

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

**Substantive Hearing
Monday, 28 September 2026 – Friday, 2 October 2026
Monday, 5 October 2026 – Friday, 9 October 2026**

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

Name of Registrant:	Glenys Wood
NMC PIN:	97H0258E
Part(s) of the register:	Midwives part of the register RM: Midwife (21 August 2000)
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, Lay member) Zeenath Uddin (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Elizabeth Fagbo (28 September 2026 – 8 October 2026) Stanley Udealor (9 October 2026)
Nursing and Midwifery Council:	Represented by Iwona Boesche, Case Presenter
Mrs Wood:	Not present and unrepresented at the hearing
Facts proved:	Charges 1a, 1a(i), 1a(ii), 1a(iii), 1a(iv), 1b, and 4
Facts not proved:	Charges, 2a, 2b, 2c and 3a, 3b and 3c
Fitness to practise:	Impaired

Sanction:

Striking-off order

Interim order:

Interim suspension order (18 months)

Final outcome:

FTP impaired – striking off order

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Wood was not in attendance and that the Notice of Hearing letter had been sent to Mrs Wood's registered email address by secure email on 27 August 2026.

Ms Boesche, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing and, amongst other things, information about Mrs Wood's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Wood has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Wood

The panel next considered whether it should proceed in the absence of Mrs Wood. It had regard to Rule 21 and heard the submissions of Ms Boesche who invited the panel to continue in the absence of Mrs Wood. She submitted that Mrs Wood had voluntarily absented herself.

Ms Boesche submitted that Mrs Wood had ceased to engage with the NMC and she had made the decision to disengage from these proceedings. She had applied for agreed removal from the register, which had been refused. Ms Boesche submitted that as a

consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor who referred the panel to the test in paragraph 15 of *General Medical Council v Adeogba* [2016] EWCA Civ 162. This was whether Mrs Wood had deliberately chosen not to exercise her right to be present or to give adequate instructions to enable lawyers to represent her.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised ‘*with the utmost care and caution*’ as referred to in the case of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Wood. In reaching this decision, the panel has considered the submissions of Ms Boesche, the NMC proceeding in absence bundle containing correspondence from Mrs Wood and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Wood has informed the NMC of her intention to disengage from these proceedings.
- No application for an adjournment has been made by Mrs Wood;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 10 witnesses are scheduled to attend this hearing to give live evidence,
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Wood in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no formal response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Wood's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Wood. The panel will draw no adverse inference from Mrs Wood's absence in its findings of fact.

Details of charge

1. On 13 September 2023:
 - a. Knowing that Patient A had attended the Hospital with vaginal bleeding:
 - i. Improperly delegated the taking of initial observations of the patient to a maternity support worker ('MSW')
 - ii. Failed to review the observations taken by the MSW
 - iii. Failed to respond to requests for help made by Patient A's family
 - iv. Incorrectly told Colleague C that Patient A was being triaged by Colleague A
 - b. Went on a break wearing a notice to that effect, without ensuring that Patient A had not been triaged.

2. On 14 September 2023:

- a. Asked Colleague D to record on BadgerNet an incorrect admission time of Patient A
- b. Asked Colleague E to record on BadgerNet an incorrect admission time of Patient A
- c. Allowed Colleague E to use your login details to record the admission time

3. Your conduct as specified in charge 2 was dishonest in that you:

- a. Knew the time to be incorrect
- b. Knew that it was wrong to record an incorrect admission time
- c. Intended that any reader of the records would believe that Patient A's admission had taken place later than it actually had.

4. Your conduct as specified in charges 1ai and/or 1aii and/or 1aiii and/or 1aiv resulted in the loss of a chance of survival for Baby A

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

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

At the outset of the hearing Ms Boesche, on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partially in private on the basis that proper exploration of the linked cases of Mrs Wood and Miss Duignan (Colleague C), 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 Mulhern, on behalf of Rachel Smedley (Miss Smedley), did not oppose this application.

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.

The panel determined to go into private session as and when matters relating to [PRIVATE], in order to protect their right to privacy.

Decision and reasons on application to admit hearsay evidence of Sharon Anderson

The panel heard an application made by Ms Boesche under Rule 31 to allow the written statement and exhibits of Sharon Anderson (Ms Anderson) into evidence. She referred the panel to an email dated 23 February 2026 from Ms Anderson to the NMC case officer which detailed the reason for her non-attendance at this hearing:

'...[PRIVATE]

I appreciate the offer of support but I already have this. I cannot move on and focus on my personal or professional life whilst I keep being asked about the events of that night.

I was previously told by the NMC they understood this and I would not be asked to attend the hearings. Please can this remain the case?...

Ms Boesche submitted that the statement and exhibits of Ms Anderson are relevant to charges, particularly charge 2 in relation to Mrs Wood. She submitted that the evidence also provides a helpful explanation of the IT system BadgerNet.

Ms Boesche submitted that Miss Smedley and her representative have had sight of these documents prior to this hearing and therefore, there is no prejudice in admitting this evidence. She submitted that the evidence is not sole and decisive and that in due course, the panel will hear from other colleagues in relation to events within the charges.

Ms Boesche submitted that Miss Smedley is the only registrant present at this hearing and is represented. However, Mrs Wood and Miss Duignan have disengaged with these

proceedings and therefore, cannot put questions to this witness. Further, she submitted that, Ms Mulhern, on Miss Smedley's behalf, has indicated there will be no objection to the admission of this evidence. Therefore, Ms Boesche submitted that it is in the public interest, to admit the evidence of Ms Anderson and it would not be prejudicial to do so.

Ms Mulhern submitted that she did not oppose this application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to admitting the evidence of Ms Anderson serious consideration. The panel noted that Ms Anderson's evidence and respective statements had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement ... is true to the best of my information, knowledge and belief' and signed by her. It took into account Ms Anderson's reasons for not attending this hearing in the email dated 23 February 2026 and noted that it was not helpful that it was not helpful that the NMC had stated in an email dated 22 October 2024 that she could sign her statement and *'that would be the extent of your involvement with this case, there would be no expectation for you to attend a hearing'*.

