Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 15 January 2026 – Monday, 26 January 2026
Tuesday, 5 May 2026
Tuesday 18 August 2026
Monday, 16 November 2026
Tuesday, 17 November 2026 (In Camera)
Wednesday, 18 November 2026
Thursday, 19 November 2026 (In Camera)
Friday, 20 November 2026

Virtual Hearing

Name of Registrant:	**Tracey Claire Miller**
NMC PIN:	07B3165E
Part(s) of the register:	Midwives part of the register RM, Registered Midwife (14 September 2007)
Relevant Location:	Gloucestershire
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, Lay member) Michelle Wells-Braithwaite (Registrant member) John Marley (Lay member)
Legal Assessor:	Ian Ashford-Thom (15 January 2026) Kenneth Hamer (16 – 26 January 2026, 18 August 2026, 16 November 2026 – 20 November 2026)
Hearings Coordinator:	Peaches Osibamowo (15 January- 26 January 2026 and 18 August 2026) Zahra Khan (5 May 2026 only) Fabbiha Ahmed (16 November 2026 – 20 November 2026)
Nursing and Midwifery Council:	Represented by Unyime Davies, Case Presenter (15 January- 26 January 2026, Tuesday, 5 May 2026, Monday 16 November 2026 – Friday, 20 November 2026) Represented by Sally Denholm, Case Presenter (18 August 2026 only)

Ms Miller:	Not present and represented by Simon Holborn (NMC Watch)
No case to answer:	Charges 1g, 1h, 4b (1st limb), 4d and 4e
Facts proved:	Charges 1a, 1c (in relation to tranexamic acid), 1e, 1f, 2a, 2b, 3a, 3c, 4b (2nd limb), 4c, 5b, and 6
Facts not proved:	Charges 1b, 1c (in relation to Syntocinon) 1d, 3b, 4a, 5a, 5c, 7a, 7b, 7c, 7d and 7e
Fitness to practise:	Impaired
Sanction:	**Striking-off Order**
Interim order:	**Interim Suspension Order (18 months)**

Details of charge

That you, a registered midwife:

1) On 22 September 2019 in respect of Patient B:

a) Failed to escalate that a shoulder dystocia had been identified by ringing the call bell and/or notifying the Registrar.

b) Failed to escalate to the Registrar that she had suffered a post-partum haemorrhage and/or request a medical assessment be undertaken and/or pull the emergency bell.

c) Commenced an infusion of Tranexamic Acid and/or Syntocinon without consulting the Registrar and/or in the absence of a prescription from the Registrar.

d) Issued and signed for the prescription of Tranexamic Acid and/or Syntocinon.

e) Your conduct at charge 1c) and/or 1d) was outside the scope of your practice.

f) Asked Ms Boyd to retrospectively sign for the prescription/s of Tranexamic Acid and/or Syntocinon after the medication/s had already been administered.

g) Inaccurately recorded in her notes at 21:23 that you had discussed the patient with Ms Boyd.

h) Your conduct at charge 1g) was dishonest in that you intended to create a misleading impression that Ms Boyd had authorised the

Syntocinon infusion when you knew she had not.

2) On 13 January 2020 in respect of Patient D:

a) Did not escalate to the Registrar that shoulder dystocia had been identified.

b) Did not record in her notes or electronic summary of care that shoulder dystocia had been identified during labour and/or actions taken in respect of this.

3) On 12 February 2020 in respect of Patient C:

a) Performed a manual breech extraction.

b) Your conduct at charge 3a) contravened the wishes of Patient C and/or clear clinical intention to deliver her baby by caesarean section.

c) Your conduct at charge 2a) was outside the scope of your practice.

4) On 17 May 2020 in respect of Patient A:

a) Did not discuss her clinical presentation with a Registrar and/or request an examination from a Registrar prior to commencing a Syntocinon infusion.

b) Commenced a Syntocinon infusion in the absence of a prescription and/or verbal order from a Registrar.

Or in the alternative, allowed and/or permitted Ms Downey to commence the Syntocinon infusion in the absence of a prescription

and/or verbal order from a Registrar

c) Your conduct at charge 4b) was outside the scope of your practice.

d) Asked Ms Boyd to retrospectively sign for the prescription of Syntocinon after the medication had already been administered.

e) Your conduct at charge 4d) was dishonest in that you intended to create a misleading impression that Ms Boyd had authorised the Syntocinon infusion when you knew she had not.

5) Between 9 and 10 October 2021 in respect of Woman B:

a) Incorrectly commenced her insulin infusion at sliding scale 1 which was not in accordance with the prescription for sliding scale 3.

b) Failed to adequately monitor and/or identify that the incorrect sliding scale of insulin was being administered and/or adjust accordingly.

c) Failed to identify, act on and/or escalate her raised blood glucose levels for obstetric review.

6) On or around 13 April 2022 performed a controlled Artificial Rupture of Membranes ("ARM") on Woman A in circumstances where the baby's presentation rendered the procedure outside the scope of your practice and/or an Obstetrician should have been notified.

7) Demonstrated bullying and/or intimidating and/or harassing behaviour towards colleagues in that:

a) On unknown dates refused to speak to and/or ignored Ms Boyd when working together on shift.

b) On an unknown date during a handover meeting called Ms Harford "*that little cunt out there"* or words to that effect.

c) On an unknown date, dismissed Ms Hearn's concerns about a category one c-section patient.

d) On unknown dates, criticised Ms Hearn in front of patients' family by stating "You should not do it like that" and "this is how you should do it" or words to that effect.

e) On an unknown date, criticised Ms Hearn in front of another colleague.

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

Submissions on application to amend the charge

At the start of the hearing on day 1, the panel heard an application made by Ms Davies, on behalf of the NMC, to amend the wording of the stem of charge 1.

The proposed amendment was to amend the stem of the charge to '*on or around 22 September 2019'*. It was submitted by Ms Davies that the proposed amendment would provide clarity and more accurately reflect the evidence.

That you a registered midwife,

1) **On or around** 22 September 2019 in respect of Patient B:

a) Failed to escalate that a shoulder dystocia had been identified by ringing the call bell and/or notifying the Registrar.

b) Failed to escalate to the Registrar that she had suffered a post-

partum haemorrhage and/or request a medical assessment be undertaken and/or pull the emergency bell.

c) Commenced an infusion of Tranexamic Acid and/or Syntocinon without consulting the Registrar and/or in the absence of a prescription from the Registrar.

d) Issued and signed for the prescription of Tranexamic Acid and/or Syntocinon.

e) Your conduct at charge 1c) and/or 1d) was outside the scope of your practice.

f) Asked Ms Boyd to retrospectively sign for the prescription/s of Tranexamic Acid and/or Syntocinon after the medication/s had already been administered.

g) Inaccurately recorded in her notes at 21:23 that you had discussed the patient with Ms Boyd.

h) Your conduct at charge 1g) was dishonest in that you intended to create a misleading impression that Ms Boyd had authorised the Syntocinon infusion when you knew she had not.'

The panel heard submissions from Mr Holborn, on Ms Miller's behalf, who stated that he was not opposed to the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons on application to amend the charge

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 Ms Miller 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 better reflect the evidence and ensure clarity.

Further application to amend the charge

During the hearing, the panel heard an application made by Ms Davies to amend the wording of charge 3c.

Ms Davies submitted that the reference to charge 2a is a typographical error and that the charge should read *'Your conduct at **charge 3a)** was outside the scope of your practice'*. Ms Davies submitted that this amendment does not cause any prejudice to Ms Miller as it is correcting a minor typographical error, rather than a substantive change.

"That you a registered midwife,

3) On 12 February 2020 in respect of Patient C:

a) Performed a manual breech extraction.

b) Your conduct at charge 3a) contravened the wishes of Patient C and/or clear clinical intention to deliver her baby by caesarean section.

c) Your conduct at ~~charge 2a)~~ **charge 3a** was outside the scope of your practice."

Mr Holborn submitted that he supported the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted not that the application was not opposed by Mr Holborn and decided that this was a typographical error. The panel agreed to the amendment.

Submissions on application for hearing to be held in private

At the outset of the hearing, Mr Holborn, on Ms Miller's behalf, made a request that this case be held in partly in private on the basis that proper exploration of Ms Miller's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Davies submitted that she supported the application to the extent that any reference to Ms Miller's [PRIVATE] should be heard 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.

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

The panel determined that it would go into private session when matters relating Ms Miller's [PRIVATE] are raised in order to protect her privacy.

Submissions on an application for a postponement

[PRIVATE].

Mr Holborn submitted that he is currently representing another registrant in another NMC substantive hearing and when he was notified of the date of this hearing on 17

December 2025, he emailed the NMC immediately to advise that he would be unable to proceed with this hearing on these specific dates, as he had already been instructed on other matters. He submitted that the NMC advised him to apply for an adjournment on Ms Miller's behalf on day 1 of the hearing. He further submitted that he has 3 other matters listed for next week, one of which is a highly important Court of Appeal hearing.

Mr Holborn submitted that Ms Miller was only aware of this hearing when he notified her of the hearing and that the hearing bundles were sent to him on or around 7 January 2026. He submitted that Ms Miller had applied for an agreed removal from the Register on 28 August 2023 but this was declined. She has not worked in midwifery since 2022 and has no interest in returning to midwifery. However, because of other commitments Mr Holborn has not yet fully explored this option with her again.

Mr Holborn submitted that if the panel does not grant the adjournment application he will do his best to represent Ms Miller. He submitted that this application should be granted as Ms Miller is not in attendance [PRIVATE]. He acknowledged that it may be inconvenient but regretfully applies seeks to postpone this matter.

In response to panel questions, Mr Holborn submitted that it would be preferable to delay the hearing to provide Ms Miller with further time to properly consider this matter and allow her more time to prepare herself for the proceedings.

Ms Davies opposed this application to postpone the hearing. She submitted that Ms Miller received emails from the NMC on 4 November 2025 and 18 November 2025 regarding a potential pre-meeting for this case. She submitted that neither email received a response and there has been very little engagement from Ms Miller until Mr Holborn's involvement in this case.

