Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 5 May – Wednesday, 13 May 2026

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

Name of Registrant:	**Madalin Steines Thompson**
NMC PIN:	19I3218E
Part(s) of the register:	Registered Midwife (RM) – 09 December 2019
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Mark Gower (Chair, Lay Member) Karen Shubert (Registrant Member) David Anderson (Lay Member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Angela Nkansa-Dwamena Priyam Jain (12 May 2026)
Nursing and Midwifery Council:	Represented by Denise Amaning, Case Presenter
Miss Thompson:	Present and represented by Laura Paisley, instructed by Powell Spencer & Partners Solicitors (PSP)
Facts proved by admission:	Charges 1a, 1b, 3a, 3b, 5b and 5c
Facts proved:	Charge 7
Facts not proved:	Charges 2a, 2b, 4a, 4b, 5a and 6
Fitness to practise:	Impaired
Sanction:	**Caution Order (2.5 years)**
Interim order:	N/A

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Amaning, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of the stem of the charges, under Rule 28 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The proposed amendment was to correct an administrative error, replacing the word 'nurse' with 'midwife'. Ms Amaning submitted that the use of the word 'nurse' was an oversight, as you are a registered midwife.

Ms Amaning submitted that this slight administrative amendment, does not change the landscape of the case, add in any new evidence or add to the seriousness of the case.

Original Charge

That you a registered nurse,

1) On or around 18 April 2022, incorrectly recorded that:

    a) at 01.46, X5 inflation breaths were given to Baby A.

    b) at 01.47, Colleague A gave ventilation breaths to Baby A.

Proposed Amendment

That you a registered ~~nurse~~ **midwife**,

1) On or around 18 April 2022, incorrectly recorded that:

a) at 01.46, X5 inflation breaths were given to Baby A.

b) at 01.47, Colleague A gave ventilation breaths to Baby A.

Ms Paisley, on your behalf, indicated that she did not object to this amendment.

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

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 you 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 accuracy.

Details of charge (as amended)

That you a registered midwife,

1) On or around 18 April 2022, incorrectly recorded that:

   a) at 01.46, X5 inflation breaths were given to Baby A.

   b) at 01.47, Colleague A gave ventilation breaths to Baby A.

2) Your actions in charge 1 were dishonest in that you deliberately sought to represent that:

   a) X5 inflation breaths were given to Baby A when you knew that Baby A had not received X5 inflation breaths.

   b) Colleague A had given ventilation breaths to Baby A when you knew that they had not.

3) Provided a statement dated 10 February 2023 to HM Coroner which incorrectly stated that:

   a) At 01.46 you commenced inflation breaths to Baby A.

   b) At 01.47, Colleague A commenced ventilation breaths to Baby A.

4) Your actions in charge 3 were dishonest in that you deliberately sought to represent to HM Coroner that:

   a) at 01.46 you had commenced inflation breaths to Baby A when you knew that you had not.

   b) At 01.47, Colleague A had commenced ventilation breaths to Baby A when you knew that they had not.

5) Failed to disclose that you had made incorrect records in relation to Baby A to the following:

a) The University Hospitals Sussex (the Trust)
b) Healthcare Safety Investigation Branch (HSIB)
c) HM Coroner in your statement dated 10 February 2023

6) Your actions at charge 5 lacked integrity in that they were contrary to your duty of candour.

7) Failed to record your observations made about Patient A and Baby A's care in a timely manner.

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

Background

On 26 February 2024, the Nursing and Midwifery Council (NMC), received a referral from University Hospitals Sussex NHS Foundation Trust (the Trust), raising concerns about you. The charges arose whilst you were working as a Band 6 Midwife at the Trust.

On 18 April 2022, at approximately 01:43 hours, Patient A gave birth to Baby A. It is reported that within the first few minutes of Baby A's life, Baby A became dusky with poor muscle tone and neonatal resuscitation was commenced. An emergency call bell was used for extra assistance; however upon the arrival of the assistance, Baby A's condition had improved, and no further action was required from the team.

Approximately two hours later, Baby A's condition appeared to deteriorate. The baby became floppy and was not able to breathe and once again, resuscitation commenced and Baby A was subsequently transferred to a Special Care Unit. At three days of age, Baby A had a poor prognosis and was moved to a palliative care pathway. Baby A died at four days of age. A postmortem examination was undertaken and it was reported that the cause of Baby A's collapse could not be determined.

It is alleged that you incorrectly retrospectively recorded that you had provided care to Baby A on 18 April 2022 in the patient records and also in your written statement to the coroner. The records reflected that ventilation breaths had been given to Baby A by another midwife, when they had not.

These records were used for the Trust's comprehensive medical notes review (CMNR) and the Healthcare Safety Investigation Branch (HSIB) investigation, which reportedly resulted in the investigations being based on inaccurate records. In addition, a coroner's inquest was undertaken, and it was reported that you provided a written statement to the coroner, which also included false and inaccurate information.

It is said that you later gave oral evidence to the coroner and confirmed that your entries did not reflect the care that was provided to Baby A, by you or another midwife. It is reported that you had not witnessed the resuscitation of Baby A and you had made assumptions, which included ventilation breaths being given by another midwife, when they had not. It is alleged that you failed to alert anyone of your inaccurate record-keeping for a period of two years, up until your oral evidence to the coroner.

It is the NMC's case that your actions were dishonest, in that you were well aware that you had not administered x5 inflation breaths to Baby A and that you had not witnessed Colleague A deliver ventilation breaths to Baby A. By creating records to show that these events took place when you knew they did not, the NMC alleges that you deliberately sought to misrepresent the information.

The NMC further alleges that your actions lacked integrity as you subsequently failed to report to the Trust, HSIB and the coroner that you had created incorrect records and that this failure was in breach of your professional duty of candour.

Decision and reasons on application to admit hearsay evidence

After opening the NMC's case, Ms Amaning made an application to admit the evidence of Claire Rogers (Ms Rogers), contained within the transcript of the coroner's court dated 13 February 2024, as hearsay evidence. She informed the panel that Ms Rogers was the second midwife who attended to Baby A at the relevant time and she submitted that the NMC seeks to rely upon her account.

Ms Amaning submitted that it would be fair to admit this evidence and relevant as it goes towards Charges 1-4, which would assist the panel when considering whether inflation and ventilation breaths were provided to Baby A.