The panel determined that Ms Anderson's statements and exhibits are not the sole or decisive evidence in respect of this case, as there are nine other witnesses scheduled to give evidence at this hearing. The panel also determined that these statements address serious, alleged conduct and therefore they provide wider contextual information relevant to the matters. In relation to the risk of fabrication, the panel was of the view that the evidence and statements of Ms Anderson were obtained during a formal investigatory process and were reliable as they were consistent with contemporaneous documentation, and there was no reason to think that she might be mistaken. She was not the subject of

any criticism and so had no reason to be other than completely truthful, and there was no suggestion that any of her evidence was fabricated.

The panel noted that there was no medical evidence to support the application and took this into account. It also took into account that as a registrant Ms Anderson had a professional obligation to attend if asked.

The panel considered whether Mrs Wood would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms Anderson to that of allowing hearsay testimony into evidence. The panel considered that as Mrs Wood had been provided with a copy of Ms Anderson's evidence and respective statement, she would have been in a position to cross-examine her had she attended. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC would be deprived, as would the panel, from reliance upon the live evidence of Ms Anderson and the opportunity of questioning and probing that testimony.

However, it noted that Ms Mulhern did not seek to challenge this evidence, and there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that the evidence and statement of Ms Anderson was relevant and that it would be fair to admit them as hearsay evidence. The panel was mindful that this would be hearsay evidence, and that it would consider what weight it deemed appropriate to give to the evidence when it reached the stage at which it would evaluate all the evidence before it.

The panel granted the application.

Background

On 10 July 2024, the NMC received a referral from Patient A, mother of Baby A, in relation to the events which took place between 13 and 14 September 2023, whilst Miss Smedley was working a night shift as a midwife in the telephone triage department at Kings Mill Hospital ('the Hospital') of Sherwood Forest NHS Foundation Trust ('the Trust').

Patient A was a first-time mother at 41 weeks gestation and began having contractions on 13 September 2023. Patient A contacted the Triage department at 19:07 and spoke to a midwife, Mrs Wood. Patient A explained that she was concerned that her membranes may have ruptured and that her contractions were increasing in frequency and severity. Mrs Wood provided advice, which was in line with guidance, but did not make a contemporaneous note of the call.

Patient A attended the Hospital thinking that she was in early labour and was seen by a midwife based on the labour ward, Ms Anderson. Patient A had planned to have a homebirth. A membrane sweep was undertaken, and Patient A was advised that there could be some blood as a result of the sweep, but she was able to go home as she was not in labour yet and to contact the Hospital once in labour and with any concerns.

It is alleged that around 00:30 Patient A was in her birthing pool when she felt hot, went to the bathroom, and after hearing a '*pop*' and noticed a large amount of blood and called the Hospital. Miss Smedley was the midwife who took the call and are said to have not accurately assessed and recognised the amount of vaginal bleeding and abdominal pain reported by Patient A. Nor were any questions asked about other maternal symptoms. It is also alleged that Miss Smedley failed to record the telephone conversation via the clinical triage note section on BadgerNet in a timely manner. The telephone conversation was allegedly recorded on the system by Miss Smedley retrospectively at around 04:00, Miss Smedley advised Patient A to attend the Hospital however Miss Smedley did not arrange admission by ambulance. Patient A lived approximately 15 minutes away and made her own way there supported by family members. It was considered that arrival by ambulance

may have alerted the midwifery team to the serious condition of Patient A but did not cause any delay in arrival.

Miss Smedley advised her colleague, Mrs Wood, that Patient A was coming back to the hospital and was bleeding vaginally. Patient A arrived at the Hospital at approximately 01:05 and was shown to a room. It is not alleged that Miss Smedley was present at the time Patient A arrived or at any time before she went to surgery. Mrs Wood and Mrs Duignan were at the reception desk at this time and the receptionist, Karen Hughes (Ms Hughes), had been on her break. Miss Smedley had been completing checks on emergency equipment elsewhere in the hospital when Patient A arrived at the hospital. It is alleged that when Ms Hughes returned from her lunch break, she was asked by Mrs Wood to log Patient A's arrival time as 01:16 but refused to do so. It is alleged that Mrs Wood then asked another colleague, Hadleigh Cox (Ms Cox), to help her record Patient A's admission time on BadgerNet.

It is alleged that there was a 37-minute delay between Patient A's arrival at the Hospital and her receiving care, despite her partner Person A, and her mother, Person B, calling out for help three times. It is alleged that the midwives (Mrs Wood and Miss Duignan) remained at the desk and were heard laughing and joking. Patient A subsequently underwent a category 1 emergency caesarean section (CS) at 02:02. Baby A passed away on the 15 September 2023. The cause of Baby A's death was hypoxic ischemic encephalopathy (brain injury caused by lack of oxygen) and acute chorioamnionitis (inflammation of the placenta and membranes).

The case was reviewed in the Coroner's Court in July and the narrative verdict was that neglect contributed to the death of Baby A.

Decision and reasons on application to admit hearsay evidence of Karen Hughes

The panel heard an application made by Ms Boesche under Rule 31 to allow the written statement of Ms Hughes into evidence. Ms Boesche referred to the panel to relevant

documents and pages. She also referred to the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* and reminded the panel that under Rule 31, the panel has the discretion to admit evidence in the proceedings, including hearsay evidence, as long as it meets the criteria of being relevant and fair.

Ms Boesche submitted that the hearsay evidence is relevant to the charges, particularly the charges against Mrs Wood and Miss Duignan as the accounts are directly related to the case. She submitted that as Mrs Wood and Miss Duignan's have absented themselves and therefore, would not be able to challenge this witness.

Ms Boesche also submitted that Ms Mulhern has also stated that she does not intend to challenge this evidence either and agreed the following on Miss Smedley behalf:

1. Witness statement of Karen Hughes was edited by agreement on 29 September 2026.
2. The Panel to take the statement in its edited form as the evidence. Any reference within the evidence as a whole which makes reference to the redacted phrases should be disregarded.
3. Miss Smedley was not at the desk at 01:10.

Ms Boesche and Ms Mulhern also agreed for redactions/amendments to be made in the following:

- The NMC witness statement bundle of Mrs Wood on page 26, paragraph eight, removing the words '*as was grateful*' and paragraph nine, removing the words '*Rachel had been in the back office.*' Also, paragraph 11 '*Glenys and Rachel*', should be amended to '*Glenys and another*'.

