

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Thursday 1 May 2026 – Thursday 7 May 2026**

Virtual Meeting

Name of Registrant: **Katie Louise Windle**

NMC PIN: 18A0198E

Part(s) of the register: Midwives part of the register
RM: Midwife – 21 September 2018

Relevant Location: Doncaster

Type of case: Misconduct

Panel members: Shaun Donnellan (Chair, Lay member)
Zoe Wernikowski (Registrant member)
Jim Blair (Registrant member)

Legal Assessor: John Bassett

Hearings Coordinator: Petra Bernard

Facts proved: Charges 1b), 2a), 2b), 4), 5a), 5b), 5c), 5d), 5e), 5f),
5g), 5h), 6a), 6b), 6c), 7b), 8), 9a), 9b), 11a), 11b)
and 12)

Facts not proved: Charges 1a), 3), 7a) and 10)

Fitness to practise: Impaired

Sanction: **Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Substantive Meeting had been sent to Mrs Windle's registered email address by secure email on 7 January 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Substantive Meeting provided details of the allegations and date this meeting was to be held. The panel noted that Mrs Windle had been afforded ample opportunity to submit any documentation she wished the panel to consider in advance of the meeting.

In the light of all of the information available, the panel was satisfied that Mrs Windle has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered midwife:

- 1) On 16 November 2020 having admitted Patient A to the labour room
 - a) Failed to recognise that Patient A was in active labour following Patient A's examination in Triage or
 - b) Failed to conduct an adequate examination of Patient A to determine their stage of labour and incorrectly determined that Patient A was in the latent

phase of labour when they were in active labour

- 2) Between 16 November 2020 and 17 November 2020 failed to advocate for Patient A's birth wishes
 - a) to have a pool birth
 - b) to have a physiological 3rd stage

- 3) On 17 November 2020 exaggerated Patient A's blood loss as being 420mls in order to administer an oxytocin injection

- 4) On 11 April 2022 incorrectly advised Patient B not to attend hospital when Patient B contacted the hospital with pains in abdomen and back

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:
 - a) When Patient B stood up to relieve their pain you said to them "What on earth do you think you are doing? Stop being so ridiculous" or words to that effect
 - b) When Patient B said they were in severe pain and needed help, you sighed and said "I will page the doctor if that makes you feel any better" or words to that effect
 - c) When Patient B's waters broke and they apologised, you said "stop being stupid, they are your waters for God's sake" or words to that effect
 - d) When Patient B said they could not sit on a wheelchair you said "I suggest you sit down now unless you want your baby to be delivered on this floor" or words to that effect
 - e) When Patient B asked for pain killers you said "no chance now it's too late" or words to that effect
 - f) When Patient B could not stop the urge to push and their baby was delivered you said "and that's exactly why I told you to stop pushing, look what's happened now" or words to that effect

- g) When Patient B's baby was taken to neonatal for breathing support you said "he might not be ok you know, and if he is then it will be a long journey ahead for you" or words to that effect
 - h) When Patient B's partner gave them a drink of water you said "for God's sake can't you just leave her alone or words to that effect
- 6) Between 11 April 2022 and 12 April 2022 following Patient B's waters breaking:
- a) Failed to cover up Patient B's exposed lower body
 - b) Made Patient B walk in a public area with their trousers around their ankles
 - c) Failed to offer Patient B a change of clothing
- 7) Between 11 April 2022 and 12 April 2022:
- a) failed to promptly administer a steroid injection to Patient B
 - b) failed to provide pain relief to Patient B at the appropriate time
- 8) On 12 April 2022 inserted your hand into Patient B's vagina and roughly removed the placenta
- 9) On 10 September 2022 were rude to Patient C and/or their partner:
- a) When Patient C's partner informed you that Patient C's waters had broken you said "it's ok she's still going home"
 - b) When Patient C asked you to stop speaking down to them you said "ok I'll leave you to it" or words to that effect, and walked out of the room
- 10) On 10 September 2022 failed to provide pain relief to Patient C when they requested it.
- 11) On 13 September 2022:
- a) failed to perform an Amnisure Vaginal test on Patient D
 - b) instead you asked patient D to perform their own Amnisure Vaginal test

12) Between 26 October 2022 and 27 October 2022 incorrectly advised Patient E not to attend hospital

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

Background

The Nursing and Midwifery Council (NMC) received a referral from the Director of Midwifery at Doncaster and Bassetlaw Hospitals NHS Foundation Trust (the Trust) on 29 December 2022, in relation to several concerns raised in relation to Mrs Windle's care and attitude toward patients in her care. Mrs Windle had been employed by the Trust as a Band 6 midwife in the Triage department at the Trust (Triage).

Mrs Windle has provided a letter of reflection in which she apologises for her actions. [PRIVATE].

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Julie Scott: Intrapartum Matron at the Trust, at the material time
- Matt Proctor: Midwife at the Trust, at the material time

- Laura Cooke: Midwife at the Trust at the material time
- Katie Heaton: Midwife at the Trust at the material time
- Patient B: Patient at the Trust at the material time
- Patient C: Patient at the Trust at the material time
- Patient D: Patient at the Trust at the material time
- Patient E: Patient at the Trust at the material time

The panel has drawn no adverse inference from Mrs Windle's limited engagement with the NMC. The panel has come to its own decisions based on the evidence before it.

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

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

In the panel's consideration of the element of failure in each of the sub-charges 1a) 1b), 2a), 2b), 6a), 6c), 7a), 7b), 10), 11a), the panel had regard to all the evidence before it where it is recorded that Mrs Windle was the midwife on shift responsible for the patients' care. The panel reminded itself that as the registered midwife Mrs Windle had a professional duty of care toward these patients. The panel applied this reasoning to each of these sub-charge below accordingly.

Charges 1a)

- 1) On 16 November 2020 having admitted Patient A to the labour room

- a) Failed to recognise that Patient A was in active labour following Patient A's examination in Triage or

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statements of Ms Julie Scott (Ms Scott), Mr Matthew Proctor (Mr Proctor), Ms Katie Heaton (Ms Heaton) also the responses given during the investigation interview on 21 April 2021 by Mrs Windle.

Mrs Windle had recorded in Patient A's medical notes at 23.50 that Patient A was in the '*latent phase*' of labour.

Ms Scott in her witness statement states:

'...Mrs Windle thought [Patient A]'s contradictions [sic] had slowed down even though the other midwife diagnosed active labour...

...

