Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

13-17 May 2019, 20-24 May 2019, 27-31 May 2019.

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

Name of registrant:	Mrs Dinah Kavaarpuo
NMC PIN:	03E0690O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – May 2003 Registered Midwife – January 2006
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Barbara Stuart (Chair, Lay member) Yvonne O'Connor (Registrant member) Beth Maryon (Registrant member)
Legal Assessor:	Justin Gau
Panel Secretary:	Calvin Ngwenya
Nursing and Midwifery Council:	Represented by Katie Mustard, of Counsel
Mrs Kavaarpuo:	Present and represented by Briony Molyneux, Counsel, instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	10, 16, 27, 29 and 42.
No case to answer:	8, 11, 17, 40, 41.
Facts found proved:	1, 2, 3, 4, 7, 9, 12, 18, 19, 20, 21.1, 21.2, 21.3, 21.4, 21.5, 22, 23, 24, 25, 28, 30, 31, 32, 33.1, 33.3, 33.4, 35.1, 35.2, and 38.
Facts found not proved:	5.1, 5.2, 6, 13, 14, 15.1, 15.2, 26, 33.2, 34.1, 35.3, 36, 37, 39.1, 39.2 and 39.3.

Fitness to practise:	Impaired
Sanction:	Striking Off Order
Interim Order:	Interim Suspension Order (18 months)

Decision and reasons on application to amend charges:

The panel heard an application made by Ms Mustard, on behalf of the NMC, to amend the wording of charges 16, 17 and 32.

With regard to charge 16, the proposed amendment was to anonymise and replace the name of the witness to 'Colleague B' in line with the NMC's witness anonymisation policy.

In charge 17, which currently reads: "Between 0030-0200 you did not document in the maternal notes every 30 minutes", the proposed amendment was to replace the word 'maternal' with the word 'labour' and delete the words 'every 30 minutes'.

With regard to charge 32 which currently reads: "Left Patient D alone while she was in the lithotomy positon and with a needle in situ", the proposed amendment was to delete the word 'alone'.

Ms Mustard submitted that the proposed amendments, which would not alter the substance of the charges, were merely to provide clarity and accurately reflect the evidence before the panel. Therefore, they could be made without prejudice.

Ms Molyneux on your behalf did not object to the application.

The panel heard and accepted the advice of the legal assessor.

Rule 28(1) of Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules"), states:

28 (1) At any stage before making its findings of fact …

(i) … the Conduct and Competence Committee, may amend

(a) the charge set out in the notice of hearing …

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

The panel noted that the applications to amend charges 16, 17 and 32 were not opposed. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy and to anonymise the name of the witness appropriately.

Details of charges as amended:

That you, a registered midwife;

In relation to Patient A on 2 February 2016;

1. You did not stop one or more vaginal examinations when asked to do so.

2. You did not record all vaginal examinations conducted on Patient A

3. You inserted your fingers into Patient A's vagina to direct pushing which was not clinically justified.

4. Did not provide appropriate support to Patient A during labour in that you did not offer encouragement to Patient A

5. Did not adequately communicate in that you;
   5.1 did not explain the significance of increased fetal heart rate
   5.2 did not explain why Patient A had to get out of the bath

6. You did not provide Patient A with pain relief when it had run out

7. Told Patient A to lie on her back and/or adopt the Lithotomy positon which was not clinically justified.

8. You pulled the baby from Patient A's vagina which was not clinically justified.

9. At 1830 performed an ARM on Patient A with no clinical justification.

10. Did not plot the fetal heart rate every 5 minutes during the second stage of labour

In relation to Patient B on the night shift of 28 June 2016;

11. Continued a vaginal examination when consent had been withdrawn.

12. Did not document Patient B's discomfort during vaginal examinations

13. Used a 'directed pushing technique' which was not clinically justified.

14. Did not support Patient B in using the birthing pool

15. Did not appropriately communicate with Patient B in that you;
   15.1 Did not explain to Patient B the significance in a decrease in the fetal heart rate
   15.2 Did not explain why you were getting a Doctor.

16. Did not counter sign Colleague B's entries in the labour notes

17. Between 0030-0200 you did not document in the labour notes.

18. Did not record Patient B's urine output at 2350.

In relation to Patient C on the night shift of 10-11 September 2016;

19. Did not stop a vaginal examination when you were asked to do so on one or more occasion

20. Conducted a vaginal examination straight after Patient C waters had broken with no clinical justification

21. Did not communicate appropriately with Patient C in that you;
    21.1 did not raise your voice when asked to do so
    21.2 did not fully explain the need for Konakoin
    21.3 did not communicate the reasons why you asked Patient C to lie on her side when it was painful to do so
    21.4 Did not immediately explain why Patient C had to adopt the lithotomy position
    21.5 Did not clearly explain whether the baby was advancing.

22. Did not provide appropriate emotional support in relation to pain relief

23. Told Patient C to adopt the lithotomy position with no clinical justification.

24. Recorded in the patient notes that Patient C was happy with the lithotomy positon when she was not.

25. Your actions in charge 24 were dishonest.

26. Did not provide practical support in relation to pushing

27. Did not document your discussion with Patient C in relation to Konakoin

28. Left patient C covered in blood waiting to be taken down to theatre

In relation to Patient D on 22 September 2016 you;

29. Did not stop rubbing Patient D's abdomen when you were asked to do so.

30. Did not stop suturing when you were asked to do so by Patient D

31. Continued to suture when you were asked to stop by Colleague A.

32. Left Patient D while she was in the lithotomy positon and with a needle in situ.

33. Did not adequately communicate with Patient D in that you;
    33.1 Did not explain to Patient D how to increase the strength of contractions
    33.2 Did not explain why you were rubbing her abdomen
    33.3 Did not explain how to deliver the placenta
    33.4 Did not explain what the injection for the placenta was for

In relation to Patient E on 9 September 2016 you;

34. Did not communicate adequately with Patient E in that you;
    34.1 Did not explain different positions Patient E could take
    34.2 Did not explain alternative pain relief to the epidural
    34.3 Did not explain that you were going to touch her abdomen

35. Did not provide adequate guidance and/or support during labour in that you
    35.1 Did not explain how to push
    35.2 Did not provide adequate direction throughout the process.
    35.3 Told Patient E to look at the CTG monitor to know when she was having a contraction.

36. At around 0140-0145 increased syntocinon infusion which was not clinically justified.

37. Did not adequately and/or accurately record the increase of syntocinon

38. Said to Patient E that she would be unable to cope or words to that effect

39. At the following times you incorrectly counted Patient E's contractions
    39.1 0215
    39.2 0330
    39.3 0530

40. Did not document the fluid input and output of Patient E

41. Broke Patient E's waters which was not clinically justified.

42. At 0040 commenced IV fluids after citing a Patient Controlled Epidural and Analgesia

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

Admissions:

Following the reading of the charges, Ms Molyneux on your behalf indicated that you admitted the facts alleged in charges 10, 16, 27, 29 and 42.

In the light of the above, the panel found charges 10, 16, 27, 29 and 42 proved by way of your admissions.

Decision and Reasons on application pursuant to Rule 31:

The panel heard an application made by Ms Mustard to allow three of the NMC's witnesses, Patient C, Patient D and Patient A, to give their evidence via video link. She submitted that whilst the NMC had made efforts to secure the witnesses' attendance, they were unable to attend for different reasons.

With regard to Patient C, Ms Mustard referred the panel to an email dated 8 April 2019 from Patient C's employers explaining why she could not attend due to work commitments. In relation to Patient D, Ms Mustard informed the panel that she could not attend due to child care commitments and the difficulties of travelling to London with a young baby. With regard to Patient A, Ms Mustard referred the panel to a letter dated 15 March 2019 from Patient A's GP supporting her non-attendance due to health concerns. Ms Mustard submitted that all of the witnesses' evidence was relevant, and that it would be fair and proportionate to adduce it by video link as the evidence can be properly tested.

Ms Molyneux on your behalf 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.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of the witnesses in person to that of giving evidence via video link.

The panel noted that the application was not opposed.

The panel determined that in light of the difficulties which had been explained by Ms Mustard in respect of each witness, the NMC had made reasonable efforts to secure their attendance in person.

The panel accepted the reasons that were given for the witnesses' non-attendance.

The panel determined that the witnesses' evidence was relevant to these proceedings and there was no dispute between the parties in that respect.

In all the circumstances, the panel came to the view that it would be fair to accept the witnesses' testimony via video link.

Decision and Reasons on application pursuant to Rule 31:

The panel heard an application made by Ms Mustard to adduce as hearsay evidence, an email dated 14 September 2016, from Ms 4, Midwife at Birth Afterthoughts Service (the Service), in relation to a complaint from Patient B. Ms Mustard submitted that the complaint email should be admitted into evidence subject to the questions of relevance and fairness. She referred the panel to the case of *Thorneycroft v NMC [2014] EWHC 156 (Admin); Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216* and *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin),* for the factors it should take into account in reaching its decision in relation to this application.