- The NMC witness statement bundle of Miss Smedley page 26 and paragraph eight, the words '*as was Rachel*' should be removed. Page 26 and paragraph eight, the words '*Rachel was in the back office*' should be removed. Also, on page 27, Paragraph 11 the words '*Glenys and Rachel*', should be amended to '*Glenys and another*'.
- The NMC witness statement bundle of Miss Duignan page 25, paragraph seven the words '*as was Rachel*' should be removed and on page 26 paragraph 10 the words '*Glenys and Rachel*', should be amended to '*Glenys and another*'.

Further, Ms Boesche submitted that it is in the public interest, that evidence is before the panel as it expedites the case. She submitted that the attendance of Ms Hughes would not add anything material to the case itself.

Ms Mulhern did not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to allowing the statement of Ms Hughes into evidence careful consideration. The panel determined that the statement of Ms Hughes is not the sole and decisive evidence in respect of this case, as there are nine other witnesses scheduled to give evidence at this hearing. Also, it determined that her statement provided context to the evidence. The panel was of the view that the individuals (colleagues) who made local statements did not have any reason to fabricate their statements as it reflects the evidence evaluated in the determination from the Coroner, dated 5 July 2024.

Further, the panel noted that Miss Smedley and her legal representatives would have been aware of the existence of this statement as it was included in the bundles that were sent to Miss Smedley and her representatives in advance of the hearing. The panel also noted that Ms Mulhern did not challenge this evidence, and that Mrs Wood and Miss Duignan have chosen to disengage from these proceedings and therefore, cannot cross examine or question Ms Hughes regarding her account/statement.

The panel noted that the consideration of fairness applied to both parties as well as taking into account the public interest. In these circumstances, the panel decided that it would be fair and relevant to accept the statement of Ms Hughes into evidence but would give what it deemed the appropriate weight once the panel had heard and evaluated all of the evidence before it.

Decision and reasons on application to amend the charge

The panel decided, of its own volition to amend the wording of charge 1b.

The proposed amendment was to correct a typographical error by removing the word '*not*', in order accurately reflect the evidence.

"That you, a registered nurse:

1. On 13 September 2023:

b. Went on a break wearing a notice to that effect, without ensuring that Patient A had ~~not~~ been triaged

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

Ms Boesche supported the application.

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

The panel was of the view that such an amendment was in the interest of justice because the charge as drafted was incoherent. The panel was satisfied that there would be no prejudice to Mrs Wood and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate for the amendment, as applied for, to ensure accuracy.

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 Boesche on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Wood.

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.

As Mrs Wood had not engaged with the proceedings, the panel required the NMC to adduce evidence to support the allegations. The panel would find them proved only if evidence sufficient to prove the charges was adduced by the NMC. The panel accepted the legal assessor's advice that they were obliged to subject that evidence to careful scrutiny and not accept it unquestioningly.

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

- Patient A: Mother of Baby A

- Person A: Father of Baby A
- Person B: Patient A's mother
- Paula Shore: Director of Midwifery and Divisional
Director of Nursing for Women and
Children's
- Hadleigh Cox: Maternity Support Worker
(Colleague E)
- Hollie Proskurnia: Healthcare Support Worker
- Ella Haines: Band 6 Midwife
- Anne Kabia: Elective Care Matron

The panel also took account of the witness statements and exhibits from the following witness on behalf of the NMC, which were admitted as hearsay evidence:

- Sharon Anderson: Registered Midwife (Colleague A)
- Karen Hughes: Receptionist (Colleague D)

The panel considered carefully how much weight to give to the hearsay evidence. It noted that it was, for the most part demonstrably reliable as it had been accepted by the Coroner in her inquest findings. Nor was it contradicted by any information or documentation from Mrs Wood or from anyone else with knowledge of what occurred to Patient A and Baby A at the relevant times.

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

NMC. Mrs Wood had decided not to engage with the proceedings, and so there was nothing from Mrs Wood to assist the panel in deciding upon the charges beyond material already supplied to the Trust internal investigation and the Coroner.

The Coroner having conducted an extensive judicial enquiry made findings of fact. The panel adopted those judicial findings to inform its deliberations as to the charges, while bearing in mind that the purpose of the Coroner's report was different to that of an NMC regulatory fitness to practise panel.

The panel took into account evidence that the triage function is divided between the initial telephone triage and prompt clinical face to face triage assessment when the patient has arrived. These roles are distinct and defined to help ensure that the midwife on telephone triage is always available to attend to callers because they are not engaged in hands on care.

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

Charge 1a

The stem of charge 1 is that:

“1. On 13 September 2023:

a. Knowing that Patient A had attended the Hospital with vaginal bleeding:”

The panel found that Miss Smedley, the telephone triage midwife, did not record the telephone call in the computerised BadgerNet system. However, soon after conducting the telephone triage, she informed Mrs Wood that, on her advice, Patient A would be returning to the Hospital. The reason was not because she was in labour but because she was in acute pain and was suffering vaginal bleeding, and Miss Smedley had written ‘PVB’ (meaning vaginal bleeding) on the whiteboard prior to Patient A arriving back at the Hospital.

Accordingly, the stem of charge 1 is made out. Mrs Wood was clearly informed by the telephone triage midwife that Patient A was attending the Hospital by reason of vaginal bleeding.

Charge 1a (i) – (iv)

- i. Improperly delegated the taking of initial observations of the patient to a maternity support worker ('MSW')
- ii. Failed to review the observations taken by the MSW
- iii. Failed to respond to requests for help made by Patient A's family
- iv. Incorrectly told Colleague C that Patient A was being triaged by Colleague A

Each of these subcharges is found proved.

Charge 1a(i)

- "1. On 13 September 2023:
 - a. Knowing that Patient A had attended the Hospital with vaginal bleeding:
 - i. Improperly delegated the taking of initial observations of the patient to a maternity support worker ('MSW')

In reaching its' decision, the panel took into account the documentation and interview notes of the staff obtained in the Hospital's investigation into the circumstances of that night shift. It was clear, and Mrs Wood had never disputed that, when Patient A arrived back at the Hospital soon after 01:00 she had asked that she be placed in Room 2. The MSW, Hollie Proskurnia ("Ms Proskurnia") had offered to take the basic observations of Patient A and Mrs Wood had asked her to do so. These were limited to pulse, temperature, blood pressure and respiration rate. The MSW, who gave oral evidence to the panel, said that these were normal. Mrs Wood asked no more than whether they were within normal limits and the MSW said this was so. The MSW could not find a way to

record these observations and eventually gave the piece of paper on which she had written them to a student midwife to record them on BadgerNet.

