

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

**Substantive Meeting
Monday 19 – Wednesday 21 October 2026**

Virtual Meeting

Name of Registrant:	Yvette Veronica Lake
NMC PIN:	83Y3241E
Part(s) of the register:	Registered Nurse RN1 Adult Nurse – March 1986 Registered Midwife – November 1990
Relevant Location:	Leeds
Type of case:	Misconduct
Panel members:	Rachel Cook (Chair, lay member) Anne Rachael Browning (Registrant member) Louise Print-Lyons (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Shela Begum
Facts proved:	Charges 1, 2, 3, 4 and 6
Facts not proved:	Charge 5
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - suspension order

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Lake's registered email address by secure email on 20 July 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations and the fact that the meeting would be held virtually, on or after 25 August 2026.

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

The panel noted that the Rules do not require delivery of the Notice of Meeting and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Details of charge

That you a registered midwife in relation to Patient A and Baby A's care:

1. On 31 December 2019 failed to:
 - 1.1 Recognise / categorise the CTG trace as pathological at around 23.35.
 - 1.2 Request a review from the obstetric team.
2. On 1 January 2020 failed to:
 - 2.1 Recognise / categorise the CTG trace as pathological at 01.18.
 - 2.2 Request a review from the obstetric team.
3. On 1 January 2020 failed to:
 - 3.1 Recognise / categorise the CTG trace as pathological at around 01.40.
 - 3.2 Request a review from an obstetric consultant.

4. On 1 January 2020, concerns having been raised at 02.10, failed to seek a review from an obstetric consultant.
5. On 1 January 2020 at 01.50 failed to discuss birthing options for Baby A with Patient A and Mr 1.
6. On 1 January 2020 failed to document within the electronic records your involvement with Patient A and Mr 1;
6.1 At 01.40
6.2 At 01.50

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

Background

Miss Lake first joined the Nursing and Midwifery Council's (NMC) register as a registered midwife on 5 November 1990. On 11 November 2020, the NMC received a referral from Patient A and Mr 1, the parents of Baby A, who died on 1 January 2020.

On 1 January 2020, Baby A was born at Leeds General Infirmary. Baby A was in a poor condition at birth and died 27 minutes later. The Healthcare Safety Investigation Branch (HSIB) investigated the circumstances surrounding Baby A's death and published a report in August 2020, followed by an addendum report published in December 2020. The HSIB investigation identified concerns about the care provided to Patient A and Baby A during labour.

At the time of the events, Miss Lake was working as the labour ward coordinator during the night shift of 31 December 2019 to 1 January 2020. Patient A was in active labour and was receiving care from another midwife, Ms Yasmin Karolia.

The NMC's allegations concern Miss Lake's assessment and categorisation of the cardiotocography (CTG) traces, her failure to seek appropriate obstetric review, her

response to concerns raised about Patient A's care, an alleged failure to discuss birthing options with Patient A and Mr 1, and her documentation of her involvement in their care.

On 12 to 14 December 2022 and 9 February 2023, a coroner's inquest was held into the circumstances of Baby A's death.

The NMC obtained expert evidence from Gemma McIntyre, a Midwifery Educator and Maternal Investigator (report dated 12 November 2025), and Michael Bowen, a Consultant Obstetrician & Gynaecologist (report dated 29 May 2026). Their reports addressed aspects of the care provided to Patient A and Baby A and the clinical concerns arising during the relevant period.

Miss Lake completed and returned a NMC formal response to the charges, known as a Case Management Form (CMF), on 6 March 2026 in which she admitted all of the charges and accepted that her fitness to practise was currently impaired by reason of her misconduct. She stated that she had retired in 2020 and was no longer practising as a midwife.

Decision and reasons on facts

At the outset of the meeting, the panel had regard as to whether it remained appropriate to convene as a meeting (rather than a hearing). The panel was in receipt of bundle of 1670 pages which included a case summary on behalf of the NMC and completed CMF dated 6 March 2026 from Miss Lake.

Taking into account that Miss Lake had not indicated that she wished the matter to proceed as a hearing; that she had stated that she would be unable to attend if it proceeded as a hearing; and that the panel was in receipt of an NMC case summary which set out their position, the panel considered it to continue to be fair and appropriate for the case to proceed as a meeting.

The panel noted that Miss Lake was not represented at these proceedings and that, although she had indicated her admissions in the CMF, by way of ticking a box, she had provided no further comments or explanation in respect of those admissions. In the

circumstances, the panel considered it appropriate to review the evidence in relation to each charge to ensure that its findings, and Miss Lake's admissions, were fair and properly supported by the material before it.

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

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

- Gemma McIntyre: Independent Expert Witness -
Registered Midwife, Educator and
Maternity Investigator.
- Michael Bowen: Independent Expert Witness -
Consultant Obstetrician &
Gynaecologist

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC which included witness statements from Patient A and Mr 1 (both dated 23 May 2023) as well as documentation from Miss Lake.

Charges 1 – 4 and 6

The panel considered each of charges 1 to 4 and charge 6 individually. In respect of each charge, the panel took account of Miss Lake's admission in her CMF and was satisfied that the admission was supported by the relevant expert evidence of Ms McIntyre. The panel was therefore satisfied that the admissions were consistent with the available evidence and that there was a sufficient evidential basis to accept them. Accordingly, the panel found charges 1 to 4 and charge 6 proved in their entirety.

Charge 5

5. On 1 January 2020 at 01.50 failed to discuss birthing options for Baby A with Patient A and Mr 1.

This charge is found NOT proved.