Ms Mustard submitted that, save for charge 11, the complaint email which is a contemporaneous record of Patient B's account is not the sole and decisive evidence in relation to the allegations pertaining to Patient B's care. She noted that the complaint email is supported by Ms 4's unchallenged witness statement, which confirms the contents as being an accurate record of what was discussed at the Service. Ms Mustard further noted that the panel has heard other evidence from Colleague B in relation to the allegations pertaining to Patient B's care. Ms Mustard referred the panel to an email

from Patient B explaining why she declined to take part in this process due to concerns about the detrimental impact these proceedings could have on her health.

Ms Mustard submitted that in these circumstances it would be fair to admit the complaint email into evidence, and as an experienced professional panel, it would give it the appropriate weight once it had evaluated all the evidence.

Ms Molyneux, on your behalf conceded that the complaint email is relevant. However, she opposed the application on the grounds of fairness. She submitted that the complaint email was not obtained in anticipation of being used in these regulatory proceedings and had no statement of truth attached to it. Ms Molyneux noted that Patient B, who has never formed part of these proceedings, has not commented on the veracity of the complaint email or whether it accurately reflects her account. Ms Molyneux submitted that the contents of the email which are not Patient B's own words, but an account from Ms 4 to another colleague amounted to multiple hearsay evidence.

Ms Molyneux submitted that in light of Patient B's absence, there was no way of challenging or testing her account which relates to a large proportion of the very serious allegations against you. Ms Molyneux submitted that notwithstanding the reasons given for Patient B's non-attendance, the NMC last made contact with her in 2017 and no recent approach has been made to secure her attendance. Ms Molyneux submitted that in these circumstances it would be unfair to admit the complaint email, and the panel cannot remedy any potential prejudice in the weight to be attached to the hearsay evidence.

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 legal assessor also referred the panel to the principles in the cases of *Thorneycroft* and *El Karout*.

The panel had careful regard to the submissions from Ms Mustard and Ms Molyneux. It had regard to the provisions of Rule 31 and bore in mind that the admission of hearsay evidence should not be regarded as a routine matter.

The panel first considered the question of relevance and noted that there was no dispute between the parties in respect of relevance.

The panel noted that the complaint email consisted of an account which was supposedly given to Ms 4 at the Service by Patient B in relation to the care you provided. The email was sent by Ms 4 to her colleague some five days after Patient B's session at the Service. Therefore, the complaint email was not a direct account from Patient B in relation to the care you provided. The panel considered that it would not have been envisaged by Patient B that her account at the session would be used for these formal proceedings and the information was not in the form of a witness statement. The panel noted that, in her email to the NMC dated 22 August 2017, Patient B had made reference to having had several interviews and providing detailed written accounts of her care to the Royal Hallamshire Hospital Sheffield Teaching Hospitals NHS Foundation Trust ("the Trust"). However, those detailed written accounts have not been presented to the panel and there is no confirmation from Patient B that the contents of the complaint email are true and accurate.

The panel further considered the issue of reliability by assessing the evidence it did have in relation to the allegations, namely Colleague B's evidence. The panel noted inconsistencies between Colleague B's evidence and the contents of the complaint email, particularly in relation Patient B's consent to vaginal examinations. As such, the panel could not be satisfied that the evidence in the complaint email was demonstrably reliable. The panel therefore determined that the only realistic way of testing the evidence in Patient B's complaint email and its reliability would be through the cross examination of Patient B. However, that would not be possible in light of Patient B's absence from these proceedings. In these circumstances, the panel did not consider that admission of Patient B's complaint email would be fair.

Taking all these factors into account, the panel rejected the NMC's application.

Decision and reasons on application to amend charges:

At the end of the NMC's witness evidence, Ms Mustard made a second application to amend the wording of charges 1 and 2 which read:

1. *You did not stop one or more vaginal examinations when asked to do so.*

2. *You did not record all vaginal examinations conducted on Patient A.*

With regard to charge 1, the proposed amendment was to replace the words "one or more vaginal examinations" with the words "directed pushing". With regard to charge 2, the proposed amendment was to replace the words "all vaginal examinations" with the words "directed pushing".

Ms Mustard submitted that the application in respect of both charges was being made due part of Colleague C's oral evidence that what she referred to in her witness statement as 'vaginal examination' was in fact a similarly intimate procedure called 'directed pushing'. Ms Mustard submitted that the amendments which merely clarify the position and reflect the evidence can be made without prejudice as they do not alter the gravity, mischief or substance of the allegations.

Ms Molyneux on your behalf opposed the application on the basis that it would be unfair to amend the charges at this stage of proceedings. She submitted that it was clear from Colleague C's witness statement that she made a distinction between vaginal examinations and directed pushing. Therefore, the NMC has had ample time to review the evidence and clarify the allegation prior to closing its case. Ms Molyneux submitted that your defence and the cross examination of witness had been prepared on the basis of 'vaginal examinations' therefore it would be inherently unfair to amend the charges at this stage when the relevant NMC witnesses have been heard and released.

The panel had careful regard to the submissions of Ms Mustard on behalf of the NMC and those from Ms Molyneux on your behalf.

The panel heard and accepted the advice of the legal assessor.

Rule 28(1) of Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules"), states:

28 (1) At any stage before making its findings of fact …

(i) … the Conduct and Competence Committee, may amend

(a) the charge set out in the notice of hearing …

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

Having carefully considered the evidence from Ms 1, Colleague B, Colleague C and Patient A, the panel was of the view that the term 'vaginal examination' was a broad enough term to cover actions that would include a specific examination and also the insertion of fingers into the vagina to direct pushing. In these circumstances, the panel determined to reject the application to amend charges 1 and 2 as it is unnecessary at this stage of proceedings.

Decision and Reasons on Application of no case to answer:

The panel considered an application by Ms Molyneux on your behalf that there is no case to answer in respect charges 4, 6, 8, 11, 14, 17, 35.1, 35.2, 39.1, 39.2, 39.3, 40 and 41. Ms Molyneux informed the panel that having had preliminary discussions with

Ms Mustard, it has been confirmed that her application in respect of charges 11, 17 and 40 would not be contested by the NMC.

With regard to the contested applications, Ms Molyneux referred the panel to the principles set out in the case of *R v Galbraith [1981] 1 WLR 103* in relation to the guidance to be followed in no case to answer applications. Ms Molyneux addressed the panel on each of the individual contested charges and outlined the evidence that has been presented by the NMC thus far. She submitted that she was relying on the second limb of the *Galbraith* test in that the evidence presented in support of the charges was either tenuous, weak, inconsistent with other evidence, vague or contradictory. Ms Molyneux submitted that taking the NMC's evidence at its highest in relation to the charges that are subject of her application, a panel properly directed, could not find the charges proved. Therefore, the panel should stop the charges at this stage.

Ms Mustard, on behalf of the NMC, confirmed that the no case to answer application was not opposed in relation to charges 11, 17 and 40. However, it was opposed in relation to all the other charges on the grounds that the panel has been presented with sufficient evidence that a panel properly directed, could potentially find the charges proved. Ms Mustard directed the panel to specific witness statements, oral and documentary evidence that has been presented in support of charges 4, 6, 8, 14, 35.1, 35.2, 39.1, 39.2, 39.3 and 41. She made submissions as to how the evidence was sufficient for a case to answer and why the panel might benefit from your account in relation to those allegations. Ms Mustard submitted in these circumstances there was sufficient evidence on which the panel could find the charges proved.

The panel heard and accepted the advice of the legal assessor who referred it to the principles in the cases of *Alexander v Arts Council for Wales [2001] EWCA Civ 514* and the case of *Galbraith.*

In reaching its decision, the panel took account of the submissions of Ms Molyneux, on your behalf and the submissions of Ms Mustard, on behalf of the NMC. The panel has

made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented at this stage such that a properly directed panel might find the facts of the charges against you proved and whether you had a case to answer. The panel was not determining whether the facts had been found proved.

The panel addressed each of the charges separately and considered the evidence that it had been presented in support of each of them.

The panel first considered charge 4 and took into account the evidence it had heard to support the allegation that you did not provide appropriate support to Patient A during labour in that you did not offer encouragement to Patient A. The panel had regard to Patient A's witness statement as well as her oral evidence. In her statement, Patient A stated: "I was exhausted and wanted someone to say to me "Come on. You can do it" but was told by Dinah "You're not doing it right. Baby is still all the way up there", which will stay with me forever. When I was first admitted onto the Labour Ward, Dinah was quite friendly and found a bath for me to use which I really appreciated. However as my labour progressed, her tone became more aggressive, very much a 'do what I tell you to do' tone." In her oral evidence, Patient A reiterated the fact that her perception was that she did not receive adequate encouragement from you and that whilst you seemed friendly at the start, your approach became negative as the labour progressed. The panel also noted the evidence of Colleague C that your communication was "quite aggressive in nature and not very encouraging". The panel had regard to Ms 1's evidence that it is a midwife's duty to offer the appropriate level of support and encouragement during labour.

Taking all of the above into account, the panel concluded that it had been presented with sufficient evidence on which it could find that the matters alleged in charge 4 proved. The panel therefore determined that based on the evidence before it, it was unable to accede to an application of no case to answer.