While it was not inappropriate for Mrs Wood to have assistance in triaging Patient A, the panel heard from Anne Kabia (Ms Kabia), the Elective Care Matron that *“the HCSW who undertook Patient A’s Obs should not have been alone, this was unacceptable”* and *“HCSWs are not trained to take fetal measurements, check bleeding take oxygen saturation levels, do a cardiotocograph and other such ‘higher level’ obs.”*

Although maternal observations were clinically relevant in the context of vaginal bleeding and acute pain, they were not a substitute for a timely midwifery triage assessment, including assessment of the nature and severity of bleeding, pain, maternal wellbeing and fetal wellbeing. The panel considered that Mrs Wood retained responsibility for ensuring that any delegated task was appropriate, appropriately supervised, promptly reviewed and incorporated into a full triage assessment.

Accordingly, the NMC have provided evidence to prove, on the balance of probabilities that the taking of the initial observations of Patient A was delegated to an MSW, and that it was inappropriate for her to have done so.

Charge 1a(ii)

“1. On 13 September 2023:

- a. Knowing that Patient A had attended the Hospital with vaginal bleeding:
- ii. Failed to review the observations taken by the MSW”

This charge is found proved.

In reaching this decision, the panel took into account and accepted the evidence of Ms Proskurnia. It also took into account the Coroner’s Judgment, dated 5 July 2024 and noted the following:

‘...I find it was MW Wood who asked that the Health Care Support Worker (HCSW) take Pnt. A into Room 2, and she was also asked by Ms Wood to complete the maternal observations, noted as being recorded at 01.14. I find that when completed the HCSW gave those observations to MW Wood. MS Wood explained in evidence that she thought MW Anderson was assessing Pnt. A at this time- I simply do not understand why she thought this, if that is what she thought – she had not seen MW Anderson go into the room, and she knew the HCSW had not seen MW Anderson either...’

The panel had no evidence before it that Mrs Wood had reviewed any of the observations taken by the maternity support worker of Patient A, only asking for and receiving an assurance that they were ‘ok’. The panel noted that Mrs Wood did not take the detail of the observations from Ms Proskurnia who eventually enabled them to be recorded by giving them to a student midwife.

Therefore, on the balance of probabilities the panel found charge 1a(ii) proved.

Charge 1a(iii)

“1. On 13 September 2023:

- a. Knowing that Patient A had attended the Hospital with vaginal bleeding:
- iii. Failed to respond to requests for help made by Patient A’s family”

This charge is found proved.

In reaching this decision, the panel took into account the Coroner’s Judgment, dated 5 July 2024, specifically the following:

‘...I accept, both Pnt. A Psn. A and mother called out or came out of the Room 2 door, which remained open, on 2 or 3 occasions, to ask for help.

MW Wood's evidence is that she remained sitting at the desk from 01.05 to 01.35, but she says she did not hear or see the family at all. The distance from the end of the desk to the Room 2 door, is only some 4m I understand, the unit was quiet, with no further Triage patients expected or in the Triage assessment rooms...'

The panel also took into account the oral evidence of Patient A, Person A, and Person B, all of whom stated clearly that both Patient A's partner and mother (Persons A and B) had called out for help several times. The panel accepted the evidence of Person A that he was both loud and vocal in calling for help, and the evidence of all the witnesses (by reference to a detailed diagram of the triage ward) that there was only a short distance between Room 2, where Patient A was, and the midwives' station. Having considered the proximity of Room 2 to the midwives' station, the evidence that the unit was quiet, the number and volume of the requests for help described by the witnesses, and the absence of evidence of any competing emergency, the panel was satisfied on the balance of probabilities that the requests for assistance were audible to Mrs Wood and that she failed to respond appropriately.

The panel accepted the evidence of the witnesses as follows:

Patient A stated the following in her written statement dated 6 January 2025:

'...I recall my mum and keep Psn. A Psn. A shouting for help three times...'

Person B stated the following in his witness statement dated 7 January 2025:

'...We could clearly hear their conversation so I believe they should have heard my multiple calls for help. I can't help but feel that they chose to ignore it.

...

...

When no one else came in, I shouted for help again and I recall seeing the clock showing 01:31...'

The panel accepted the Coroner's findings which also accepted this evidence.

Therefore, the panel found charge 1a(iii) proved.

Charge 1a(iv)

"1. On 13 September 2023:

a. Knowing that Patient A had attended the Hospital with vaginal bleeding:

iv. Incorrectly told Colleague C that Patient A was being triaged by Colleague A"

This charge is found proved.

In reaching this decision, the panel took into account the Coroner's Judgment, dated 5 July 2024. It also took into account the reflective account of the Band 7 co-ordinator for the maternity unit, Kathryn Duignan [Colleague C], regarding the night of 13 September 2023, which stated the following:

'...[Mrs Wood] then informed me that MW SA [Mrs Anderson – Colleague A], a senior band 6 Labour ward midwife, would be attending triage assessment room 2 to assess patient A. At the time, I understood that [Mrs Wood] and [Mrs Anderson], had discussed Patient A and agreed that [Mrs Anderson], would see her as she had cared for the patient during her earlier admission. I was, therefore, under the mistaken belief that Patient A would be seen and assessed promptly by an experienced midwife. I later found out, having discussed the incident

with [Mrs Anderson], that she had only agreed to assess and care for Patient A if she was in labour, which she was not...'

The panel accepted the Coroner's findings. These were that it was inexplicable that Mrs Wood could have such an understanding. Ms Anderson was a birthing midwife, not a triage midwife. She had, the Coroner found, been entirely clear that she would accept responsibility for Patient A if, and only if, she was in labour. This was in accordance with the roles of all the midwives on duty that night. It was made clear by the midwife who undertook the telephone triage (Miss Smedley) that Patient A was not in labour and was returning because of acute pain and vaginal bleeding. There was no reason at all for Mrs Wood to think that Ms Anderson, who was not present in the triage part of the Hospital when Patient A returned, was going to be triaged by Ms Anderson (in the charge referred to as "Colleague A").

Therefore, the panel found charge 1a(iv) proved

Charge 1b

"That you, a registered nurse:

1. On 13 September 2023:
 - b. Went on a break wearing a notice to that effect, without ensuring that Patient A had been triaged

This charge is found proved.