Ms Amaning referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted the following with respect to the factors set out in the case:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Amaning submitted that Ms Rogers' verbal account of her actions on the night shift of 18 April 2022 was not the sole and decisive evidence in support of the charges. She informed the panel that it would hear directly from Claire Parr (Ms Parr), who was involved in the local investigation, in addition to your verbal account which you gave to the coroner on 12 February 2024, where you accept Ms Rogers' account and the fact that your records were incorrect. Additionally, Ms Amaning invited the panel to admit the transcript of Hannah Moss' (Ms Moss) evidence and the witness statement of Ms Rogers, contained within your registrant bundle, into evidence as you seek to rely on them for your case.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Amaning submitted that given your acceptance of Ms Rogers' account, there is no challenge to this evidence.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Amaning submitted that there is no evidence before the panel to suggest that the verbal account of Ms Rogers was fabricated. Rather, the evidence is derived from transcripts of her oral evidence given at the coronial inquest.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Amaning submitted that the charges are serious and, should the NMC be successful, there would be an impact on your career.

v. Whether there was a good reason for the non-attendance of the witness and
vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Amaning informed the panel that Ms Rogers was not called to give evidence in this case as you agree with her evidence that the ventilation breaths were not delivered to Baby A. She submitted that a proportionate decision was taken by the NMC not to obtain further evidence from Ms Rogers or have her attend the hearing as she would simply be repeating and confirming the evidence which does not appear to be in dispute.

vii. Whether the registrant had prior notice that the witness statement would be read:

Ms Amaning submitted that you have had prior notice of these proceedings and the evidence the NMC seeks to rely on, as a case management form was sent to you.

Ms Amaning invited the panel to permit the oral disclosures of Ms Rogers to be admitted as evidence in this case as it would be in the interests of justice to do so.

This was a joint position with Ms Paisley, who indicated that she did not object to the evidence being admitted in this case.

The panel 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.

In these circumstances, the panel came to the view that it would be fair and relevant to admit the evidence of Ms Rogers and Ms Moss but would give what it deemed

appropriate weight once the panel had heard and evaluated all the evidence before it.

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

Prior to hearing witness evidence, Ms Paisley made an application for parts of this hearing to be held in private. This is on the basis that proper exploration of your case involves references to your health. This application was made pursuant to Rule 19 of the Rules.

Ms Amaning indicated that she supported this application to hear references to your health in private.

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 may be references to your health, the panel determined to hold these matters in private as and when such issues are raised in order to protect your privacy.

Further decision and reasons on application for hearing to be held in private

During the course of your evidence, matters pertaining to your health and personal circumstances appeared to be inextricably linked to the answers you gave in cross examination. A Rule 19 application had already been granted, allowing for parts of the hearing pertaining to your health to be held in private. However, during cross examination, two members of the public were observing the hearing, and the panel was concerned that continuously moving from private to public session was causing disruption to your evidence.

Ms Paisley and Ms Amaning agreed that, in fairness to you, you should be able to provide full answers in response to questions asked during cross-examination and continuing in private session would facilitate this.

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.

In the interests of justice and fairness, the panel determined that the remainder of your evidence should be heard in private and that this would facilitate the smooth running of the hearing.

Decision and reasons on facts

At the outset of the hearing, Ms Paisley informed the panel that you made admissions to Charges 1a, 1b, 3a, 3b, 5b and 5c. In relation to Charges 5b and 5c, Ms Paisley clarified that these charges are admitted only on the basis that the failure to disclose was made in ignorance of the records being incorrect.

The panel therefore finds Charges 1a, 1b, 3a, 3b, 5b and 5c proved in their entirety, by way of your admissions.

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

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

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

- Claire Parr: Divisional Quality and Safety Lead at the Trust.

The panel also heard evidence from you under oath.

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

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

Charges 2a and 2b

2) Your actions in charge 1 were dishonest in that you deliberately sought to represent that:

   a) X5 inflation breaths were given to Baby A when you knew that Baby A had not received X5 inflation breaths.

   b) Colleague A had given ventilation breaths to Baby A when you knew that they had not.

These charges are found NOT proved.

In reaching this decision, the panel considered your admissions to Charges 1a and 1b. The evidence before the panel consisted largely of the coronial transcripts outlining the oral evidence given by you and Ms Rogers at the inquest, the Comprehensive Medical Notes Review (CMNR) led by Ms Parr dated November 2022, the HSIB report and other supporting documentary evidence, including Baby A

and Patient A's medical notes. The panel also had regard to your oral and documentary evidence.

The panel had regard to Baby A's and Patient A's medical notes. Within your retrospective entry, you had noted that at 01:46 hours on 18 April 2022, x5 inflation breaths had been administered to Baby A and that Baby A had cried at breath two with good chest rise and tone. You had recorded that at 01:47 hours, Baby A's poor tone had returned and ventilation breaths had been administered by Ms Rogers. The panel considered that the above records made by you were made retrospectively. The contemporaneous records written by Ms Rogers, which made no reference to the inflation breaths, were limited in detail. There were no contemporaneous records from you between 01:35 hours and 01:52 hours.

Within her NMC witness statement dated 5 September 2024, Ms Parr stated:

> *'Madalin's witness statement to the Coroner, which I exhibit as CP/09, states at paragraph 31 that she provided inflation breaths to Baby A as she appeared dusky with a poor tone at 0146hours. It is stated that on the second inflation breath Baby A responded with a vigorous cry, good tone, heart rate and respiratory effort. Madalin then states at, paragraph 32, Baby A's tone again became poor and the emergency bell was pulled at which point Clare Rodgers gave Baby A ventilation breaths at 0147hours. In Madalin's verbal evidence to the Coroner she stated it was Clare that provided inflation breaths to Baby A initially and at the point the emergency bell was pulled she could only see the back of Clare holding a ventilation mask and had assumed she had started ventilation breaths.'*

The NMC's case is that, in making the relevant entries in the medical notes, you sought to misrepresent the care that had been given to Baby A and that you were acting dishonestly.

Always bearing in mind that the burden of proving you acted dishonestly remained on the NMC throughout, the panel considered whether there was a reasonable alternative explanation for your actions.

You accepted that you were the nominated midwife for Patient A and the midwife primarily responsible for Baby A's care. You rightly agreed that you were the midwife primarily responsible for the accuracy of Baby A's notes.

The panel acknowledged that you had accepted that this had been incorrectly recorded by you as this had not happened. During your oral evidence, you recognised that your record was ambiguous and poorly worded. However, you explained that it was not your intention to mislead as, at the time, you genuinely believed that these events had occurred. In relation to the inflation breaths, you stated that you had written *'x5 inflation breaths'* with the intention of conveying that the first step of neonatal resuscitation had commenced but you now realise that you should have stated who had undertaken this care. You said that you had documented *'baby cried @ breath 2'* because you could hear Ms Rogers counting and you could see her holding the T-piece and mask over Baby A's face.

With respect to the ventilation breaths, you explained that you thought the inflation breaths had been successful due to Baby A's cry and that Ms Rogers had moved onto the next step of neonatal resuscitation. You further explained that you made this assumption because Ms Rogers still had the mask over Baby A's face and had been moving her thumb, which you interpreted as ventilation breaths; you described the motion of using the thumb to force air into the device. She then asked you to pull the emergency bell, which you considered an indication that further assistance was required.