The panel next considered charge 6 and took into account the evidence it had heard to support the allegation that you did not provide Patient A with pain relief when it had run out. The evidence in support of the charge came from Patient A where she states: “The gas and air I had been using stopped so I asked for a new one. I was told by Dinah that I wasn’t allowed anymore as it would get in the way of pushing. I didn’t have any pain relief from here onwards but I would have used it if it had been made available to me.” Patient A reiterated that point in her oral evidence when she stated: “I said it wasn’t working (Entonox)…I was told it was and my partner tried it and agreed it was not working…It was then looked at properly and taken away”. Taking all of the above into account, the panel concluded that it had been presented with sufficient evidence on which it could find that the matters alleged in charge 6 proved. The panel therefore determined that based on the evidence before it, it was unable to accede to an application of no case to answer.

The panel next considered charge 8, namely that you pulled the baby from Patient A’s vagina which was not clinically justified. The panel noted that the evidence in support of this charge came from Colleague C. The panel noted that when the alleged incident was reported to Ms 1 at the time, she did not take any immediate or further action about the concerns raised. The panel took into account the fact that at the time, Colleague C was an inexperienced student midwife on her fourth shift of her placement. The panel considered it had no other evidence which corroborated Colleague C’s account. In her oral evidence, Colleague C confirmed in cross examination that other than the issue relating to directed pushing, she saw nothing clinically wrong about your practice. The panel was therefore of the view that, taking account of all the evidence before it in relation to charge 8, there was no prospect that a properly directed panel could find the facts proved. The evidence was tenuous and weak. It therefore found that you have no case to answer in respect of charge 8.

The panel next considered charge 11, that you continued a vaginal examination when consent had been withdrawn by Patient B. The only evidence in relation to this allegation came from Colleague B. However, in her witness statement Colleague B

stated: “While I cannot recall if Dinah explained to Patient B what she was doing, I do recall Patient B giving consent for the examinations. I therefore did not have any concerns about consent or Patient B’s understanding of the procedure.” The panel noted that the application in respect of this charge was not contested by the NMC. The panel determined that there was no evidence before it in support of the charge11. Accordingly, the panel acceded to the application and determined that there was no case to answer in respect of charge 11.

The panel next considered charge 14 and took into account the evidence it had heard to support the allegation that you did not support Patient B in using the birthing pool. The panel had regard to Patient B’s labour notes, Colleague B’s witness statement as well as her oral evidence. In her statement, Colleague B stated: “I recall Patient B being generally quite uncomfortable due to back and pelvic pain which meant that she really struggled to be on her back so she wanted to get into the birthing pool, however Dinah appeared reluctant to let her do this.” In her oral evidence Colleague B told the panel that you were not being supportive to Patient B in using the birthing pool. She said “Dinah appeared reluctant to let her use it…” The panel noted the reason you allegedly gave for not allowing Patient B to use the pool, that she was only 4cm dilated. However, Ms 1 stated that the birthing pool could be used by any patient who was in established labour. Taking both Colleague B’s and Ms 1’s evidence, together with Patient B’s labour notes, into account, the panel concluded that it had been presented with sufficient evidence on which it could find that the matters alleged in charge 14 proved. The panel therefore determined that based on the evidence before it, it was unable to accede to an application of no case to answer.

The panel next considered charge 17, namely that between 0030-0200 you did not document in the labour notes. Having had careful regard to Patient B’s labour notes for 28 June 2016, the panel determined that it was clear that you made several entries in relation to the care provided to Patient B between 0030-0200. The panel noted that the application in respect of this application was not contested by the NMC. In these circumstances, the panel was therefore of the view that, taking account of all the

evidence before it, there was no prospect that a properly directed panel could find the facts of charge 17 proved. It therefore found that you have no case to answer in respect of charge 17.

The panel next considered charges 35.1 and 35.2 and took into account the evidence it had heard to support the allegations that you did not adequately communicate with Patient E in that you did not explain how to push and did not provide adequate direction throughout the process. The evidence in support of the charge came from Patient E. In her witness statement, which was supplemented with her oral evidence to the panel, Patient E stated: “I felt I had lost control because I didn’t know what position to put myself in and didn’t know what to do. There were no instructions or calming words from Dinah so I would know what was happening…I was then told by Dinah that I couldn’t push until 05:00 so as soon as the clock turned 05:00, I pushed. Dinah did not explain to me why I couldn’t push until 05:00. Every time I felt pressure I pushed and as this was my first labour I had no idea what I had to do or what was coming.”

Taking all of the above into account, the panel concluded that it had been presented with sufficient evidence on which it could find that the matters alleged in charge 35.1 and 35.2 proved. The panel therefore determined that based on the evidence before it, it was unable to accede to an application of no case to answer in relation to these charges.

The panel next considered charges 39 and took into account the evidence it had heard to support the allegations that you incorrectly counted Patient E’s contractions at 0215, 0330 and 0530. The panel had regard to the evidence from Ms 2, together with Patient E’s labour notes and CTG trace results. The panel noted documentary evidence demonstrating that you palpated Patient E’s contractions and you made entries of the contraction counts at the relevant times. However, the panel had regard to Ms 2’s evidence that the contractions were incorrectly counted. Having had careful regard to the CTG trace results, the panel had no evidence as to how you reached the contraction counts made in Patient E’s notes.

Taking into account Ms 2's evidence, together with Patient E's labour notes and CTG trace results, the panel concluded that it had been presented with sufficient evidence on which it could find that the matters alleged in charge 39 proved. The panel therefore determined that based on the evidence before it, it was unable to accede to an application of no case to answer.

The panel next considered charge 40, namely that you did not document the fluid input and output of Patient E. Having had careful regard to Patient E's labour notes for 9 September 2016, the panel determined that it was clear that you made several entries in relation to Patient E's fluid input and output. The panel noted that the application in respect of charge 40 was not contested by the NMC. In these circumstances, the panel was therefore of the view that, taking account of all the evidence before it, there was no prospect that a properly directed panel could find the facts of charge 40 proved. It therefore found that you have no case to answer in respect of charge 40.

The panel next considered charge 41 and took into account the evidence it had heard to support the allegations that you broke Patient E's waters which was not clinically justified. The panel had regard to the evidence from Ms 1, together with Patient E's labour notes. The panel noted the entry in Patient E's notes at 1800 on 9 September 2016, with the reference SROM (Spontaneous Rapture of the Membranes). In her oral evidence to the panel Ms 1 confirmed that the SROM acronym was reference to the rupture of the waters. Ms 1 stated: "This is a woman whose fore waters have broken based on notes." The panel noted that Patient E had stated that she had gone to the Hospital with her waters leaking. The panel also took into account your entry in Patient E's notes that at 2045 where you wrote: "…4cm dilated, no membrane felt". The panel concluded that all this information was indicative of the waters having broken without your intervention. In these circumstances, the panel was therefore of the view that, taking account of all the evidence before it, there was no prospect that a properly directed panel could find the facts of charge 41 proved. It therefore found that you have no case to answer in respect of charge 41.

Background:

You were referred to the NMC by the Trust, where you were employed as a Band 6 Midwife between January 2006 and February 2017. The referral was in relation to episodes of care you provided to five patients, Patient A, B C, D and E, on the Jessop Wing (the Hospital) where you worked on a rotational post between the Labour, Postnatal and Antenatal wards. The concerns raised about your practice included:

- A lack of support, care and compassion demonstrated by you towards women in your care on five separate care episodes;
- Inadequate communication and record keeping whilst providing care;
- Lack of informed consent when performing vaginal examinations and acting inappropriately when consent had been withdrawn;
- Positioning women in lithotomy and utilised directed pushing techniques without clinical justification and against the women's wishes;
- Failure to provide evidenced based care and to act within Trust guidelines.

With regard to Patient A, the concerns regarding your practice were raised with the Matron for the Labour Ward and Advanced Obstetric Care Unit, Ms 1, by a Student Midwife, Colleague C. At the time, Colleague C was a first year student midwife who was observing and providing care with direct supervision from you. However, you had overall responsibility for Patient A. Colleague C alleged that you had been rough and aggressive whilst providing care to Patient A on 2 February 2016. You allegedly inserted your fingers into Patient A's vagina without clinical justification or rationale for the procedure. It is alleged that despite Patient A telling you that she did not want to be examined, you went ahead with the vaginal examinations and ignored her wishes. Patient A stated that she felt like her wishes and needs were the very least of your concerns. You then failed to record all the vaginal examinations you conducted on Patient A in her labour notes.

Later that day you allegedly informed Patient A that her baby's heart rate was increasing without explaining the significance of increased fetal heart rate, only stating that you would have to get the doctors if Patient A's baby was not born in half an hour. It is alleged that you did not provide appropriate support to Patient A during labour in that you did not offer encouragement to Patient A, were aggressive in your tone of voice and did not provide her with pain relief when it had run out. It is further alleged that you told Patient A to adopt the Lithotomy positon and performed an ARM (artificial rupture of membranes) on Patient A when it was not clinically justified. Colleague C further stated that as Patient A's baby's head was born at appropriately 19:55hrs, you allegedly pulled the baby's body without waiting for the next contraction.