The panel considered the allegation that Miss Lake failed to discuss birthing options for Baby A with Patient A and Mr 1 at approximately 01:50 on 1 January 2020.

The panel noted the phrase 'failed to' and reminded itself of the need to establish at the outset that Miss Lake had a duty to discuss birthing options for Baby A with Patient A and Mr 1.

The panel noted that Miss Lake had admitted this particular in her CMF. The panel considered whether her admission was an acceptance of the factual allegation that she had not discussed birthing options.

When considering whether Miss Lake was under a duty to discuss birthing options for Baby A with Patient A and Mr 1, the panel had regard to the expert report of Ms McIntyre dated 12 November 2025, in particular paragraphs 10.2.1 which state:

"Whilst it is a fundamental responsibility of a midwife to share information and discuss options with a woman, in my opinion, discussions about mode of birth are the role of the obstetric team. Whilst many midwives would pre-empt the decision-making of the obstetric team and discuss the potential options in order to prepare the woman and her partner, there is no requirement for this to occur. Furthermore, it would be my expectation that if that were to occur that it would more likely fall to the caring midwife, as they will usually have built up a rapport with the woman and can provide support and reassurance. It is my opinion that the level of communication between Midwife Lake and Pnt. A and [Mr 1] met the standard expected of a reasonably competent registered midwife."

The panel noted Ms McIntyre's opinion that the discussions between Miss Lake, Patient A and Mr 1 met the standard expected of a reasonably competent registered midwife. The panel also considered her evidence concerning the respective responsibilities of the midwife providing direct care and the wider obstetric team in relation to discussions about birthing options.

The panel had regard to the role Miss Lake was undertaking at the relevant time as labour ward coordinator, rather than the midwife providing direct care to Patient A. The panel considered whether, in her role as labour ward coordinator, Miss Lake was under a professional duty to discuss birthing options with Patient A and Mr 1.

The panel accepted Ms McIntyre's expert opinion, that there was no requirement for a midwife to pre-empt the obstetric team's decision by discussing potential birthing options, and that such a discussion would more likely fall to the midwife providing direct care.

Accordingly, although Miss Lake admitted the charge, the panel was not satisfied that the evidence established that Miss Lake was under a duty to discuss birthing options with Patient A and Mr 1.

The panel therefore found charge 5 not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Lake'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, Miss Lake's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the NMC's statement of case in which it submitted the following:

"14. The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:

"[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances."
As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively

"[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired." And "The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner."

15. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct. 16. At the relevant time, Ms Lake was subject to the provision of the Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code").

The NMC considers the following provisions of the Code to have been breached in this case:

[...]

17. The concerns in this case are serious and relate to Ms Lake's failures in fundamental clinical areas of midwifery practice. Ms Lake's conduct, as detailed in the charges, falls significantly short of what would be expected of a registered midwife. The areas of concern identified relate to basic midwifery skills and practice. Ms Lake's failing to recognize/categorise the CTG trace as pathological and failing to request a review from the obstetric team, on more than one occasion, was a significant departure from the fundamental principles of the Code of prioritising people and preserving safety. Furthermore, her record keeping was inadequate and her clinical decision-making unsafe. The misconduct in this case is serious because Ms Lake failed to provide safe and effective care to a Patient in her care.

18. The overall conduct is a serious matter. It is submitted that these failings are clear examples of misconduct, failing far short of what is deemed proper conduct of a professional, and these errors go against basic and fundamental matters of patient care.

19. The conduct involves a serious departure from the standards expected of a registered midwife and the facts are sufficiently serious to constitute misconduct."

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Miss Lake's fitness to practise impaired. In its statement of case, the NMC submitted:

"20. Impairment needs to be considered as at today's date, i.e. whether Ms Lake's

fitness to practise is currently impaired. The NMC defines impairment as registered professional's suitability to remain on the register without restriction. There is no burden or standard of proof to apply as this is a matter for the Fitness to Practise Committee panel's own professional judgement.

21. A question that will assist the Panel to decide whether a professional's fitness to practise is impaired is:

*"Can the nurse, midwife or nursing associate practise safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired. Answering this question involves a consideration of both the nature of the concern and the public interest.*

22. When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

- 1. has [Ms Lake] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
- 2. has [Ms Lake] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
- 3. has [Ms Lake] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
- 4. has [Ms Lake] in the past acted dishonestly and/or is liable to act dishonestly in the future.*

23. It is the submission of the NMC that 1, 2 and 3 above can be answered in the affirmative in this case.

24. The midwifery expert Gemma McIntyre has provided her opinion. Ms McIntyre is an experienced midwife, educator and maternity investigator. Ms McIntyre

qualified as a midwife in 2012 and has continued experience in providing antenatal, intrapartum, postnatal and newborn care in all areas of midwifery practice. In her report dated 12 November 2025, she sets out her opinions at paragraphs 10.1-10.3 and 11 of the report

[...]

25. Ms Lake's failure to categorise the CTGs as pathological together with her failure to escalate them to the obstetric team for an urgent review placed patient A and Baby A to an unwarranted risk of harm. This is a case which directly relates to patient care. Ms Lake's actions and inactions compromised patient safety and had the potential to cause serious harm to the patient in her care. Ms Lake's conduct has put a patient at unwarranted risk of harm and due to her lack of insight and remediation, there is a risk of the conduct being repeated.

26. The concerns about Ms Lake's actions are serious as this is a serious departure from the standards expected of a registered health professional. Registered health professionals occupy a position of privilege and trust in society and are always expected to meet adequate standards of providing patient care. Patients and families must be able to trust registered health professionals with their lives and the lives of their loved ones.