A nurse/midwife will perform a vaginal inspection to determine if the patient is in latent labour or active labour. Once a patient is in active labour, there should be regular observations and monitoring. Mrs Windle didn't reassess her again by doing a vaginal examination.

Because Mrs Windle's mindset was that [Patient A] was in latent stage, she wasn't prepared for [Patient A] being in active labour...'

Ms Heaton in her witness statement states:

'I saw Katie come out of Room 5 very quickly and ask Karen (the Coordinator) to classify [Patient A] as latent stage. I remember thinking at the time that it's been less than 10 minutes, how can you determine how many times the woman has contracted in 10 minutes. Matthew had spent 45 minutes with [Patient A] in Triage before determining that she was in active labour...'

Mr Proctor in his witness statement states:

I remember that her contractions had slowed down which was uncommon...

I stayed with her for 45 to 60 minutes before doing an internal examination...

...

I established the lady to be in active labour and handed over to my colleagues.

Katie took the lady into another room and left triage...'

Katie disagreed with my assessment because she thought the lady's contractions had slowed down and she wasn't in active labour. That's okay and it isn't uncommon for midwives to disagree. It can happen where a patient's contractions slow down.'

The panel had sight of Patient A's medical notes where it is recorded at 22:17 on 16 November 2020 as '*Contractions Established*'. At about 23:38 care of Patient A was passed to Mrs Windle and the panel has carefully considered the notes she made between that time and 01:21 on 17 November 2020 when Patient A's baby was delivered.

It is apparent from the evidence of Mr Proctor that midwives can and do differ in their assessment whether a patient is in the active phase of labour rather than the latent phase. In these circumstances, the panel cannot be satisfied on the balance of probabilities that Mrs Windle, in the words of the charge, '*failed to recognise that Patient A was in active labour following Patient A's examination in Triage.*'

The panel therefore finds this charge not proved.

Charge 1b)

- 1) On 16 November 2020 having admitted Patient A to the labour room Failed to
 - b) conduct an adequate examination of Patient A to determine their stage of labour and incorrectly determined that Patient A was in the latent phase of labour when they were in active labour

This charge is found proved.

The panel noted that this charge is drafted as an alternative to charge 1a).

In reaching this decision, the panel took into account the witness statements of Ms Scott, Mr Proctor, Ms Heaton, Ms Laura Cooke (Ms Cooke) and the responses given during the investigation interview on 21 April 2021 by Mrs Windle.

Ms Cooke states:

'When we usually assess a patient, we take at least 10 minutes to see how many contractions there are. Anything under 10 minutes is inadequate for purposes of determining whether a patient is in latent (early) or active (advanced) labour.

You would want to know the frequency of the contractions for at least 10 minutes or even longer to come to an accurate conclusion. Anything less could be insufficient.

A midwife can make a mistake between a latent labour and an active labour. But you can rule this out by doing a vaginal examination (VE). Katie didn't bother doing a VE examination, she made a judgment by looking at [Patient A]. I didn't see a VE examination on [Patient A]'s medical records.'

Ms Heaton in her witness statement states:

'I saw Katie come out of Room 5 very quickly and ask Karen (the Coordinator) to classify [Patient A] as latent stage. I remember thinking at the time that it's been less than 10 minutes, how can you determine how many times the woman has contracted in 10 minutes. Matthew had spent 45 minutes with [Patient A] in Triage before determining that she was in active labour ...'

The panel accepted this evidence and considered that it reflects the standard of care expected of a midwife examining a patient in order to assess whether they are in the

active stage of labour. In this case, the panel would have expected Mrs Windle to be particularly careful in her examination as she would have known that Mr Proctor had assessed Patient A as being in the active phase.

The panel was satisfied that Mrs Windle had a professional duty of care toward the Patient A. The panel concluded that Mrs Windle had failed to conduct an adequate examination of Patient A to determine their stage of labour and incorrectly determined that Patient A was in the latent phase of labour when they were in active labour. The panel therefore finds this charge proved.

Charge 2a)

2) Between 16 November 2020 and 17 November 2020 failed to advocate for Patient A's birth wishes

a) to have a pool birth

This charge is found proved.

In reaching this decision, the panel took account of the witness statements of Ms Scott Ms Heaton, Ms Cooke and Mrs Windle's statement to the Trust.

The panel first considered the meaning of the word 'advocate' and took it by its ordinary meaning in this context, to support Patient A's requests and speak up on her behalf.

Ms Cooke in her local investigation statement stated:

'The pool room was free therefore she would have been able to have her wishes granted and proceed with a pool birth.'

Ms Cooke's local Investigation meeting notes of 1 July 2021 where Mrs Windle reportedly stated:

'... if she thinks I am doing a fucking pool birth, then she can think again and she is not having a physiological 3rd stage.'

Ms Heaton in her local interview stated:

'KW then went into triage for handover of the woman, speaking to the triage midwives MP and LC, stating she couldn't be bothered with no water birth that evening. At this point the woman was in the same room behind the curtains and may have possibly heard the comments made.'

Mrs Windle in her local statement to the Trust stated:

'As I have already agreed my attitude towards to the pool birth wasn't as it should have been and I didn't advocate for my woman as I should and normally do.'

Mrs Windle in local investigation interview on 21 April 2021 stated:

'It is the leaning over and auscultating. I am competent however leaning over the pool on that day would have caused me pain I therefore escalated this to the coordinator.'

...

JT – did you tell the co-ordinator that you had concerns auscultating.

KW – No I did escalate to the coordinator about my concerns re auscultating and she said Midwife KH would undertake the auscultations

JT – All 3 midwives spoke to the lady and they say she mentions she was disappointed

The panel saw no evidence of escalation to the coordinator or any other midwife. The panel determined that it was Mrs Windle's role to support Patient A to have a pool birth which was the mode of birth Patient A wanted. However for Mrs Windle's own reasons she instead chose not to.

The panel determined that there was no medical reason recorded by Mrs Windle for not adhering to Patient A's wishes to have a pool birth, other than her own personal issue of a [PRIVATE].

In the local statement written on 13 December 2020, Ms Heaton stated:

'KW then went into triage for handover of the woman, speaking to the triage midwives MP and LC, stating she couldn't be bothered with no water birth that evening. At this point the woman was in the same room behind the curtains and may have possibly heard the comments made.'