With regard to Patient B, the concerns in relation to the care you provided were raised when Patient B attended a Birth Afterthoughts session at the Hospital on 7 September 2016, where women and their partners reflect on their birth experiences. The concerns related to 29 June 2016, when you had been providing care to Patient B with Colleague B who was a student midwife at the time. In a meeting with management about the concerns raised by Patient B, Colleague B alleged that the vaginal examination you performed on Patient B may have been "a bit rough" and recalled Patient B asking you to stop the examination "once or twice". It is therefore alleged that you continued the vaginal examination when consent had been withdrawn, and directed a pushing technique when it was not clinically justified. It is further alleged that you failed to document in Patient B's labour notes her discomfort during vaginal examinations and her urine output at 2350hrs and also that you did not counter sign Colleague B's entries in the labour notes. Patient B is also said to have raised concerns about your communication skills and your failure to support her in using the birthing pool.

In relation to Patient C, the concerns related to the care you provided on 10-11 September 2016. In her complaint letter to the Hospital, Patient C stated that you subjected her to painful vaginal examinations with one in particular being "excruciating." It is also alleged that despite Patient C and her husband's repeated requests, you did not stop the examinations. You are then alleged to have conducted a further vaginal examination without clinical justification straight after Patient C's waters had broken.

Patient C also raised concerns about your communication skills and your inability to explain your rationale and clinical justification for the actions you took during labour, including not explaining or documenting the need for Konakoin, why she had to adopt the lithotomy position or the reasons for asking her to lie on her side when it was painful to do so. Patient C stated that on a number of occasions both she and her husband had to ask you to repeat information and to do so louder, due to Patient C suffering from hearing impairment. You allegedly failed to provide appropriate emotional support to Patient C in relation to pain relief and dishonestly recorded in her patient notes that she was happy with the lithotomy positon when that was not the case. It is further alleged that you left Patient C covered in blood when she waiting to be taken to theatre.

With regard to Patient D, the complaints related to the care you provided on 22 September 2016. Patient D raised concerns about your communication skills and your failure to support her during labour, including failing to stop rubbing her abdomen when she asked you to, not explaining to her how to increase the strength of her contractions and not explaining what the injection for the placenta was for. Patient D stated that she was concerned about your "cold demeanour" from the very beginning.

Patient D had sustained a second degree tear to her perineum during labour and needed suturing under local anaesthetic. However, when the suturing started Patient D explained that she could feel the needle and told you to stop but you allegedly ignored her and continued suturing. She allegedly had to shout *"Please stop. You're hurting me."* When Patient D became very distressed, you went to call the Band 7 Coordinator, Colleague A, for assistance, but you allegedly left Patient D while she was in the lithotomy positon and with a needle in situ. When you returned with Colleague A, she instructed you to stop stitching and complete it when Patient D was ready. However, it is alleged that you said "I'll just finish". Colleague A stated that despite gaining Patient D's trust and assuring her that the suturing would stop, you attempted to put another stitch in and she had to tell you to stop.

With regard to Patient E, the complaints related to the care you provided on 9 September 2016. Patient E raised concerns about your communication skills and your

failure to support her during labour, including failing to explain the different positions Patient E could adopt during labour, alternative pain relief and providing adequate direction throughout the labour process. You allegedly said to Patient E that she would be unable to cope or words to that effect, incorrectly counted her contractions and told her to look at the Cardiotocography (CTG) monitor to know when she was having a contraction. There were also concerns raised about your documentation in relation to the care you provided to Patient E. You allegedly increased syntocinon infusion without clinical justification and failed to adequately or accurately record the increase of syntocinon. It is further alleged that you broke Patient E's waters when it was not clinically justified and commenced IV fluids after citing a Patient Controlled Epidural and Analgesia.

Following the complaints from the patients, the Trust instructed Ms 1 (Matron at Jessop Wing) and Ms 2 (Author of investigation report for Local Supervisory Authority), to investigate the concerns raised about your practice. After careful consideration of all the evidence, including your responses in investigatory meetings, the matter was referred to a disciplinary panel. You were invited to a disciplinary hearing on 6 April 2017, for which you provided a written account. However, you resigned from the Trust prior to your disciplinary hearing.

Decision on the findings on facts and reasons:

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Ms Mustard, on behalf of the NMC and those made by Ms Molyneux on your behalf.

The panel heard and accepted the advice of the legal assessor, which included advice in respect of the test it should apply in determining the allegation of dishonesty at charge 25. The legal assessor also gave the panel advice in relation to your good character and how good character could be a positive feature in assessing credibility. The panel was reminded 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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel heard oral evidence from nine witnesses called on behalf of the NMC.
The witness statements of Ms 3 (Band 6 Midwife at the Hospital) and Ms 4 were agreed and admitted into evidence. The panel also heard oral evidence from you.

The panel began by considering the credibility of the witnesses in the order they gave their evidence.

Colleague A:
The panel was of the view that Colleague A was a credible, measured and balanced witness who assisted the panel as best she could. She was consistent in her account of events, gave clinical rationale for her views and had a clear recollection of the incidents in question. The panel determined that Colleague A's evidence was reliable.

Patient C:
The panel found Patient C to be a credible and reliable witness. She was consistent in her account of events as she perceived them at the time. She did not seek to embellish her account and she was articulate and frank notwithstanding that she was speaking about difficult experiences.

Patient E:
The panel found Patient E to be a credible and reliable witness. Whilst she was unclear in her recollection about the sequence and timing of certain events, she was consistent and had detailed accounts in relation to the matters she remembered. The panel found her credible in relation to the matters she could remember.

Colleague C:

The panel was of the view that Colleague C was a credible and reliable witness. She was confident and measured. Her account and recollection of events was consistent with her witness statement and her more contemporaneous accounts.

Patient D:

The panel found Patient D's evidence credible and reliable. Her evidence was candid, fair and measured. She had a clear recollection and gave a detailed account of the incidents as she perceived them at the time.

Colleague B:

The panel found Colleague B to be a credible and reliable witness. Her evidence was clear, confident and measured, and she did not embellish her account. Colleague B made concessions when she could not remember certain aspects of her evidence.

Patient A:

The panel found Patient A's evidence credible and reliable. The panel noted that despite being upset by having to recall very difficult experiences, Patient A gave clear and consistent evidence about the incidents as she perceived them at the time. When she could not remember certain events or conversations she said so.

Ms 2:

Ms 2's evidence was knowledgeable and gave clear and straightforward responses to questions. She accepted where she had made errors when discrepancies were highlighted in her investigation report during cross examination and therefore found her to be honest and credible.

Ms 1:

The panel found Ms 1's evidence credible, measured and balanced. She was professional in her approach and very knowledgeable in relation to midwifery matters. She gave clear and concise responses to questions and she had a good recollection of the events in question. The panel found her evidence reliable.

The panel next considered the credibility of your evidence. It found that whilst you were initially confident, consistent and clear in your evidence, during cross examination your demeanour changed and you became vague and inconsistent, frequently giving one word answers to questions. However, in response to panel questions you improved your engagement with questions but still remained inconsistent. For example, there were inconsistencies in relation to the number of vaginal examinations you said you had undertaken on Patient A. In the local investigation meeting you said it was three times and in the investigation meeting outcome letter it states that you had said that you inserted your fingers on two occasions. In oral evidence you stated that it had only occurred on one occasion. However, you could not explain these discrepancies in your oral evidence and suggested the meeting notes were inaccurate. When asked in cross examination if there was a risk of fetal distress from an ARM (artificial rupture of membranes) you stated there was no risk at the point you did an ARM. However, in response to panel questions you conceded that there was always a risk of fetal distress from an ARM. In its consideration of your evidence the panel had regard to good character advice, it being relevant to questions of credibility and propensity. However, the panel concluded that you were not wholly credible and reliable on all issues.

The panel went on to consider each of the outstanding charges, and made the following findings:

In relation to Patient A on 2 February 2016:

Charge 1:

1. You did not stop one or more vaginal examinations when asked to do so.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement evidence of Colleague C and Patient A which were admitted as their evidence in chief and supplemented with their oral evidence. In her witness statement Patient A stated: “I had a lot of vaginal examinations during my labour which were all performed by Dinah. Despite telling Dinah that I did not want to be examined, the examinations went ahead anyway until I had to scream at her “Get the fuck away from me” as she was being really rough.” In her evidence to the panel Patient A reiterated that you did not stop when she asked you to and said: “She did what needed to be done and then stopped – it didn’t stop straight away.”

In her witness statement Colleague C stated: “The patient was screaming and crying for Dinah to stop and her partner was also crying. The patient was clearly in distress and telling Dinah to stop so she should have stopped, but she didn’t…I know that Dinah ignored the patients request because she continued on with the examination.”

The panel considered that it had previously determined that the term ‘vaginal examination’ was a broad enough term to cover actions that would include a specific vaginal examination and also the insertion of fingers into the vagina to direct pushing. Whilst the panel appreciates that there may have been a technical distinction between vaginal examinations and inserting fingers to direct pushing, the distinction was not one that could be easily recognised by a lay person or an inexperienced student midwife. It also believed that the seriousness of the issue here was your failure to stop performing and intimate procedure when asked to. The panel determined that Patient A and Colleague C’s evidence and interpretation of the procedure, was that it was a vaginal examination. The panel determined that they both referred to an intimate procedure which should be documented for which consent was required and where consent had been withdrawn.

