Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Thursday, 4 June 2026

Virtual Hearing

Name of Registrant:	**Rachel Mugechi Muchoki**
NMC PIN:	16H0400E
Part(s) of the register:	Registered Midwife - 9 September 2016
Type of case:	Lack of competence
Panel members:	Vicki Wells (Chair, Registrant member) Jayne Walker (Registrant member) Rosemary Chapman (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Khatra Ibrahim
Nursing and Midwifery Council:	Represented by James Holloway, Case Presenter
Mrs Muchoki:	Present and represented by Martyn Hynes, instructed by Thompsons Solicitors
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Impaired
Outcome:	**Conditions of practice order (18 months) to come into effect at the end of 13 July 2026 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to replace the current suspension order with a conditions of practice order for a period of 18 months.

This order will come into effect at the end of 13 July 2026 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the second review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 13 December 2024. This was reviewed on 4 December 2025, where that reviewing panel decided to impose a further suspension order for a period of 6 months.

The current order is due to expire at the end of 13 July 2026.

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

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

> *'That you a registered midwife, between 1 September 2016 and 17 September 2020 failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5/6 midwife, in that you;*
>
> 1) *Did not fully complete your competencies/preceptorship programme which commenced in September 2016.*
> 2) *During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;*
>   a. *Were slow in recording documentation.*
>   b. *Prioritised written documentation over providing urgent care.*
>   c. *Did not realise that Patient C had given birth to their baby in a water pool.*
>   d. *Were unable to escalate concerns to senior staff members*

e. Were unable to operate the electronic intravenous pumps on the labour ward.

f. Were unable to change bags of I.V. fluid in the timeframe appropriate for the clinical situation

3) Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;

a. Communication with patients

b. Normal labour & birth

c. Medicines management

d. Information from vaginal examinations.

e. Use of medical equipment

4) On or around 14 October 2016;

a) Were unable to perform a vaginal examination correctly.

b) Incorrectly inserted a catheter into an unknown patient's vagina

c) Incorrectly attempted to break the waters of an unknown patient in labour.

5) Between 14 October 2016 and 23 December 2016 worked continuously in a supernumerary role.

6) Between 6 November 2016 and 13 December 2016;

a. Were unable to comply with a competency checklist.

b. Were unable to utilise a learning tool.

7) Were unable to successfully complete a 4-week action plan commencing 27 November 2016 as you were unable to;

a. Create adequate care plans for one or more patients;

b. Apply guidelines to individual patients.

c. Identify clinical mistakes

8) On 20 December 2016:

a. Selected the wrong tool to assess a fetal heart rate.

b. Were unable to prioritise care needs.

9) On unknown dates, whilst providing care to one or more new mothers;

a) Did not explain the difference between breastfeeding and formula milk.

b) Did not explain that formula milk is heavier and could inhibit a new-born's ability to want to feed from the breast.

And in light of the above and charges 10-18, below, your fitness to practise is impaired by reason of your lack of competence.

10) [PRIVATE]

11) On 16 September 2019 whilst providing midwifery care to Patient X;

a) Did not provide adequate care/support to Patient X whilst they were in pain due to contractions/labour

b) Asked one of Patient X's family members to hold the Doppler ultrasound whilst you left the room to contact the labour ward coordinator

c) Did not adequately communicate to Patient X/Patient X's family why the Oxytocin drip was resumed.

d) were unable to demonstrate proficiency in;

i) Usage of Oxytocin guidelines

ii) CTG interpretation/Change of care plan

12) Between October 2019 and April 2020, whilst working on the Infant Feeding Team,

a) Did not communicate with colleagues/management adequately, in that you, on one or more occasion;

i) Did not approach your line manager to discuss care plans.

ii) …

iii) Did not discuss or request feedback

iv) …

b) During tongue tie clinics, were unable to demonstrate proficiency in;

i) Securing babies;

ii) Handling babies.

iii) Holdings babies in a towel.

iv) Did not communicate advice adequately with patients.

13) Around 22 January 2020;

a) …

b) Did not know how to operate a breast pump.

14) On 28 April 2020, after having a supervision meeting with Colleague X, left your shift incomplete.

15) On 11 September 2020

a) Incorrectly discharged Patient A with Patient Z's postnatal discharge notes/pack.

b) Did not;

i) Contact the Community Midwife Team regarding Patient A's discharge.

ii) Email a discharge summary to the Community Midwife Team regarding Patient A's discharge.

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

i) Failed to pull/press the emergency call bell.

ii) Did not assess Baby C's breathing.

iii) Did not assess Baby C's airways.

iv) Did not assess Baby C's circulation.

v) Did not move Baby C to the resuscitaire.

vi) Went to look for Colleague Y/the Midwife in charge of Baby C

vii) Went to look for a stethoscope/thermometer

d) When asked by Colleague Y if you had taken any action regarding Baby C colour/breathing difficulties, you responded using words to the effect 'Nothing it is your lady'.

e) Did not know how to use a SATS monitor.