During cross-examination, you told the panel that although Ms Rogers had her back to you, you could still see Baby A's head as you were not far from the resuscitaire, where this care was being undertaken. You told the panel that you were unable to discuss the care given to Baby A with Ms Rogers as you had to provide direct patient care to Patient A and then had to deal with Baby A's subsequent collapse. You said

that when you made your retrospective entries, you had to rely on your memory as you only had Ms Rogers' contemporaneous notes, which were very limited. The panel noted that there were no retrospective entries made by Ms Rogers.

The panel had regard to NMC guidance titled 'Making decisions on dishonesty charges and the professional duty of candour' dated 6 May 2025 (*reference DMA-8*), which outlines:

- *'what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*
- *whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *whether there is evidence of alternative explanations, and which is more likely.'*

In considering your explanation, the panel took into account the wider context. It noted that the night in question had been a particularly difficult and distressing shift for you due to the events that unfolded including, Baby A's collapses and Patient A's postpartum haemorrhage. In addition, the panel took into account that although you had been a qualified midwife for over two years, this had been the first time you had experienced a neonatal resuscitation that had reached the extent of Baby A's second resuscitation, in which you were directly involved.

The panel considered your detailed witness statement and oral evidence and accepted your account. Throughout your evidence, you were clear, consistent and expanded on key aspects. It considered that you gave your evidence naturally and you did not seek to minimise your mistakes or shortcomings and you also did not seek to shift blame or accountability.

The panel noted that it is the NMC's case that because you could not see the care being given to Baby A and you were not directly involved in Baby A's first resuscitation, you knew that the information you had recorded was incorrect and

therefore, your actions were dishonest. However, the panel accepted that although you had made assumptions about Baby A receiving ventilation breaths, you believed that this had happened due to your perception of Ms Rogers' actions. In the panel's judgement, in order to ensure the accuracy of notes in a serious situation involving two midwives, it would be best practice for those notes to be completed after the midwives had discussed the events with a view to ensuring that the notes were accurate and comprehensive. You told the panel that there was no opportunity to do so due to the ward activity and the competing responsibilities that you and Ms Rogers had.

Further, the panel took into account that later on in the shift, you had been involved in a more extensive resuscitation of Baby A where you were directly responsible for administering inflation and ventilation breaths to Baby A. The panel considered that it was credible that when you were much later asked to describe your actions for the purpose of writing your witness statement for the coroner's court, in your memory you conflated the two separate resuscitations. You adopted your inaccurate notes, which did not state who delivered the inflation breaths. You therefore wrongly but honestly asserted that you had delivered inflation breaths to Baby A during the first emergency.

The panel concluded that your significant mistake in documenting that x5 inflation breaths and ventilation breaths had been given to Baby A, when they had not, was not an intention to mislead. The panel considered that the NMC has not provided any evidence to refute your explanation, nor has it suggested any motive or advantage you would have from recording such information dishonestly. By documenting that these actions had happened, you had painted a worse clinical picture of Baby A's condition, which would have attracted further scrutiny of the care provided to Baby A.

In light of the above, the panel determined that you did not seek to deliberately misrepresent that Baby A had received x5 inflation breaths and ventilation breaths, when this had not happened.

Accordingly, the panel found Charges 2a and 2b not proved.

Charges 4a, 4b and 5a

4) Your actions in charge 3 were dishonest in that you deliberately sought to represent to HM Coroner that:

    a) at 01.46 you had commenced inflation breaths to Baby A when you knew that you had not.

    b) At 01.47, Colleague A had commenced ventilation breaths to Baby A when you knew that they had not.

5) Failed to disclose that you had made incorrect records in relation to Baby A to the following:

    a) The University Hospitals Sussex (the Trust)

These charges are found NOT proved.

The panel considered Charges 4a and 4b with Charge 5a because your actions between the events of Baby A's care and the coroner's inquest raised similar questions as to your honesty and integrity in relation to your account of the treatment given to Baby A.

In reaching these decisions, the panel again considered your admissions to Charges 3a and 3b. The panel noted that these charges relied on much the same evidence as Charges 2a and 2b and arose from the same inaccuracies identified within the clinical records, with the addition of the coronial transcript evidence.

The panel accepted the following timeline of events:

- April 2022 – The incident
- July 2022 – HSIB interview
- October 2022 – HSIB final report and request for a coronial statement
- November 2022 – CMNR report issued
- February 2023 – Your coronial statement was submitted

- March 2023 – Your first knowledge of the CMNR report
- April 2023 – You first received the CMNR
- August 2023 – Meeting with the Trust, where you realised your entries were incorrect
- February 2024 – the coroner's inquest takes place

You told the panel that you had requested for more time to complete your coronial witness statement, as [PRIVATE]. However, you said that you were informed by the Trust's legal department that providing the statement was a legal requirement and needed to be completed. You said that you were emailed the notes and you received no support or guidance in preparing the statement, which was significant as you were unfamiliar with legal processes.

The panel accepted that any statement provided to the coroner would be largely based on Patient A's and Baby A's care notes available at the time.

The panel heard evidence that you were asked to provide your coronial witness statement at a time when [PRIVATE] arising from the incident. The panel had sight of [PRIVATE] and accepted your evidence regarding your state of mind, including that you were also [PRIVATE] and that this was at the time at which you were informed the coronial inquest was to be held. The panel accepted that you nevertheless fully engaged with the Trust in the lead-up to the inquest, including through emails and meetings. The panel noted that you returned to work in April 2023 but [PRIVATE] related to the incident.

The panel also heard evidence that you had concerns regarding inaccuracies within the CMNR, prior to your awareness of the inaccuracies in your own records, which you had raised at the earliest opportunity and wanted the coroner to be aware of. Ms Parr accepted in evidence that you had raised issues in relation to the inaccuracies within the CMNR. Additionally, the panel heard that there was an issue regarding legal representation for which you sought clarity on more than one occasion, having been informed that your legal support might be withdrawn depending on your agreement with the Trust's position.

The panel heard that following completion of your coronial witness statement (between approximately October 2022 and February 2023), a number of internal meetings took place to consider the evidence of those involved in Baby A's care. You said that it was during a meeting on 4 August 2023, you became aware that Ms Rogers had not provided ventilation breaths, and that your own records relating to the inflation breaths were inaccurate. There is no evidence of any records of the 4 August meeting. Your assertions are uncontested by the NMC.

You said that during the 4 August 2023 meeting, you made all present, including the Director of Midwifery and a representative of the Trust's legal team, aware that your records were incorrect and stated that you wished the coroner to be informed:

> *'I then acknowledged aloud to the room that my notes must then be wrong as RM Rogers was the midwife completing the resuscitation. I was not asked at any point to write an amended statement to the coroner explaining that my notes were wrong.'*

The panel saw email correspondence in which you had attempted to raise these concerns and noted that you did not receive a response following an email you sent in September 2023. The panel noted that it is not contested by the NMC that there was conflict between the midwives' accounts and the Trust's position and that another review was not undertaken despite the highlighted inaccuracies. The panel noted that you only learned a week before the inquest that you and the Trust would be separately legally represented and that you said that the Trust advised you to raise the inaccuracies at the inquest.