The panel determined that Mrs Windle had made it clear that she was not going to give Patient A the pool birth she wanted. The panel determined that there were other medical professionals on duty who could have helped however Mrs Windle did not escalate to them accordingly, rather it was her own choice not to adhere to Patient A's wishes.

The panel concluded that Mrs Windle had failed to advocate for Patient A's birth wishes to have a pool birth in accordance with her wishes.

This charge is therefore found proved.

Charge 2b)

2) Between 16 November 2020 and 17 November 2020 failed to advocate for Patient A's birth wishes

b) to have a physiological 3rd stage

This charge is found proved.

In reaching this decision the panel took into account the witness statements of Ms Cooke and Ms Heaton.

Ms Heaton stated in her local statement:

'...The above woman attended triage for a labour assessment, P1, who advised on admission she would like a water birth with physiological third stage. ... At the time the next midwife to care for a woman was KW. As she heard the woman's wishes she very quickly stated "absolutely not, she's not fucking having a pool birth, put her in room 5"...'.

Ms Cooke in her witness statement states:

'I heard Katie say to Matthew loudly that she was not going to look after [Patient A] in the pool and that she could not be bothered with a physiological third stage.'

The local interview exchange on 21 April 2021 between Ms Julie Todd (Ms Todd) and Mrs Windle includes:

'JT – Was there a Physiological 3rd stage – that was touched on a few times. How are you aware she wanted a 3rd stage?

KW - I spoke to her and I am happy with this. This is my normal practice when a woman expresses a desire for a physiological third stage to ask if she would accept active management if clinically indicated. I had checked that if she needs an active 3rd stage, she gave her consent and I asked her again and said can I give you this as she was having a bit of a bleed

JT – Why did you manage this yourself and not call for help

KW – I did not call for help because the other midwife was there and I gave the lady the oxytocin'

And between Ms Todd and Ms Cooke:

JT - What did you hear Katie Windle say that you felt was unprofessional?

LC – She came through into the triage area and she said that 'if she thinks I am doing a fucking pool birth, then she can think again and she is not having a

physiological 3rd stage'. It was offensive to us as midwives and to the patient. And it was along the lines of I can't be bothered.

The panel relied on its reasoning in charge 2a). The panel determined that Mrs Windle had a duty to advocate for Patient A to have a physiological 3rd stage birth and failed to adhere to her wishes. This charge is therefore found proved.

Charge 3

- 3) On 17 November 2020 exaggerated Patient A's blood loss as being 420mls in order to administer an oxytocin injection

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Ms Heaton. The panel noted that there was no mention of any pads being weighed to confirm the amount of blood loss.

The panel had regard to Patient A's medical notes of 16 November 2020. It noted that Mrs Windle had recorded an estimated Blood Loss of 420mls. Ms Heaton in her local statement stated:

'Unless the woman had a larger blood loss as placenta was delivered, in my opinion I feel the woman's EBL was documented more than it was, with a total of 420mls.'

Ms Heaton in her local investigation interview stated:

'...In my opinion the woman's EBL of 420mls seems a bit of a precise amount. Unless she did lose a good amount after I left the room, I felt it was documented to warrant active 3rd stage...'

The panel had regard to the different amounts of estimated and approximate blood loss recorded in Patient A's medical notes at various times:

'01.08 ACTIVELY BLEED APPROX 200MLS AND DISCUSSED [Patient A] INFORMED CONSENT

*..
01.11 PLACENTA DELIVERED BY CTT. EBL 400MLS*

*...
02.20 ASSISTED TO SHOWER. ADDITIONAL LOSS OF 70MLS ON INCO WHILST BREASTFEEDING. EBL TOTAL 420MLS...;*

Ms Scott in her witness statement states:

'MW Kate Heaton (second midwife) questioned Mrs Windle's decision to administer the injection. Mrs Windle documented 200mls but MW Katie Heaton said the bleeding wasn't that much.'

The panel was of the view that that there was no evidence to show that anyone had measured the blood loss in the pad to categorically show that it was exaggerated to be 420mls. The panel determined that this was effectively a difference of two professionals' subjective opinions.

The panel therefore concluded that there is insufficient evidence show that Mrs Windle had exaggerated Patient A's the blood loss to be 420mls in order to administer an oxytocin injection. This charge is therefore found not proved.

Charge 4

4) On 11 April 2022 incorrectly advised Patient B not to attend hospital when Patient B contacted the hospital with pains in abdomen and back

This charge is found proved.

In reaching this decision, the panel took into account Patient B's formal written complaint dated 12 August 2022 and witness statement dated 25 July 2024.

Patient B wrote in her complaint:

On the 11/04/22 I rang maternity triage due to myself being 32+6 days pregnant, having reduced movements, pressure above my pubic bone, lower back pain that was getting severe and pains in my lower abdomen. I spoke to a midwife named Kat and explained how I wanted some advice as I was experiencing these things and she abruptly told me that what I was experiencing was a urinary tract infection that has potentially spread to my kidneys which is why I was experiencing such pain. I explained how I was extremely concerned as I am a first time mother and it was the first time I have noticed reduced movements and that the pains I was feeling were coming and going and becoming more severe, Kat then began to tell me how triage isn't a service for urinary tract infections as they only have 'baby doctors' and that I needed to ring out of hours urgent treatment centre service. I told Kat how I have been encouraged to ring triage if I have any concerns regarding reduction of movements or any symptoms of preeclampsia as I have been having my blood pressure monitored and she replied with "it will be a waste of your time and my time if you come into see us, but I can't stop you, I will just have to send you away".

I rang Out of hours and they were extremely shocked that I had been advised to ring themselves as the symptoms I was displaying suggested I needed an ambulance as they were all signs of preterm labour.

...

I arrived at A&E and at this point the pain I was experiencing was only worsening and A&E told me I should of gone straight to triage, I explained who I had rang and what they had advised so A&E staff rang triage with the phone on loud speaker, Kat picked up the phone and stated "we are overrun and short staffed so you need to see her". A&E staff explained how it is a maternity related issue and needs to be seen at triage, Kat sighed loud over the phone and said "send her over" and then put the phone down.