27. The Code divides its guidance for nurses into four categories which can be considered as representative of the fundamental principles of nursing care. These are:

- a) Prioritise people;*
- b) Practise effectively;*
- c) Preserve safety and*
- d) Promote professionalism and trust*

28. The NMC has set out above how, by identifying the relevant sections of the Code, Ms Lake has breached fundamental tenets of the nursing profession. These sections of the Code define, in particular, the responsibility to prioritise people, preserve safety and promote professionalism and trust to ensure safe conduct and

practice.

29. The panel may also find it useful to consider the comments of Cox J in Grant at paragraph 101:

“The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case”.

30. Impairment is a forward-thinking exercise which looks at the risk the registrant’s practice poses in the future. The NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

31. The failings involved in this case are directly linked to her clinical practice. The NMC’s guidance at FTP-16a states that “Generally issue about the safety of clinical practice are easier to address, particularly where they involve isolated incidents”, and examples are given such as medication administration errors, poor record keeping and failings in a discrete and easily identifiable area of clinical practice. This suggest the concerns in this case are remediable. However, Ms Lake has not provided any evidence of insight, reflection, strengthened practise or testimonials.

32. We consider Ms Lake has displayed insufficient insight into the seriousness of the concerns and her fitness to practice remains impaired, which Ms Lake has accepted.

33. We consider there is a continuing risk to the public due to Ms Lake’s lack of full insight.

34. Therefore, the NMC considers that a finding of impairment is necessary in this case to protect the public.

Public interest

35. In *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

“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.”

36. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

37. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

38. As such, the misconduct is not easily remediable. It is further submitted that the concerns have not been remediated and are therefore highly likely to be repeated should Ms Lake be permitted to practise as a midwife again.

39. The NMC considers that there is a public interest in a finding of impairment being made in this case to uphold proper standards of conduct and behavior. Ms

Lake's conduct engages the public interest because there is no evidence that Ms Lake has shown sufficient insight into the issues raised.

40. The public would also expect the NMC to ensure that those on its register maintain the required standards of professionalism. The public would therefore expect the NMC to regulate or restrict the practice of nurses whose behaviour remains liable in the future to put patients at unwarranted risk of harm.

41. The NMC therefore considers that a finding of impairment is necessary in this case to protect the public interest."

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* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

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 Miss Lake's actions did fall significantly short of the standards expected of a registered midwife, and that Miss Lake's actions amounted to breaches 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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

8 Work co-operatively

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to you practice

To achieve this, you must:

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

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

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

20 Uphold the reputation of your profession at all times.

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

In determining whether the facts found proved amounted to misconduct, the panel took into account the expert evidence of Ms McIntyre, and Mr Bowen. The panel considered the expert evidence alongside the facts found proved, the relevant provisions of the Code, and the responsibilities associated with Miss Lake's role as labour ward coordinator. The panel recognised that a breach of the expected standards does not automatically amount to misconduct. It was therefore necessary to determine whether the nature and seriousness of the failings in each charge were such that they demonstrated a falling short of what would be proper in the circumstances and whether they crossed the threshold for misconduct.

Charges 1 – 3

The panel noted Ms McIntyre's evidence at paragraphs 10.1.1 and 10.1.2 of her expert report, which explained the role of the labour ward coordinator and the process for interpreting cardiotocography (CTG) traces:

"10.1.1 The role of the labour ward coordinator in 2019, in relation to individual CTG traces, was to be a point of contact should the caring midwife have concerns or require support in interpreting a CTG trace. Usual practice was for the caring midwife to provide one-to-one care and analyse the CTG on a minimum of an hourly basis.[...]"

10.1.2 NICE (2014; 2017) provides a detailed, systematic methodology for analysing each of the four features of a CTG trace, which results in an overall categorisation of normal, suspicious, or pathological. There are then further instructions on what actions should be taken depending on the categorisation, which range from 'no additional action required' (normal categorisation) to an urgent review by the obstetric team (pathological)."

The panel considered this evidence important in establishing the professional responsibilities against which Miss Lake's conduct had to be assessed. It recognised that, although the labour ward coordinator's role was not necessarily to undertake the caring midwife's ongoing CTG assessments, it carried a responsibility to provide appropriate support and oversight where concerns arose. The panel considered that this responsibility required Miss Lake, as a senior midwife, to recognise when a CTG trace was abnormal and to ensure that appropriate action was taken. The distinction between a normal, suspicious and pathological trace was material because each categorisation required a different clinical response. The panel was satisfied that recognising a pathological trace and ensuring urgent obstetric review were not matters of discretion once the relevant clinical features had been identified; they were necessary steps in responding safely to potential fetal compromise.

In relation to Charge 1, the panel considered Ms McIntyre's evidence at paragraphs 10.1.3 and 10.1.4 of her report, in which she stated:

“10.1.3 According to her witness statement, Midwife Lake reviewed the CTG trace remotely from the computer room shortly after 23:32, when she was informed that was fully dilated, and categorised the CTG as normal. In my opinion, there were variable decelerations with concerning characteristics (reduced variability within the deceleration) in over 50% of contractions for the last 30 minutes. This is an abnormal feature, making the CTG trace pathological and therefore, required escalation to the obstetric team for an urgent review. In addition to this was the risk factor of meconium stained liquor, meaning there was a lower threshold for escalation to the obstetric team. In my opinion, the failure to recognise this, categorise the CTG as pathological, and request a review from the obstetric team fell far below the standard expected of any reasonably competent registered midwife.