Following your poor and inaccurate record-keeping, it appears that you had actively attempted to alert the Trust and the coroner to the errors. There was no evidence before the panel to suggest that you intended to mislead the coroner; rather you had raised the issue with the coroner during your oral evidence.

In these circumstances, the panel was not satisfied that you knowingly provided inaccurate information to the coroner. The panel therefore found Charges 4a and 4b not proved.

For the reasons set out above, the panel also found Charge 5a not proved.

Charges 5b and 5c

The panel accepted that you made admissions to Charges 5b and 5c. These admissions were qualified as being made on the basis that you had not originally disclosed making incorrect records, but that this omission was not made knowingly. The panel concluded, for the reasons set out above, that your failure to disclose was indeed in ignorance of the fact that the records were incorrect.

Charge 6

6) Your actions at charge 5 lacked integrity in that they were contrary to your duty of candour.

This charge is found NOT proved.

Charge 6 is predicated on you knowingly failing to act with integrity in relation to inaccurate records. The panel accepted that at the time the entries were made, you were unaware that your records were inaccurate.

The panel accepted evidence that the CMNR was not circulated until March 2023 and that you did not receive it until April 2023. The panel noted that you raised concerns about inaccuracies shortly thereafter and once you became aware that there were errors within your own entries, you made efforts to correct them, including raising them with the Director of Midwifery and seeking to ensure the coroner was informed.

The panel considered the duty of candour. While this duty always remains, the panel concluded that your lack of awareness at the relevant time meant that you could not have breached your duty of candour. The panel considered that once you became aware, you acted in accordance with the duty of candour by attempting to correct the record and alert the appropriate individuals, actions which did not lack integrity.

The panel therefore found Charge 6 not proved.

Charge 7

7) Failed to record your observations made about Patient A and Baby A's care in a timely manner.

This charge is found proved.

The NMC's evidence relating to this charge is summarised at paragraph 14 of Ms Parr's witness statement:

> *'There are occasions where a midwife is unable to complete notes at the time of care as there is an expectation that physically providing the necessary care comes first. In any event it would be expected that the notes are completed by the end of shift or the next day at the latest. There is no known reason why the notes relating to Baby A's birth were not written following the birth and immediate postnatal care.'*

Your case was that it was not reasonable to expect the notes to be completed on the same shift as the events they described because you had been working without a break for 11 hours and felt exhausted at the end of the shift, and distressed following the traumatic events involving Baby A.

In reaching its decision, the panel accepted that, in accordance with *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code), there is a clear duty upon you to record care in a

timely manner. Although there is no clear definition within NMC guidance regarding what constitutes a ‘timely’ record, the panel was of the view that although retrospective entries are not controversial, they should be completed by the end of an episode of care, namely the end of the shift. The panel found that while some elements of Patient A and Baby A’s care was documented contemporaneously, it determined that significant portions were not.

The panel recognised that contemporaneous documentation during labour and birth is best practice, however it is not always possible due to the provision of hands-on clinical care. The panel heard that following Baby A’s first resuscitation, Patient A required attention due to bleeding and then suturing had to be undertaken and you resumed note-taking at 02:30 hours. Further notes were made, followed by Baby A’s second collapse.

The panel considered your evidence that the APGAR scores and birth summary were written at 03:45 hours, following Patient A’s suturing. The panel did not accept this, noting that there was no evidence to support your account, such as a signed or dated entry. The panel accepted the NMC’s position that it was likely that entries were made retrospectively many hours later.

The panel found that there were significant gaps in your records and that entries were added retrospectively on the next shift, nearly 16 hours later, after you had been asked to make the entries by two separate managers. The panel heard that due to [PRIVATE], you felt that you were unable to complete your documentation by the end of the shift. However, as the nominated midwife responsible for Patient A’s care, the panel determined that you were required to ensure that records were completed contemporaneously or as close to the time of the events as possible, as other healthcare professionals caring for both Patient A and Baby A would need to rely on your records for their ongoing care. You did not even write on the records, at the end of the shift, that you were not in a position to complete them until later.

Your omission to record the APGAR score close to the time of the events, particularly as the APGAR score you had calculated differed from that recorded by

Ms Rogers, was made more serious because of the significant delay before you recorded it.

The panel therefore found Charge 7 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct

The panel next heard submissions from Ms Amaning and from Ms Paisley in relation to misconduct.

Ms Amaning invited the panel to find that the facts found proved amounted to misconduct. She referred the panel to the relevant NMC guidance and submitted that the proven charges represented serious departures from the standards expected of a registered midwife. Ms Amaning submitted that your conduct fell significantly short

of what would be proper in the circumstances and was capable of amounting to serious professional misconduct.

Ms Amaning submitted that Charges 1a and 1b related to the fundamental professional obligation of accurate record keeping. She submitted that by incorrectly recording that Baby A had received x5 inflation breaths and ventilation breaths, you created an inaccurate clinical picture of Baby A's condition and treatment. Ms Amaning submitted that the inaccurate records had the potential to mislead healthcare professionals involved in Baby A's care and were later relied upon during the Trust's CMNR and the HSIB investigation. She submitted that your records also had the potential to cause significant distress to Baby A's parents because they suggested that Baby A had required more extensive resuscitation than had actually occurred.

In relation to Charges 3a and 3b, Ms Amaning submitted that your witness statement to HM Coroner was a formal legal document containing a declaration of truth and that the public would expect such statements to be accurate and reliable. She submitted that by incorrectly asserting that you had personally delivered inflation breaths and that Ms Rogers had delivered ventilation breaths, your conduct amounted to a serious departure from the standards expected of a registered midwife. Ms Amaning submitted that the seriousness of the misconduct did not depend upon a finding that you had knowingly misled the coroner but rather arose from the fact that the information provided was materially inaccurate and had the potential to undermine the inquest process.

In relation to Charges 5b and 5c, Ms Amaning submitted that your failure to disclose to the HSIB and the coroner that your records were inaccurate amounted to serious misconduct because both bodies relied upon accurate and reliable information in conducting their investigations. She submitted that although the panel had accepted that your omission arose through ignorance of the inaccuracies, the fact remained that materially flawed information had been relied upon during those investigations.

Ms Amaning submitted that Charge 7 represented serious misconduct because you failed to complete records contemporaneously or as soon as reasonably practicable following the events in question. She submitted that the entries were completed retrospectively approximately 16 hours after the events and only after requests from management. Ms Amaning submitted that as the nominated midwife responsible for Patient A and Baby A's care, you were professionally obliged to ensure that records were completed in a timely manner so that other healthcare professionals could rely upon them. She submitted that the delay in recording observations, including the APGAR scores, increased the risk of inaccurate information being recorded based upon memory and reconstruction.