Ms Davies submitted that there is a public interest in the efficient disposal of these cases to protect the public and maintain confidence in the profession. The allegations date back to 2019 and it is likely that if this matter is adjourned a relisting may not be until 2027. Ms Davies submitted that memories fade and there are a

number of witnesses who have been warned to give evidence in this case. There will be significant inconvenience to those who have made themselves available to give evidence at this hearing.

Ms Davies submitted that Ms Miller had sufficient time to secure alternative representation at an earlier stage and the panel were not provided with evidence that she made effort to do this when she was made aware that Mr Holborn was not available on the dates listed for this hearing.

Ms Davies submitted that the case of *Nabili v General Medical Council* [2018] EWHC 3331 (Admin) supports the contention that a registrant is not automatically entitled to an adjournment to obtain legal representation of their choice.

Ms Davies submitted that it is in interest of justice for this case to proceed swiftly asks that the panel rejects the postponement application.

In response to panel questions, Ms Davies confirmed that the NMC invited Mr Holborn to make an application for adjournment on the first day of this hearing when he notified the panel of his limited availability.

The panel accepted the advice of the legal assessor, which included reference to the NMC rules and fitness to practise guidance.

Decision and reasons on application for a postponement

The panel did not grant the application to postpone this hearing.

The panel noted that although Mr Holborn applied for an adjournment this request was technically asking for a postponement as his wish was for the hearing to not progress from this point onwards before the charges are read into the record.

The panel considered that Ms Miller was notified of this hearing in November and December 2025 in accordance with the NMC rules on notice for substantive

hearings. Ms Miller was aware that the case was on going and that it would progress to a substantive hearing at some point.

[PRIVATE].

The panel noted Mr Holborn's reference to a potential consensual panel determination and an agreed removal application, however, were aware that he has not taken instructions on these matters. The panel was not aware of any change in circumstances since the original application so it did not consider these potential applications to be relevant in their decision making on the application to postpone the hearing.

The panel next considered the issue of Mr Holborn's availability. It accepted that he is not available for four of the scheduled hearing days and that he notified the NMC at the earliest opportunity and followed their advice to apply for an 'adjournment' on day 1 of the hearing.

The panel further considered that witness availability is limited. It decided that postponing the hearing would be inconvenient to witnesses and any further delays could impact their accurate recollection of the incidents in question.

The panel took into account the public interest in the expeditious disposal of this case. The charges arose in 2019, 2020, 2021 and 2022. The panel decided that a further delay in hearing this case is not in the public interest and potentially not in Ms Miller's interest.

In light of this, the panel decided to deny the application to postpone this hearing. however, the panel took into account Ms Miller's expectation that she would be legally represented based on the NMC's advice to Mr Holborn concerning the application for postponement. The panel concluded that fairness to Ms Miller required it to accommodate Mr Holborn's existing engagements and only proceed on days when he is available to ensure she remains represented throughout the proceedings.

Whilst recognising that it may not be able to conclude the matter, the panel decided that it would be beneficial to progress the matter within the time available.

Background

The charges arose whilst Ms Miller was employed as a Band 7 senior midwife at Gloucestershire Hospitals NHS Foundation Trust ("the Trust").

The first referral to the NMC alleges that there were multiple reports of bullying as well as clinical concerns including:

- Managed a post partum haemorrhage without appropriate escalation.

- Administered medicines without prescription and asking doctors who were not present to prescribe in retrospect.

- Inappropriately performed a breech extraction in theatre despite the presence of a registrar and consultant.

- Practised outside of her sphere of midwifery practice in managing emergencies without appropriate escalation.

The referrer stated that that they are concerned for the safety of women, neonates and their colleagues.

A second referral was received on 8 July 2022, from Gloucestershire NHS Foundation Trust ('The Trust').

The Trust raised a number of concerns about Ms Miller, including:

- Ms Miller performed a controlled Artificial Rupture of Membranes (ARMs) outside the scope of her practice.
- Ms Miller incorrectly administered an insulin infusion and failed to adequately monitor the patient.

Ms Miller resigned from the Trust in July 2022.

Submissions on application of no case to answer

At the conclusion of the NMC's case, the panel heard an application from Mr Holborn that there is no case to answer in respect of charges 1h, 2a, 2b, 3(c), 4b, 4c, 4e, and 6. This application was made under Rule 24(7) and 24(8) of the Rules.
Mr Holborn provided the panel with written submissions.

Mr Holborn submitted that the test for a submission of no case to answer was set out in the case of *R v Galbraith* [1981] 1 WLR 1039. He submitted that the test is whether there is no evidence upon which a reasonable panel could find the charge proved, or the evidence is so weak, tenuous or inconsistent that no reasonable panel, properly directed, could find the charge proved.

Mr Holborn submitted that the NMC's case is fundamentally flawed as it has not established what Ms Miller's scope of practice was or should be and with this missing baseline any alleged departures cannot be assessed.

In relation to charge 2, Mr Holborn submitted that an NMC witness supported Ms Miller in parts and stated that she is a '*competent practitioner'* in shoulder dystocia management and was entitled to manage this as a part of her proper practice. He submitted that the Trust concluded there was no case to answer on this matter.

Mr Holborn submitted that there is no case to answer on charge 2 in its entirety based on both limbs of the Galbraith test.

In relation to charge 3c, Mr Holborn submitted that the Trust's Breech Birth Policy states that the obstetrician will attend '*should the midwife need help'* which presupposes that the midwife may be conducting the breech birth. This is supported by Ms Harrison. Mr Holborn submitted that the NMC cannot prove that breech delivery is outside scope when their own evidence, Trust policy, and national guidance all confirm it is within scope. Mr Holborn submitted that there is no case to answer in relation to charge

3c.

In relation to charge 4b, Mr Holborn submitted that the Syntocinon infusion was '*commenced by midwife AD'* not Ms Miller. He submitted that Ms Miller was the second checker. He submitted that midwives are expressly authorised to administer Syntocinon under Trust policy, therefore, the NMC cannot prove that it was outside Ms Miller's scope of practice.

Mr Holborn submitted that there is no case to answer in relation to charge 4c and that the NMC's evidence that Syntocinon can be prescribed by a midwife in these circumstances. It was therefore not out of Ms Miller's scope of practice.

Mr Holborn referred to the case of *Ivey v Genting Casinos* [2017] UKSC 67 and stated that dishonesty requires proof of intent. Mr Holborn submitted that the NMC have provided no evidence of dishonest intent and that there is no case to answer in relation to charge 4e.

Mr Holborn submitted that the NMC's investigation gave evidence that the baby '*may have been cephalic'* at the time of the ARM procedure and it was therefore within the scope of Ms Miller's practice. He submitted that there was no case to answer in relation to charge 6.

In relation to charge 1h, Mr Holborn submitted that there is no evidence that the clinical note entry made at 21:23 was inaccurate. He submitted that Ms Boyd's denial must be viewed in the context of her admitted hostility. The evidence is at best a conflict between contemporaneous notes and a later recollection by a biased witness, which is not sufficient to prove dishonesty.

Mr Holborn submitted that there is no evidence of dishonest intent, the entry was made by another midwife and the evidence of Ms Boyd must be treated with caution given her admitted animosity. He submitted that there is no case to

answer in relation to charge 1h.

Ms Davies opposed the application and referred to the *Galbraith* test. She highlighted that the test states that if there is some evidence but its strength relies on witnesses or the reliability of the evidence, it must be left to the panel to decide. She also submitted that a jury properly directed would agree that evidence deemed to be inadmissible should not form part of the assessment of the *Galbraith* test, as a properly directed jury would not be considering inadmissible evidence.

Ms Davies rejected the submission that the NMC's case is fundamentally flawed as it does not set out what Ms Miller's scope of practice should have been. She submitted that the baseline of what would be expected by Ms Miller has been set out in several policy documents and the witness statements of multiple witnesses. She further submitted that the panel has heard oral evidence from doctors and nurses who would set out not just the conduct that was outside Ms Miller's scope of practice but also why the conduct was outside Ms Miller's scope of practice.

Ms Davies referred to charge 2 and submitted that the panel has heard good quality and clear evidence from Ms Harrison who identified what occurred during the birth to show that shoulder dystocia had occurred and that this should have been recorded in the patient summary notes. Therefore, the *Galbraith* test is not met in relation to charge 2 as the panel has clear evidence regarding this point, evidence that an assessment is being invited on witness reliability.

Ms Davies submitted that in considering charge 3c, the panel are being asked to consider a charge on breech extraction rather than breech delivery. The panel has heard evidence that a breech extraction is clearly outside the scope of Ms Miller's practice. She submitted that there has been evidence on the point from Ms Harrison and Ms Cordell who are consistent, particularly regarding Ms Miller's scope of practice. Ms Harrison's written statement states that *'midwives are not able to carry out breech extractions. These are doctor only roles'* which is corroborated by Ms

Cordell. Ms Davies invited the panel to consider this evidence and submitted that the *Galbraith* test is not met for this charge.

Ms Davies submitted that Charge 4b is an alternative charge and the panel should consider the entirety of a charge when considering whether there is a case to answer. She submitted that the application seems to be inviting the panel to consider only part of this charge. She submitted that there is evidence that the test is met as the panel have heard from Ms Harrison who provided evidence of a second checker and from Ms Boyd who remained consistent on this matter. Ms Davies submitted that the panel should look at charge in the alternative and consider whether Ms Miller allowed or permitted Ms Downey to commence the Syntocinon infusion in the absence of a prescription or verbal order from Ms Miller.

Ms Davies referred to charge 4c and the submission that the policy document states that oxytocin may be administered by a midwife. She invited the panel to consider the entirety of the document and the circumstances of this case. Ms Harrison stated in oral evidence that she would have expected Ms Miller to discuss this case with a registrar as there is a possibility of obstructed labour with women who have previously birthed. This evidence is corroborated by the oral evidence of Ms Boyd who stated that Syntocinon should only be given after a review from a obstetrician, when given to augment labour. Ms Davies submitted that this shows two clear explanations provided by two witnesses which indicates that the charge is met. Therefore, when the panel looks at the entirety of this evidence at its highest, the *Galbraith* test should fail on both limb 1 and 2.