The evidence obtained in the Hospital's internal enquiry from Mrs Wood and from the Band 7 co-ordinator Ms Duignan made it clear that it was accepted by Mrs Wood that Mrs Wood decided to take a break while Patient A was in Room 2 (without having been triaged) but decided to take her break sitting at the midwives' station. This was not usual, and in a

misplaced attempt at humour Ms Duignan placed a “post it note” on Mrs Wood’s uniform on which she had written “on a break” or something similar.

Patient A was not triaged until 01:42 by Ms Anderson, who on passing through the triage section enquired about Patient A, and on being told that she had not been triaged immediately went to see Patient A herself.

From these facts it is apparent that Mrs Wood went on a break after Patient A had been placed in Room 2 and without Patient A being triaged. It was Mrs Wood who should have triaged Patient A. The significance of the note attached to her is that while Patient A was in distress with vaginal bleeding, Mrs Wood, with knowledge of that fact, took a break and did so only a few metres away from where Patient A.

It was also apparent from the NMC evidence (and not suggested by Mrs Wood) that anyone else was to triage Patient A during that break. In particular Ms Anderson was not in the triage part of the maternity department at the time, and Mrs Wood’s own case, stated to the Coroner, was that she “assumed” that Ms Anderson would triage Patient A and not that she had ever asked her to do so.

Therefore, the panel found charge 1b proved.

Charges 2a, 2b and 2c

“2. On 14 September 2023:

- a. Asked Colleague D to record on BadgerNet an incorrect admission time of Patient A
- b. Asked Colleague E to record on BadgerNet an incorrect admission time of Patient A
- c. Allowed Colleague E to use your login details to record the admission time”

These charges are found NOT proved.

Colleague D is Karen Hughes, receptionist. Colleague E is Hadleigh Cox, a MSW who is proficient in the technology systems used by the Hospital and as a result is sometimes asked for help by those less skilled in the use of those systems.

In reaching its decision, the panel took into account the Coroner's Judgment, dated 5 July 2024. It took into account evidence from Ms Hughes and Ms Cox.

The panel considered the meeting notes of Anne Kabia (Ms Kabia) dated 18 September 2023 regarding her discussion with Ms Hughes, in which the following was stated:

'...Karen [Hughes, the reception clerk] clarified that she returned from break at 01:10am, both Triage Midwives were sat at the Nurses station and Karen asked them if AB had arrived in Triage room 2 as her name was written on the white board.

The response from the Triage Midwives was that she had arrived but were unable to be clear at what time.

Karen therefore documented the time in the ward diary as 01:10 and this is reflected on care flow....'

Ms Hughes stated in her witness statement that she returned from her break at 01:10 to find Patient A in the department, but no entry of time of arrival. She stated that she entered 01:10 in Care Flow as being the latest Patient A could have arrived given Ms Hughes return from her break.

Ms Hughes stated Mrs Wood and Ms Cox had '*settled on*' Patient A's arrival time being 01:16. However, she was not present during that conversation which took place when Mrs Wood and Ms Cox were viewing entries on an iPad.

The panel took into account the written and oral evidence of Ms Cox, endorsed by Ms Kabia who stated that that BadgerNet imports data from Careflow, but not always accurately and that this can mean that the time the Careflow *entry* was made will show on BadgerNet as the time of the patient's arrival in her statement Ms Kabia said '*I became aware during this investigation that there was a known issue with the route between Careflow and BadgerNet, pulling details through which had been ongoing since well before 13 September*'.

The panel accepted the evidence of Ms Hughes, in that she clear that she was not trained in, and did not understand how to work, the BadgerNet system.

Ms Cox stated that Mrs Wood had noticed the timing error, she having logged on to BadgerNet, and that Mrs Wood was trying to amend the BadgerNet entry to correct the time of arrival to that entered by Ms Hughes on Care Flow, as the BadgerNet entry was showing the time (01:16) Ms Hughes had entered 01:10 in Care Flow as the arrival time of Patient A.

The panel determined that there was no evidence before it to undermine the evidence of Ms Cox, which it determined was consistent over time from the contemporaneous statement. It was also consistent with the entries in BadgerNet.

The panel concluded that:

- Mrs Wood was logged into BadgerNet at the time the change was made.
- Mrs Wood did not ask Ms Hughes (Colleague D) to record an incorrect admission time of Patient A on BadgerNet It was the reverse, as Mrs Wood was seeking to change the incorrect record on BadgerNet of 01:16 to the arrival time recorded by Ms Hughes of 01:10.

- Mrs Wood had asked Ms Cox (Colleague E) to change the incorrect time entry to the correct time of Patient A from 1:16 to 1:10, as Ms Cox knew how to make the change; and
- Mrs Wood allowed Ms Cox (Colleague E) to correct the admission time on her behalf. Mrs Wood's was already logged on, she was present throughout and had full knowledge of the changes being made and the purpose. Ms Cox did not log on using Mrs Wood's user ID and password merely assisted Mrs Wood with some technical support.
- The alteration was from 1:16 – 1:10 was to an *earlier* time, not a later time, and the amendment was to change the entry back to the time of arrival recorded by the receptionist (Ms Hughes).

For these reasons, the panel determined that it was correct of Mrs Wood to amend the BadgerNet entry which had pulled through the incorrect time of the entry recorded by Ms Hughes on Careflow, in order to ensure the correct time was recorded on BadgerNet.

Therefore, the panel found charges 2a, 2b and 2c not proved.

Charges 3a, 3b and 3c

“3. Your conduct as specified in charge 2 was dishonest in that you:

- a. Knew the time to be incorrect
- b. Knew that it was wrong to record an incorrect admission time
- c. Intended that any reader of the records would believe that Patient A's admission had taken place later than it actually had.”

These charges are found NOT proved.

As the panel found charges 2a, 2b and 2c not proved, charges 3a, 3b and 3c fell away.

In any event it was alleged that the time had been changed to an incorrect time. However, the panel found that Mrs Wood intended to correct the time to Patient A's actual recorded time of admission.

It cannot be dishonest to correct an incorrect entry.

The gravamen of charge 4 is that Mrs Wood failed to attend to Patient A, and there would be no reason for her to make a dishonest entry to backdate the time of arrival, as (at that time) she would have had no reason to do so.

Therefore, the whole of charge 3 was based on a false premise.

Charge 4

"4. Your conduct as specified in charges 1ai and/or 1aii and/or 1aiii and/or 1aiv resulted in the loss of a chance of survival for Baby A"

This charge is found proved.