The panel noted your claim in evidence that you immediately stopped your first vaginal examination when asked to do so by Patient A and denied that Patient A had sworn at you. However, the panel noted that Patient A and Colleague C’s evidence was clear

and both were adamant that you did not stop when asked to do so. Colleague C told the panel that she also remembered Patient A's partner crying and saying stop. The panel found Patient A and Colleague C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient A and Colleague C. It therefore found the facts alleged in charge 1 proved on the balance of probabilities.

Charge 2:

2. You did not record all vaginal examinations conducted on Patient A.

This charge is found proved.

In reaching its decision, the panel took into account the witness statement evidence of Ms 1 and Ms 2 which were admitted as their evidence in chief and supplemented with their oral evidence. Ms 1stated: "Every time a vaginal examination is performed, this should be recorded in a patient's notes. It goes without saying that you should always write that consent was obtained as part of the intimate examination. If a patient does not consent to the procedure or asks you to stop during the procedure, you should not go any further and explain to the patient why the examination is necessary." The panel also noted Ms 2's evidence that: "If you are putting your fingers into a woman's vagina, I would class that as an examination, and therefore should be documented in the patient's notes."

The panel noted your claim in evidence that you inserted your fingers to assist with pushing. The panel considered that it had previously determined that the term 'vaginal examination' was a broad enough term to cover actions that would include a specific examination and also the insertion of fingers into the vagina to direct pushing. In the panel's view, that was an intimate procedure which required consent from the patient.

Furthermore, the consent for such an intimate procedure had to be documented in the patient notes even if you did not consider the procedure a vaginal examination. The panel also noted your admission in evidence that some vaginal examinations or directed pushing was not noted in patients' notes.

Having had careful regard to Patient A's oral evidence and her Labour notes for 2 February 2016, the panel noted that there was no documentation in relation to all of the vaginal examinations conducted by you on Patient A or whether consent had been given for those examinations. In these circumstances, the panel found charge 2 proved.

Charge 3:

3. You inserted your fingers into Patient A's vagina to direct pushing which was not clinically justified.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1, Ms 2, Patient A and Colleague C which were admitted as their evidence in chief and supplemented with their oral evidence. The panel had regard to Ms 1's evidence that: "Part of the complaint with the vaginal examinations was that Dinah was inserting her fingers into Patient A's vagina to direct pushing. If you are inserting your fingers into a patient's vagina you have to have a reason to do it. You wouldn't do it unless it gives you information or there was an emergency such as a prolapsed cord, in which case you would need to act."

The panel noted your evidence that you had made a clinical decision to assist with pushing when you inserted your fingers in Patient A's vagina. Therefore the issue was whether directed pushing was clinically justified. In your evidence to the panel you accepted that directed pushing is not a technique that you learned from training or any

of your studies, it was a technique you said that you had observed other practitioners perform.

Ms 1 told the panel that there was no evidence to suggest direct pushing helps at all and that it can be extremely uncomfortable for the woman. Ms 1 told the panel that directed pushing was not advocated at the Hospital and in the meeting she had with you about this incident in February 2016 you agreed that you would not use the procedure as it had no clinical benefit. Ms 2's evidence was that directed pushing was old fashioned and the current approach is to leave women to naturally push, especially if there is no epidural.

Having regard to all of the above, the panel found that you inserted your fingers into Patient A's vagina to direct pushing which was not clinically justified. It therefore found charge 3 proved on the balance of probabilities.

Charge 4:

4. Did not provide appropriate support to Patient A during labour in that you did not offer encouragement to Patient A.

This charge is found proved.

In reaching this decision, the panel took into account the written evidence of Patient A which was admitted as her evidence in chief and supplemented with her oral evidence. In her witness statement Patient A stated: "As Dinah was examining me, I remember her telling that I wasn't doing it right (in relation to pushing) which made me feel completely horrendous… I was exhausted and wanted someone to say to me *"Come on. You can do it"* but was told by Dinah *"You're not doing it right. Baby is still all the way up there"*, which will stay with me forever." Patient A further stated: "There were times when Dinah's communication felt very aggressive such as when she told me that I wasn't pushing right as the baby hadn't moved. The aggressiveness was in her tone of

voice and it was as though she had no understanding of my situation. Dinah was very matter of fact and not supportive at all."

In her oral evidence to the panel Patient A stated you used an aggressive and stern tone, she said "I understand that midwives need to be stern but I can specifically remember her saying 'you are not doing it right' I perceived her to be quite forceful." Patient A's evidence was that you became annoyed and frustrated.

The panel also noted the evidence of Colleague C that your communication was "quite aggressive in nature and not very encouraging".

Your evidence was that you did provide the support and whilst Patient A may have expected more, the support you provided was adequate and appropriate. The panel considered that whilst you may initially have come across as being supportive, Patient A was clear in her complaint letter to the Hospital, her witness statement and oral evidence, that as her labour progressed, you became aggressive and your demeanour changed. The panel found Patient A and Colleague C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient A and Colleague C. It therefore found the facts alleged in charge 4 proved on the balance of probabilities.

Charge 5.1:

5. Did not adequately communicate in that you;

    5.1 did not explain the significance of increased fetal heart rate

This charge is found not proved.

In reaching this decision, the panel noted that the only direct evidence in support of this charge came from Patient A, where she stated: “Around 19:00, Dinah informed me that my baby’s heart rate was increasing but she failed to communicate the significance of this, just stating that she would have to get the doctors if my baby wasn’t born in half an hour. She did not give me any further information than this which made me feel terrified.” The panel noted that Colleague C had not raised a specific concern about this issue.

The panel had regard to Patient A’s evidence that she thought the issue of the fetal heart rate was mentioned as part of a conversation about involving a doctor in her care. However, she accepted that you might have mentioned the fetal heart rate in a separate conversation and she could not be certain that you had not explained the significance of the fetal heart rate then.

In the absence of any further evidence, in particular evidence which would corroborate the accounts given by Patient A, the panel has concluded that it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not explain the significance of increased fetal heart rate. Accordingly, the panel found charge 5.1 not proved.

Charge 5.2:

5. Did not adequately communicate in that you;

5.2 did not explain why Patient A had to get out of the bath.

This charge is found not proved.

In reaching this decision, the panel noted that the only direct evidence in support of this charge came from Patient A, where she stated: “I remember Dinah saying at one point

“Listen. You need to get out of the bath now.” I didn’t want to and on voicing this I was told by Dinah “You can’t have this baby in the bath. You need to get out.” She gave no further explanation that this. What I needed from her was more care and understanding. I didn’t ask her why because I had given up at this point.” The panel noted that Colleague C had not raised a specific concern about this issue.

The panel noted your evidence that you explained that as the water was getting cold it would not be good for the patient or conducive for child birth. The panel had regard to the entry you made in the labour notes in relation to this incident, where you wrote “encouraged her to come out.”

In the absence of any further evidence, in particular evidence which would corroborate the accounts given by Patient A, the panel has concluded that it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not explain why Patient A had to get out of the bath. Accordingly, the panel found charge 5.2 not proved.

Charge 6:

6. You did not provide Patient A with pain relief when it had run out.

This charge is found not proved.

In reaching this decision, the panel had regard to the evidence of Patient A that: “The gas and air I had been using stopped so I asked for a new one. I was told it was working. My partner…checked and informed them it had run out. I was told by Dinah that I wasn’t allowed anymore as it would get in the way of pushing and told it was time to get out the bath. I didn’t have any pain relief from here onwards but I would have used it if it had been made available to me.” The panel noted that Colleague C had not raised a specific concern about this issue.

The panel accepted your evidence that the pain relief had not run out and the reasons for the removal of the gas and air cylinder. The panel accepted the evidence that as Patient A was moving to a bed which had access to gas and air on the wall there was no need for a gas cylinder. The panel considered that whilst Patient A was convinced that the cylinder was faulty and the pain relief had run out, it could not be satisfied on the basis of the evidence that was the case. Furthermore, there was no evidence to suggest that Patient A had requested further pain relief following the removal of the gas cylinder.

In the absence of any further evidence, in particular evidence which would corroborate the accounts given by Patient A, the panel has concluded that it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not provide Patient A with pain relief when it had run out. Accordingly, the panel found charge 6 not proved.

Charge 7:

7. Told Patient A to lie on her back and/or adopt the Lithotomy positon which was not clinically justified.

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Patient A that: “I was told by Dinah I had to lay on my back with my legs in stirrups which meant that I couldn’t move. I didn’t want to be in that position at all because of what I had learnt in attending a hypnobirthing course during pregnancy so I wanted to remain upright and ‘breathe the baby down’. I also had a lot of back pain. I was in this position for the majority of the time I was pushing.” In her oral evidence, Patient A said she told you she didn’t want to

be on her back because she was uncomfortable and had a lot of pain in her back but you told her it was best to lie on her back.

The panel had regard to Colleague C's evidence that: "The patient wanted to give birth on all fours however Dinah requested she lay on the bed. We generally recommend that patients give birth in an upright position in labour due to the aid on gravity; it depends on the clinical circumstances and what the patient wants. I think the patient should have been able to stay on all fours because this is the position she wanted to adopt and there was no clinical reason she couldn't have."