Ms Davies noted that charge 4e stems from charge 4d. She submitted that in oral evidence Ms Boyd detailed that Ms Miller had asked her to retrospectively sign a prescription. She referred to NMC guidance DMA-8 relating to dishonesty charges. She submitted that this charge does not meet the test of no case to answer as there is evidence from Ms Boyd regarding the circumstance. She submitted that the evidence requires an assessment of Ms Boyd's reliability when the panel are considering this charge. The panel may consider this later in proceedings but in accordance with *Galbraith*, if an assessment of reliability is required and if the evidence is not weak then it is not something that meets the *Galbraith* test for no

case to answer, and it should be left to the panel's final determination of the evidence.

Ms Davies referred to charge 6 and submitted that inadmissible evidence should not be considered in deliberations on this application. She submitted that the *Galbraith* test is not met on limb 1 or 2.

Ms Davies referred to charge 1h which stems from charge 1g. She submitted that the NMCs evidence is that whilst Ms Miller provided information to the midwife who appears to have recorded the information, the actual recording of the information was by the primary midwife. She submitted that it is a matter for the panel but if charge 1h specifies that Ms Miller's conduct at charge 1g is dishonest it is right that the panel may consider whether there is evidence of a case to answer at 1g. She submitted that if the panel conclude that there is no evidence of a case to answer at charge 1g, it will follow that there is no evidence of a case to answer at charge 1h. However, this is a matter for the panel.

When asked by the legal assessor, Ms Davies submitted that acting '*outside the scope practice'* meant that either Ms Miller was not qualified or authorised to perform the function, or that it was inappropriate for her to do so in the particular circumstances.

In response to Ms Davies' submission, Mr Holborn submitted that he is not sure there was a definition of scope of practice at the outset of the hearing and it seems that the panel are being asked to decide what a midwife should or should not do in a complex situation and no expert evidence was called by the NMC.

The panel accepted the advice of the legal assessor.

Decision and reasons on application of no case to answer

Charges 1g and 1h

In considering 1h, the panel considered that this sub charge arises from charge 1g. In considering charge 1g the panel had regard to the clinical entry for patient B made at 21.23 where it is documented '*discuss with S Boyd'*. The panel accepted that there is no evidence that Ms Miller made the entry. The evidence shows that the midwife in charge of caring for Patient B made the entry. Therefore, she cannot have been dishonest in making a note that has not been proven to have been recorded by her. The panel therefore found no case to answer in relation to charge 1g, consequently, charge 1h falls away.

Charge 2a

The panel considered the evidence that there was a shoulder dystocia and it was not escalated. As Ms Miller was the liaison between midwives and the medical team she had a duty to ensure that the situation was escalated. The evidence is not so weak and tenuous that when taken at its highest no chance panel could not find it proved. The panel concluded that there is a case to answer in relation to charge 2a.

Charge 2b

The panel reviewed Patient D's clinical record and electronic summary of care. There was no record of a shoulder dystocia in the patient's electronic summary of care, and there is therefore a case to answer.

Charge 3c

The panel found that there is evidence that Ms Miller may have acted outside the scope of her practice in the circumstances at the time with Patient C in performing a manual breech extraction. The panel made reference to the evidence of Ms Cordell which is supported by the consultant obstetrician who provided a statement to the local investigation. In light of this, the panel found that there is a case to answer for charge 3c.

Charge 4b

The panel found that there was no evidence to support the first limb of charge 4b as there was no oral or documentary evidence to confirm that it was Ms Miller who commenced the Syntocinon infusion. Therefore, there is no case to answer in relation to the first limb of charge 4b. However, the panel considered that there was evidence from Ms Harrison and Ms Boyd that Ms Miller was a senior midwife involved in Patient A's care and that she allowed and/or permitted Ms Downey to start the infusion in the absence of a prescription and/or verbal order from a registrar. Therefore, the panel decided that there was a case to answer for the alternative in the second limb of charge 4b.

Charge 4c

The panel considered the written evidence of Ms Harrison who stated that midwives cannot make the decision on whether a drug or surgical intervention is most appropriate. The panel noted that when Syntocinon is used for augmentation purposes, as was the plan in this particular case, it is a prescription only medication. Therefore, the panel found that there is a case to answer in relation to charge 4c.

Charges 4d and 4e

The panel accepted that it is not clear from evidence that Ms Miller asked Ms Boyd to retrospectively sign for the prescription and in so far as there is some evidence, there is a contradiction between the Datix and Ms Boyd's oral evidence as it was not clear that they had been asked to sign for the medication retrospectively. The panel decided that there was inherent weakness in the evidence in support of charge 4d and when taken at its highest it would be insufficient to find the charge proved. The panel therefore determined there was no case to answer in respect of charge 4d and that consequently 4e which is dependent upon charge 4d, also falls away.

Charge 6

The panel heard evidence that conducting an ARM at stage -3 runs the risk of a cord prolapse and this should be performed in the presence of a doctor. There is evidence to suggest that the position the baby was in rendered it inappropriate to

perform an ARM in this case. In light of this, the panel decided that there is a case to answer in relation to charge 6.

Application to admit the evidence of Ms Miller

The panel heard an application made by Mr Holborn under Rule 31 to allow the written evidence of Ms Miller. He submitted that Ms miller is unable to attend due to [PRIVATE] and she would like to put forward her version of the story.

Ms Davies did not object to the application in principle but noted that she has not yet seen the document. It is common practice that it is admitted registrants.

The panel accepted the advice of the legal assessor.

The panel decided to admit the registrant's bundle as it is fair and relevant to do so. It is important that she is allowed to put forward her version of events and not being present it is her way to put forward her version of events.

Decision and reasons on facts

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 Davies on behalf of the NMC and by Mr Holborn, on your behalf.

The panel has drawn no adverse inference from the non-attendance of Ms Miller.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Ms Kate Harrison: Lead for Improvement and Delivery at The Trust at the time of the incidents.
- Ms Sophie Boyd: Obstetrics and Gynaecology Registrar at The Trust at the time of the incidents.
- Ms Victoria Cordell: Obstetrics and Gynaecology Registrar at The Trust at the time of the incidents.
- Ms Amanda Westerby: Band 7 Lead Midwife at the Trust at the time of the incidents.
- Ms Jossette Jones: Lead for Quality and Governance in Women's and Children's division at The Trust at the time of the incidents.
- Ms Emma Evans: Band 6 core midwife at The Trust at the time of the incidents.
- Ms Jade Hearn: Band 5 midwife at the Trust at the time of the incidents.
- Ms Dawn Huchence: B Band 6 Midwife at The Trust at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice in writing of the legal assessor. The legal assessor gave advice on the burden and standard of proof, separate treatment of the allegations, the wording of the charge, the approach to the evidence and referred to appropriate case law.

The panel considered the witness and documentary evidence provided by both Ms Davies on behalf of the NMC and Mr Holborn on your behalf.

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

Charge 1a

1a) 'That you a registered midwife, on 22 September 2019 in respect of Patient B:

Failed to escalate that a shoulder dystocia had been identified by ringing the call bell and/or notifying the Registrar

This charge is found proved.

In reaching this decision, the panel took into account the written evidence of Ms Miller, the oral and written evidence of Ms Boyd and Trust guideline on Shoulder Dystocia.

The panel referred to Ms Miller's job description for her role as a senior midwife of the Trust, part of which was to act as the liaison between the midwives and the medical team. This document outlines her duties including the '*procurement of medical assistance'* and '*adhering to all trust policies and procedures'.*

The panel was satisfied that Ms Miller was the midwife in charge and was called into the patient's room to assist, it was Ms Miller's duty to have escalated a shoulder dystocia due to it being an obstetric emergency as set out in the Trust guideline.

The panel noted that the midwife notes record that a 'McRoberts' procedure was used during the baby's delivery by Ms Miller, and had regard to the oral evidence of Ms Boyd that this procedure is specifically used in the event of a shoulder dystocia.

The panel acknowledged that there is no entry relating to a shoulder dystocia in the patient notes recorded by the doctor after the birth of the baby or at 23:45 when the doctor first reviewed Patient B. The panel accepted the oral evidence of Ms Boyd who stated that '*she didn't know about it'* (the shoulder dystocia) before that point or she would have documented it before her entry at 23:45 because '*it would have been pertinent for future risk'*. The panel decided that Ms Boyd was not aware of the shoulder dystocia before this point, therefore, it had not been escalated to them, as required by Trust policy and Ms Miller's duties as set out in her job description.

The panel noted that Ms Miller's written statement about the birth of this baby sent to the NMC on 10 June 2020 or in her written statement dated 23 January 2026 does not refer to shoulder dystocia. However, from the evidence before it, the panel was satisfied that there had been a shoulder dystocia during the birth of Patient B's baby and that Ms Miller was aware of it and had failed to escalate it by ringing the call bell or notifying the doctor.

In light of this, on the balance of probabilities, the panel finds charge 1a proved.

Charge 1b)

'That you, a registered midwife:

1) On 22 September 2019 in respect of Patient B:

b) Failed to escalate to the Registrar that she had suffered a post-partum haemorrhage and/or request a medical assessment be undertaken and/or pull the emergency bell.'

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Boyd and Trust Guidelines on Post-Partum Haemorrhage.

The panel made reference to the guidelines and Ms Miller's job description and found that she had a duty to escalate a post-partum haemorrhage (PPH) by '*calling for appropriate help'.*

However, the panel noted that the documented blood loss at the time recorded by the midwife looking after Patient B was 350ml, then 400ml. The blood loss recorded at the registrar's assessment at 23:45 was 500ml. Therefore, when Ms Miller went into the patient's room there was no PPH based on the definition as set out in the Trust guideline. The panel was of the view that the administration of Tranexamic Acid and Syntocinon was given to prevent further blood loss due to the patient's low platelet count. Although the panel decided that the blood loss was not escalated to the registrar who it accepted did not see the patient until 23:45, the panel was not satisfied that there was an emergency that required escalation prior to that point. Consequently, Ms Miller did not have a duty to escalate a PPH as at that particular time there was insufficient blood loss to meet the threshold for a PPH as set out in the Trust policy and it was therefore not an emergency that warranted an escalation.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 1c

'That you, a registered midwife:

1) On 22 September 2019 in respect of Patient B:

c) Commenced an infusion of Tranexamic Acid and/or Syntocinon without consulting the Registrar and/or in the absence of a prescription from the Registrar.'