...I arrived at Triage ... The pains got worse and I needed to stand up to relieve the pain and Kat then stated 'what on earth do you think you are doing? Stop being so ridiculous, I need you on this monitor to check your baby' I instantly

apologised and explained how I was in such severe pain and I needed some help. Kat then sighed and said 'I will page the doctor if that makes you feel any better' in a very sarcastic tone of voice. ...I asked to use the toilet, my waters broke whilst I was in the toilet so I shouted for help. I was extremely apologetic and embarrassed by this as they had broken all over the floor and all down my clothing. Kat then said "stop being stupid, they are your waters for godsake" as my first reaction was I'd been incontinent of urine and this is the reason I apologised. Kat then made me walk from the toilet across the corridor with my underwear and trousers around my ankles as they were wet through, I felt extremely undignified and there was no point where anyone tried to help me cover up whilst walking to the treatment room. I was spoken to with the most outright disrespect and I feel my care was most definitely careless. ...Kat continued to tell me how I wasn't in labour and that I must have a kidney infection and this is what was causing such bad pain. The doctor came and examined me and then spoke to Kat and asked her if she had administered me any steroids as she could feel my baby's head as I was fully dilated and ready to give birth. The steroids I should have been given to help my baby's lungs as he was premature we're not administered as she refused to check me when I first arrived at triage, I was administered the injection but this was far too late as baby was delivered shortly after. She asked me to sit down on a wheelchair as she needed to take me to the delivery suite and I told her I couldn't sit down as I felt like I was going to sit on my baby's head, and Kat then said "I suggest you sit down now unless you want your baby to be delivered on this floor" I was absolutely shocked at this statement and so upset by it. I got to the delivery room and I began to push I asked for pain killers and she said "no chance now it's too late". Kat then told me to stop pushing but I apologised again and told her that I couldn't stop as my body was pushing itself. Minutes later I delivered my baby in one large push which resulted in some vaginal tears, to which Kat then stated in a sarcastic voice "and that's exactly why I told you to stop pushing, look what's happened now". My baby was taken from me as he needed breathing support and was taken to the neonatal unit for care. I then got really upset and scared about my baby and my partner was trying to give me reassurance and Kat then stated "he might not be ok you know, and if he is then it will be a long journey ahead for you". My

partner and I were absolutely astounded by this comment and this is something no parent should ever have to hear off a supposed professional who's care I was under at that time. I was in complete shock of the whole situation and the staff members negligence made the whole situation even more horrendous.

Shortly after the birth I was told that the after birth was struggling to be delivered and if it took much longer then I would need to go to theatre to get it removed.

Another midwife was looking after me at this point, the placenta still wasn't coming so I was administered an injection to help this. Kat then came back into the room and said "let me have a go, I'll get it out" and then proceeded to insert her hand inside of my body and very roughly removed the placenta, I shouted in pain and Kat then stated "that's how you do it". I was in utter shock

but glad that it was finally over. Following this the doctor had to come and suture the vaginal tears and I needed to be catheterised, the doctor explained how I needed to drink more fluids as my urine was dark and I seemed dehydrated. So my partner give me a drink of water as this is what was recommended and Kat said to my partner "for godsake can't you just leave her alone" I was also absolutely disgusted by this remark and my partner was really taken back by this.

Overall I had the most appalling neglectful care, and the birth of my first child is something that will traumatise me for the rest of my life due to the negligence and disregard of this midwife.

I would like this matter to be taken seriously as no woman should ever be made to feel this way or receive the lack of dignity and respect that I did.'

The panel determined Patient B's account of this incident to be both credible and reliable and her witness statement dated 25 July 2024 to be consistent with her above written complaint.

The panel considered the detail and extent of Patient B's account of the incident in her complaint. The panel determined that it had no reason to believe that Patient B had fabricated her account. The panel noted that Patient B had asked for an ambulance and had to get herself to hospital. Accident and Emergency (A&E) were so concerned they put out their request for a doctor on loudspeaker.

Ms Heaton in her witness statement stated:

'It was the wrong advice because any lady that is pregnant at 32 weeks, should be invited into Hospital. You shouldn't make an assessment over the phone, even if you thought it was a urine infection. Mrs Windle should have invited [Patient B] into the Hospital to exclude that she was in premature labour.

Mrs Windle didn't consider that [Patient B] was in premature labour, she termed it as urine infection because [Patient B] had symptoms of an urine infection, i.e. lower back pain. Mrs Windle should have been more cautious because she was pregnant. Urgent care would have been better to assess [Patient B].'

The panel noted that Mrs Windle has not provided any account in relation to this incident.

The panel had regard to Patient B's medical notes of 11 April 2022 and noted that she had symptoms of a urine infection six weeks prior and had been on a course of antibiotics. The panel was of the view that this, as well as the fact that Patient B was only 32 weeks gestation, should have informed Mrs Windle that Patient B should be admitted to hospital to be assessed and checked.

The panel determined that Mrs Windle had incorrectly advised Patient B not to attend hospital when Patient B contacted the hospital with pains in abdomen and back. The panel therefore finds this charge proved.

Charge 5

Charge 5 has a number of sub-charges. Each charge alleges that Mrs Windle was rude to Patient B and/or their partner. The panel has considered each sub-charge separately but as it has already stated, it is of the view that Patient B's written account of this incident to be both credible and reliable, and her witness statement dated 25 July 2024 consistent with her above written complaint of 12 August 2022. The panel determined

that Patient B had provided a detailed accounts of the events which are both consistent with each other. The panel determined that Patient B had no motive, prior history or dispute with Mrs Windle and could find no reason why she would have fabricated the matter in the detail she has provided.

Charge 5a)

5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

a) When Patient B stood up to relieve their pain you said to them “What on earth do you think you are doing? Stop being so ridiculous” or words to that effect

This sub-charge is found proved.

In reaching this decision, the panel took into account Patient B’s formal written complaint dated 12 August 2022 and witness statement dated 25 July 2024.

Patient B’s witness statement states:

‘The pains got worse and I need to stand up to relieve the pain and Katie then stated ‘what on earth do you think you are doing? Stop being so ridiculous, I need you on this monitor to check your baby’. I instantly apologised and explained how I was in such severe pain and I needed some help.

Charge 5b)

5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- b) When Patient B said they were in severe pain and needed help, you sighed and said “I will page the doctor if that makes you feel any better” or words to that effect

This sub-charge is found proved.

Patient B in her witness statement states:

‘...Katie then sighed and said ‘I will page the doctor if that makes you feel any better’ in a very sarcastic tone of voice.’

Charge 5c)

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- c) When Patient B’s waters broke and they apologised, you said “stop being stupid, they are your waters for God’s sake” or words to that effect

This sub-charge is found proved.