The panel had regard to your evidence that Patient A was using different positions during labour and delivered her baby on all fours as you documented in her notes. However, in her evidence to the panel, both Patient A and Colleague C were clear and adamant that Patient A was on her back for delivery of her baby. Patient A also recalls that her legs were in stirrups.

The panel noted that this was Patient A's first labour and therefore it was more likely than not, that she would have a clear recollection of this incident. The panel noted that this was corroborated by Colleague C's evidence that Patient A wanted to give birth on all fours.

The panel found Patient A and Colleague C's evidence consistent, credible and reliable in relation to this incident and therefore determined that you told Patient A to lie on her back for delivery.

In considering whether your actions were clinically justified, the panel had regard to Ms 1's evidence that "Lithotomy was usually only adopted by an obstetrician or if there was to be a forceps delivery. She added that in recent research – Cochrane 2017 (research database), when compared to other positions, lithotomy played no part in assisting delivery and pushing. The panel also had regard to the Local Clinical Practice guidelines which were exhibited where it states under 'second stage of labour' at 5.8

“Ensure bladder empty at outset of pushing (if appropriate) encourage women to avoid supine and semi supine positions.”

Having regard to all of the above, the panel found on the balance of probabilities that you told Patient A to lie on her back and/or adopt the Lithotomy positon which was not clinically justified. The panel therefore found charge 7 proved.

Charge 9:

9. At 1830 performed an ARM on Patient A with no clinical justification.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C which was admitted as her evidence in chief and supplemented by her oral evidence. The panel had careful regard to an entry in Patient A’s labour notes which indicated that you had performed an ARM at 18:30. In her NMC witness statement Ms 2 stated: “If labour is progressing normally there shouldn’t be any need to break a woman’s waters. ARM is performed by using two fingers to spread the vaginal wall and then insert a plastic hook into the vagina to rupture the membranes…The only time you would perform ARM is if you had concerns about slow progress in labour or if the woman requested it…You could also perform ARM if there is any bleeding because this would let you know if there had been a placental abruption. In Patient A’s case, there was no clinical indication to have performed ARM because labour was progressing normally…”

The panel had regard to your evidence that your performed ARM to help the baby’s head move down and that there was no risk of fetal distress at that point. As noted above however, in response to panel questions you accepted that there was always a risk of fetal distress when an ARM is performed.

The panel accepted Ms 2's evidence that if labour is progressing normally there should not be any need to break a woman's waters and the only time you would perform ARM is if you had concerns about slow progress in labour, but you would need to establish why and obtain full consent. Having had careful regard to Patient A's notes, the panel considered that there were no concerns which justified ARM in relation to the progress Patient A was making in labour. As such there was no clinical justification for ARM.

Having weighed all the evidence in relation to this allegation, the panel determined that you performed an ARM on Patient A with no clinical justification. The panel therefore found the facts alleged in charge 9 proved on the balance of probabilities.

In relation to Patient B on the night shift of 28 June 2016:

Charge 12:

12. Did not document Patient B's discomfort during vaginal examinations.

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Colleague B and Ms 1 which were admitted as their evidence in chief and supplemented with oral evidence. In her witness statement Colleague B stated: "Dinah recorded three vaginal examinations being performed; 22:30, 02:30 and 05:30. This roughly accords with my memory although I think more may have performed although I can't say exactly how many or when. There is no written record by Dinah that Patient B asked her to stop the exam." In her evidence to the panel Colleague B said it was obvious that Patient B was uncomfortable and had to shout out "stop". The panel also noted the more contemporaneous local statement Colleague B in which she stated that: "When Patient B was due to be examined I noticed that she was extremely uncomfortable lying on her back. Dinah examined her and almost immediately Patient B shouted 'Stop, Stop!'"

The panel had regard to Ms 1's evidence that: "Every time a vaginal examination is performed, this should be recorded in a patient's notes. It goes without saying that you should always write that consent was obtained as part of the intimate examination. If a patient does not consent to the procedure or asks you to stop during the procedure, you should not go any further and explain to the patient why the examination is necessary." The panel also noted Ms 2's evidence that: "If you are putting your fingers into a woman's vagina, I would class that as an examination, and therefore should be documented in the patient's notes."

Your evidence was that you did not document Patient B's discomfort as it was not above and beyond previous reactions you had seen for such a procedure. However, the panel found Colleague B's evidence consistent, credible and reliable in relation to this incident.

Having had careful regard to Patient B's notes for 28 June 2016, the panel noted that there was no documentation in relation to Patient B's discomfort during vaginal examinations. In these circumstances, the panel found charge 12 proved.

Charge 13:

13. Used a 'directed pushing technique' which was not clinically justified.

This charge is found not proved.

In reaching this decision, the panel noted that the only direct evidence in support of this charge came from Colleague B where she stated: "I have been asked by the NMC investigator whether I recall Dinah using the directed pushing technique with Patient B. This was something that Dinah did with all patients. I remember Dinah trying it with Patient B but she didn't want it and wanted to get back in the pool. I personally wouldn't do it routinely and I do not think it was necessary."

The panel considered that prior to her NMC statement which was obtained some year and a half after the incident, Colleague B had not mentioned anything in relation to this allegation. In the absence of any further evidence, in particular evidence which would corroborate the accounts given by Colleague B, the panel has concluded that it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find this charge proved on the balance of probabilities. Accordingly, the panel found charge 13 not proved.

Charge 14:

14. Did not support Patient B in using the birthing pool.

This charge is found not proved.

The panel noted that the only direct evidence in support of this allegation came from Colleague B where she states: “I recall Patient B being generally quite uncomfortable due to back and pelvic pain which meant that she really struggled to be on her back so she wanted to get into the birthing pool, however Dinah appeared reluctant to let her do this. We generally always encourage patients to mobilise and adopt different positions. When Patient B first came onto the Labour Ward, she had been examined in Triage as being 4cm dilated. I don’t know if this is a rule but Dinah said that Patient B couldn’t go into the pool until she was at least 5cm dilated. This decision seemed strange to me because by the time the pool filled up, Patient B would have been almost 5cm dilated...”

The panel had regard to your evidence that you did support Patient B in using the birthing pool and your perceived reluctance was due to the fact that having made a clinical assessment of Patient B, you concluded she was not sufficiently dilated to be allowed in the birthing pool in line with the Hospital policy. Having had careful regard to Patient B’s labour notes, the panel determined that there was clear documentation

demonstrating that you had supported Patient B in using the birthing pool. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not support Patient B in using the birthing pool. It therefore found charge 14 not proved.

Charge 15.1:

15. Did not appropriately communicate with Patient B in that you;

    15.1 Did not explain to Patient B the significance in a decrease in the fetal heart rate.

This charge is found not proved.

The panel noted that the only direct evidence in support of this allegation came from Colleague B where she states: “I also felt Dinah could have been clearer in terms of her communication with Patient B. I can recall one example where the fetal heart rate had dropped very slightly but then it recovered. Dinah then monitored Patient B using Cardiotocography (“CTG”) and immediately went to get the doctor but didn’t explain to Patient B why she was doing this.”

The panel had regard to your evidence that you did explain the significance in a decrease in the fetal heart rate to Patient B. The panel noted detailed reference to what had been discussed with Patient B in her labour notes between 2235 and 2300 which appeared to support your assertion that the significance in a decrease in the fetal heart rate was explained to Patient B. In the absence of any further evidence to corroborate the account given by Colleague B, the panel has concluded that it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not explain to Patient B the significance in a decrease in the fetal heart rate. Accordingly, the panel found charge 15.1 not proved.

Charge 15.2:

15. Did not appropriately communicate with Patient B in that you;

15.2 Did not explain why you were getting a Doctor.

This charge is found not proved.

The panel noted that the only direct evidence in support of this allegation came from Colleague B where she states: “Dinah then monitored Patient B using Cardiotocography (“CTG”) and immediately went to get the doctor but didn’t explain to Patient B why she was doing this.”

The panel had regard to your evidence that you did explain to Patient B why you were getting a Doctor. The panel noted an entry in Patient B’s labour notes which appeared to support your assertion that you had explained to Patient B why you were getting a Doctor. The panel determined that in the absence of any further evidence to corroborate the account given by Colleague B, it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not explain why you were getting a doctor. Accordingly, the panel found charge 15.2 not proved.

Charge 18:

18. Did not record Patient B’s urine output at 2350.

This charge is found proved.

Ms 2’s evidence was that: “Dinah also failed to record Patient B’s urine output…Dinah recorded that Patient B had mobilised to the toilet. Dinah recorded ‘PU’ which means

‘passed urine’ but she has not recorded how much. It was important this was recorded because a full bladder can effect descent of the fetal head…It is reasonable to expect a registered midwife to keep clear, accurate and contemporaneous records relating to their practice. Dinah acknowledged that Patient B should have had a fluid balance chart but stated at interview that she had not completed one as she ‘did not have time’ recalling that she was busy preparing Patient B for her epidural...”

The panel noted that in your entry in Patient B’s notes you wrote “PU” (passed urine). However, you did not specify Patient B’s urine output at this time. Having regard to all of the above, the panel found charge 18 proved.