10.1.4 My reasoning that this fell far below rather than below is that Midwife Lake categorised the CTG as normal, which is vastly different to pathological, and is a significant departure from the NMC Code (2018) point 13.1. The failure to recognise the CTG trace as pathological had the potential to cause actual harm.”

The panel accepted Ms McIntyre’s evidence that the CTG features present at this time required the trace to be categorised as pathological and an urgent obstetric review to be requested. It considered that the difference between the categorisation Miss Lake made and the categorisation identified by the expert was significant. The categorisation of the trace as normal indicated that no additional action was required, whereas a pathological categorisation required urgent escalation. The panel considered that recognising and categorising the CTG as pathological was fundamental to the safe management of labour.

The panel considered that meconium-stained liquor, as identified by Ms McIntyre in Paragraph 10.1.3, was an additional risk factor. Ms McIntyre’s evidence explained that there was a lower threshold to request a review from the obstetric team. The panel was satisfied that the clinical circumstances, meconium-stained liquor and CTG abnormalities called for prompt obstetric involvement, rather than reassurance that the trace was normal as asserted by Miss Lake.

The panel accepted that the categorisation of a pathological trace as normal represented a substantial departure from the standard of practice described in the expert evidence and

the requirement under the Code to recognise and respond to worsening conditions. The panel considered that the significance of the failure lay not only in the incorrect assessment itself, but also in the resulting absence of the urgent clinical review that the trace required. This created a risk that developing fetal compromise would not be identified and acted upon in a timely manner.

The panel was therefore satisfied that the failures established by Charge 1 were serious. It concluded that Miss Lake's failure to recognise and categorise the CTG as pathological, together with her failure to request an obstetric review, fell significantly below the standards expected of a registered midwife and amounted to misconduct.

In relation to Charge 2, the panel considered Ms McIntyre's evidence at paragraphs 10.1.5–10.1.7 of her report which stated:

"10.1.5 At 01:18, Midwife Lake attended Pnt. A to complete a "coordinator's ward round" and categorised the CTG as "suspicious but acceptable at this stage as the fetal heart decelerated during a contraction but returned to normal after the contraction. In my opinion, the CTG remained pathological and had worsened, with a baseline above 160bpm, and a baseline variability of between 5 and 25bpm and variable decelerations with concerning characteristics (reduced variability within the deceleration) in over 50% of contractions for the last 30 minutes. Urgent escalation to the obstetric team was required.

10.1.6 Midwife Lake failed to recognise the CTG trace as pathological and therefore, did not escalate this to the obstetric team. The NMC Code (2018) point 13.1 highlights the role of the clinician in accurately identifying worsening conditions. In my opinion, the failure to recognise this, categorise the CTG as pathological, and request a review from the obstetric team fell far below the standard expected of any reasonably competent registered midwife.

10.1.7 My reasoning that this fell far below rather than below is that, as a senior midwife, it was the responsibility of Midwife Lake to recognise the CTG trace as pathological and to take into account the low threshold for intervention, given the additional risk factors of prolonged rupture of membranes, meconium stained liquor,

and slow progress in the second stage. By agreeing with the categorisation of the CTG trace provided by Ms Karolia, she provided false reassurance that the CTG was normal for the stage of labour.”

The panel accepted Ms McIntyre’s evidence that the CTG remained pathological at 01:18 and that the need for escalation had become more pressing as the trace worsened. It considered this important because Miss Lake was not assessing the trace in isolation from the preceding clinical circumstances. The evidence indicated that the abnormalities had persisted and that the additional risk factors remained relevant. The panel concluded that the appropriate response required recognition of the continuing risk and action to obtain an urgent obstetric review.

The panel accepted Ms McIntyre’s evidence that the description of the trace as “suspicious but acceptable at this stage” provided false reassurance. In the panel’s view, the categorisation suggested that the trace could be accepted in the circumstances, when the expert evidence of Ms McIntyre established that it remained pathological and required urgent escalation. The panel considered that this could discourage or delay the intervention needed to address the risk of fetal compromise.

The panel determined that given Miss Lake’s seniority, experience and her role as labour ward coordinator, she would have been expected in the circumstances to recognise the significance of the CTG abnormalities and ensure that the appropriate response followed. The additional risk factors identified by Ms McIntyre of *‘of prolonged rupture of membranes, meconium stained liquor, and slow progress in the second stage’*, made it particularly important that the trace was not viewed in isolation or treated as acceptable merely because the fetal heart rate returned to its previous level after a contraction.

The panel further considered that the failure identified in Charge 2 was particularly serious because, by 01:18, the CTG continued to demonstrate pathological features and had worsened. The panel considered that the significance of this evidence lay in the need for Miss Lake to recognise the deteriorating clinical picture and respond accordingly. It was not simply a question of how the CTG was described, but whether Miss Lake recognised the significance of the abnormalities and took the action required in response. The panel attached particular weight to Ms McIntyre’s evidence that, given Miss Lake’s senior role

and the additional risk factors present, she was responsible for recognising the pathological trace and ensuring that an urgent obstetric review was requested. The panel therefore concluded that the failure to recognise and categorise the CTG as pathological, and to request a review from the obstetric team, fell far below the standard expected of a reasonably competent registered midwife and amounted to misconduct.

In relation to Charge 3, the panel considered Ms McIntyre's evidence at paragraphs 10.1.8–10.1.10 of her report which stated:

“10.1.8 Midwife Lake returned to the room at 01:40 and observed Pnt. A pushing. She informed Ms Karolia that she would inform the obstetric team that Pnt. A needed a review but that they were busy with another woman. Midwife Lake states that she then left the room and informed Dr Sharp of the need to review and then returned to update Pnt. A and [Mr 1]. There is no documented CTG assessment by Ms Lake at this time, however, In the transcription from the inquest she states that she informed Dr Sharp that the CTG was suspicious. In my opinion, the CTG remained pathological and required urgent escalation to the obstetric team for a review.