In reaching this decision, the panel took into account the Coroner's Judgement, dated 5 July 2024 which made the following findings:

'...Bby. A died from hypoxic ischaemic encephalopathy, caused by a placental abruption, secondary to sub clinical acute chorioamnionitis. The abruption led to a major antepartum haemorrhage, which was not recognised as an obstetric emergency that required immediate assessment of maternal and fetal wellbeing.

Bby. A mother Pnt. A was not seen for 37 minutes on arrival at the Triage unit, at Kings Mill Hospital at 01.05 hours, when she was in pain and with significant vaginal bleeding, Had she been seen on arrival as she should have been,

would have been delivered by an emergency Category 1 caesarean section, likely by 01.25, certainly by 01.35, instead of at 02.02 hours as occurred. Bby.

A

Had he been delivered at either of these earlier times, he would on balance have survived. The delay in Triage assessment made a more than minimal, negligible or trivial contribution to Bby. A Bby. A death. death was contributed to by neglect ...'

The panel accepted the findings of the Coroner. It determined that Mrs Wood knew that Patient A had arrived and was in acute pain as she was sat at the midwives' station when Patient A arrived, in a wheelchair provided for her by the security guard as she had arrived as she was in great pain. Mrs Wood saw Patient A and told the staff to put her in Room 2.

The panel noted the detailed chronology prepared by the Coroner from which it was apparent that:

- Miss Smedley was on telephone triage duty that night and would not have been expected to care for Patient A on her arrival at the Hospital;
- At the end of the call to the telephone triage unit which she handled correctly, she advised Patient A's partner and mother (with whom she spoke) that Patient A needed to return to the hospital immediately;
- That the family decided to take Patient A by car to the Hospital because they lived only 10-15 minutes away, and that the Coroner agreed that this caused no delay as an ambulance would meant no quicker arrival (and the ambulance crew would not have been available to give antenatal care in Patient A's case);

- After telling Mrs Wood and the Band 7 coordinator about Patient A (when they had no other patient to attend to) Miss Smedley left (entirely properly) to carry out other professional duties;
- That although Miss Smedley did not record the call properly in the computerised BadgerNet system there was no evidence that the midwives in the triage team ever looked for a BadgerNet entry for Patient A;
- That whatever was put in a BadgerNet entry would need to be verified on the arrival of the patient by the triage nurse;
- That the concept of triage is to give swift analysis of the medical presentation of a patient arriving at a hospital;
- After the call to the telephone triage midwife (Miss Smedley) and before Patient A arrived, Miss Smedley told the Band 7 coordinator and Mrs Wood orally, both then sitting at the nursing station, that Patient A was arriving shortly, had abdominal pain and vaginal bleeding, and ensured that the entry on the whiteboard stated “PVB” (to indicate vaginal bleeding) alongside her name;
- That at the time of Patient A’s arrival there was no other patient in the triage department;
- That when Patient A arrived at the Hospital, she was in acute constant pain (not contractions) such that the security guard provided her with a wheelchair to get her to the triage department of the Hospital;
- That it would be expected of any midwife that they would act immediately to triage a patient who they knew was in abdominal pain with vaginal bleeding;

- That the Hospital protocol was that triage should take place within 15 minutes (and that 37 minutes was outside any possible parameter): and
- That Mrs Wood was sitting at the midwives' station and that she (and the Band 7 coordinator sitting with her) ignored the several calls for help from Patient A's partner and mother asking for someone to come and attend to Patient A.
- The relevance of this evidence was that Mrs Wood had been informed by Miss Smedley that Patient A was returning with acute abdominal pain and vaginal bleeding, and that Patient A was not thought to be in established labour. The panel then considered independently whether Mrs Wood's subsequent actions and omissions caused or materially contributed to the delay in assessment.

The panel noted that after taking detailed medical evidence the Coroner concluded that Baby A was alive on arrival at the Hospital (because he was born alive by Caesarean section at 02:02), and that the chance of life was lost at 01:42, some 37 minutes after Patient A arrived. The panel noted that it was Ms Anderson who realised there was an emergency, and that was at 01:42. Baby A was born at 02:02, 20 minutes after Ms Anderson triaged Patient A.

Patient A suffered a placental abruption (an obstetric emergency), and it was that which caused her pain and vaginal bleeding and led her to return to the Hospital. It follows that had Mrs Wood triaged Patient A at, or soon after her arrival in the triage part of the maternity ward at 01:05 this would have been recognised and Baby A would have been born soon after 01:25, over 15 minutes before the chance of survival was lost.

For these reasons, the panel determined that the failure of Mrs Wood to triage Patient A after her arrival, when she remained sitting at the midwives' station with no other task to require her attention for some 37 minutes, resulted in the loss of a chance of survival for Baby A.

For these reasons, the panel found charge 4 proved.

Fitness to practise

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

Submissions on misconduct and impairment

Ms Boesche invited the panel to take the view that the facts found proved amount to misconduct.

Ms Boesche referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. She identified the specific, relevant standards which the NMC suggest had been breached by Mrs Wood and amounted to misconduct: 1.1, 1.2, 1.4, 2.1, 2.6, 8.2, 8.3, 8.5, 11.1, 11.2, 11.3, 13.1, 13.2, 15.2, 19.1, 19.2, 20.1, 20.3, and 20.8 She also referred to the cases of

*Roylance v General Medical Council*_(No 2) [2000] 1 A.C. 311 and the NMC guidance on Misconduct FTP-2a.

Ms Boesche submitted that Mrs Wood's conduct was a significant departure from the fundamental principles of the Code of prioritising people and promoting professionalism and trust.

Ms Boesche submitted that Mrs Wood's conduct breached fundamental tenets of the profession, failed to uphold the reputation of the profession at all times, and brought the profession into disrepute.

Ms Boesche also submitted that if no finding of misconduct was made, the professional standards would be undermined. She submitted that Mrs Wood's behaviour in the charges proved was a departure from good and safe professional practice and constitutes misconduct.

Ms Boesche 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Boesche submitted that the following questions outlined in the case of *Grant* can be answered in the affirmative in respect of this case, in that Mrs Wood:

- *Has 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*
- *Has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or*

- *Has in the past committed a breach of one of the fundamental tenets of the profession and/or is liable to do so in the future and/or*
- ...