Ms Amaning referred the panel to the relevant provisions of the Code. In particular, she submitted that provisions 10.1, 10.2, 10.3 and 10.4 were engaged.

Ms Amaning further submitted that provisions 13, 19 and 20 of the Code were also engaged. She submitted that given your own evidence regarding the [PRIVATE] you experienced following the events involving Baby A, you had a professional responsibility to recognise the limits of your competence and fitness to practise safely at that time. She submitted that your conduct demonstrated a failure to reduce the risk of harm associated with your practice and fell short of the obligation to uphold the reputation of the profession at all times.

In conclusion, Ms Amaning submitted that your conduct represented a significant departure from the fundamental professional obligation of accurate and timely record keeping. She submitted that the creation of inaccurate records based upon assumption and reconstruction, together with the subsequent inaccurate information provided to the coroner, undermined public trust and confidence in the profession and amounted to serious misconduct.

Ms Paisley submitted that whilst the panel was likely to conclude that some of the proved charges amounted to misconduct, not every charge reached that threshold.

Ms Paisley submitted that Charge 1a may not amount to misconduct. She reminded the panel that the record in question reflected your genuinely held belief at the time and submitted that the omission of the word ‘commenced’ did not necessarily amount to a serious breach of professional standards which fellow practitioners would regard as deplorable. Ms Paisley submitted that Charge 1a concerned a narrower inaccuracy than Charge 1b and that the panel should carefully consider whether it was sufficiently serious to amount to misconduct.

Ms Paisley accepted that the panel may conclude that Charge 1b amounted to misconduct. She submitted that although the record reflected your genuinely held belief, you accepted that records should not include care which had not actually been delivered. Ms Paisley accepted that the record-keeping obligations under provision 10 of the Code were engaged in respect of this charge.

Ms Paisley further accepted that the panel may conclude that Charges 3a and 3b amounted to misconduct. She submitted that although your witness statement to the coroner reflected your genuinely held recollection and belief at the time, you accepted that statements prepared for coronial proceedings must be accurate and reliable. Ms Paisley further acknowledged that provision 10 of the Code was also engaged with respect to these charges.

In relation to Charges 5b and 5c, Ms Paisley submitted that these charges should not amount to misconduct because at the relevant time you were unaware that your records were inaccurate. She submitted that, without knowledge of those inaccuracies, you could not reasonably have been expected to correct them. Ms Paisley submitted that the issues arising from inaccurate record keeping had already been addressed through Charges 1b, 3a and 3b and that Charges 5b and 5c did not represent separate serious misconduct because your omissions occurred through ignorance rather than deliberate concealment.

Ms Paisley accepted that the panel may conclude that Charge 7 amounted to misconduct. She submitted that although there was no allegation of lack of competence, the panel may conclude that your failure to complete records in a timely

manner represented an omission falling short of expected professional standards. She further accepted that provision 10 of the Code was engaged in respect of this charge.

Ms Paisley submitted that the case was fundamentally one concerning record keeping under provision 10 of the Code. She submitted that the panel may conclude that there had been no breach of the provisions relating to integrity, dishonesty or wider professional misconduct obligations under provision 13 or 20 of the Code. She further submitted that whilst provision 19 may arguably be engaged, the panel should carefully consider the wider context in which the events occurred, including the culture within the Trust and the evidence that senior management expected retrospective entries to be completed despite the distressing circumstances.

Ms Paisley submitted that you had not sought at any stage to shift blame onto others and had instead accepted responsibility for the inaccuracies in your documentation. She invited the panel to consider the significant contextual pressures and emotional distress present at the time when determining whether the conduct found proved amounted to misconduct.

Submissions on impairment

Ms Amaning moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Amaning submitted that your fitness to practise was currently impaired on both public protection and public interest grounds. She submitted that the panel should consider whether your conduct had in the past, or was liable in the future, to put patients at unwarranted risk of harm, bring the profession into disrepute, or breach

fundamental tenets of the profession. Ms Amaning submitted that the limbs ‘a’, ‘b’ and ‘c’ in *Grant* are engaged in this case.

Ms Amaning submitted that your conduct engaged fundamental concerns relating to patient safety and accurate clinical record keeping. She submitted that the retrospective and inaccurate records created a misleading clinical picture of Baby A’s condition and treatment and gave the impression that Baby A had required more intervention than had actually occurred. Ms Amaning submitted that the delay in completing records created a risk that other healthcare professionals would not have access to accurate and reliable information regarding the care provided to Patient A and Baby A.

Ms Amaning further submitted that the inaccurate records and subsequent inaccurate witness statement had the potential to undermine public trust and confidence in the profession. She submitted that registered midwives occupy positions of trust and that members of the public are entitled to expect that midwives will maintain accurate, timely and reliable records and provide truthful and accurate accounts during investigations and coronial proceedings.

Ms Amaning submitted that the conduct found proved represented breaches of fundamental tenets of the profession and brought the profession into disrepute. She submitted that accurate record keeping is an essential professional obligation and that the creation of inaccurate records based upon assumption and reconstruction represented a serious departure from the standards expected of a registered midwife.

In relation to insight and remediation, Ms Amaning acknowledged that there were contextual factors present during the relevant period and accepted that you had demonstrated some insight into the concerns. However, she submitted that contextual pressures and remediation did not remove the need for regulatory action where public confidence and professional standards remained engaged.

Ms Amaning submitted that even if the panel considered the risk of repetition to be low, a finding of impairment remained necessary on wider public interest grounds. She submitted that a finding of impairment did not require a high ongoing risk of repetition where the seriousness of the misconduct itself was capable of undermining public confidence in the nursing and midwifery profession and the regulatory process.

Ms Amaning therefore invited the panel to conclude that a finding of current impairment was necessary in order to uphold proper professional standards and maintain confidence in the profession.

Ms Paisley submitted that although current impairment is not defined within the Nursing and Midwifery Order or the Rules, fitness to practise concerns a registrant's ability to practise safely and effectively without restriction. Ms Paisley agreed that the panel would be assisted by the principles set out in *Grant* and *Cohen v General Medical Council*.

Ms Paisley accepted that limbs 'b' and 'c' of the Grant test were engaged, namely that your conduct had brought the profession into disrepute and breached fundamental tenets of the profession. However, she submitted that limb 'a', concerning unwarranted risk of harm to patients, was less clear in this case. She submitted that although poor record keeping can generally create risks, Baby A did not suffer direct harm as a result of the allegations found proved and had already been transferred by the time the retrospective entries were completed. Ms Paisley submitted that the records were therefore not relied upon for the delivery of further clinical care.