Patient B in her witness statement states:

‘While in the toilet my waters broke, and I shouted for help. I was extremely apologetic and embarrassed by this as they had broken all over the floor and all down my clothing. My first reaction was I’d been incontinent of urine and this is the reason I apologised. Katie then said “stop being stupid, they are your waters for God’s sake”’

Charge 5d)

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- d) When Patient B said they could not sit on a wheelchair you said “I suggest you sit down now unless you want your baby to be delivered on this floor” or words to that effect

Patient B in her witness statement states:

‘Katie asked me to sit down on a wheelchair as she needed to take me to the delivery suite and I told her I couldn’t sit down as I felt like I was going to sit on my baby’s head. Katie then said, “I suggest you sit down now unless you want your baby to be delivered on this floor”. I was absolutely shocked at this statement and so upset by it.’

Charge 5e)

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- e) When Patient B asked for pain killers you said “no chance now it’s too late” or words to that effect

This sub-charge is found proved.

Patient B in her witness statement states:

‘I got to the delivery room, and I began to push. I asked for pain killers and Katie said, “no chance now it’s too late”. Katie then told me to stop pushing but apologised again and told her that I couldn’t stop as my body was pushing itself’

Charge 5f)

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- f) When Patient B could not stop the urge to push and their baby was delivered you said “and that’s exactly why I told you to stop pushing, look what’s happened now” or words to that effect

This sub-charge is found proved.

Patient B’s witness statement states

‘Minutes later I delivered my baby in one large push which resulted in some vaginal tears, to which Katie then responded, in a sarcastic voice, “and that’s exactly why I told you to stop pushing, look what’s happened now”.’

Charge 5g)

- 5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

- g) When Patient B’s baby was taken to neonatal for breathing support you said “he might not be ok you know, and if he is then it will be a long journey ahead for you” or words to that effect

This sub-charge is found proved.

Patient B in her witness statement states:

‘My baby was taken from me to the neonatal unit for care as he needed breathing support. I then got really upset and scared about my baby and my partner was trying to give me reassurance. Katie then stated “he might not be ok you know, and if he is then it will be a long journey ahead for you”. My partner and I were absolutely astounded by this comment; this is something no parent should ever have to hear off a supposed professional, whose care I was under at that time.’

Charge 5h)

5) Between 11 April 2022 and 12 April 2022 were rude to Patient B and/or their partner:

h) When Patient B's partner gave them a drink of water you said "for God's sake can't you just leave her alone or words to that effect

This sub-charge is found proved.

Patient B in her witness statement states:

'The doctor explained how I needed to drink more fluids as my urine was dark and I seemed dehydrated. Following this advice, my partner gave me a drink of water, and Katie said to my partner "for God's sake can't you just leave her alone". I was absolutely disgusted by this remark and my partner was really taken back by this.'

In reaching this decision, the panel took into account Patient B's formal written complaint dated 12 August 2022 and witness statement dated 25 July 2024.

The panel therefore finds charge 5 proved in its entirety.

Charge 6

6) Between 11 April 2022 and 12 April 2022 following Patient B's waters breaking:

- a) Failed to cover up Patient B's exposed lower body
- b) Made Patient B walk in a public area with their trousers around their ankles
- c) Failed to offer Patient B a change of clothing

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Patient B's initial email complaint of 12 August 2022 and witness statement dated 25 July 2024.

Patient B in her witness statement states:

Katie then made me walk from the toilet across the corridor with my underwear and trousers around my ankles as they were wet through. I felt extremely undignified and there was no point where anyone tried to help me cover up whilst walking to the treatment room. I was spoken to with outright disrespect and I feel I was not treated with the proper care.

And Patient B's written complaint states:

'Kat asked me to walk to the treatment room to get myself prepared for seeing the doctors and I asked to use the toilet, my waters broke whilst I was in the toilet so I shouted for help. I was extremely apologetic and embarrassed by this as they had broken all over the floor and all down my clothing. Kat then said "stop being stupid, they are your waters for godsake" as my first reaction was I'd been incontinent of urine and this is the reason I apologised. Kat then made me walk from the toilet across the corridor with my underwear and trousers around my ankles as they were wet through, I felt extremely undignified and there was no point where anyone tried to help me cover up whilst walking to the treatment room.'

As already stated the panel considers Patient B to be credible and reliable and there is no reason to doubt what she has stated.

The panel took account that Mrs Windle has not provided an account, reflection or any explanation for her conduct. The panel was satisfied that Mrs Windle had a professional duty of care toward the Patient B. The panel determined that Mrs Windle had failed in her duty of care to Patient B to cover up her exposed lower body when she walked in a public area with trousers around her ankles and to offer Patient B a change of clothing. The panel therefore finds this charge proved in its entirety.

Charge 7a)

7) Between 11 April 2022 and 12 April 2022:

a) failed to promptly administer a steroid injection to Patient B

This charge is found NOT proved.

In reaching this decision, the panel took into Patient B's initial written complaint of 12 August 2022 and witness statement dated 25 July 2024.

Patient B in her witness statement states:

'The doctor came and examined me and then spoke to Katie and asked her if she had administered me with any steroids as she could feel my baby's head; I was fully dilated and ready to give birth. I should have been given the steroids to help my baby's lungs as he was premature. However, they had not administered as Katie had refused to check me when I first arrived at triage. I was then administered the injection but this was far too late as baby was delivered shortly after. (I would say it was 10 minutes after the injection, potentially even sooner as once I had the injection I got taken down to the delivery suite, got onto the bed and I had a couple of contractions and then I delivered him in one large push).'

The panel noted that Ms Scott's witness statement is silent in relation to this charge and Mrs Windle makes no reference to it.

The panel considered that Patient B having not been admitted when she first arrived at triage, may have interpreted that she should have been given administered the steroid injection sooner than it was given. The panel was of the view that, in the circumstances it is difficult to say when the appropriate time would have been for the steroid injection to be administered to Patient B. The panel determined that there is no clinical evidence to support that a steroid injection should be promptly administered in these circumstances.

The panel could not be satisfied that there was sufficient evidence to support this sub-charge in order to prove that Mrs Windle had a duty to promptly administer the steroid injection to Patient B. The panel therefore finds this charge not proved.

Charge 7b)

7) Between 11 April 2022 and 12 April 2022:

b) failed to provide pain relief to Patient B at the appropriate time

This charge is found proved.

In reaching this decision, the panel took into Patient B's initial written complaint of 12 August 2022 and witness statement dated 25 July 2024.