Ms Boesche submitted that the first three limbs of the *Grant* test are engaged. She submitted that Mrs Wood's behaviour in the charges found proved put Patient A at an unwarranted risk of harm, and resulted in the loss of chance of survival of Baby A. She submitted that Mrs Wood's behaviour brought the profession into disrepute, breached fundamental tenets of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust.

Ms Boesche referred the panel to the witness statement of Mrs Wood from the Trust's internal investigation which expressed regret at the outcome for Patient A and Baby A, but did not show insight into her own actions. She submitted that Mrs Wood has not engaged with these proceedings, and there is no evidence before the panel at present to suggest that Mrs Wood has accepted responsibility for her conduct or has engaged in any reflection or remediation of the concerns identified. Therefore, Ms Boesche submitted that there is a high risk of Mrs Wood repeating the conduct identified, and consequent risk of harm to the public if she were permitted to practise unrestricted at this time.

Ms Boesche submitted that, due to the seriousness of the misconduct identified, a finding of impairment is required to maintain public confidence in the profession and to uphold proper professional standards. She submitted that public confidence in the profession and the NMC as its regulator would be undermined if such conduct were not marked as unacceptable. For these reasons, Ms Boesche invited the panel to find that the public interest also required a finding that Mrs Wood's fitness to practise is currently impaired by reason of her misconduct.

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* and *Nandi v*

General Medical Council [2004] EWHC 2317 (Admin), and the NMC Guidance notes FTP-2a and DMA-1.

Decision and reasons on misconduct

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.*’ It also considered the NMC’s Guidance on misconduct and impairment, and that the identified misconduct must be considered as deplorable or blameworthy.

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

The panel considered that the facts found proved were a breach of the fundamental tenet of the profession; the panel found Mrs Wood failed to ensure that Patient A received timely assessment and appropriate escalation despite knowing that she had attended with constant acute abdominal pain and vaginal bleeding, and this resulted in a loss of a chance of survival of Baby A.

The panel was of the view that Mrs Wood’s actions did fall significantly short of the standards expected of a registered midwife, and that her actions and inactions amounted to breaches of multiple parts of the Code, particularly:

‘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

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

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Wood's actions and inactions in the charges found proved were sufficiently serious in nature that they met the threshold for misconduct.

The panel found that Mrs Wood's conduct involved patient safety failures and a failure to act urgently which had catastrophic consequences, and that such behaviour did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct. The panel determined that her behaviour would be considered deplorable by fellow practitioners, thereby damaging the trust that they and the public place in the profession.

The panel was satisfied that Mrs Wood's actions and inactions in relation to patient safety failures and her failure to act urgently which had catastrophic consequences, had caused actual harm to Patient A, and resulted in the loss of a chance of survival for Baby A. Mrs Wood's primary role on the shift was to triage patients on arrival and she failed to do this. The panel was satisfied that awareness and appropriate escalation of patient deterioration are fundamental tenets of the midwifery profession that were breached by Mrs Wood's misconduct. It was satisfied that her actions and inaction had damaged the reputation of the profession and brought the profession into disrepute.

In these circumstances, the panel determined that Mrs Wood's actions did fall seriously short of the conduct expected of a midwife and she failed in her duty to uphold the standards and values of midwifery, amounting to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Wood'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 *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/ 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 considered the test in *Grant*. It was satisfied that the first three limbs were engaged as to the past and future.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that although the misconduct identified is difficult to remediate, it was capable of being addressed. However, Mrs Wood has not engaged with these proceedings, has chosen not to attend the hearing and is no longer practising as a midwife. The panel noted that Mrs Wood had shown some remorse during the Trust's internal investigation which was as follows:

'The delay in the patient being seen may have had an impact on her care, the bleeding could have been assessed earlier and concerns escalated sooner, more promptly. For this I have deep regret and sadness'.

The panel found that this did not demonstrate personal responsibility, full remorse, or insight into the consequences of her actions.

The panel had no further evidence before it to suggest that Mrs Wood has accepted responsibility for her conduct, has reflected on her behaviour, or has taken any steps to remediate the concerns. In light of this, the panel was not satisfied that the conduct is highly unlikely to be repeated. The panel determined that should Mrs Wood repeat her behaviour in the future; there would be a risk of harm to patients. On the basis of all the information before it, the panel decided that there is a risk to the public if Mrs Wood were permitted to practise without restriction. The panel therefore decided that a finding of impairment is necessary on the ground 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 recognised that there is a high bar for the making of a finding of current impairment in the public interest. Given the tragic and foreseeable consequences of Mrs Wood's actions and inactions, the panel determined that a finding of impairment on public interest grounds is also required as public confidence in the profession would be seriously damaged if a finding of impairment were not made in this case. It was of the view that a member of the public in possession of all the facts in this case would expect a finding of impairment to be made. There is a public expectation that the regulator would act in a case of this nature in order to uphold public confidence in the midwifery profession and its reputation. The panel therefore decided that a finding of impairment is also necessary on the ground of public interest and therefore so finds.

Having regard to all of the above, the panel was satisfied that Mrs Wood'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 Mrs Wood's name off the register. The effect of this order is that the NMC register will show that Mrs Wood 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 Boesche submitted that the most appropriate and proportionate sanction in this case is a striking-off order. She submitted that the aggravating features of this case were:

- conduct which recklessly put people receiving care at risk of suffering harm
- failure to attend hearings, or to engage in the Fitness to Practise (FtP) process, without good reason
- absence of insight

Ms Boesche submitted that, in considering the available sanctions from the least restrictive order, taking no further action or a caution order would not be appropriate in this case. She asserted that the concerns in this case were too serious and were not capable of being remedied.

Ms Boesche submitted that a conditions of practice order would not be appropriate or proportionate in this case. She submitted that the concerns were too serious and there was evidence of deep-seated attitudinal concerns in this case. She highlighted that Mrs Wood had not made any admissions and Person A had stated that Mrs Wood was always rude. Ms Boesche submitted that a combination of Mrs Wood's behaviour, which included taking a break whilst a patient was having antenatal bleeding, and her lack of engagement with the proceedings is suggestive of deep-seated attitudinal issues. Ms Boesche highlighted that Mrs Wood is no longer working as a midwife and therefore, a conditions of

practice order would not achieve any pragmatic result. She asserted that, in any event, the concerns are so serious that only a removal from the register would serve as an appropriate sanction.