10.1.9 Whilst Midwife Lake states she did inform Dr Sharp of the suspicious CTG, Dr Sharp has no recollection of this. As Dr Sharp was busy with another emergency situation at the time it was the role of Midwife Lake to escalate to another member of the obstetric team for review, namely the obstetric consultant. Furthermore, Midwife Lake confirms in the transcript that she recognised that Pnt. A needed an assisted birth. In my opinion, the failure to escalate Pnt. A care to the obstetric consultant on call fell far below the standard expected of any reasonably competent registered midwife.

10.1.10 My reasoning that this fell far below rather than below is that, as a senior midwife, it was the responsibility of Midwife Lake to recognise that she needed to escalate Pnt. A care to the consultant obstetrician at 01:50 and to do so. had the potential to cause actual harm.”

The panel considered that the central issue in Charge 3 was whether Miss Lake had taken sufficient steps to secure an urgent obstetric review, given the continuing pathological CTG. It accepted Ms McIntyre's evidence that, as Dr Sharp was occupied with another emergency, Miss Lake should have escalated the concerns to another appropriate member of the obstetric team, namely the obstetric consultant. The panel considered that an attempt to contact an unavailable clinician was not sufficient where an urgent review remained necessary.

The panel also considered the evidence that Miss Lake had recognised the need for an assisted birth. The panel considered that recognising the need for an assisted birth should have reinforced the need to escalate to the obstetric consultant, particularly in circumstances where the CTG remained pathological.

The panel took into account that there was no documented CTG assessment by Miss Lake at this time and that Dr Sharp did not recall being informed of the concerns. However, the panel considered that the key issue was whether Miss Lake had taken sufficient steps to secure an urgent obstetric review. Given that Dr Sharp was occupied with another emergency, the panel considered that Miss Lake should have escalated the concerns to the obstetric consultant to ensure that Patient A received the necessary assessment without further delay.

The panel considered Miss Lake's senior role as labour ward coordinator, the continuing pathological CTG and the need for an obstetric review. It concluded that these circumstances required effective escalation to an appropriately qualified obstetric clinician. The failure to secure that review exposed Patient A and her baby to the risk of delay in receiving necessary assessment and intervention. The panel therefore determined that the failure established by Charge 3 fell far below the standard expected of a reasonably competent registered midwife and amounted to misconduct.

With regards to charges 1 – 3, the panel also took into account Mr Bowen's evidence which stated:

"In my opinion, when considered cumulatively, the failures by both Midwife Karolia and Midwife Lake to correctly categorise the CTG and to escalate concerns for

urgent obstetric review represent a serious and sustained failure in basic intrapartum care. These were not isolated lapses but a pattern of omissions occurring over a prolonged period in the presence of a progressively abnormal CTG with a clear trajectory of deterioration.

The CTG from approximately 22:50 hours onwards demonstrates features that are inconsistent with a normal or reassuring trace, including a sustained rise in baseline and recurrent decelerations. From this point, the trace indicates evolving fetal compromise. The persistence of these abnormalities over several hours, without recovery, would have been readily apparent to a reasonably competent midwife, and the associated risk of fetal hypoxia and serious harm would have been obvious. In those circumstances, the failure to recognise the CTG as abnormal and to escalate appropriately represents a marked departure from fundamental principles of safe practice, namely the requirement to identify potential fetal compromise and act without delay. This failure to escalate is particularly significant, as escalation is the primary mechanism by which deteriorating fetal well-being is addressed in labour.

Taken together, the repeated misclassification of the CTG as reassuring, combined with the absence of timely escalation despite ongoing abnormalities, amounts to a gross failure in basic care. The clinicians did not need to diagnose pathology with precision; rather, they were required to recognise that the CTG was not normal and indicated increasing risk, and to act accordingly.”

The panel considered Mr Bowen’s evidence relevant to the seriousness of the failures identified in Charges 1–3. It considered that the persistence and progression of the CTG abnormalities demonstrated a developing clinical risk, rather than isolated concerns. The panel regarded it as particularly significant that Miss Lake was not required to diagnose the precise pathology but was expected to recognise that the trace was not reassuring and ensure timely obstetric review. It considered this a fundamental aspect of safe midwifery practice, particularly given Miss Lake’s senior role as labour ward coordinator.

The panel took this evidence into account when assessing the significance of the individual failures established by each charge. It concluded that those failures involved not

simply shortcomings in CTG interpretation, but a failure to respond appropriately to the developing clinical concerns. Having considered the circumstances of each charge alongside the wider clinical context, the panel determined that each of Charges 1–3 fell far below the standard expected of a reasonably competent registered midwife and amounted to misconduct.

Charge 4

The panel considered Ms McIntyre's evidence at paragraphs 10.1.11 of her report which stated:

"10.1.11 At 02:10, Ms Karolia states in her witness statement that she informed Midwife Lake of her concerns regarding the changes on the CTG trace and lack of progress, and that she was told that Dr Sharp was assisting with a birth in another room."

The panel considered that the significance of this evidence was that concerns about Patient A's clinical condition and progress had been expressly brought to Miss Lake's attention. In the context of the preceding concerns and the need for timely obstetric input, the panel considered that Miss Lake was required to take appropriate steps to secure a review by an obstetric consultant. The fact that Dr Sharp was occupied did not remove the need for escalation; rather, it required Miss Lake to identify an alternative means of obtaining the necessary review.