Patient B in her witness statement states:

'I got to the delivery room, and I began to push. I asked for pain killers and Katie said, "no chance now it's too late". Katie then told me to stop pushing but I apologised again and told her that I couldn't stop as my body was pushing itself.'

...

'The pains got worse and I needed to stand up to relieve the pain and Katie then stated 'what on earth do you think you are doing? Stop being so ridiculous, I need you on this monitor to check your baby'.

The panel considered Patient B's evidence that she was moving around in pain asking for pain medication for help with her pain. It determined that Mrs Windle had the opportunity to provide Patient B some pain relief medication, had a duty to do so and chose not to. The panel therefore finds this charge proved.

Charge 8

8) On 12 April 2022 inserted your hand into Patient B's vagina and roughly removed the placenta

This charge is found proved.

In reaching this decision, the panel took into Patient B's initial written complaint of 12 August 2022 and Ms Scott's witness statement dated 25 July 2024.

Ms Scott in her witness statement states:

[Patient B] also complained that Mrs Windle removed the placenta roughly. The placenta is soft and tender. It is uncommon for the placenta to be removed roughly but it can be an uncomfortable experience for a patient. There was no long term harm to the patient but the patient's experience was negative.

There was no physical harm caused but certainly a potential risk of harm. From a mental health perspective, [Patient B] suffered from severe birth trauma because of her birth experience. She felt upset when she was in pain and was in fact in labour all along...'

Patient B in her witness statement states:

'Shortly after the birth I was told that the after birth was struggling to be delivered and if it took much longer then I would need to go to theatre to get it removed. Another midwife was looking after me at this point. The placenta still wasn't coming so I was administered an injection to help this.

Katie then came back into the room and said, "let me have a go, I'll get it out" and then proceeded to insert her hand inside of my body and very roughly removed the placenta. I shouted in pain and Katie then stated, "that's how you do it". I was in utter shock but glad that it was finally over.

...

Following this, the doctor had to come and suture the vaginal tears and I needed

to be catheterised...’.

The panel considered whether the placenta could have been removed without it being removed roughly. The panel had regard to Ms Scott’s witness statement. It took account that some two years after the incident Patient B was still able to provide a detailed account and was still upset by it.

The panel was of the view that Patient B’s description of how the incident unfolded in her initial account was credible and consistent with her witness statement. The panel took account that Mrs Windle is silent on the incident and has not provided any evidence or information in relation to this charge.

The panel considered the nature of a placenta and the risk of harm that could be caused by removing it roughly, including the potential to require surgical removal if any parts of it remained inside Patient B.

The panel determined Patient B’s experience to be beyond mere discomfort, she had a rough experience which was traumatic for her, which underlines the *‘roughly’* element in this charge.

The panel therefore determined that Mrs Windle did insert her hand into Patient B’s vagina and roughly removed the placenta. The panel therefore finds this charge proved.

Charge 9a)

9) On 10 September 2022 were rude to Patient C and/or their partner:

a) When Patient C’s partner informed you that Patient C’s waters had broken you said “it’s ok she’s still going home”

This charge is found proved.

In reaching this decision, the panel took into account Patient C’s initial complaint email dated 22 Sep 2022 and witness statement dated 30 May 2024.

Patient C states in her witness statement:

'... She was again unprofessional, patronising and condescending from the minute she took me into a room to be examined. Upon examining me I was told that I was only 2cm and would be sent home despite how close together my contractions were becoming. ... Despite me knowing I was in active labour she refused to believe this and was very dismissive. Just after the examination, I felt what I believed to be my waters pop and sure enough as soon as I stood up they were gushing. Katie had left the room at this point and my husband went to tell her to which her response was "it's ok she's still going home". I heard this as Katie and my husband were just outside the door, which was open. She then came back into the room asking if the waters were clear which they weren't due to baby pooing inside of me and becoming distressed and at this point Katie placed me on the monitor.'

Patient C stated in her initial complaint email:

'She initially examined me and told me I was only 2cm and would be sent home despite how close together my contractions were becoming. I accepted this but did explain that at my sweep the day prior the community midwife had expressed that my cervix was favourable (the opposite to what Katie said) and she didn't think the baby would be long. Katie responded to this by telling me that community midwives don't know what they are talking about. Following this I got up off the bed at which point Katie had left the room and my waters went. My husband went to tell Katie and her response was "it's ok she's still going home" she then came back into the room asking if the waters were clear which they weren't...I genuinely believe that had I been sent home as Katie wanted the outcome would have been very different.'

The panel considered the proximity in time from the incident happening on 10 September 2022 and the date she wrote her initial complaint of 22 September 2022. The panel was of the view that Patient C's statement echoes her initial complaint.

The panel considered the fact that Patient C had previously raised a complaint against Mrs Windle. The panel carefully considered whether it may have influenced Patient C in making her September 2022 complaint against her. The panel was of the view although Patient C had come across Mrs Windle before it also highlights the fact that she had previously had a poor experience with her. The panel determined that the complaint was contemporaneous to the incident. The panel concluded that on balance and in the circumstances it had seen evidence before it, of a pattern emerging in regarding Mrs Windle's behaviour as described by Patient C. This reinforced the panel's view of the veracity of Patient C's complaint.

The panel determined Mrs Windle was rude to Patient C and/or her partner as charged. The panel therefore finds this charge proved.

Charge 9b

9) On 10 September 2022 were rude to Patient C and/or their partner:

b) When Patient C asked you to stop speaking down to them you said "ok I'll leave you to it" or words to that effect, and walked out of the room

This charge is found proved.

The panel relied upon its reasoning in charge 9a).

In reaching this decision, the panel took into account Patient C's initial complaint email dated 22 Sep 2022 and witness statement dated 30 May 2024.

The panel therefore finds this charge proved.

Charge 10

10) On 10 September 2022 failed to provide pain relief to Patient C when they requested it.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Patient C dated 30 May 2024 and to Patient C's medical record of 10 September 2022.

Patient C in her witness statement stated:

'After my waters broke my contractions were very painful and were back-to-back and no pain relief had been offered other than co-codamol which never actually arrived. I explained to Katie that I didn't want to be on the drip and given how quickly I myself could see that my labour was progressing it was unnecessary. At this point I was in extreme pain and was begging for pain relief (after asking several times with the only response being that there is a shortage of diamorphine and nothing could be offered as I wasn't on the delivery suite.)'