Ms Boesche referred the panel to the NMC Guidance: Deciding between suspension and strike-off (SAN-3). She submitted that it was unlikely that Mrs Wood would try to address the concerns and therefore, it would not be appropriate for a suspension order to be imposed with the hope that Mrs Wood would be able to return to practise safely. Ms Boesche also highlighted that the NMC Guidance stated that professionals are under an obligation to cooperate with the regulator and when professionals have failed to engage, it would not usually be appropriate to use a suspension order as a means of giving them a last chance to engage, reflect or show insight.

Ms Boesche also referred the panel to the NMC Guidance on Sanctions for the highest risk cases, particularly, *'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.'* She submitted that this applied to Mrs Wood who went on a break, during the crucial time when Baby A could have had a chance of survival.

Ms Boesche referred the panel to the NMC Guidance on Striking off order (SAN-2e) which sets out the conditions for a striking off order. She asserted that only a removal from the register could ensure that public confidence in the profession would be maintained. She submitted that there was no insight from Mrs Wood. Ms Boesche highlighted that there was no evidence of reflection, remediation, relevant training, supervised practice, or safe practice. She asserted that there was no realistic prospect that after a suspension, Mrs Wood would have gained insight and strengthened her practice such that the risk she poses would have been reduced.

Ms Boesche submitted that the NMC Guidance states that the types of case that are most likely to result in a striking-off order include where the professionals fail to engage with the fitness to practise process. She submitted that, in this case, Baby A's chance of survival was lost through actions or inactions of Mrs Wood. Ms Boesche therefore concluded that the public trust in the midwifery profession could not be maintained unless Mrs Wood was removed from the register.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Wood'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:

- Mrs Wood was directly responsible for the triage of Patient A on arrival and despite her awareness of Patient A's presentation on arrival, including constant acute abdominal pain and visible distress, she failed to triage or escalate Patient A for immediate care.
- Mrs Wood's misconduct was very serious and caused actual harm to Patient A and resulted in the loss of a chance of survival for Baby A.
- Mrs Wood's inactions were not a momentary lapse. There was a period of 37 minutes where she could and should have attended to Patient A but did not do so.
- During this period, Mrs Wood would have heard calls for help from Patient A's family but did not respond.
- Patient A was only triaged when another midwife came into the triage department and did so on her own initiative.

- Mrs Wood has failed to demonstrate insight into her misconduct.
- Although Mrs Wood demonstrated some remorse, she failed to take full responsibility for her actions.
- There was no evidence of strengthened practice.
- Mrs Wood has failed to engage with the NMC Fitness to practise process.

The panel determined that there was insufficient evidence to indicate any mitigating features in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate and not proportionate in view of the seriousness of the case. It had earlier decided that there is a risk of repetition, that Mrs Wood breached fundamental tenets of the midwifery profession, and that her misconduct would undermine the public confidence in the midwifery profession if she were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be 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) 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 noted that it had earlier determined that Mrs Wood’s misconduct posed a risk of harm to patients and public safety. In view of its findings on misconduct and impairment, the panel decided that this case was not at the lower end of the spectrum of impaired fitness to practise. Given the seriousness of the case, the public protection and public

interest considerations identified, the panel determined that an order that does not restrict Mrs Wood's midwifery practice, would not be appropriate or proportionate in the circumstances. The panel therefore concluded that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether to place a conditions of practice on Mrs Wood's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c) particularly:

- *'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)*
- *.....*
- *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.'*

Although the panel had earlier determined that Mrs Wood's misconduct was capable of being addressed, there was no evidence to indicate that she would comply with any conditions of practice given her lack of engagement with these proceedings. The panel also noted that Mrs Wood is no longer a practising midwife and did not intend to practise in future. Furthermore, given Mrs Wood's desire to leave the midwifery profession, and her failure to provide the panel with information about her current circumstances, the panel had no confidence that conditions of practice could be workable.

The panel noted that the concerns were serious. The panel also noted Mrs Wood's lack of engagement and insight into the severity and the impact of her misconduct on Patient A, Baby A, their families, the public and the midwifery profession. The panel determined that there were no relevant, proportionate, workable and measurable conditions that could be formulated to address the risk of repetition.

The panel was of the view that this poses a risk of harm to patients' safety and the public should Mrs Wood change her mind and seek to return to midwifery practice. Consequently, the panel determined that a conditions of practice order would not protect the public nor be in the public interest.

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) 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 overarching 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 was of the view that Mrs Wood's failure to triage Patient A, her failure to respond to requests for help from Patient A's family at the time of the incident and her failure to escalate Patient A for immediate care despite her awareness of Patient A's presentation on arrival, which resulted in the loss of a chance of survival for Baby A, seriously calls into question her suitability to continue practising as a registered midwife.

Given Mrs Wood's lack of engagement with these proceedings, her lack of insight and accountability for her actions, together with no evidence of strengthened practice, the panel determined that there was no realistic possibility that she would address the concerns to such a level where she could return to practise safely. This poses a serious risk of harm to patient safety and the public.

The panel also determined that given the seriousness of the concerns and Mrs Wood's lack of insight and accountability for her actions, a suspension order would also not be sufficient to uphold public confidence in the profession and maintain professional standards in the midwifery profession.

The panel concluded 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 following considerations as set out in the NMC Guidance entitled '*Striking-off order*' (SAN-2e):

- *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 was of the view that all of the criteria set out above are met in this case. The panel determined that the serious breach of fundamental tenets of the profession, evidenced by Mrs Wood's misconduct, is fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case raise serious and significant questions about Mrs Wood's professionalism and to allow her to continue practising would not protect the public and would undermine public confidence in the midwifery profession and in the NMC as a regulatory body.

Given the serious nature of the concerns as a result of Mrs Wood's misconduct, her lack of engagement and insight into the severity and the impact of her misconduct on Patient A, Baby A, their families, the public and the midwifery profession; the panel determined that there was no amount of insight and reflection in this case which could keep patients and the public safe, maintain public confidence in the profession, and uphold professional standards.

Balancing all of these factors and after considering all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Wood's actions in bringing the midwifery 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 a striking-off order would be sufficient and proportionate in this case and this is the only sanction which would be sufficient to protect the public.

The panel determined that this order is also necessary to maintain public confidence in the midwifery profession, and to uphold the professional standards of behaviour expected and required of a registered midwife.

This will be confirmed to Mrs Wood in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Boesche. She submitted that, given the seriousness of the concerns and the panel's findings on sanction, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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 was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

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 in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.