This charge is found proved in relation to Tranexamic Acid and not proved in relation to Syntocinon.

In reaching this decision, the panel took into account Ms Miller's written evidence, the prescription and the oral and written evidence of Ms Kate Harrison and Ms Boyd.

The panel noted that in her written evidence Ms Miller accepted that Tranexamic Acid is a prescription only medication. Ms Boyd stated in her oral evidence that she was asked to prescribe this medication retrospectively and this is consistent with her witness statement and the DATIX of the incident.

The panel made reference to the patient's clinical notes and the drug chart and found that Tranexamic Acid was administered to the patient at 21:20 which was before the registrar reviewed the patient at 23:45. Therefore, the panel is satisfied that this medication was administered in the absence of a valid prescription from the registrar.

The panel noted that Ms Miller stated that Syntocinon is on the midwife's exemption list. The panel acknowledged that in some circumstances midwives can give Syntocinon without a prescription and made reference to the patient notes which show an entry at 21:23 that states '*commence 40 units of synto'* after discussing with the registrar. The panel had sight of a prescription for Oxytocin (also known as Syntocinon) which was time stamped 21:29 but it was unclear whose signature this was, and the panel could not be certain that this was administered by Ms Miller. The panel found that there was conflicting evidence as to whether there was discussion or consultation with the registrar. However, without any evidence that Ms Miller was the midwife who commenced the infusion of Syntocinon, it could not find this charge proved in relation to Syntocinon.

In light of this, on the balance of probabilities, this charge is found proved in relation to Tranexamic Acid and not proved in relation to Syntocinon.

Charge 1d

1) On 22 September 2019 in respect of Patient B:

d) Issued and signed for the prescription of Tranexamic Acid and/or Syntocinon.

This charge is found NOT proved

In reaching this decision, the panel took into account the two week in patient prescription chart.

The panel understood 'issuing' to mean retrieving the medication from the medication store. The panel understood 'signed for the prescription' to mean signing to authorise the drug to be administered.

There is no evidence to show who issued the medication and Ms Miller signed to indicate that the drug was given. She was not signing to prescribe the drugs herself.

The charge is specific in relation to both the issue and signing for the prescription. The panel noted that the contemporaneous note shows that the prescription was signed for by '*S Boyd'*. Although there is evidence that Ms Miller administered the tranexamic acid, the panel is not satisfied that there is evidence that Ms Miller issued and signed for the prescription because both are signed by S Boyd and there is no evidence to prove that Ms Miller issued either drug.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 1e

a) Your conduct at charge 1c) and/or 1d) was outside the scope of your practice.

This charge is found proved.

Charge 1d was found not proved, so the panel only considered charge 1e in

relation to charge 1c.

In reaching this decision, the panel took into account Ms Miller's written evidence and noted her admission that 'Tranexamic Acid is a prescription only medication and that proper prescription documentation should be in place before administration.' This was confirmed by Ms Harrison and Ms Boyd.

The panel is satisfied that your conduct at 1c in that you Commenced an infusion of tranexamic acid without consulting the registrar and/or in the absence of a prescription from the registrar was out of the scope of Ms Miller's practice.

In light of this, on the balance of probabilities, this charge is found proved in relation to charge 1c in relation to tranexamic acid.

Charge 1f

> f) Asked Ms Boyd to retrospectively sign for the prescription/s of Tranexamic Acid and/or Syntocinon after the medication/s had already been administered.

This charge is found proved

In reaching this decision, the panel took into account Ms Miller's written evidence and the oral and written evidence of Ms Boyd.

The panel made reference to the chronology of events as stated in the contemporaneous notes. The panel accepted that Ms Boyd did not see the patient until 23:45 at which point she documented in the medical notes the plan for Tranexamic Acid and a Syntocinon infusion. The panel looked at the prescription chart and noted that Tranexamic Acid was administered at 21:20 and Syntocinon was administered at 21.29. Ms Boyd was clear in oral evidence that it was Ms Miller who had asked her to sign this prescription retrospectively, though this was not clear in the Datix. Ms Boyd admitted that she signed the prescription but stated that she should not have done so.

Consequently, the panel decided that there was a retrospective signing for the drugs and considered whether Ms Miller asked Ms Boyd to do this. The panel accepted the evidence of Ms Boyd and found her to be consistent in her written statement and oral evidence. The panel found that in admitting that she had signed the prescription retrospectively, Ms Boyd exposed poor practice on her part and therefore found it unlikely that she would fabricate it. The panel understood that there is some ill feeling between Ms Boyd and Ms Miller but noted that Ms Miller has not challenged Ms Boyd's account.

In light of this, on the balance of probabilities, the panel found this charge proved.

Charge 2a

On 13 January 2020 in respect of Patient D:

a) Did not escalate to the Registrar that shoulder dystocia had been identified.

This charge is found proved

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Harrison and Patient D's clinical notes.

The panel had sight of the patient D's clinical notes which show that Ms Miller was in the room and involved in the delivery of the baby. There is an entry at 06.35 which referred to a woodscrew manoeuvre, which is specific to shoulder dystocia. This confirms that a shoulder dystocia was present.

The panel accepted the evidence of Ms Harrison who referred to the Trust Guideline that Shoulder Dystocia is an obstetric emergency which should be immediately escalated to an obstetric doctor. None of the subsequent clinical

entries made by the obstetric team refer to a shoulder dystocia. The panel was aware that this would be important to record in terms of future risk. The panel was of the view that this indicated that the obstetric team were not aware of the dystocia because it was not escalated to them.

The panel noted that Ms Miller does not deny this allegation in her written evidence but refers to Ms Harrison's witness statement which confirmed that no harm was caused. Ms Miller also referred to previously receiving an award for assisting with the birth of a baby with shoulder dystocia. Notwithstanding this, and considering the scope of this charge which is specific to escalating the obstetric emergency, the panel found that Ms Miller did not escalate to the registrar the shoulder dystocia on this occasion.

In light of this, on the balance of probabilities, the panel finds this charge proved.

Charge 2b

> 2b) Did not record in her notes or electronic summary of care that shoulder dystocia had been identified during labour and/or actions taken in respect of this

This charge is found proved

In reaching this decision, the panel took into account Ms Miller's written evidence and patient D's clinical notes.

The panel was aware that the primary midwife had documented that a woodscrew manoeuvre had been undertaken. The panel was aware that a woodscrew manoeuvre is a technique employed to rotate the foetal shoulders in cases of shoulder dystocia to aid vaginal delivery.

Other than the reference to the woodscrew manoeuvre, there was no subsequent direct reference to shoulder dystocia made in Patient D's notes or

electronic summary of care and no details of how the obstetric emergency was dealt with. The panel was satisfied that there was no clear record of shoulder dystocia in Patient D's notes or electronic summary of care. Considering the nature of shoulder dystocia as an obstetric emergency, the panel would have expected to see an explicit reference to this in the notes.

The panel acknowledged that Ms Miller was not the primary midwife and that the allegation is limited to a fact that she did not record matters. The panel noted that the allegation did not allege that Ms Miller had a duty or obligation to record it, simply that she did not record it.

In light of this, on the balance of probabilities, this charge is found proved.

Charge 3a

3) On 12 February 2020 in respect of Patient C:
a) Performed a manual breech extraction.

This charge is found proved.

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Victoria Cordell and the breech extraction guidance.

The panel considered the difference between breech extraction and breech delivery. It noted that an extraction is a manoeuvre reaching into the uterus to assist the delivery, whereas a breech delivery is a hands-off approach. A breech extraction is a procedure which should be performed by an obstetric doctor.

The panel heard evidence that Ms Cordell saw Ms Miller 'reach right up into the uterus to get the second foot'. In oral evidence Ms Cordell also stated that Ms Miller rotated the baby several times. She referred to the contemporaneous operative note. The panel considered that this account was consistent with Ms

Cordell's written evidence and the contemporaneous statement given by the consultant which stated:

> *"I found pt in lithotomy and Sr Millers hand well into uterus and delivery of second foot. This was followed by a difficult breech extraction mainly by Sr Miller up to trunk".*

The panel further noted that in written evidence Ms Miller admitted her involvement in performing a manual breech extraction. However, she asserted that she was asked to do this by Ms Cordell. The panel preferred the consistent and credible account given by Ms Cordell and the consultant in charge.

In light of this, on balance of probabilities, this charge is found proved.

Charge 3b

> b) Your conduct at charge 3a) contravened the wishes of Patient C and/or clear clinical intention to deliver her baby by caesarean section.

This charge is found NOT proved

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Cordell and the consent form signed 2 February 2020.

The panel noted that Patient C had consented to a caesarean section due to complications with a previous birth. The patient was taken to theatre with the intention of delivery by caesarean section and the abdomen was being cleaned in preparation of this procedure. The panel acknowledged that it was a fast-moving situation and the baby's foot had been delivered. The panel noted that there were accounts by other professionals in the internal investigation which indicated that there was confusion about what the mode of delivery would be in this case.

The panel considered that, although Ms Cordell said in her witness statement that:

> *"Pt C stated that she did not want a vaginal breech delivery and wanted a C-section*",

when asked by panel, Ms Cordell stated that they did not recall what Patient C's wishes were in the fast-evolving situation and whether she had changed her mind. The panel noted that Patient C appeared to be content with the outcome and did not submit a complaint.

The panel acknowledged that Ms Cordell, during the internal investigation, stated that communication was not very clear and could have been better, therefore, the clinical intention may not have been very clear. Consequently, the panel could not be sure that the clinical intentions or the patient's wishes at the time were clear.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 3c

> 3c) Your conduct at charge 3a) was outside the scope of your practice.

This charge is found proved

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Cordell and the Trust guidelines.

The panel made reference to the Trust guidelines which state that breech extractions should only be performed '*under exceptional circumstances'.* The panel also took account of Ms Harrison's written evidence stating that *'midwives are not able to carry out breech extractions'* these are a '*doctor only role'.* Ms Cordell also confirmed in her oral evidence that breach extractions should not be performed by midwives.

