.

The panel had also found that Mrs Penny demonstrated limited insight into the seriousness of the concerns. There was no persuasive evidence of remediation and no evidence that the attitudinal concerns underpinning the dishonesty had been addressed. The panel considered whether there was a realistic prospect that, following a period of suspension, Mrs Penny would develop sufficient insight, strengthen her practice and be able to return safely to unrestricted practice. There was no evidence before the panel demonstrating such a realistic prospect.

Mrs Penny had not attended the hearing or engaged fully with the fitness to practise process. She had not provided recent evidence of reflection, training, strengthened practice, updated competency assessment or safe clinical practice. The panel therefore had no evidential basis upon which to conclude that a period of suspension would lead to

meaningful remediation. The panel reminded itself that suspension should not be imposed merely to provide a registrant with a final opportunity to engage, develop insight or address concerns, particularly where there is no indication that the registrant is likely to do so.

The panel also considered the wider public interest. It determined that well-informed members of the public would be seriously concerned if a registrant who had demonstrated persistent and serious deficiencies in practice and acted dishonestly in relation to clinical records were permitted to return to unrestricted practice after a temporary period of suspension.

The panel concluded that a suspension order would not be the appropriate or proportionate sanction and would be insufficient to maintain public confidence in the profession and insufficient to declare and uphold proper professional standards.

The panel therefore rejected a suspension order.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). It recognised that striking off is the most serious sanction available and should be imposed only where no lesser sanction would be sufficient. Having rejected all lesser sanctions, the panel determined that this case falls within the definition of being a 'highest risk case'.

The panel also had regard to the NMC Guidance on '*Deciding between suspension and strike off*' (Reference SAN-3 Last Updated: 28/01/2026).

The panel further had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*

- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel considered whether Mrs Penny's conduct was fundamentally incompatible with continued registration. The panel concluded that it was. The panel determined that this case involved a combination of:

- Persistent and serious lack of competence;
- Repeated failings affecting patient safety;
- Significant deficiencies in clinical judgment;
- Repeated failures in assessment, escalation, medicines management and record keeping;
- Extensive but unsuccessful remediation efforts;
- Serious misconduct;
- Dishonest clinical record keeping;
- Limited insight;
- An absence of persuasive evidence of remediation;
- Unresolved attitudinal concerns; and
- No realistic evidence that Mrs Penny could safely return to unrestricted practice.

The panel considered that honesty and integrity are fundamental tenets of the nursing and midwifery professions. Patients, colleagues and members of the public must be able to trust that registered professionals accurately record the care they have provided and act honestly at all times. Mrs Penny's dishonest conduct represented a serious departure from

those fundamental standards. It concerned patient care, occurred in a clinical environment and had the potential to place a vulnerable newborn baby at risk.

The panel determined that the charges found proved raised fundamental questions about Mrs Penny's professionalism and trustworthiness.

It considered that public confidence in the profession would be seriously undermined if a registered midwife who had demonstrated persistent deficiencies in practice and dishonesty in relation to clinical records were permitted to remain on the Register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Penny's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case. It was of the view that no lesser sanction would adequately protect the public, maintain public confidence in the profession or uphold proper professional standards.

The panel was mindful that a striking-off order would have a significant personal and professional impact upon Mrs Penny. However, it concluded that her interests were outweighed by the need to protect the public and satisfy the wider public interest. The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

Accordingly, the panel determined that a striking-off order was the only appropriate and proportionate sanction in this case.

This will be confirmed to Mrs Penny in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Penny's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Kabasinskas submitted that the striking-off order imposed by the panel would not take effect immediately. He reminded the panel that there is a statutory 28-day appeal period and that, if Mrs Penny appeals the decision, the substantive sanction will not take effect until the appeal has been determined.

Mr Kabasinskas therefore submitted that it was necessary for the panel to impose an interim order to address the risks arising during the appeal period**.** He referred the panel to the NMC guidance entitled "*Decision-making factors for interim orders*" (INT-2). He acknowledged that the guidance is principally directed toward applications for interim orders at the beginning of the fitness to practise process. However, he submitted that its core principles remained relevant.

Mr Kabasinskas submitted that the panel did not need to reconsider whether there was sufficient evidence of concern. The panel had already made findings of fact and had determined that Mrs Penny's fitness to practise was impaired by reason of lack of competence and misconduct.

Mr Kabasinskas submitted that the panel had already assessed the seriousness of Mrs Penny's conduct and the associated risks when determining impairment and sanction. The panel had found that Mrs Penny posed a continuing risk to public safety, that there was a

risk of repetition and that the wider public interest was engaged. It had also concluded that the concerns were sufficiently serious to require a striking-off order.

Mr Kabasinskas submitted that an interim order was necessary on both statutory grounds of protection of the public and the wider public interest. He reminded the panel that the test was one of necessity rather than mere desirability. The panel would need to be satisfied that there was a real risk to members of the public if no interim order were imposed.

Mr Kabasinskas submitted that the panel had already found that Mrs Penny had not remediated the clinical concerns, had demonstrated limited insight and presented a continuing risk of repetition. He therefore submitted that the same considerations which supported the finding of current impairment on public protection grounds also established that an interim order was necessary. Without an interim order, Mrs Penny could remain entitled to practise without restriction during the statutory appeal period and, if an appeal were lodged, throughout the period in which that appeal remained unresolved. Mr Kabasinskas submitted that this would expose members of the public to the risks already identified by the panel.

Mr Kabasinskas further submitted that an interim order was necessary to maintain public confidence in the nursing and midwifery professions and to uphold proper professional standards. The panel had imposed a striking-off order, having determined that Mrs Penny's conduct was fundamentally incompatible with continued registration. Mr Kabasinskas submitted that public confidence would be seriously undermined if Mrs Penny were nevertheless permitted to practise without restriction during the statutory appeal period or while any appeal was being determined.

Mr Kabasinskas acknowledged that the panel had two available forms of interim order namely an interim conditions of practice order or an interim suspension order. However, he submitted that only an interim suspension order was appropriate.

An interim conditions of practice order would be inconsistent with the panel's substantive decision. The panel had already determined that workable and sufficient conditions could not be formulated and that Mrs Penny should be permanently removed from the Register.

Accordingly, Mr Kabasinskas invited the panel to impose an interim suspension order.

Mr Kabasinskas submitted that the interim suspension order should be imposed for a period of 18 months. He explained that, if Mrs Penny did not appeal within the statutory 28-day period, the interim order would cease to have effect when the substantive striking-off order came into force.

However, if Mrs Penny appealed, the duration of the appeal would be governed by the High Court's caseload and would not be within the control of either the NMC or Mrs Penny. He therefore submitted that 18 months was a necessary and proportionate period to allow for any appeal to be resolved.

Mr Kabasinskas reminded the panel that the interim order would be reviewed every six months. A reviewing panel would have the power to vary or revoke the order, although it would not have the power to extend it. Any extension beyond the original period would require an application to the High Court.

For those reasons, Mr Kabasinskas submitted that the panel should impose an interim suspension order for a period of 18 months on the grounds that it was necessary for the protection of the public and otherwise in the public interest.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to the fact that this period would cover the statutory time in which an appeal may be brought.

The panel was mindful that the duration of any appeal proceedings would not be within the control of either Mrs Penny or the NMC. It therefore considered that an 18-month order was required to ensure that the public remained adequately protected pending the final resolution of any appeal.

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

That concludes this determination.