In relation to Patient C on the night shift of 10-11 September 2016:

Charge 19:

19. Did not stop a vaginal examination when you were asked to do so on one or more occasion.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C, Ms 1 and Ms 2 which were admitted as their evidence in chief and supplemented with their oral evidence. In her witness statement Patient C stated: “The vaginal examination recorded as being performed at 00:15 is not clear in my mind but the other two stick out as being horrendous. The vaginal examination at 22:25 was performed just after my waters broke. I remember writhing and gripping the bed – there wasn’t a lot I could do to get away from the pain…During both vaginal examinations, I told Dinah that it hurt and asked her to stop but she didn’t; the level of panic was indescribable. I remember shouting ‘stop, stop, stop’ but she didn’t which made me feel like an uncooperative piece of meat.”

The panel noted the entry you made in Patient C's labour notes 10-11 September 2016 where you wrote "Patient C felt uncomfortable and asked me to stop." Your oral evidence was that you stopped immediately and that Patient C complained of pain because she may have been experiencing a contraction at that time.

However, in her evidence to the panel Patient C reiterated that she could feel you carry on even after she had asked you to stop and there was, in her opinion, no way that her comments could have meant anything else other than to stop. In her oral evidence Patient C said: "It was a simple instruction which anyone would've understood." The panel also had regard to Ms 2's evidence that: "…during my meeting with her…Patient C recalled how during labour she was 'subjected to painful vaginal examinations' by Dinah with one in particular being 'excruciating' that, unlike her previous experiences (with other midwives), did not stop despite 'repeated requests' to do so."

In her witness statement Ms 1 stated: "The main issues appeared to be around communication, not adhering to the patient's birthing plan and the lack of empathy from Dinah. Patient C also raised concerns with the way Dinah carried out vaginal examinations. Patient C claimed that despite begging Dinah to stop the examinations, she didn't stop."

The panel found Patient C's evidence consistent, credible and reliable in relation to this incident. Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 19 proved on the balance of probabilities.

Charge 20:

20. Conducted a vaginal examination straight after Patient C's waters had broken with no clinical justification.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 2. In her witness statement Patient C stated: “The vaginal examination at 22:25 was performed just after my waters broke. I remember writhing and gripping the bed – there wasn’t a lot I could do to get away from the pain.”

Ms 2 stated: “Dinah has recorded that she performed a vaginal examination at 22:25…but this was just after [Patient C’s] waters had broken so there should have been no need to do so. I do not know what Dinah’s rationale was for doing the vaginal examination as she did not record this, as I would have expected her to.” In her evidence to the panel Ms 2 said that there was no clinical justification for a vaginal examination after a spontaneous rupture of membranes.

You told the panel that your clinical justification for the vaginal examination was to establish whether Patient C was fully dilated but you could not explain why you thought it was necessary to establish this. However the panel noted that the NICE guidelines detail that clinicians should ‘be sure that an examination is necessary and will add important information to the decision making process.’

The panel considered Ms 2’s oral evidence that: “If everything is natural, the patient should dilate 1cm every 2 hours, if as expected it is not clinically indicated to make interventions. The panel had careful regard to Patient C’s Birthing plan and noted that she had expressly stated: *“I would prefer no vaginal examination.”* The panel considered that given the clear preference in Patient C’s birthing plan, you would have appreciated the need not to perform unnecessary vaginal examinations and respect Patient C’s wishes. Having had careful regard to Patient C’s notes, the panel considered that there were no concerns which justified a vaginal examination following the breaking of her waters. Accordingly, the panel concluded that there was no clinical justification for a vaginal examination at that stage of Patient C’s labour.

Having weighed all the evidence in relation to this allegation, the panel determined that you conducted a vaginal examination straight after Patient C’s waters had broken with

no clinical justification. The panel therefore found the facts alleged in charge 20 proved on the balance of probabilities.

Charge 21.1:

21. Did not communicate appropriately with Patient C in that you;

21.1 did not raise your voice when asked to do so

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C, Ms 1 and Ms 2. In her witness statement Patient C stated: “I do not recall how many times I asked Dinah to repeat what she had said but it would have been numerous. Throughout the night, I gave up asking Dinah and just looked at my husband to repeat what had been said. As the night escalated, it became more and more of a problem as I wanted Dinah to say something in a clear and concise way; all I wanted was clear answers to simple questions.”

Patient C told the panel that she and her husband informed you of her hearing impairment on several occasions. She said “We had hammered home that I was deaf, it was very difficult to interact with her.”

The panel had regard to Ms 2’s evidence that: “Patient C recalled that on a number of occasions both her and her husband had to ask Dinah to repeat information and to do so louder, due to Patient C suffering from hearing impairment. They alleged that their repeated requests made ‘no difference’ and that throughout labour, Patient C had to look to her husband to relay information provided by Dinah but that ‘most of the time [Dinah’s] answers were so vague and useless”.

Your evidence was that you were only told once by Patient C's husband that she had a hearing impairment. You told the panel you bore in mind during your interactions with Patient C that in her birth plan her wish was for all communication to be conducted through husband and that she also wanted a hypno birth. However, you did raise your voice when asked to do so.

The panel noted that Patient C had raised concerns about communication in her more contemporaneous complaint letter to the Hospital dated 11 December 2016, where she wrote: "Both myself and my husband made it very clear on a number of occasions that I am quite deaf and Dinah to repeat what she had said and speak a little louder for my benefit. At no point did our requests make a difference." The panel also noted Ms 1's evidence that:"[Patient C] also stated that throughout her labour, the communication from Dinah was unclear and she felt she had to keep asking questions and guess to try and understand what was going on which lead to confusion and then panic." Patient C was clear that she informed everyone from the outset that she had a hearing impairment but this was not taken into account by you. The panel also noted that Patient C's birthing plan in fact stated 'I am happy for you to direct questions to [my husband] *in the first instance* and not me' it did not state that all communications were to be conducted through her husband and the evidence from Patient C was that there was no communication with her husband either. The panel found Patient C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 21.1 proved on the balance of probabilities.

Charge 21.2:

21. Did not communicate appropriately with Patient C in that you;

21.2 did not fully explain the need for Konakoin.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 2. In her witness statement Patient C stated: “I decided that unless there was a reason that would put our child at increased risk, we would prefer them not to have any Vitamin K supplement administered as a matter of course. When asked by Dinah, we both communicated this and asked if there was any reason that our daughter would be at increased risk. Dinah’s face looked shocked and she seemed incredulous at our hesitation and simply listed the organs that could be affected by Vitamin K deficiency. I did not want to know what organs could be affected, I wanted to know whether my daughter was at increased risk…If Dinah had clearly communicated that our daughter was at increased risk then I would have definitely agreed for it to have been administered.” In her oral evidence Patient C reiterated the point that you did not give her an answer as to whether her baby was at an increased risk as to be given Vitamin K.

The panel also noted Ms 2 evidence that: “Following birth, Patient C and her husband informed Dinah that they did not wish for routine Konakion to be administered to their daughter unless she was at an increased risk of bleeding. Feeling that the birth had been traumatic for them, they asked Dinah if it could also have been for their baby, thus placing her at an increased risk of haemorrhage. Both Patient C and her husband recalled Dinah seeming ‘incredulous’ at their hesitation to accept Konakion for their daughter and the answer they were given by Dinah as being totally unhelpful and ‘not answering the question at all’.

Your evidence was that it was not possible to give a definitive answer and you could not determine if a baby needed Konakoin by just looking at it. However, you explained to Patient C that it was recommended that all babies are given Vitamin K.

The panel had regard to Patient C’s birth plan in relation to her expressed wish for Konakion not to be administered routinely unless there was a reason that would put her child at a ‘significant risk’. Patient C therefore wanted an answer as to whether her baby was at risk that would warrant the administration of Konakion. The panel noted

your evidence that you sought to explain the general benefits of Konakion. However, on basis of Patient C's evidence and her labour notes, you did not explain whether Patient C's baby needed Konakion following the birth. In your oral evidence you acknowledged that you should have secured advice from a paediatrician to answer Patient C's questions.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 21.2 proved on the balance of probabilities.

Charge 21.3:

21. Did not communicate appropriately with Patient C in that you;
21.3 did not communicate the reasons why you asked Patient C to lie on her side when it was painful to do so.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 2. In her witness statement Patient C stated: "Around the time my waters broke, Dinah requested a couple of times that I try laying on my left side. I do not remember what position I had been in previously. This position was extremely painful and thus was absolutely not a position that I would naturally move to. When I couldn't bear to remain on my left side for more than a few seconds, the reaction from Dinah was, again, of annoyance. At the time my husband and I did not know why she had requested that I adopt this position, and it is still a mystery. When asked, the most we could glean from Dinah's response was something about 'a bit of cervix'."

Ms 2 stated: "If Dinah thought that Patient C wasn't pushing effectively then it was her responsibility to inform her of that and explain to her what to do. It is expected that in the absence of any clinical indication otherwise, a registered midwife should support a woman to adopt whichever position they find most comfortable throughout labour'.

Your evidence was that you would always support women in adopting their preferred positions. You said you did not ask Patient C to lie on her side and you do not remember talking about ‘a bit of cervix’ or an instance where you would have used that term in relation to Patient C.