The panel accepted Ms Miller's written evidence that she has delivered ten breech babies but again noted that a breech delivery is different to a breech extraction.

The panel decided that breech extractions were outside Ms Miller's scope of practice.

In light of this, on the balance of probabilities, this charge is found proved.

Charge 4a

4) On 17 May 2020 in respect of Patient A:

a) Did not discuss her clinical presentation with a Registrar and/or request an examination from a Registrar prior to commencing a Syntocinon infusion

This charge is found NOT proved

In reaching this decision, the panel took into account Ms Miller's written evidence, Patient A's clinical notes and the Datix dated 21 May 2020.

The panel noted that whilst the Datix recorded that Ms Miller had already commenced a Syntocinon infusion, there was no evidence before it that it was specifically Ms Miller who did this. A different midwife records in the medical notes 'commenced oxytocin' but doesn't record whether she commenced or Ms Miller. Therefore, regardless of whether there was or was not a discussion about the patient's clinical presentation and/or request for an examination from a Registrar prior to commencing Syntocinon, without any clarity about who had commenced the Syntocinon, the panel could not find charge 4a proved.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 4b

4b) or in the alternative, allowed and/or permitted Ms Downey to commence the Syntocinon infusion in the absence of a prescription and/or verbal order from a Registrar

This charge is found proved, being the alternative to the first limb of charge 4b

In reaching this decision, the panel took into account Ms Miller's written evidence, the oral and written evidence of Ms Boyd and the clinical records.

The panel noted the oral evidence of Ms Boyd who was clear that the prescription was signed retrospectively and that at the time the infusion was commenced, it had not been prescribed, nor a verbal order issued. The panel considered that Ms Boyd was honest in her evidence and accepted that she should not have prescribed the drug retrospectively, rather, she should have challenged the request, which strengthened her evidence. Her statement is supported by the contemporaneous Datix entry which shows that the prescription was signed retrospectively.

The panel made reference to Ms Miller's written evidence that stated that she did not administer the drug and although she was *'involved in this incident'* and she was the '*second checker'*. Thereby, she allowed it to be administered by Ms Downey in the absence of a valid prescription. The panel preferred the consistent and credible account given by Ms Boyd that no verbal order for the Syntocinon had been given.

The panel decided that in her role as a senior midwife, Ms Miller should have known that this was not in line with the Trust guidance and thereby permitted Ms Downey to commence the infusion.

In light of this, on the balance of probabilities, this charge is found proved.

Charge 4c

4c) Your conduct at charge 4b) was outside the scope of your practice

This charge is found proved in relation to the alternative charge 4b

In reaching this decision, the panel took into account Ms Miller's written evidence and the oral and written evidence of Ms Kate Harrison.

The panel made reference to its decision in charge 4b. It accepted that Syntocinon for augmentation purposes requires a prescription.

The panel accepted the evidence of Ms Harrison who stated that '*a registrar should have examined the woman before starting the syntocinon infusion to ensure there was no obstruction to the pelvis, as this woman had a baby previously'* and *'if all was okay to proceed, a registrar should then have written the prescription for Ms Miller to administer the syntocinon drip'.*

The panel considered Ms Miller's contention that she was permitted to administer Syntocinon for augmentation purposes, however, this is contradicted by other evidence, including the Trust Labour policy which Ms Miller would have been aware of.

In light of this, on the balance of probabilities, this charge is found proved.

Charge 5a

5) Between 9 and 10 October 2021 in respect of Woman B:

a) Incorrectly commenced her insulin infusion at sliding scale 1 which was not in accordance with the prescription for sliding scale 3.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms Miller's written evidence, the incident reporting investigation form and the prescription chart for intravenous insulin.

The panel had regard to the insulin chart and acknowledged that it was not named but it was satisfied that it relates to Woman B as it was produced and referred to as part of an internal investigation. The panel noted that the infusion started at 15.40 and Ms Miller, in written evidence, states that she was on a night shift, which would have started later that day. The panel found no evidence that Ms Miller was on the day shift and it was not contested that she was on a night shift, and therefore it considered it unlikely that she could have commenced the infusion.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 5b

> 5b) Failed to adequately monitor and/or identify that the incorrect sliding scale of insulin was being administered and/or adjust accordingly.

This charge is found proved

In this context, the panel considered that ‘adequately monitoring’ the administration of insulin would have entailed checking the infusion against the prescription, checking blood glucose levels, and titrating the dose accordingly.

In reaching this decision, the panel took into account the written evidence of Ms Miller, the prescription chart, Trust Guidance on ‘Diabetes in Pregnancy’ which details the required units of insulin for difference blood glucose levels during labour and postnatally.

Ms Miller has not disputed that she was the midwife responsible for providing one-to-one care for this patient. Ms Miller stated in her response to the charges that she was following the prescription prescribed by the doctor. The contemporaneous clinical record shows that the patient was monitored approximately every hour in accordance with the guideline. However, it is clear from the insulin chart that Ms

Miller continued with the sliding scale 1 regime, which was not what was prescribed by the doctor. This shows that she did not identify that the incorrect sliding scale of insulin was being administered.

The panel did note that multiple different signatures appear on the clinical record during the course of the night, but given that Ms Miller admitted that she was 'providing one to one care for this patient' and that she was 'following the prescription provided by the doctor' the panel was of the view that she failed to identify that the incorrect sliding scale of insulin was being administered and consequently did not adjust the dose accordingly.

The panel was of the view that the prescription for the insulin was clear and unambiguous. It showed that Woman B should have had an infusion of 16 units per hour, however, during Ms Miller's night shift was given between 3 and 4 units per hour until 05:00 when the dose was increased to 24.

In the light of this, on the balance of probabilities, this charge is found proved.

Charge 5c

5c) Failed to identify, act on and/or escalate her raised blood glucose levels for obstetric review.

This charge is found NOT proved

The panel was mindful that there is a separate charge (5b) relating to failing to adequately monitor and adjust the insulin dose. Accordingly, the allegation of failed to identify and failed to act is a duplication of charge 5b. The essential issue in charge 5c is whether the NMC has satisfied the panel to the standard of proof that Ms Miller failed to escalate Woman B's raised blood glucose levels for obstetric review.

In reaching this decision, the panel took into account the written evidence of Ms Miller, Trust Guidelines on 'Diabetes in Pregnancy'.

The panel had regard to the prescription chart and noted that the patient's capillary blood glucose was monitored as rising throughout the course of the night, during the shift when Ms Miller was the midwife caring for this patient. Ms Miller appears to have identified the rising blood glucose levels, as the insulin dose was increased from 2 units to 4 units during the course of the night shift. The panel noted that whilst this was the incorrect dose because the incorrect sliding scale was being used, it did demonstrate that Ms Miller had taken action, albeit the incorrect action.

Further, the panel in reviewing the Diabetes in Pregnancy guidance, it noted that it is only when a patient's blood glucose level is greater than 24.1 that the doctor should be called. The panel did not have any evidence before it to indicate that the patient's blood glucose level rose as high as 24 during Ms Miller's shift. The highest recording by Ms Miller was a blood glucose level of 20.1, therefore, the panel did not find that escalation for obstetric review was necessary.

In the light of this, the panel concluded that charge 5c was not proved.

Charge 6

> 6) On or around 13 April 2022 performed a controlled Artificial Rupture of Membranes ("ARM") on Woman A in circumstances where the baby's presentation rendered the procedure outside the scope of your practice and/or an Obstetrician should have been notified.

This charge is found proved

In reaching this decision, the panel took into account the written evidence of Ms Miller, the oral and written evidence of Ms Emma Evans and the Trust Guidelines on Cord Presentation and Cord Prolapse.

The panel made reference to the Trust guidelines and accepted that it would be inappropriate to conduct an ARM at 3cm above the ischial spines (-3) without the presence of an obstetrician. It noted that the guidelines state that one should 'avoid

ARM if the presenting part is high'. The panel was aware that -3 position is a high presenting position.

The panel noted that Ms Miller has not disputed that she did an performed an ARM on Woman A. In her written evidence, Ms Miller states 'ARM was performed' and goes on to state 'at the time I performed the ARM'. In Ms Miller's 'memory catcher' she stated that *'fetal lie was considered to be -3 but in a fixed position'* and '*cephalic'*.

The panel accepted the evidence of Ms Evans who stated that she believed that Ms Miller '*practiced outside of her sphere of practice'*. To support that view, Ms Evans gave evidence about the requirement for fundal pressure and the volume of fluid that was released after the ARM. This supported other evidence that the baby's presenting part was high and that the ARM should not be performed by midwife. The panel found that Ms Evans' oral and written evidence was consistent.

In light of the evidence before it, the panel accepted that Ms Miller performed an ARM and it was out of the scope of her practice to do so.

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

Charge 7

7) Demonstrated bullying and/or intimidating and/or harassing behaviour towards colleagues in that:

a) On unknown dates refused to speak to and/or ignored Ms Boyd when working together on shift.

This charge is found NOT proved

In reaching this decision, the panel took into account the written evidence of Ms Miller and the oral and written evidence of Ms Boyd.

The panel acknowledged a difficult working relationship between Ms Miller and Ms Boyd who stated, in oral evidence, that Ms Miller had '*deliberately ignored me and I felt isolated'* on shift. The panel noted that Ms Boyd was unable to give specific examples of how she was ignored or when Ms Miller refused to talk to her.

The panel decided that it needed specific evidence to show that Ms Miller had '*refused'* to speak to Ms Boyd as opposed to not speaking to her and therefore the conduct did not amount to bullying or intimidating or harassing behaviour towards Ms Boyd.

Therefore, NMC has not discharged its burden of proof and on the balance of probabilities, this charge is found not proved.

Charge 7b

7b) On an unknown date during a handover meeting called Ms Harford "*that little cunt out there"* or words to that effect.

This charge is found NOT proved

In reaching this decision, the panel took into account the written evidence of Ms Miller and the oral and written evidence of Ms Amanda Westerby.

The panel noted that Ms Westerby stated that she reported this incident but she explained that she did not do so immediately because she had seen Ms Miller take a disliking to people very quickly.