The panel had regard to Patient C's medical records of 10 September 2022 where Mrs Windle records at 18:23 that she was had '*utilised simple analgesia at home*' for pain and at 19:35 records '*Advised Patient C is requesting pethidine and nil avail on Triage*'.

The panel was of the view that there is some ambiguity in Patient C's statement. The panel took account that Patient C states that she was offered co-codamol and that it did not arrive. However it noted that Mrs Windle had noted in Patient C's medical record that pethidine was not available at the time in Triage.

The panel determined that the duty on Mrs Windle to provide pain relief to Patient C in this instance has not been met in relation to this charge. The panel was therefore finds this charge not proved.

Charges 11a) and 11b)

11) On 13 September 2022:

- a) failed to perform an Amnisure Vaginal test on Patient D
- b) instead you asked patient D to perform their own Amnisure Vaginal test

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Ms Scott's witness statement and Patient D's dated 23 June 2024 and to Patient D's medical record of 10 September 2022.

Patient D witness statement states:

'...she took me into another room to be swabbed to see if my waters had broken. She said to me "do you want to do the swab yourself, or would you like me to do it?"

...

Because she'd asked me if I wanted to do it myself, I presumed it was normal for me to do so. She explained that I had to leave the swab in for a certain period of time, which I no longer recall, and then leave it on the side for her. I don't recall her explaining it in any more detail than that. I did do the swab myself, and the test came back to state that my waters had not broken.'

Ms Scott in her witness statement states:

'Mrs Windle asked [Patient D] to perform the Amnisure vaginal test herself, this test should be performed by a midwife to ensure accuracy and validity.

...

The vaginal test involves inserting the speculum into the vagina. It's not appropriate for a patient to do the vaginal test herself. Mrs Windle should have performed the test on [Patient D], it's part of the midwife's duty.'

The panel had regard to Patient D's initial complaint email dated 13 October 2022, which states:

'However when I got home on the 13th September my waters broke which I rang triage at 4pm and they advised me I had to wait 4 hours before coming in so I went in at 8pm, when I got there the midwife took me in for an assessment which involved me being swapped [sic] however the midwife gave me the swab and let me do it myself.

...

'Why did I swab myself to see if my waters had gone shouldn't this have been done by a midwife?'

The panel determined that Mrs Windle owed a duty of care to Patient E who was in her care. The panel concluded that Mrs Windle had failed to perform an Amnisure Vaginal test on Patient D and instead she asked patient D to perform their own Amnisure Vaginal test. The panel therefore finds this charge proved.

Charge 12

12. Between 26 October 2022 and 27 October 2022 incorrectly advised Patient E not to attend hospital

This charge is found proved.

In reaching this decision, the panel took into account Ms Scott's witness statement and Patient E's statement dated 23 June 2024 and medical record of 10 September 2022.

Patient E witness statement dated 3 July 2024 states:

'I got home around midnight that night, my mum was with me. My contractions became more stronger and were coming more regularly, maybe every 3 minutes. I started to bleed (from my vagina). It was scary because this was my first baby, I didn't know if that was normal. My mum was freaking out and she's had 4

children. My mum called the Hospital a few times and on each occasion, she spoke to Katie. My mum had the phone calls on loud speaker so I was able to hear all that was said.

Katie told my mum that I wasn't ready for birth. I was screaming in the background, which Katie commented on, stating that I did sound "uncomfortable". At one point, Katie told my mum to give me a paracetamol. My mum told her that I had started to bleed, and Katie asked how much of it was blood and how much of it was water. My mum wasn't able to answer that. Katie advised my mum to take a tramadol for her Fibromyalgia, because I wasn't giving birth anytime soon. The ambulance staff that later attended advised that even they, as medical professionals would not be able to determine how to separate blood and water.'

The panel had regard to Patient E's medical record where Mrs Windle recorded:

*'Unconvincing history of SROM [Spontaneous Rupture of Membranes].' ...
'Advised to wear a thick maternity pad and monitor PV loss to establish if appears more mucoid show or liquor'.*

The panel had regard to Patient E's initial complaint email dated 3 November 2022.

'Last Monday the 24th October I attended the womens hospital for my second sweep where I was advised that I was 2 dilated. On the evening of Wednesday 26th I attended triage in pain and suspected labour, I was assessed and sent home after being told I was 1cm dilated. After returning home, another four calls were made to triage through the night by my mother trying to have me admitted onto the labour ward.

...

During this time I was haemorrhaging huge amounts of blood, my mum called triage again and she was advised to monitor me for half an hour to try and decipher how much was blood and how much was water, she was then to call triage back after half an hour. How the hell my mum is supposed to measure this,

I have absolutely no clue. The attending paramedic advised that they would not even be able to measure the difference.

My mum did not call back within half an hour as during this time, I gave birth at home on my bed. My mum was actually on hold to triage when the baby came, ended the call and dialled 999. Two ambulances and five paramedics attended. Paramedics were so shocked by the amount of blood they took photographs of my bed, I lost 7.5 pints of blood and had 4 transfusions.

On the way to the hospital the ambulance crew fought to keep me awake and alert, they called the hospital to ask if they could administer a drug I needed to slow the blood loss, the hospital told them not to administer anything until I arrived at the hospital. The paramedic called back and told the hospital that they were giving me the drug as I urgently needed it.

When we arrived at hospital I spent in 3 hours in theatre as the placenta had been attached to the wall of the uterus and was coming away in bits.

What I want to know is;

Why my calls were not being taken seriously regarding me being in active labour'

The panel had sight of a letter from the Trust dated 24 February 2023 to Patient E in response to her complaint. The letter stated:

'You phoned again at 5.36 hours on the 27 October 2022 as you were unsure whether your waters had broken and were told to stay at home. At this contact in view of the fact that you had already attended the unit in the latent phase of labour you should have been invited to attend in person to be assessed. I am really sorry that this did not happen and you were not taken seriously resulting in you birthing your baby at home without an appropriate clinician.'

By reference to Patient E's medical notes it is clear to the panel that it was Mrs Windle who spoke to Patient E at 05.30 on 27 October 2022.

The panel considered that in her statement Patient E states she started bleeding not long after she got home, her mother called the hospital and Mrs Windle told her mother

that Patient E was not ready for birth. In the circumstances, the panel considered that in the words of the charge Mrs Windle had '*incorrectly advised Patient E not to attend hospital*'.