The panel considered that, as a senior midwife and labour ward coordinator, Miss Lake was expected to respond appropriately when concerns were raised and ensure that they reached a clinician able to assess Patient A's condition. The panel concluded that her failure to seek a review from an obstetric consultant fell far below the standard expected of a reasonably competent registered midwife and amounted to misconduct.

Charge 6

The panel considered Ms McIntyre's evidence at paragraphs 10.3.1 of her report which stated:

“Midwife Lake had involvement with Pnt. A and [Mr 1] on at least three occasions during the second stage of Pnt. A labour. The first was at 01:18, and she documented her review on the electronic system. Midwife Lake then returned to the room at 01:40 and 01:50, but did not document this within the electronic records. 10.3.2 NMC Code (2018) points 10.1, 10.2 and 10.4 describe appropriate record keeping standards for midwives and nurses. In my opinion, the failure of Midwife Lake to document her involvement in Pnt. A care fell below the standard expected of any reasonably competent registered midwife.”

The panel recognised that accurate record keeping is a fundamental professional responsibility, supporting continuity of care and enabling clinicians to understand the assessments undertaken, decisions made and actions taken.

The panel considered the omission of records at both times to be a failure to meet the expected standard. It did not regard the absence of documentation as trivial, particularly given the clinical circumstances in which Miss Lake was involved in Patient A’s care. However, the panel distinguished between establishing that a professional standard had been breached and determining whether that breach was sufficiently serious to amount to misconduct.

In reaching its decision, the panel considered the specific nature of the allegation and the extent of the failing established. It concluded that, although the omissions were a matter of professional concern, the failure to document the record on two occasions does not demonstrate a sufficiently serious departure from the expected standards to amount to misconduct. The panel agreed with Ms McIntyre fell below the standard expected but not far below.

The panel therefore determined that Charge 6 fell below the standard expected of a reasonably competent registered midwife but did not, on its own, amount to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

The panel determined that limbs a – c of the “test” were engaged and that limb d was not relevant.

Miss Lake’s misconduct had placed Patient A and her baby at risk of harm. The panel considered that the failures to recognise and appropriately categorise the CTG traces as pathological, and to secure timely obstetric review, were serious clinical failings. The panel considered that these responsibilities were fundamental to safe midwifery practice and were not peripheral aspects of Miss Lake’s role. As a senior midwife acting as labour ward coordinator, Miss Lake was expected to recognise deviations from the normal CTG pattern, appreciate their significance and ensure that appropriate action was taken. The repeated nature of the failures, over a period of more than two hours, demonstrated the significance of the concerns about Miss Lake’s practice. The panel was satisfied that the conduct had exposed Patient A and her baby to an unwarranted risk of harm.

Miss Lake’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. As an experienced midwife, she was expected to recognise and accurately interpret CTG findings, identify signs of fetal deterioration and escalate concerns promptly to ensure that appropriate clinical intervention could be considered. The panel considered that these failures went to the heart of Miss Lake’s professional responsibilities to prioritise patient safety, exercise sound clinical judgement and seek appropriate assistance when a situation falls outside, or is beyond, the safe management of her own practice.

In considering whether Miss Lake is liable in the future to act so as to put a patient or patients at unwarranted risk of harm, breach fundamental tenets of the profession or bring the profession into disrepute the panel went onto consider the factors as set out in the case of *Cohen* such as insight, remorse and remediation.

Regarding insight, the panel noted that the material before it included extracts from a statement by Miss Lake's dated 29 November 2022, reproduced in Ms McIntyre's report at paragraph 8.3.7 as set out below. The panel recognised that this statement had not been prepared specifically for the purpose of addressing insight or remediation in these proceedings and the panel did not have sight of Miss Lake's full statement. It nevertheless went onto consider whether any of the extracts, highlighted by Ms McIntyre, evidenced insight by Miss Lake. In paragraph 8.3.7, the extract from Miss Lake states:

"...On reflection and on reviewing the notes I can see that there were some instances where the care I provided could have been better and for that I am truly sorry. I believe I did not interpret Pnt. A's CTG accurately and underestimated the deterioration of the CTG during the second stage of labour and I should have escalated concerns much earlier to Dr Cianter as Dr Sharp was busy with other deliveries and Pnt. A was a high risk case with poor progress in the second stage...."

The panel noted that Miss Lake acknowledged that she had not interpreted Patient A's CTG accurately, had underestimated its deterioration and should have escalated her concerns earlier. The panel considered that this demonstrated some recognition, at that time, of shortcomings in her practice. However, the panel considered that the extract did not address the misconduct found proved in these proceedings in sufficient detail to demonstrate insight. In particular, it did not fully demonstrate Miss Lake's understanding of her role and responsibilities in the failings identified and the significance of those failings.

The panel had not been provided with any further evidence from Miss Lake demonstrating her current insight into the seriousness of her misconduct or her understanding of what she should have done differently to avoid similar failings in the future. Nor had it been provided with evidence of any subsequent reflection, remorse or steps taken to strengthen

her practice. The panel therefore considered that, while the extract demonstrated some acknowledgement of failings, it was insufficient to establish insight into the misconduct found proved. The panel was also concerned that the extract from this statement is approximately four years old and does not illustrate Miss Lake's current level of insight.

The panel next considered whether the misconduct was capable of being remedied. It determined that it was. The concerns related to clinical knowledge, recognition and interpretation of CTG traces, and the need to escalate concerns appropriately. These are matters that can, in principle, be addressed through reflection, relevant training and demonstrated changes to professional practice.