The panel found Ms Westerby a reliable witness with no apparent reason to fabricate her evidence. It decided that she provided a plausible explanation for why she did not report the matter immediately and that she did report the incident to a senior midwife in due course.

The panel accepts that the comment was made, however there was no evidence that it was made towards Ms Harford, and it did not amount to bullying or

intimidating or harassing behaviour towards Ms Harford. The panel decided that the comment was an example of inappropriate behaviour by Ms Miller.

In light of this, on the balance of probabilities, this charge is found not proved.

Charge 7c

c) On an unknown date, dismissed Ms Hearn's concerns about a category one c-section patient.

This charge is found NOT proved

In reaching this decision, the panel took into account the written evidence of Ms Miller and the oral and written evidence of Ms Hearn.

The panel considered that Ms Hearn stated, in oral evidence, '*on one occasion I escalated concerns and Ms Miller dismissed it and said the patient was fine'*. The panel noted that Ms Hearn did not provide a specific reason as to why she felt she was dismissed by Ms Miller.

The panel did not have sight of any evidence that indicated sufficient grounds for clinical concern. Ms Miller had received the CTG at Ms Hearn's request and she had no concerns at that point. The panel decided that there was a valid clinical reason for Ms Miller to dismiss the concern.

The panel further noted that Ms Miller was a senior midwife and Ms Hearn had not specifically articulated how Ms Miller dismissed her. Therefore, the panel decided that there was insufficient evidence to prove that Ms Miller's behaviour amounted to bullying or harassing or intimidating.

Therefore, on the balance of probabilities, the panel found this charge not proved.

Charges 7d and charge 7e

7) Demonstrated bullying and/or intimidating and/or harassing

behaviour towards colleagues in that:

d) On unknown dates, criticised Ms Hearn in front of patients' family by stating "You should not do it like that" and "this is how you should do it" or words to that effect.

e) On an unknown date, criticised Ms Hearn in front of another colleague

This charge is found NOT proved

The panel considered charges 7d and 7e together because they are closely linked on the same evidence.

In reaching this decision, the panel took into account the written evidence of Ms Miller and the oral and written evidence of Ms Hearn.

The panel accepted that Ms Hearn stated that she kept a diary, reported the incidents internally and was upset by Ms Miller's criticism in front of a patient's family and how this negatively affected her in the workplace. In written evidence Ms Hearn stated that she *'did feel that Ms Miller was not approachable to ask for any help or advice because she would always make you feel rubbish.'* The panel found Ms Hearn to be consistent in her oral and written evidence.

The panel noted that the charges relate to specific examples of behaviour in clinical situations within the workplace. Ms Miller was Ms Hearn's senior midwife at the time, therefore she had an obligation to support and develop Ms Hearn's skills as a midwife and provide feedback on her performance. The panel accepted that this was not carried out in an appropriate manner as Ms Miller's words resulted in Ms Hearn feeling incompetent and led her to, at times, question her clinical ability and whether she should leave the profession. However, reflecting on the judgement made by Lord Nicholls as cited in the legal advice, the panel did not find that Ms Miller's conduct amounted to bullying, harassing or intimidating, although it was '*unattractive and unreasonable'* but was not *'oppressive and unacceptable'*. The

panel considered that whilst Ms Miller's method of identifying areas for a junior midwife to develop her practice was inappropriate, it could not be certain that Ms Miller's conduct was wholly unacceptable in the circumstances as it was her role to provide feedback to Ms Hearn.

In light of this, the panel decided that the NMC has not satisfied the panel that Ms Miller's conduct in charges 7d and 7e fall within the definition of bullying, harassing or intimidating a colleague. Therefore, on the balance of probabilities, charges 7d and 7e are found not proved.

Proceeding in absence – 16 November 2026

Before resuming the case on 16 November 2026, the panel satisfied itself that Ms Miller had been informed of the resuming date and reconsidered whether it was fair to proceed in her absence, having heard submissions from both parties.

Ms Miller had sent written submissions via her representative explaining that she did not wish to join the hearing and asked for it to continue without her. The panel was satisfied on this basis that she had voluntarily absented herself from the hearing and had opportunity to provide written representations and that it was fair to proceed in her absence.

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 Ms Miller's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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, Ms Miller's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Davies 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 and midwives 2015' (the Code) in making its decision.

Ms Davies identified the specific, relevant standards where Ms Miller's actions amounted to misconduct, namely, Codes: 1.2, 8.2, 8.5, 10.1, 10.2, 13.1, 13.2, 13.3, 18,19.1 and 20.1.

Ms Davies submitted that Ms Miller's actions fell significantly short of the standards expected of a registered senior Band 7 midwife. Ms Davies told the panel that Ms Miller had coordinating responsibilities, at the time of the allegations, and that her actions were serious enough to amount to misconduct.

Ms Davies grouped together Charges 1a, 1c, 3a, 3c, 4b, 4c and 6. She submitted that these charges involved the same theme of Ms Miller working outside her scope of practice. Ms Davies submitted that the facts found proved at these charges were not technical breaches. Ms Davies submitted that there were clear, well established and unambiguous processes in place that should have been well known to a midwife of Ms Miller's seniority. Ms Davies submitted that the scope of practice and safe medication management are fundamental tenets of midwifery practice.

Ms Davies grouped together the next set of charges 1a,1f, 2a and 2b. She submitted that these charges involved a failure to escalate obstetric emergencies and to record

them. Ms Davies submitted that Ms Miller's actions placed a vulnerable patient at real risk of serious harm. She also submitted that the charges found proved demonstrated a pattern of conduct over approximately 2 years. She submitted that fellow practitioners would regard Ms Miller's conduct as deplorable.

Mr Holborn submitted that the charges found proved are serious. He submitted that this, however, does not automatically amount to misconduct. Mr Holborn submitted that Ms Miller has not worked since 2022 but has engaged and cooperated with the process.

Mr Holborn submitted that, it is Ms Miller's case, that she does not feel that the background and context to her actions were fully appreciated. Mr Holborn submitted that, notwithstanding this, Ms Miller recognises that factual findings have been made. Mr Holborn submitted that the panel should assess the individual findings carefully, together with its cumulative effects. He submitted that the panel should not make a finding of misconduct without being satisfied that the threshold is met.

Submissions on impairment

Ms Davies 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 Davies referred to the *Grant* "test" and submitted that limbs (a), (b) and (c) are engaged both in the past and as to the future. Ms Davies submitted, in relation to limb (a), that the actions in the charges found proved placed women and/or babies at an unwarranted risk of harm.

Ms Davies submitted that, in relation to limb (b), members of the public would be concerned to learn that as senior midwife had repeatedly undertaken or permitted interventions reserved for doctors and failed to escalate obstetric emergencies.

Ms Davies submitted that, in relation to limb (c), working within the limits of competence, safe medicine management, timely escalation and accurate record keeping are fundamental tenets of midwifery.

Ms Davies submitted that in principle clinical failings are capable of remediation. However, she submitted that Ms Miller's actions have not been remediated and that there is a real risk of repetition. Ms Davies submitted that Ms Miller's earlier remediation and reflection did not result in sustained safe practice and could be indicative of an attitudinal concern towards working beyond the limits of her practice.

Ms Davies submitted that there is no evidence of up-to-date training, testimonials or safe practice. She submitted that the concerns have not been addressed. She submitted that Ms Miller is impaired on both public protection and public interest grounds. Ms Davies submitted that a well-informed member of the public, aware of the pattern of a senior midwife acting beyond her scope of practice, would be concerned if a finding of impairment was not made.

Mr Holborn submitted that Ms Miller has not worked since 2022. He referred the panel to Ms Miller's witness statement and reflective piece. He submitted that Ms Miller's reflective piece recognises the importance of patient safety, escalation, working within professional limits and clear communication.

Mr Holborn submitted that Ms Miller has undertaken steps that she feels are suitable and has not avoided her responsibility. Mr Holborn submitted that Ms Miller has left midwifery and has no intentions of returning now or in the future. Mr Holborn submitted that Ms Miller has established a different career where she is working with the public, training and supervising others and has had positive feedback.

Mr Holborn submitted that there is no risk of repetition because Ms Miller is not going back to clinical practice, has engaged with the proceeding, has provided a response and that there have been no further concerns since the issues arose in 2022.
The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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 Ms Miller's actions did fall significantly short of the standards expected of a registered midwife, and that Ms Miller's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care

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:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

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

19 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
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore considered each charge found proved in turn:

Charge 1a)

The panel took into account that Ms Miller was a senior Band 7 midwife and, as such, should have been familiar with the relevant policies and procedures for managing shoulder dystocia. The panel considered that, as a PROMPT (Practical Obstetric Multi-Professional Training) trainer, Ms Miller possessed the necessary skills and knowledge to recognise and undertake shoulder dystocia delivery but should have understood the importance of escalating the situation immediately. The panel determined that Ms Miller had a clear duty and professional responsibility to ensure that the appropriate medical staff were informed promptly of this obstetric

emergency and on hand to assist in the event of any complications, but she failed to fulfil this responsibility.

The panel determined that Ms Miller's failure to follow the relevant procedure placed the unborn baby at unwarranted risk of significant harm. Therefore, the panel determined that Charge 1a meets the threshold for serious misconduct.

Charge 1c and 1e)

The panel considered Charge 1c and 1e separately, while recognising that they related to the same incident.

The panel noted that tranexamic acid is a prescription only medication and that Ms Miller was aware that no prescription was in place. There was no evidence before the panel to suggest that Ms Miller was qualified to prescribe this medication or that any exceptional circumstances justified proceeding without the appropriate medical prescription. The panel also noted that patients receiving tranexamic acid require appropriate monitoring. Given Ms Miller's experience as a Band 7 midwife, the panel considered that she should have been aware of the relevant policies and the limits of her scope of practice. The panel therefore determined that both Charges 1c and 1e amounted to serious misconduct.

Charge 1f)

The panel previously found that Ms Miller asked Ms Boyd to retrospectively sign for a prescription for tranexamic acid more than 2 hours after it had been administered. The panel considered that, as an experienced Band 7 midwife, Ms Miller should have been familiar with the relevant policies and procedures for the requirement for tranexamic acid to be prescribed by a doctor prior to administration.