The panel was satisfied that there was sufficient evidence to show that Mrs Windle had incorrectly advised Patient E not to attend hospital. The panel therefore finds this charge 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 Mrs Windle's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as 'a professional on our register can practise as a nurse, midwife or nursing associate 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, Mrs Windle's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of

practice and behaviour for nurses, midwives and nursing associates (2015)' (the Code) in making its decision.

It is the NMC's position that the misconduct in this case is serious. Mrs Windle's actions, which included failures to advise patients to attend hospital, resulting in delay in patients receiving necessary treatment, rude, uncaring behaviour towards patients and, exposing patients to risk of fatal harm, were significant departures from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

The NMC submitted that Mrs Windle's conduct as detailed in the charges, fell significantly short of what would be expected of a registered midwife.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

In the circumstances of this case, the NMC represented that a finding of impairment was required for reasons of public protection and in the wider public interest.

The panel accepted the advice of the legal assessor. This included reference to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and Dame Janet Smith's test as set out in the Fifth Report from The Shipman Enquiry.

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 concluded that Mrs Windle's actions did fall significantly short of the standards expected of a registered midwife, and that her actions amounted to a breach of the provisions of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion*
- 1.2 make sure you deliver the fundamentals of care effectively*
- 1.3 avoid making assumptions and recognise [diversity and] individual choice*
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
- 1.5 respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively*
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing*
- 2.3 encourage and empower people to share in decisions about their treatment and care*
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.5 work with colleagues to preserve the safety of those receiving care

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges found proved and was of the view that both individually and collectively, Mrs Windle's actions amounted to conduct unworthy of a registered midwife and would be considered deplorable by fellow practitioners.

The panel determined that Mrs Windle's actions had the potential to undermine the public's confidence and trust placed in the midwifery profession and the NMC as regulator.

In light of the above, the panel found that Mrs Windle's actions did fall 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, Mrs Windle's 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.

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

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

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

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) ...'*

The panel found the above three limbs a), b) and c) apply in this case.

The panel considered whether Mrs Windle's behaviour is easily remediable. The panel determined that Mrs Windle has demonstrated limited understanding of how her actions put patients at an unwarranted risk of harm by her failure to provide the fundamentals of maternity and midwifery care to a number of patients she was responsible for. The panel determined that Mrs Windle's failures were not one-off errors but a repeated pattern of poor behaviour which indicate deep-seated attitudinal issues which are significantly difficult to remediate.

The panel considered whether Mrs Windle has already remediated her behaviour. The panel considered Mrs Windle's insight. The panel took account that she had made some apologies at a local level, however was of the view that she has not recognised her poor behaviour. The panel had sight of the reflective letter Mrs Windle provided. It

noted that she explains that [PRIVATE], however, there is minimal reflection on the gravity of her misconduct. The panel therefore concluded that Mrs Windle has not demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the midwifery profession. The panel therefore concluded that Mrs Windle has not already remedied her misconduct.

The panel considered whether Mrs Windle's misconduct is highly unlikely to be repeated. The panel took into account that Mrs Windle has not provided any evidence of any steps taken to strengthen her practice, relevant training courses undertaken to address her misconduct or testimonials. The panel determined that this indicates that Mrs Windle is likely to repeat such conduct in the future. The panel concluded that there is nothing before it that would give it confidence or satisfaction that her conduct would not be repeated. The panel therefore determined that Mrs Windle's conduct is more likely than not to be repeated.

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

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

The panel was satisfied that, having regard to the nature and extent of the misconduct in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* if a finding of current impairment were not made. The panel was of the view that a reasonable, informed member of the public would be very concerned if Mrs Windle's fitness to practise was not found to be impaired and therefore public confidence in the midwifery profession would be undermined if Mrs Windle were allowed to practise unrestricted.

Having regard to all of the above reasons the panel was satisfied that Mrs Windle's fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on '*The purpose of and approach to sanctions*' (Reference: SAN-1 Last Updated 28/01/2026) and '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 7 January 2026, the NMC had informed Mrs Windle that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired.

The NMC submitted that a striking-off order is the appropriate and proportionate sanction in the circumstances of the case, sufficient to protect the public, the public interest and maintain confidence in the profession.

Decision and reasons on sanction

Having found Mrs Windle's fitness to practise currently impaired by the matters found proved, 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:

- Mrs Windle was devoid of any meaningful reflection or significant insight on the impact of her unprofessional conduct on patients in her care
- Abuse of a position of trust
- Conduct which deliberately or recklessly put people receiving care at risk of suffering harm and caused actual harm
- A pattern of misconduct over a period of time
- Vulnerability of persons receiving care
- Failure to work collaboratively with colleagues

The panel noted that Mrs Windle mentioned [PRIVATE], but given that there was no supporting evidence from [PRIVATE] the panel did not consider this to be a mitigating feature in this case.

The panel first considered whether to take no action however decided that this would be inappropriate in view of the seriousness of the case.

The panel noted that Mrs Windle wrote in her reflective letter:

'... I shall not wish to reapply to the register again. Please can you accept this reflection in support of my voluntary removal.'

It also noted that Mrs Windle's name remains on the register only because she is subject to these proceedings. However, the panel had regard to NMC guidance Rev-2H (Last update: 13 August 2024), which states:

'A panel will allow a professional to lapse with impairment where:

- *the professional would no longer be on the register but for the order in place;*
- *the panel can no longer conclude that the professional is likely to return to safe unrestricted practice within a reasonable period of time;*
- *a striking off order isn't appropriate.'*

Given the seriousness of Mrs Windle's misconduct, the panel decided it would not be appropriate to make no order and allow her registration to lapse.

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

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

The panel considered that Mrs Windle's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Windle's practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Mrs Windle's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges proved in this case. It bore in mind that it had identified deep-seated attitudinal issues, furthermore Mrs Windle has expressed in her reflective letter that she has no desire to continue to practise as a midwife. Having regard to the nature and

seriousness of Mrs Windle's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and uphold professional standards.

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

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

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

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

realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'

Given Mrs Windle's lack of engagement, limited insight, lack of remorse, together with no evidence of relevant training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

In this particular case, the panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering a striking-off order, the panel had regard to the following considerations as set out in the NMC Guidance entitled '*Striking-off order*' (Reference: SAN-2e Last Updated: 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel found Mrs Windle's actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Windle's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs Windle's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

This will be confirmed to Mrs Windle in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Windle's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that Mrs Windle's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, it considers that an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the substantive striking-off order 28 days after Mrs Windle is sent the decision of this hearing in writing.

That concludes this determination.