Ms Paisley submitted that there was no ongoing risk of repetition and that the concerns in this case were remediable and had in fact been remediated. Ms Paisley submitted that you had demonstrated significant insight into the failures in your record keeping and fully recognised the seriousness of inaccurate documentation. She submitted that you accepted that records must be accurate, contemporaneous

and reliable and that inaccurate records had the potential to misinform investigations and affect others involved in Baby A's care and the subsequent coronial proceedings.

Ms Paisley submitted that throughout your evidence you had been candid and open with the panel. She reminded the panel of its own findings that you had been clear and consistent in your evidence, had not minimised your mistakes and had not sought to shift blame or responsibility onto others.

In relation to remediation, Ms Paisley submitted that you had undertaken extensive training, reflection and professional development specifically directed towards the concerns identified in this case. She referred the panel to the training records, reflective material, witness statements and supporting documentation contained within the bundle, including reflective supervision meetings relating to documentation and record keeping.

Ms Paisley further submitted that you had continued to practise safely and effectively as a midwife throughout the proceedings whilst subject to an interim conditions of practice order. She submitted that your documentation had therefore been subject to heightened scrutiny and monitoring over a prolonged period. Ms Paisley referred the panel to the evidence of Ms Alexandra Winstanley, who had undertaken approximately 190 reviews of your documentation and identified only a very small number of minor errors.

Ms Paisley submitted that there were no concerns regarding your honesty or integrity. She informed the panel that since the events in question, you had progressed professionally into a senior role involving education, training and policy development. She submitted that you had led the redevelopment of the fetal remains management policy and standard operating procedure, which had reportedly been implemented nationally, and that you had received recognition and awards from your employer for your contribution and professionalism.

Ms Paisley submitted that you had demonstrated exemplary standards of midwifery practice in the years following the incident and that there was no identifiable ongoing

risk to the public. She submitted that concerns had been fully remediated and there was no real risk of repetition.

Finally, Ms Paisley submitted that there were no remaining public interest concerns which required a finding of current impairment. She invited the panel to conclude that a fully informed member of the public, aware of the extensive remediation, insight, training, monitoring and positive professional practice demonstrated since the events, would not consider your current fitness to practise impaired. She therefore invited to conclude that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Johnson and Maggs v Nursing and Midwifery Council* [2013] EWHC 2140 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Grant.*

Decision and reasons on misconduct

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

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

> *'**7 Communicate clearly***
> *To achieve this, you must:*
>
> ***7.4** check people's understanding from time to time to keep misunderstanding or mistakes to a minimum.*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*

8.2 *maintain effective communication with colleagues.*

8.6 *share information to identify and reduce risk.*

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

To achieve this, you must:

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

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

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

10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*

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.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then carefully considered each of the charges found proved and the context in which they arose.

In relation to Charge 1a, the panel considered that this charge was marginally less serious than Charge 1b, as it related to the omission of the word ‘commenced’ from Baby A’s notes and arose from your assumption and partial observation of the events surrounding Baby A’s first resuscitation. The panel accepted that the inaccuracy was not deliberate and that you genuinely believed at the time that the actions recorded had occurred. However, the panel determined that this nevertheless amounted to misconduct because the record created an inaccurate clinical account based upon assumption rather than confirmed fact. The panel considered that records relating to neonatal resuscitation required a particularly high degree of accuracy and that assumptions should not have been incorporated into the clinical notes.

In relation to Charge 1b, the panel regarded this as more serious misconduct. The panel considered that recording ventilation breaths as having been given when they had not, created an inaccurate clinical picture of Baby A’s condition and treatment. The panel determined that inaccurate records of this nature were dangerous because other healthcare professionals and subsequent investigators were entitled to rely upon them as accurate accounts of the care provided. The panel considered that the inaccurate records contributed to a series of inaccuracies and inconsistencies throughout later investigations and proceedings, including the coronial process, and had the potential to cause significant distress to Patient A and the family.

In relation to Charges 3a and 3b, the panel determined that the same concerns applied to the inaccurate witness statement provided to HM Coroner. The panel considered that statements prepared for coronial proceedings and bearing a statement of truth carry significant importance. Members of the public are entitled to expect that registered midwives will provide accurate and reliable information in such circumstances. Although the panel found that you had not acted dishonestly, it determined that the inaccurate information contained within your statement represented a serious departure from the standards expected of a registered midwife.

The panel considered that the seriousness of the misconduct arose not from deliberate dishonesty, but from the inaccurate reconstruction of events based upon assumption and retrospective recollection. The panel accepted that you were working in difficult and distressing circumstances and that there were contextual pressures present on the ward at the time. However, the panel concluded that notwithstanding those pressures, you retained a professional responsibility to ensure that records and statements were accurate and completed at a time as close to the events as reasonably practicable. This is assessed to be before the end of your shift in this case.

In relation to Charges 5b and 5c, the panel concluded that these charges did not amount to misconduct. The panel accepted that at the relevant time you were unaware that your records were inaccurate and therefore did not knowingly fail to disclose the inaccuracies to the HSIB or HM Coroner. The panel considered that it would not be appropriate for these omissions arising through ignorance of the inaccuracies to be categorised as misconduct.

In relation to Charge 7, the panel determined that your failure to complete records in a timely manner amounted to misconduct. The panel considered that accurate and contemporaneous record keeping is fundamental to safe and effective healthcare practice. It accepted that contemporaneous entries are not always possible during emergency clinical situations. However, the panel determined that significant portions of the records were completed retrospectively approximately 16 hours later and only following requests from senior managers.

The panel accepted that you were [PRIVATE] following the events involving Patient A and Baby A. However, it determined that as the nominated midwife responsible for their care, you were required to ensure that records were completed contemporaneously or as soon as reasonably practicable. The panel considered that even a brief contemporaneous entry indicating that fuller notes would follow may have reduced the risk of later inaccuracies. The panel further determined that the delay in documentation significantly contributed to the inaccuracies which

subsequently arose and increased the risk of errors based upon reconstruction and memory.

The panel acknowledged that the case did not concern clinical incompetence, deliberate dishonesty or deep-seated attitudinal concerns. Nevertheless, it considered that the proven misconduct represented serious failings in relation to fundamental professional obligations concerning accurate and timely record keeping.

The panel determined that given its findings that Charges 5b and 5c do not amount to misconduct, these charges fall away.

The panel therefore concluded that your actions at Charges 1a, 1b, 3a, 3b and 7 fell seriously short of the conduct and standards expected of a registered midwife and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. 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.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing 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 proper professional standards.

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. At paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *…'*

The panel had regard to the above and determined that limbs 'a', 'b' and 'c' were clearly engaged. The panel determined that your misconduct had in the past placed patients at unwarranted risk of harm through the creation of inaccurate and retrospective records. The panel considered that the inaccurate documentation created a misleading clinical picture of Baby A's condition and the care provided. The panel accepted that Baby A had already been transferred by the time the retrospective entries were completed and therefore the records did not directly affect ongoing clinical treatment.