The panel determined that in asking Ms Boyd to retrospectively sign for a prescription for tranexamic acid more than 2 hours after it had been administered was inherently contrary to policy, and thereby, amounted to serious misconduct.

Charge 2a)

The panel noted that Ms Miller was a senior PROMPT trained midwife and should have recognised shoulder dystocia as an obstetric emergency requiring immediate escalation to the registrar, regardless of her own level of training/ experience. Ms Miller's failure to do so placed the mother and unborn baby at real risk of significant harm because the relevant professionals were not on hand to assist if required. It also meant that medical staff did not have knowledge of the incident which can have an impact on future care. The panel determined that acting beyond her scope amounted to serious misconduct.

Charge 2b)

The panel was aware that the other midwife present was the primary care giver and was therefore responsible for documenting in the patient notes. The panel considered that checking whether the care had been recorded properly and making her own notes would have been good practice but was not satisfied that Ms Miller's failure to do so fell sufficiently below the expected standard of amount to serious misconduct. The panel therefore determined that it did not meet the threshold to be considered as serious misconduct.

Charge 3a and 3c)

The panel considered Charge 3a and 3c separately, while recognising that they related to the same incident.

The panel noted that clear national and Trust guidance stipulates that manual breech extraction should only be performed by an obstetric doctor. The panel noted that a registrar was present and available to perform the procedure. The panel considered that Ms Miller, who is a senior Band 7 midwife and a PROMPT trainer, should have recognised that the procedure was outside of her scope of practice. Therefore, Ms Miller should have allowed the obstetric team to take over. There were no exceptional circumstances too justify her actions. The panel therefore determined that the conduct found proved in these charges amounted to serious misconduct.

Charge 4b and 4c)

The panel considered Charge 4b and 4c separately, while recognising that they related to the same incident.

The panel considered that, as the lead midwife in charge and the senior midwife in the room, Ms Miller was responsible for ensuring that the medication policy was adhered to. Ms Miller was the second checker and had the opportunity to stop the administration of the Syntocinon until the patient was reviewed by a doctor and for the Syntocinon to be prescribed.

Although Ms Miller did not administer the Syntocinon herself, she knew that there was no prescription in place for this and allowed it to be administered. The panel determined that this amounted to serious misconduct.

Charge 5b)

The panel determined that Ms Miller failed to spot an error over several hours. The panel determined that Ms Miller failed to identify that the insulin being administered was on the incorrect sliding scale prescription. The panel considered that upon commencing her shift, Ms Miller should have checked what was being administered against the insulin prescription which would have allowed her to identify the discrepancy and take appropriate and prompt action to correct it.

The panel therefore determined that this did meet the threshold to be considered as serious misconduct.

Charge 6)

The panel considered the evidence before it that the baby's presenting part was high and that, in these circumstances, an ARM should not be performed by a midwife without escalating and having the support of the obstetric team present during the procedure and the wider MDT (Multi-Disciplinary Team) on standby. The panel determined that Ms Miller acted outside of her scope of her practice. It considered that there are clear guidelines in place and that a midwife of Ms Miller's seniority would be aware of this.

The panel determined that Ms Miller's actions put the mother and baby at real risk of significant harm and that such actions amounted to serious misconduct.

In summary, the panel determined that Ms Miller's actions in relation to Charges 1a,1c,1e,1f, 2a,3a,3c,4b,4c,5b and 6 amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct found proved, Ms Miller'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. 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* reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence*

in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *…'*

The panel determined that limbs (a) - (c) of the *Grant "*test" are engaged in this case. The panel found that patients were put at unwarranted risk of harm as a result of Ms Miller's actions, some of which include: failing to escalate obstetric emergencies, administering medication without a prescription and disregarding policy and procedure. The panel found that there was a pattern of Ms Miller repeatedly acting beyond her scope of practice and failing to escalate matters to the obstetric doctors when required. The panel determined that Ms Miller's misconduct breached the fundamental tenets of the midwifery profession and therefore brought its reputation

into disrepute. The panel determined that the confidence in the midwifery profession would be undermined if the NMC, as its regulator, did not make a finding of impairment.

The panel considered whether the concerns were capable of remediation. It noted that, in principle, clinical concerns can be remediated through training however it determined that Ms Miller's case involves deep seated attitudinal concerns where such conduct has been repeated on several occasions over a period of time. The panel was of the view that such misconduct cannot be easily remediated.

The panel then went on to consider whether the misconduct has been remediated. The panel carefully considered Ms Miller's reflective piece and determined that her insight is limited. The panel determined that Ms Miller's reflection focused largely on the impact of the proceedings on herself, rather than the potential consequences and risks associated with her conduct for the mothers and babies in her care. While the panel acknowledge some evidence of insight compared with her previous position, it considered that Ms Miller has not yet sufficiently explored the nature of her failings and its impact in any detail. The panel also noted that Ms Miller has not shown clear remorse or acknowledged the extent of her failings. The panel had particular regard to the following sections of Ms Miller's reflective piece:

> *'…I recognise the importance of patient safety, clear communication, appropriate escalation and working within professional limits…'*

The panel determined that Ms Miller does not explain why these factors are important in maintaining patient safety.

Ms Miller, in referring to dealing with an obstetric emergency, stated:

> *'... I recognise that situations such as shoulder dystocia can develop quickly and can place a woman and baby at serious risk. Promptly calling for appropriate help, clearly communicating the situation and confirming that the right person has responded can be essential…'*

'…If I were considering a procedure in comparable circumstances, I would want to check: where the consultant was…'

The panel also determined that whilst this shows some insight, Ms Miller does not link her general insight to the specifics of the incident and her actions. Moreover, the panel considered that Ms Miller does not provide any reflection on acting outside the scope of her practice, why she did it, the potential impact it had on patients and public confidence nor what she has learnt as a result.

'…My understanding of the risks associated with medication and authorisation is: the medication was prescribed and commenced by a different midwife not myself…'

The panel further determined that Ms Miller does not explore, in detail, the specific risks associated with this medication being administered without prescription, what she would do differently in future nor what she has learnt from the incident.

The panel determined that Ms Miller does not demonstrate sufficient professional accountability or take full responsibility for her actions. The panel was not satisfied that Ms Miller has fully understood the seriousness of her failings or the potential impact it had on the patients in her care. The panel determined that Ms Miller's insight is insufficient and that there is no evidence to show she fully understands how her actions may have affected patients and colleagues and how this may affect the public confidence in the midwifery profession. The panel was particularly concerned about the lack of reflection on why Ms Miller repeatedly acted outside the scope of her practice and the potential consequences and risks in doing so.

The panel also determined that that there is no evidence of up-to-date training, or testimonials from colleagues or those who Ms Miller has worked with. The panel acknowledged that Ms Miller has not practised since 2022, however were of the view that she could have demonstrated strengthened practice in a number of ways, for example through CPD (Continual Professional Development) training, reading and critically appraising relevant research or by evidence of acquiring or developing skills

which would support her practice as a midwife in the future. In her witness statement, Ms Miller stated:

> '…*I work as a trainer, supervisor and mentor for new employees. I have received positive feedback about my work and the skills I bring to my current role…'*

The panel also determined that there was no reflection on how the skills and experience from this role may have strengthened her practice or be transferable into a midwifery role. The panel was therefore of the view that the concerns have not been addressed and that Ms Miller has not demonstrated a strengthened practice.

Having considered the nature of the misconduct, Ms Miller's reflection, her limited insight and remediation; the panel was of the view that there is a risk of repetition based on the insufficient evidence that Ms Miller's practice has been fully remediated. It noted that the concerns involved attitudinal issues, including placing her own skills and judgement above patient safety.

Accordingly, and in absence of any further evidence, the panel determined that the risk of repetition was very high and that Ms Miller's fitness to practise is currently impaired 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 determined that a finding of impairment on public interest grounds is required as a well-informed member of the public would be concerned if a finding of impairment was not made for a midwife who has acted outside of her scope of competence on several occasions. In addition, the panel concluded that public confidence in the profession and in the NMC as its regulator would be undermined if

a finding of impairment were not made in this case. The panel therefore determined that Ms Miller's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Ms Davies informed the panel that in the Notice of Hearing, dated 17 December 2025, the NMC had advised Ms Miller that it would seek the imposition of a striking off order if Ms Miller's fitness to practise was found to be impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order for a period of 12 months with a review is the more appropriate sanction in light of the panel's findings given that the dishonesty and bullying charges had been found not proved.

Ms Davies submitted that the sanction must be proportionate and balance the public interest against those of Ms Miller.

Ms Davies set out the following aggravating features:

- The concerns relate to the fundamental tenets of midwifery: safe medication administration, acting with the scope of competence and preserving patient safety
- Ms Miller acted outside the scope of her practice on several occasions

- The concerns were wide ranging and occurred over a sustained period of time, which is indicative of a pattern of behaviour
- Ms Miller has shown limited insight

Ms Davies submitted that some mitigating features could include Ms Miller's personal mitigation, previous character and length of service.

Ms Davies outlined all the sanctions available starting with the least restrictive. She submitted that a caution order would be inappropriate in Ms Miller's case as the charges found proved are not at the lower end of seriousness. Ms Davies also submitted that a conditions of practice order is inappropriate as there are concerns that remain. She submitted that Ms Miller has stated and maintained that she has no intention of returning to practice or any intentions of practising. Ms Davies submitted that there is no evidence that Ms Miller would adhere to such conditions as has shown limited insight and has provided no evidence of a willingness to respond positively training.

Ms Davies submitted that a suspension order is the most appropriate order. She referred the panel to the NMC Guidance titled *'SAN-2'*. Ms Davies submitted that some of the indicators within the suspension guidance are not present in this case, for example: there are repeated instance of misconduct, attitudinal concerns and limited insight.

Ms Davies submitted that the misconduct found is serious and a suspension order would mark the seriousness of Ms Miller's actions.

Ms Davies submitted that the public would be protected during the full period of suspension and the review would ensure that Ms Miller could not practice unless a future panel is satisfied that a risk has been addressed. She further submitted that a suspension order would maintain public confidence in the profession.