However, the panel found no evidence that Miss Lake had taken steps to remedy the concerns identified. In relation to Miss Lakes training compliance at the time of the incident, the panel noted from the second coroner's statement by the Consultant Obstetrician of the Trust, Dr Kelly Cohen, dated 1 March 2022 which states:

"One midwife (Yvette Lake) had completed all six chapters of K2 teaching, but had not attended the annual CTG teaching. This was three months overdue but had been completed in September 2018. The content of the teaching had not altered."

The panel was concerned that there is no evidence of subsequent training or other steps taken to strengthen her practice in response to the serious concerns arising from this misconduct.

In the absence of evidence demonstrating meaningful reflection or insight, remediation or an understanding of how to avoid similar failings in the future, the panel could not be satisfied that the concerns had been addressed.

The panel therefore considered that there remained a risk of repetition. Given the seriousness of the clinical failings, the fundamental importance to safe midwifery practice of CTG interpretation and escalation, and the absence of evidence that Miss Lake had remedied the concerns, the panel could not be satisfied that she would practise safely and effectively without restriction.

The panel determined that a finding of impairment was necessary on the grounds of public protection.

The panel bore in mind 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 considered that the misconduct concerned fundamental aspects of midwifery practice. The ability to recognise and appropriately interpret CTG traces, identify potential fetal compromise and ensure timely escalation is central to the safe care of women and their babies during labour. The panel considered that these responsibilities assume particular importance where a midwife is experienced and undertaking the role of labour ward coordinator, with responsibility for providing oversight and support to other midwives.

The panel considered that members of the public are entitled to expect that an experienced midwife undertaking the labour ward coordinator role will recognise when a CTG trace is not reassuring and will ensure that the appropriate obstetric team is involved when necessary. The panel reminded itself that midwives occupy a position of privilege and trust in society and are expected at all times to be professional. The repeated failures identified in this case fell significantly below that expectation. The misconduct involved the failure to interpret a trace as pathological, a failure to escalate the clinical concerns and action required to address the risk.

The panel considered that, in these circumstances, public confidence in the profession would be undermined if a finding of impairment were not made. A member of the public, aware of the findings, would reasonably expect a senior midwife who had demonstrated such serious failings in a fundamental area of clinical practice to be subject to a finding that her fitness to practise was impaired. To reach any other conclusion would risk conveying that such conduct was compatible with unrestricted practice and would fail to uphold the standards expected of the profession.

The panel concluded that public confidence in the profession would be damaged if a finding of impairment were not made in this case and therefore also finds Miss Lake's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Miss Lake's registration has been suspended.

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

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Miss Lake that it would seek the imposition of a suspension order for a period of 12 months if it found Miss Lake's fitness to practise currently impaired.

The panel had regard to the NMC's statement of case in which it submitted:

"42. The NMC considers the appropriate and proportionate sanction in this case to be a 12-month suspension order with a review.

43. The aggravating factors in this case include:

- Failures across fundamental areas of clinical practice*
- Risk of actual physical harm due to poor escalation*
- Limited evidence of remediation, remorse and insight.*

44. *There are no mitigating factors in this case.*

45. *Considering the facts of this case in line with the available sanctions in ascending order of seriousness:*

Taking no further action

46. *The NMC guidance on taking no further action (SAN-2a) states that a panel has a discretion to take no further action after a finding of impairment but will only use that discretion rarely. It is submitted that there are no exceptional features in this case that would warrant taking no further action and given the seriousness of the concerns, this would not be sufficient to protect the public, maintain standards, or maintain confidence in the NMC as a regulator.*

Caution Order

47. *The NMC guidance on caution orders (SAN-2b) states that a caution order is only appropriate if there is no risk to the public or patients, and the case is at the lower end of the spectrum of impaired fitness to practise. As there is no evidence that Ms Lake has sufficiently remediated the concerns, it is submitted that there is still a risk of harm to patients. As such, a caution order would not be sufficient to protect the public or satisfy the public interest considerations.*

Conditions of Practice Order

48. *The NMC guidance on conditions of practice orders (SAN-2c) states that the key consideration when looking at whether conditions of practice may be appropriate is whether conditions can be put in place that would be sufficient to protect patients and address public confidence in the profession and the NMC.*

49. *A conditions of practice order would not be appropriate as Ms Lake has not provided any evidence of insight, reflection, strengthened practise. Ms Lake has retired from the profession since 2021[sic], and therefore may not be in a position to provide evidence relating to her practise. However, this does not preclude Ms Lake from providing evidence of insight and remorse. There is an ongoing risk to the health, safety and well-being to the public, albeit Ms Lake is in retirement. The concerns in this case are serious and without evidence to mitigate the seriousness of the concerns, this case falls within the higher end of the spectrum. Furthermore,*

there is no evidence to suggest Ms Lake is willing to abide by conditions. Therefore, it is submitted that a conditions of practice order is not appropriate in this case.

Suspension Order

50. The Guidance (SAN-3d) states that a suspension order may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- 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.*

51. The concerns in this case are serious. The charges are at the most serious end of the spectrum and call into question Ms Lake's suitability to continue practising. There is no evidence that Ms Lake has insight into her conduct, or that she has undertaken sufficient remediation, therefore only a period out of practice would be sufficient to allow her to fully strengthen her practice.

52. NMC guidance at SAN-4 "Sanctions for highest risk cases" indicates that some concerns are higher risk because it is harder for the professional to put the matter right such as being directly responsible for exposing people receiving care to harm

or neglect. 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.