The panel nevertheless determined that inaccurate retrospective documentation created a potential risk that healthcare professionals and subsequent investigators would rely upon incorrect information. The panel considered that the inaccurate records and subsequent inaccurate witness statement contributed to a series of inaccuracies and inconsistencies which continued throughout later investigations and proceedings, including the coronial process. The family posed a number of questions which arose as a consequence of the inaccuracies, which is likely to have caused them additional distress.

The panel determined that your misconduct had brought the profession into disrepute and had breached fundamental tenets of the profession. The panel considered that accurate, clear and timely record keeping is a fundamental aspect of safe and effective nursing and midwifery practice and one upon which patients, families, healthcare professionals and external investigative bodies are entitled to rely. The panel considered that the public are entitled to expect that records relating to maternity and neonatal care will be accurate, reliable and contemporaneous and that statements subsequently provided within investigative and coronial proceedings can similarly be relied upon.

The panel determined that limb ‘d’ of *Grant*, which relates to dishonesty, was not engaged as the panel had not found the dishonesty allegations proved. The panel did not find deep-seated attitudinal concerns, criminal behaviour or conduct fundamentally incompatible with continued registration. The panel accepted that the inaccuracies arose within the context of distressing and difficult circumstances and that you genuinely believed at the time that aspects of the documentation reflected events as they had occurred. The panel determined that the misconduct arose primarily from retrospective reconstruction, assumptions and errors of recollection rather than any intention to mislead.

The panel next considered your level of insight. The panel acknowledged that you had demonstrated significant insight into the concerns identified in this case. The panel took into account your admissions to several of the charges and your acceptance that your documentation and subsequent statement contained inaccuracies which fell below the standards expected of a registered midwife.

The panel accepted that you recognised the importance of accurate, contemporaneous and reliable records and understood how inaccurate records could affect subsequent investigations and undermine trust in professional practice. However, the panel considered that your insight was not complete. In particular, the panel considered there was relatively limited reflection regarding the wider emotional impact of the inaccuracies upon Patient A and the family, as well as the impact upon public confidence in the profession.

The panel then considered whether the misconduct was capable of remediation and whether it had in fact been remediated. The panel concluded that the concerns in this case were remediable. It considered that the misconduct arose from failures in documentation, retrospective reconstruction and professional judgment rather than from deep-seated attitudinal concerns, dishonesty or fundamentally incompatible behaviour with continued registration.

The panel was satisfied that you had undertaken extensive remediation. It placed significant weight upon the substantial training and continuing professional

development you had undertaken, your reflective work, the evidence of supervision and monitoring of your documentation, your compliance with your interim conditions of practice order, the positive testimonials and character evidence provided on your behalf, and your demonstrated professional progression and increased responsibilities within your current role.

The panel noted that your documentation had been reviewed extensively whilst subject to conditions and that only a very small number of minor issues had been identified. The panel also accepted that you had demonstrated strengthened practice through reflective learning concerning communication, human factors and record keeping. The panel therefore determined that you had engaged with the regulatory proceedings and demonstrated significant remediation and strengthening of practice.

The panel was satisfied that the misconduct in this case is capable of being addressed. In light of remediation, insight and evidence of strengthened practice, the panel concluded that there was a low risk of repetition and that there was no current impairment on public protection grounds. The panel was satisfied that you were capable of practising safely and effectively.

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

The panel then turned to the wider public interest, mindful of the high bar required to find impairment on public interest grounds alone. The panel carefully weighed the significant remediation, strengthened practice and low risk of repetition against the seriousness of the misconduct found proved. The panel recognised that this was not a case involving dishonesty or deliberate concealment. The panel nevertheless considered that the misconduct was serious because it concerned fundamental professional obligations relating to accurate and timely record keeping during a continuing episode of care for a vulnerable mother and baby and because the

consequences of those inaccuracies continued into subsequent investigations and coronial proceedings.

The panel determined that this was not a single isolated oversight. The panel considered that there were several failings in record keeping and documentation over the course of one shift. The panel considered that if accurate and contemporaneous records had been completed at the relevant time, it is likely that many of the later investigative difficulties and inconsistencies would not have arisen. The panel determined that the retrospective assumptions and inaccuracies within the records contributed to a continuing chain of concerns which ultimately affected investigations and the coronial process.

The panel considered that accurate, clear and timely record keeping is a fundamental component of safe healthcare practice and one upon which patients, families, healthcare professionals and external investigations are entitled to rely. The panel determined that the retrospective assumptions and inaccuracies within the records led to further difficulties and inconsistencies. The panel accepted that you had not intended to mislead anyone and that the inaccuracies arose in the context of distressing and difficult circumstances.

The panel carefully considered whether a finding of misconduct alone would sufficiently uphold public confidence and maintain professional standards. The panel determined that it would not. The panel considered that a fully informed member of the public would be seriously concerned if misconduct of this nature, involving multiple inaccuracies in clinical documentation and subsequent consequences, were not marked by a finding of current impairment.

The panel therefore concluded that a finding of impairment was necessary on public interest grounds in order to uphold proper professional standards, maintain public confidence in the profession and the regulatory process, and appropriately mark the seriousness of the misconduct.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public interest grounds only.

Decision and reasons an application for a brief adjournment

After handing down its decision on misconduct and impairment, parties were afforded 45 minutes to prepare submissions for the sanction stage. During this time, the NMC requested a further 30 minutes as instructions had been sought but not obtained from a senior reviewing lawyer. After this time, Ms Amaning made submissions to the panel requesting for an additional 45 minutes as a senior lawyer, who was unfamiliar with the case, had been contacted and was in the process of reviewing the case.

In response to panel questions, Ms Amaning submitted that as the NMC is the party that has brought the case against you, it should have the opportunity to present its submissions with respect to sanction.

Ms Paisley indicated that she was in a position to present her submissions however, she stated that she had already informed you that there was likely to be a delay. She submitted that she sympathised with the fact that Ms Amaning was in a difficult position and stated that it was a matter for the panel as to whether an adjournment should be granted.

The panel accepted the advice of the legal assessor who referred to Rule 32 of the Rules.

The panel reluctantly decided to grant an adjournment. The panel considered that in fairness to the NMC, a short adjournment of 45 minutes over the lunch break would be appropriate. The hearing would resume with submissions on sanction at 13:15 hours.

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of two and a half years (30 months). The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Amaning submitted that the overarching objective of the NMC is public protection and to achieve that, the NMC must uphold and protect the confidence the public holds in the nursing and midwifery professions and protect and maintain the reputation of the professions.

Ms Amaning invited the panel to impose a caution order for a period in the range of three to five years as this is the most appropriate and proportionate sanction given the panel's findings with respect to misconduct and impairment. She submitted that a caution order would also adequately reflect the seriousness of this case and appropriately satisfy the wider public interest considerations.