Ms Davies submitted that a suspension order would give Ms Miller the opportunity to reflect on this panel's findings, develop her insight and demonstrate steps taken to strengthen her practice.

Ms Davies submitted that, if the panel imposes a suspension order, then it may consider the following factors to assist a future panel at a review:

- Evidence of relevant CPD training in relation to escalation and medication management
- Up to date information from her current employer to show a strengthened practice

Ms Davies submitted that a striking off order would be disproportionate at this time.

Mr Holborn outlined the following mitigating factors:

- Ms Miller is a midwife and has worked for many years without fault or criticism
- Little evidence of malice of deliberate intentions to cause problems
- Clear interest in patients
- Good length of service and good practice where she has achieved a Band 7
- Ms Miller has a previous good character
- Ms Miller has engaged with these proceedings

Mr Holborn submitted that, it is Ms Miller's case that, a conditions of practice order is the most appropriate sanction. He submitted that, if the panel is not minded to impose a conditions of practice order then it may consider imposing a suspension order.

Mr Holborn submitted that the panel should give credit for Ms Millers attendance at these proceedings and that the charges relating to dishonesty and bullying have fallen away.

Mr Holborn submitted that Ms Miller accepts that the findings are serious and has taken her job as a Band 7 midwife seriously.

Mr Holborn asked the panel to take into account the effect these proceedings have had on Ms Miller as a midwife with a record of previous good record. Mr Holborn submitted that while some of the charges concern different aspects of the same clinical incident, the panel should consider each charge separately and its context.

Mr Holborn submitted that Ms Miller has left midwifery and has established a different career. Mr Holborn submitted that Ms Miller has no intention to return to practice, he submitted that whilst he understands this is not an enforceable restriction the panel should consider it when making its decision on sanction.

Mr Holborn submitted that although Ms Miller's insight is limited it is not absent. He submitted that Ms Miller's current employment cannot provide evidence of midwifery competence but shows that she has moved on.

Mr Holborn submitted that the attitudinal issues have not yet been tested however, he submitted that there is enough evidence that can be tested and could end positively. He submitted that Ms Miller has had a substantial career in midwifery and has described professional achievements towards women and families she cared for.

Mr Holborn submitted that conditions of practice should be considered carefully. He submitted that there is no identifiable clinical employee or supervisor before the panel and that Ms Miller has not explicitly agreed to clinical training or supervision, but neither has she refused it.

Mr Holborn submitted that Ms Miller has sought to be removed from the register and will apply for voluntary removal.

Mr Holborn submitted that a suspension would prevent Ms Miller from undertaking registered practice while it's in force. He submitted that it would protect the public against the risks identified and would mark the seriousness of the panel's findings. He further submitted that a suspension order would allow the necessary time for Ms Miller to reflect, remediate and consider her position.

Mr Holborn submitted that striking off order is disproportionate as it is the most restrictive outcome. He submitted that the panel may consider workable conditions, impose a suspension order with the reasons for its duration set out and to reject a striking off order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms Miller's 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:

- Conduct which put mothers and babies receiving care at risk of suffering harm
- The vulnerability of the mothers and unborn babies in her care
- Deliberate breaches of the Code by repeatedly choosing to disregard policy and procedure
- A pattern of misconduct over a period of time
- Limited insight
- Failure to work collaboratively with colleagues, recognise and accept the importance of the wider obstetric team to keep women and unborn babies safe

The panel took into account that Ms Miller provided submissions at each stage of the proceedings through Mr Holborn and provided the panel with a document titled 'Witness statement and reflective account'. However, the panel determined that the remediation and insight shown are limited and do not address the regulatory concerns sufficiently to amount to mitigation. The panel found no other mitigating circumstances in Ms Miller's case.

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.

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 Ms Miller's actions were not at the lower end of the spectrum, and it found that there remains a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Miller's practise 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 conditions of practice on Ms Miller's registration. In considering whether a conditions of practice order is 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). Having found that Ms Miller has limited insight into the seriousness and the impact of her conduct and has shown attitudinal concerns, the panel determined that a conditions of practice order would not be appropriate in the circumstances.

The panel considered that, while in principle, clinical concerns can be remediated through conditions, there are no devisable conditions that can address Ms Miller's attitudinal concerns. The panel also noted that Ms Miller has not demonstrated a willingness to undertake training or to strengthen her practice. The panel was aware that Ms Miller completed a Personal Improvement Plan but the misconduct continued after this time which demonstrates serious attitudinal concerns.

Further the panel noted that Ms Miller's misconduct included breaching basic policy and procedure and failing to work collaboratively. In light of this, the panel considered that there are no relevant, proportionate, workable or measurable

conditions that could be formulated to protect patients and to uphold professional standards.

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

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

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

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

Whilst the panel acknowledged that some of the risks identified could be managed by Ms Miller being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards. The panel also determined that a suspension order will not address the seriousness and nature of the facts found proved.

The panel noted that the NMC had reduced its sanction bid in the light of the dishonesty and bullying charges being found not proved. However, the panel considered that the remaining charges are still extremely serious and at the highest end of the spectrum due to Ms Miller being an experienced band 7 midwife putting mothers and babies at significant risk of harm by repeatedly and deliberately failing to follow fundamental policies which are in place to maintain patient safety.

Given Ms Miller's limited insight, lack of remorse, together with no evidence of her strengthening her practice through training or development, the panel considered that there is no realistic possibility that Ms Miller will address the concerns to such a level where she could return to practise safely. The panel further noted that Ms Miller has been subject to an interim suspension order for over 4 years and has not shown adequate insight, remediation or a strengthened practice during this time. Further, Ms Miller has maintained her settled position of not wanting to return to practice throughout this time.

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

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). The panel had regard to the following section:

> *'Other types of higher risk cases*
>
> *Some concerns are higher risk because it is harder for the professional to put the matter right. Examples of this type of concern include (but are not limited to):*

- *being directly responsible for exposing people receiving care to harm or neglect. Examples might be through management of a service or setting. This is especially the case where the professional put their own priorities, or those of their organisation, before ensuring the safety and dignity of people receiving care.'*

Whilst the panel noted that patients had not been exposed to actual harm the risk of causing unwarranted harm in this case was such that it is a higher risk case.

The panel carefully considered each of the points 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 determined that the charges found proved raise fundamental questions about Ms Miller's professionalism and professional practice. In particular, the panel were concerned that Ms Miller acted outside her scope of practice on several occasions over a period of time. The panel noted that, given Ms Miller's seniority as a Band 7 midwife, she ought to have understood that such conduct had the potential to expose vulnerable mothers and their unborn babies to an unwarranted risk of harm. The panel determined that Ms Miller does not fully appreciate the seriousness of the impact that her actions had the potential to cause. It also noted that such conduct continued even after Ms Miller had completed a Personal Improvement Plan.

The panel determined that public confidence in the midwifery profession and in the NMC as its regulator would be seriously undermined if a midwife of such seniority continued to act outside of her scope of practice, in particular, in circumstances where the midwife fails to alert the obstetric teams during an emergency. The panel determined that members of the public and fellow practitioners would find such conduct to be deplorable.

The panel determined that whilst the misconduct found proved in theory could be addressed through significant remediation, reflection and development of insight, in Ms Miller's circumstances it considered this not to be realistically possible. The panel noted that Ms Miller had the opportunity to read its findings on facts and reflect in detail on her conduct. The panel recognised that the allegations relating to bullying and dishonesty have fallen away and had disregarded these matters. However, the panel was concerned that Ms Miller continues to minimise the seriousness of the misconduct which the panel found was proved and continues in her recent witness statement and reflective account to lack accountability for her actions and deflect blame.

The panel determined that this demonstrates a lack of appreciation of the seriousness into the charges found proved, which placed mothers and their unborn babies at unwarranted risk of harm. In the absence of sufficient insight into the nature and seriousness of Ms Miller's conduct, the panel considered that there was no realistic prospect of the concerns being adequately addressed through further reflection or remediation.

The panel recognised that a further period of suspension may provide Ms Miller with further opportunity to reflect on her practice and her future intentions. However, the panel noted Ms Miller's reflective statement clearly sets out she does not intend to return to practice and has moved onto a different career outside of midwifery. Ms Miller has maintained this settled position throughout these proceedings.

The panel also had regard to NMC Sanction Guidance *'SAN-3'* titled *'Deciding between Suspension and Strike-off'* (last updated 28 January 2026). In particular:

‘Consider the professional’s insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.’

Given Ms Miller’s intention not to return to midwifery after a prolonged period of not practising, the panel considered that, it is unlikely Ms Miller will try to address the concerns and as such a further period of suspension would serve no purpose.

Further, the panel determined that Ms Miller’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 Ms Miller’s actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered both the submissions of Ms Davies and Mr Holborn in relation to the sanction in this case. However, the panel considered that any other order will not adequately address public protection concerns or maintain public confidence in the profession or in the NMC as its regulator. The panel appreciated that Ms Davies set out points which a *‘future panel may be assisted by’* however, it determined that there is no realistic prospect of circumstances that could revoke the suspension order after a period of review.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Miller’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.

Submissions on interim order

The panel took account of the submissions made by Ms Davies. She submitted that an interim suspension order is necessary and proportionate in light of the panel's findings. Ms Davies submitted that the interim suspension order is the only interim order that is consistent with the panel's decision on striking Ms Miller off the register.

Mr Holborn submitted that a suspension order is not required. He submitted that Ms Miller does not seek to return to practice and is seeking to be removed from the register. Mr Holborn submitted that a suspension order may be convenient but is not necessary.

The panel heard and accepted legal advice.

Decision and reasons on interim order

Whilst the panel recognised that Ms Miller has stated that she has left midwifery and has no intention of returning, the panel's findings in this case are based on the need to protect the public. Accordingly, the panel determined that an Interim Order is necessary for public protection 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 determined that there remains a real risk of unwarranted risk of harm given the repeated nature Ms Miller's misconduct.

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 striking off order 28 days after Ms Miller is sent the decision of this hearing in writing. This will be confirmed to Ms Miller in writing.

That concludes this determination.