16) …

17) Were unable to complete a 4-week capability assessment commencing between 17 June 2020 – 29 July 2020.

AND in light of the above charges 10-17, and/or any associated and/or consequential health conditions, your fitness to practice is impaired by reason of your health.

18. On an unknown date between 1 September 2016 and 12 October 2016, during a spontaneous vaginal delivery were unable to prioritise tasks in that you;
a) Did not have a delivery pack ready.
b) Did not check the baby's heartbeat during the second stage of labour using a cardio-tachogram.
c) Put on sterile gloves before opening a delivery pack.'

The first reviewing panel determined the following with regard to impairment in relation to lack of competence:

'The panel considered whether your fitness to practise remains impaired.

At this hearing the panel considered that it has not seen evidence to suggest that your level of insight has fully developed.

The panel noted that you never completed your preceptorship programme or any induction. It bore in mind that there were an extensive range of issues from the fundamentals of midwifery practice to more serious concerns. The panel determined that you have not demonstrated an understanding of how your actions put the patients at risk of harm, nor an understanding of why what you did was wrong, nor how this impacted negatively on the reputation of the nursing profession.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the relevant training you have undertaken and your detailed reflection. The panel acknowledged that, through your current circumstances, you have not been able to put into practice the relevant training you have undertaken. The panel determined that your relevant training shows your motivation to return to practice. However, in the panel's judgement the fundamental issues identified have yet to be remedied. Furthermore, it found that your reflection, although detailed, was not focused on patient safety and did not meaningfully reflect on your failings.

The panel determined that whilst the concerns are remediable, they are yet to be practically tested in a midwifery setting. Therefore, the panel was not persuaded that it is highly unlikely to be repeated. The panel therefore decided that a finding of continuing impairment is necessary on the ground of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. In the panel's judgment, the public would be deeply troubled if a finding of impairment were not made given the wide-ranging competency issues. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

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

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

'The panel considered the imposition of a further period of suspension. The panel determined that your insight is not yet as developed as it needs to be in terms of the impacts of your actions on patients and your colleagues. The panel is not satisfied that you have demonstrated a meaningful understanding of why your actions were so serious. In the panel's view, it is foundational and

fundamental to have insight and knowledge into why patient safety was put risk at a result of your failings. The panel found that your reflection was more formulaic than personal.

The panel was of the view that a suspension order would allow you further time to fully reflect on your previous failings. The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. The panel concluded that a further 6-month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. It considered this to be the most appropriate and proportionate sanction available.'

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the Nursing and Midwifery Council (NMC) has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel had regard to the NMC bundle, your bundle, and the submissions from Mr Holloway on behalf of the NMC, and Mr Hynes, on your behalf.

Mr Holloway took the panel through the background of the case, and invited the panel to replace the current suspension order with a conditions of practice order.

Mr Holloway submitted that the current suspension order is due to expire on 13 July 2026, and submitted that the charges found proved relate to your clinical midwifery practice. He submitted that the facts found proved relate to a lack of competence. He referred the panel to the initial substantive decision, and submitted that your fitness

to practice was found impaired on the grounds of public protection and in the wider public interest.

Mr Holloway submitted that at the last substantive order review in December 2025, you told that reviewing panel that you had sought employment as an Executive Officer. He submitted that that reviewing panel found your fitness to practise remained impaired on both grounds, as aforementioned.

Mr Holloway referred the panel to the documents provided today, and submitted that you have undertaken some training, and that you have provided an extensive reflection on your past conduct. He submitted that although you have undertaken some training in relevant areas, there remains some training to be completed.

Mr Holloway went on to address the panel on current impairment. He submitted that you have addressed the impact your past actions had on patients, your colleagues and the wider public. He submitted that you have provided plans as to what future training and remediation you aim to carry out. He submitted that as you have been suspended for some time, you have not yet had the opportunity to demonstrate that you can practise safely and effectively, there remains a risk of repetition. He also submitted that due to the lack of testing of your clinical skills, there is no evidence of strengthening of practice. He invited the panel to find your fitness to practise remains impaired on the grounds of public protection and in the wider public interest.

Mr Holloway then went on to address the panel on sanction.

Mr Holloway submitted that in light of the charges found proved, it would not be appropriate nor proportionate to take no action.

Mr Holloway referred the panel to NMC guidance, and submitted that since the imposition of the substantive order, you have taken some steps to engage with the feedback from the previous panels. He submitted that the following conditions would be workable, proportionate and appropriate, and would work as a staged approach:

1. Directly supervised in the following areas: CTG monitoring, management of Oxytocin infusions, monitoring of deteriorating patients, training of specialist medical equipment, supervision when changing of IV fluids and catheterisation, and discharging of patients;
2. You are directly supervised until such time you are deemed competent by your supervisor;
3. When conditions 1 and 2 have been met, move to indirect supervision in the aforementioned areas; and
4. A personal development plan, where you must work with your supervisor to create one. It must address the concerns regarding your clinical midwifery practice.