53. A suspension order is therefore appropriate as the conduct in this case is compatible with continued registration.”

Decision and reasons on sanction

Having found Miss Lake'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 panel had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026). 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 placed a patient receiving care at a real risk of significant harm
- Miss Lake's failures occurred in fundamental areas of clinical practice expected of a registered midwife
- Absence of evidence of remediation and insight in relation to the misconduct found proved.

The panel did not find any evidence of mitigating features in this case. It acknowledged that Miss Lake had completed a CMF dated 6 March 2026, in which she provided some information about her circumstances and indicated that she had retired from midwifery practice. However, the panel did not consider that this constituted mitigation. The panel had no further evidence before it of personal or professional mitigation that it could properly take into account.

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 Miss Lake’s misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Miss Lake’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 placing conditions of practice on Miss Lake’s registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *‘Conditions of practice order’* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *‘no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional’s practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.’*

The panel considered that conditions of practice may be appropriate where identifiable deficiencies can be addressed through retraining or supervision and there is evidence that the professional is willing and able to engage with the necessary measures.

In Miss Lake's case, the panel had no evidence of remediation or sufficient insight into the misconduct found proved. Although the concerns were potentially capable of remediation, the panel had insufficient evidence to formulate conditions that could be appropriately monitored and assessed or to establish that Miss Lake would engage with them.

The panel therefore concluded that a conditions of practice order would not be appropriate or sufficient to address the concerns identified. In addition, the panel concluded that a conditions of practice order did not meet the wider public interest considerations in this case.

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

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

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

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

- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel recognised that the misconduct was serious. Miss Lake was an experienced midwife, and the failures found proved concerned fundamental aspects of midwifery practice, including the interpretation of the CTG and the timely escalation of concerns during the second stage of labour. The panel considered that these failures gave rise to a significant risk to patient safety and required a serious regulatory response.

However, the panel was satisfied that the misconduct was capable of remediation and was not fundamentally incompatible with Miss Lake remaining on the register. It considered that the concerns related to deficiencies in clinical practice that could potentially be addressed through appropriate professional development, reflection and training.

The panel acknowledged that there was no evidence before it demonstrating that Miss Lake had undertaken remediation or developed insight into the misconduct. It had carefully considered the limited information she had provided and recognised that the absence of evidence of insight was a significant concern. However, the panel distinguished between an absence of evidence of insight and a finding that Miss Lake was incapable of developing insight or remedying the deficiencies identified.

The panel also considered Miss Lake's brief indication that she has retired from midwifery practice and had provided limited information about her future intentions. It accepted that this created uncertainty about whether she would seek to return to practice and undertake remediation. However, it considered that the appropriate sanction must be determined by reference to the misconduct found proved and the public interest, rather than solely by reference to Miss Lake's current employment status or stated intentions.

The panel considered that a period of suspension would provide Miss Lake with a further opportunity to reflect on the misconduct found proved, take steps to address the concerns identified and strengthen her professional practice, should she wish to return to midwifery practice in the future.

The panel concluded that a suspension order would protect the public by preventing Miss Lake from practising as a registered midwife during the period of suspension. It would also mark the seriousness of the misconduct and maintain public confidence in the profession and the regulatory process.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. The panel recognised the seriousness of the misconduct and the absence of evidence of remediation or insight. It also acknowledged the concerns arising from Miss Lake's limited engagement with the proceedings and that she is currently retired. However, the panel did not consider that the misconduct was fundamentally incompatible with continued registration. The panel considered that, although the misconduct was serious, it arose from failures in clinical practice that were potentially capable of remediation. The panel also considered the importance of ensuring that the sanction was proportionate to the findings made. It did not consider that the absence of evidence of remediation or Miss Lake's retirement, in themselves, established that she was incapable of addressing the concerns or that removal from the register was necessary.

Therefore, the panel concluded that a striking-off order would be disproportionate.

The panel determined that a suspension order would provide an appropriate and sufficiently serious response to the misconduct while allowing the possibility of future remediation to be considered should Miss Lake seek to return to practice.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Miss Lake's case to impose a striking-off order at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the potential hardship such an order could inevitably cause Miss Lake should she wish to return to practise. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was necessary to mark the seriousness of the misconduct and maintain public confidence in the profession. It considered that this period would also allow Miss Lake a sufficient opportunity, should she wish to return to practice, to reflect on the misconduct, develop her insight and undertake relevant professional development and remediation.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective statement addressing the specific charges found proved, the failings in clinical practice identified and the potential consequences for patients.
- Evidence of relevant professional development and training, particularly in CTG interpretation, the recognition of fetal deterioration, escalation of concerns and the management of clinical risk.
- Evidence of any other steps taken to address the concerns identified and demonstrate insight and remediation.
- Relevant references or testimonials from employers, supervisors or other appropriate persons, including in any paid or voluntary role, where available.
- An updated statement setting out Miss Lake's intentions regarding her future in the midwifery profession.

This will be confirmed to Miss Lake in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC which stated:

"54. If a finding is made that Ms Lake's fitness to practise is impaired on a public protection and public interest basis and a suspension order imposed, the NMC invites the panel to impose an 18 month interim suspension order to be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest. This is because any sanction imposed by the panel would not come into immediate effect but only after the expiry of approximately 28 days after the sending of the decision letter or after any appeal is resolved. If an interim order were not imposed and Ms Lake lodged an appeal, she would be able to practise unrestricted until the conclusion of the appeal."

Decision and reasons on interim order

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

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

suspension order for a period of 18 months due to allow for the possibility of an appeal and to ensure that public protection and the public interest were maintained during the period that any appeal may be dealt with if lodged.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Miss Lake is sent the decision of this hearing in writing.

That concludes this determination.