Ms Amaning referred to NMC guidance (*SAN-1*) and invited the panel to take into account the principle of proportionality and seek to balance not only the public interest considerations but also your own interests.

Ms Amaning submitted that the aggravating features in your case are:

- The initial creation of the incorrect records, which was a catalyst to errors which later affected the accuracy of subsequent investigations.

- The inaccurate retrospective documentation, which created a potential risk that healthcare professionals would be misled.
- The additional distress caused to the family of Baby A as a result of your actions.
- The repetition of incorrect information not only in the retrospective entries but also in the statement produced to the Coroner.
- The delay in creating the records, which created an environment that fostered the risk of error from memory reconstruction.
- Breach of fundamental tenets of the profession relating to the keeping of clear, timely and accurate record keeping.

Ms Amaning submitted that the mitigating features in your case include your early admissions to Charges 1 and 3, the numerous training courses you have completed, the positive testimonials you have provided and your personal circumstances at the material time. Additionally, she submitted that the panel should also take into account the fact that you were in the infancy of your career.

However, Ms Amaning submitted that the panel should exercise its discretion accordingly and afford each aggravating and mitigating factor the appropriate weight. She submitted that personal mitigation is usually less relevant than other forms of mitigation, so the panel should approach this consideration with a degree of caution.

Ms Amaning referred to *SAN-1*, which outlines that evidence of insight and strengthened practice may be less important in cases where panels have found a risk to public confidence. She therefore invited the panel to attach the appropriate weight to these matters.

Ms Amaning submitted that taking no further action following a finding of impairment is usually only seen in rare and exceptional circumstances, and your case does not fall into this category. She submitted that the seriousness of the concerns, the protection of the reputation of the professions and the maintenance of public confidence mean that taking no action would be wholly inappropriate, given the panel's findings.

Ms Amaning submitted that a caution order is appropriate when a panel has decided that there is no risk to the public that requires a registrant's practice to be restricted. She submitted that your case appropriately falls within this category. She submitted that you have demonstrated significant evidence of re-training, reflection, insight and you are able to practise safely. However, a sanction is necessary to uphold professional standards and public confidence in the profession.

Ms Amaning submitted that a period of three to five years is sought to mark the public interest and reflect the seriousness of this case considering the far-reaching consequences of your inaccurate records. She submitted that a conditions of practice order would not be appropriate in this case as there are no outstanding clinical issues which need to be addressed, and the panel has found that you have remediated the concerns.

Ms Amaning referred to the more serious sanctions, namely a suspension order and striking off order, and submitted that these sanctions would be disproportionate and onerous given the circumstances of this case.

Ms Paisley submitted that she was in agreement with the NMC and she invited the panel to impose a caution order but for a period of one year (12 months). She submitted that the sanction a panel imposes must be proportionate and must strike a balance between your right to practise in your chosen career with the overarching objective of public protection.

Ms Paisley submitted that the mitigating features in your case are:

- The significant insight you have shown into your failings
- Your continued safe practice since the allegations
- The positive character statements you have provided.
- Your admissions to the charges and your reflection on Charge 7, the one charge the panel found proved.
- The fact that your records did not affect the ongoing care of Baby A.

- Your personal circumstances at the time of the allegations.

Ms Paisley submitted that it is acknowledged that the incorrect records created a risk that other healthcare professionals and subsequent investigators would rely on incorrect information. However, she submitted that this is the only aggravating feature in this case. She submitted that you have reflected at length on the impact this had and its seriousness.

Ms Paisley referred to the panel's finding that you have limited reflection in relation to the wider emotional impact of the inaccuracies on the family, as well as the impact upon public confidence in the profession. She submitted that you do acknowledge the impact upon the family, as outlined in paragraph 125 of your witness statement. She submitted that you regret your mistakes and the impact upon the family and that this is something that has not left your mind. She invited the panel to note that this is not a case where there has been no insight in this regard and that you wish to reassure the panel that you are acutely aware of the impact on the family.

With respect to public confidence, Ms Paisley submitted that you have great insight into the importance of accurate documentation and whilst the exact phrase 'public confidence in the profession' may not have been used, you fully understand the importance of public confidence in the midwifery profession and that your actions had the potential to undermine this. She submitted that this is not a case of attitudinal concerns, nor a case where there are concerns about your ability to practice.

Ms Paisley outlined the guidance in *SAN-2a* and submitted that your case is the kind of case that a caution order is intended for. It marks the seriousness of your misconduct but also reflects your extensive insight, reflection, acceptance and understanding and that a period of one year is appropriate.

Ms Paisley submitted that a conditions of practice order is not appropriate as there are no identifiable areas of concern with your clinical practice that conditions could address. She submitted that you are a careful, well respected and well trusted

midwife, who has shown exemplary practice over a number of years. She submitted that you are supported by the most senior people within your current employment and you are diligent and caring. She therefore submitted that your ability to practise without restrictions is the proper outcome in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The initial creation of the incorrect records, which led to errors in the accuracy of subsequent investigations.
- Inaccurate retrospective documentation, which created a potential risk that healthcare professionals would be misled.
- The additional distress caused to the family of Baby A as a result of your actions.
- The repetition of incorrect information not only in the retrospective entries but also in the statement produced to the Coroner.
- Breach of fundamental tenets of the profession relating to the keeping of clear, timely and accurate record keeping.

The panel also took into account the following mitigating features:

- The charges arose whilst you were at an early point in your career.
- You have provided evidence of significant re-training, reflection and insight.

- You have provided positive character references evidencing that you have worked safely and professionally in the same or similar role since the events causing concern.
- Your early admissions to Charges 1 and 3.
- Your significant personal circumstances at the material time.

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.

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

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

The panel had regard to *SAN-2a*, which outlines:

> *'A caution may be appropriate when any of the following factors are apparent (this list is not exhaustive):*
>
> - *significant evidence of re-training and reflection*
> - *significant insight which makes repetition highly unlikely*
> - *a sanction is necessary to uphold professional standards and public confidence in the profession, but the professional is able to practise safely and a more restrictive sanction would be disproportionate'*

The panel concluded that you have shown significant evidence of re-training, reflection and insight, which makes repetition of your misconduct highly unlikely. Additionally, the panel was of the view that you are able to practise safely and

restriction of your practice would be disproportionate. However, the panel considered the seriousness of the case and determined that a sanction is required to mark this.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel concluded that no useful purpose would be served by a conditions of practice order as there are no outstanding clinical issues that need to be addressed and it is not necessary to protect the public. The panel further considered that a suspension order and a striking-off order would be wholly disproportionate in this case.

The panel decided that a caution order would adequately protect the public. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel determined that imposing a caution order for a period of two and a half years (30 months), would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession but also send the public and the profession a clear message about the standards required of a registered midwife.

For this period, your employer or any prospective employer will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction.

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

This decision will be confirmed to you in writing.

That concludes this determination.