Mr Hynes, on your behalf, referred the panel to your registrant's bundle before it, and invited the panel to revoke the current suspension order. He submitted that if the panel was to revoke the order today, this would allow you to return to work unrestricted. He submitted that if the panel are not with him, a conditions of practice order would be appropriate and proportionate.

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

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

The panel considered whether your fitness to practise remains impaired.

The panel noted that the evidential burden is upon you to persuade the panel that you are now capable of safe and effective practice. The panel therefore carefully considered your evidence, which comprised of a reflective piece, two testimonials and three continuing practice documents in the areas of deteriorating patients, duty of care and record keeping.

In making its decision on impairment, the panel was mindful of the NMC's guidance Standard reviews of substantive orders before they expire (ref Rev-2a), and the

factors to be considered when reviewing what has happened to your practice since the last review.

Whilst you have not been subject to a conditions of practice order, the panel was assisted by the recommendations for the next review, which was made by the last reviewing panel on 4 December 2025.

The panel noted that the last reviewing panel found that your reflection, although detailed, was not focused on patient safety and did not meaningfully reflect on your failings. At this hearing, the panel noted that your reflective piece was comprehensive and detailed, demonstrating good insight into your lack of competence. The panel noted that you have demonstrated some positive insight into the impact your actions had on patients, colleagues and the wider public.

The panel next considered whether you have taken effective steps to maintain your skills and knowledge as a registered midwife, and whether you have remediated your lack of competence by demonstrating strengthening of practice.

Despite some strengthening of practice through evidence of learning and development, and written reflections, there remains a shortfall in your clinical knowledge. The panel noted that some of the training that you rely upon took place approximately 10 years ago which predates the substantive finding of lack of competence. Your reflection piece on '*tongue tie',* although detailed, failed to recognise potential acute risk of *'tongue tie'* to the baby, and focused entirely on maternal concerns. Your references to resources and guidance were not accurate, or up to date. For instance, in your reflective piece, you inaccurately referred to NICE as *'National Institute for Clinical Excellence'*, when it is actually named '*National Institute for Health and Care Excellence.'*

The panel determined that you have been unable to put your learning into practice, and therefore, there is very limited evidence before it to demonstrate a record of safe practice without further incident.

The panel decided that you have been unable to evidence sufficient strengthening of practice, and that your lack of competence is therefore likely to be repeated. The panel also decided that the first three limbs of the Shipman test approved of in Grant remain engaged. You remain liable in the future to act so as to put patients at unwarranted risk of harm; bring the midwifery profession into disrepute; and breach one of the fundamental tenets of the midwifery profession.

The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

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

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

Decision and reasons on sanction

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

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The

SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

As noted when finding current impairment, whilst the panel found that your level of insight is now good, there remains a real risk of repetition as you have not sufficiently strengthened your practice, which, if similar lack of competence occurred again, would have significant consequences for the health and well-being of patients and the reputation of the midwifery profession. Having considered the evidence before it, the panel decided that it is able to formulate workable conditions of practice that would protect the public, and address the wider public interest.

The panel decided that the public would be suitably protected as would the reputation of the profession by the implementation of the following proportionate conditions of practice:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must work for one substantive employer. This must not be an agency or bank.

2. You must be directly supervised in all clinical areas until assessed and deemed as competent by a Band 6 midwife or above, anytime you are working.

3. As a condition of employment, you must complete your preceptorship package in full. You must provide evidence of this to your NMC case officer upon completion.

4. You must provide evidence that is documented by a Band 6 midwife or above, who has been directly involved in your supervision and assessment within clinical practice. Evidence provided should demonstrate the following:

   a) Your increasing confidence and competence
   b) Ability to apply theoretical knowledge in those areas to support progression
   c) Continued development and consolidation of your clinical skills.

   You must provide evidence of the above in a report from your line manager/mentor/supervisor. Once completed, you must send this report to your NMC case officer two weeks before your next review hearing.

5. You must work with your line manager/mentor/supervisor to create a personal development plan (PDP). Your PDP must address the concerns in relation to the charges found proved in relation to your competence.

   You must:
   a) Send your case officer a copy of your PDP two weeks before your next review hearing. This report must show your progress towards achieving the aims set out in your PDP from your line manager/mentor/supervisor.

6. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.
b) Giving your case officer your employer’s contact details.

7. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

This conditions of practice order will take effect upon the expiry of the current suspension order, namely the end of 13 July 2026 in accordance with Article 30(1)

Before the end of the period of the order, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

This will be confirmed to you in writing.

That concludes this determination.