The panel noted that this is an issue Patient C had raised both in her specific and more contemporaneous complaint letter to the Hospital. Patient C was clear and adamant in her evidence to the panel that you did ask her to lie on her side. The panel could not understand why Patient C should claim to have been asked to move on to her left side by you if this had not happened. The panel found Patient C’s evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 21.3 proved on the balance of probabilities.

Charge 21.4:

21. Did not communicate appropriately with Patient C in that you;

21.4 Did not immediately explain why Patient C had to adopt the lithotomy position

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 2. In her witness statement Patient C stated: “As part of our preparation, my husband and I looked into the type of positions to adopt for pushing that used gravity to advantage and to work with the body, as well as methods that protected against perineal tearing. My husband and I had seen a number of videos of birth that used those positions and techniques and hoped to be able to have a similar birth experience

ourselves. When I felt the urge to push, I adopted a kneeling position on the bed, resting my arms over the raised bed head. This position felt natural for me at the time, and would have incorporated the above considerations as per my birth plan…I was very quickly told by Dinah to move out of that position and to sit on the bed with my feet on paddles that folded out from the bed. I was only in the kneeling positon for a very short amount of time but from looking at my labour notes, it was about 45 minutes. It felt like I had barely been in the kneeling position before being asked to change by Dinah."

The panel had regard to Ms 2's evidence that: "During my meeting with Patient C she recalled how on several occasions throughout her labour, Dinah instructed her to do things with no explanation or rationale for these actions. This allegation was supported by Patient C's husband who also recalled that no explanations were forthcoming, particularly in relation to Patient C being told to remain in left lateral position following ARM or being changed into lithotomy position after only pushing for five minutes…Both Patient C and her partner did not recall Dinah providing an explanation for the position change until they asked directly at 01:25 when she advised them that Patient C had been 'clenching'…"

Your evidence was that you had asked Patient C to move because her 'bum was tensing up' or 'clenching' as documented in her labour notes.

The panel noted that this is an issue Patient C had raised in her more contemporaneous and detailed complaint letter dated 11 December 2016. Patient C was clear and adamant in her evidence to the panel that you did not offer an explanation for asking her to adopt the lithotomy position. Her evidence was that you later offered an explanation when asked specifically by her husband. The panel found Patient C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 21.4 proved on the balance of probabilities.

Charge 21.5:

21. Did not communicate appropriately with Patient C in that you;
21.5 Did not clearly explain whether the baby was advancing.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 2. In her witness statement Patient C stated: “Again, simple communication was a problem for us both and we had to work for any snippet of information we received. For example, I asked a number of times if Dinah could see the baby’s head – a perfectly straightforward and reasonable question but the answers given were so vague to the point of being cryptic, leaving me to wonder whether things were progressing as they should and searching for clues rather than receiving clear information or any direct reassurance.” Ms 2’s evidence reflected Patient C’s evidence.

Your evidence was that you told Patient C when you could not see the baby’s head but as soon as you saw the head you said so and even told Patient C that the baby’s hair was black. You told the panel there was no negative atmosphere in the room and it was like you were all working together to help deliver the baby.

However, the panel determined that Patient C was clear and adamant in her evidence that you did not give a sufficient response or explanation as to whether the baby was advancing. The panel found Patient C’s evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 21.5 proved on the balance of probabilities.

Charge 22:

22. Did not provide appropriate emotional support in relation to pain relief.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C and Ms 1. In her witness statement Patient C stated: “I cried out for pain relief despite knowing that it was probably too late to do anything about it, and that my wishes were to avoid heavy duty pharmacological interventions, but at the same time these thoughts were readily accessible…I’m sure that dealing with women making repeated unrealistic last minute requests for immediate pain relief at great volume does become quite tiresome for midwives, and I’ve never been more aware of it than when I was one of those women. I would expect that a professional responding to a patient in that situation would show compassion, patience and encouragement. However, the only response I was given was something along the lines of “it’s too late for that now” with a withering look that made me feel ashamed for my behaviour and the pointlessness of my request..”

The panel had regard to Ms 1’s evidence that: “I cannot stress enough how important communication is between a midwife and a patient. As you have women in labour in pain, you have to step up your communication by explaining everything to the women in order to put them at ease because an anxious woman does not bode well with labour.”

Your evidence was that you did provide emotional support to Patient C in relation to pain relief and explained the alternatives. You told the panel that Patient C was fully dilated when she asked for diamorphine and you explained that such a drug would affect her baby if it did not wear off in time, particularly given that Patient C wanted to breast feed. Therefore you suggested that she had a bath or an epidural.

However, in her evidence to the panel Patient C said she did not recall a discussion about any alternatives for pain relief. The panel determined that whilst you might have discussed alternative pain relief, it was clear from Patient C’s evidence and complaint letter that you did not provide appropriate emotional support in relation to pain relief. Patient C stated: “At the time a few words of encouragement from our midwife, to either

of us, would have made such a difference but they never came." The panel found Patient C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 22 proved on the balance of probabilities.

Charge 23:

23. Told Patient C to adopt the lithotomy position with no clinical justification.

This charge is found proved.

In reaching this decision, the panel had regard to Patient C's evidence in relation to her preferred position where she stated: "This position (kneeling on the bed) felt natural for me at the time, and would have incorporated the above considerations as per my birth plan…I was very quickly told by Dinah to move out of that position and to sit on the bed with my feet on paddles that folded out from the bed. I was only in the kneeling positon for a very short amount of time but from looking at my labour notes, it was about 45 minutes. It felt like I had barely been in the kneeling position before being asked to change by Dinah." In her oral evidence, Patient C said the kneeling position, which felt right and natural to her did not cause her any additional discomfort. The panel noted that in your notes in her labour record you have documented that Patient C was "in lithotomy".

The panel had regard to Ms 2's evidence that: "During my meeting with Patient C she recalled how both she and her husband felt that Dinah had 'not even a neutral impact on their labour but a negative one'. Patient C's partner remembered how during the second stage of labour, they had wanted to birth on all fours but that on adopting this position they were 'immediately whipped out of it' with Dinah telling Patient C to change

into lithotomy position with no explanation despite asking ‘quite a lot’ which she felt ‘went against everything they had learnt’.”

The panel had regard to your evidence that there was no indication from Patient C or her husband that they were not happy with the lithotomy position. You said Patient C pushed effectively and when she requested a change of position you supported her immediately.

In considering whether your actions were clinically justified, the panel had regard to Ms 1’s evidence that “Lithotomy was usually only adopted by an obstetrician or if there was to be a forceps delivery. She added that in recent research – Cochrane 2017 (research database), when compared to other positions, lithotomy played no part in assisting delivery and pushing. The panel also had regard to the Local Clinical Practice guidelines which were exhibited where it states under ‘second stage of labour’ at 5.8 *“Ensure bladder empty at outset of pushing (if appropriate) encourage women to avoid supine and semi supine positions.”*

Having regard to all of the above, the panel found on the balance of probabilities that you told Patient C to adopt the lithotomy position with no clinical justification. The panel therefore found charge 23 proved.

Charge 24:

24. Recorded in the patient notes that Patient C was happy with the lithotomy positon when she was not.

This charge is found proved.

In reaching its decision, the panel had careful regard to Patient C’s labour notes for 10-11 September 2016. It noted the entry you made at 0020 where you wrote: “…in lithotomy position as has been on all fours but kept tensing up. Same explained to

Patient C and family. Happy with position." In your evidence to the panel you said there was no indication from Patient C or her husband that they were not happy with the lithotomy position and you got the impression that as Patient C went with your suggestion, she was happy with the lithotomy position. You told the panel that when you wrote 'happy' in Patient C's labour notes this was to connote that she consented to your suggestion and had no issue with the position. You conceded to the panel that Patient C had not confirmed orally at the time that she was 'happy' with this position.

The panel noted that in her evidence and complaint letter, as highlighted above, Patient C made it abundantly clear that she was not happy with the lithotomy position. Patient C said "It was shocking that the notes said I was happy with that position…when I started to cry my husband explained to Dinah that I did not want to be in that position". In her more contemporaneous complaint letter Patient C stated: "The notes state I was "happy" with the position. This could not have been further from the truth from the start. Our feelings towards the lithotomy position were made abundantly clear and were ignored."

The panel found Patient C's evidence consistent, credible and reliable in relation to this incident. Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 24 proved on the balance of probabilities.

Charge 25:

25. Your actions in charge 24 were dishonest.

This charge is found proved.

In reaching its decision, the panel considered that it had found the factual aspect of charge 24 proved as outlined above.

In determining the question of dishonesty, the panel ascertained your knowledge or belief as to the facts and then went on to consider whether your conduct would be deemed dishonest by applying the standards of ordinary decent people. The panel considered your position that there was no indication from Patient C or her husband that they were not happy with the lithotomy position and you got the impression that as Patient C went with your suggestion, she was happy with the lithotomy position.

Having accepted Patient C's evidence, the panel determined that you knowingly suggested the lithotomy when it had been made abundantly clear that Patient C was not happy with the position. The panel considered that whilst Patient C accepted your suggestion to move into the lithotomy position, there was no basis for the conclusion that she was happy with the position. Indeed the evidence was that she was very unhappy with that position. Therefore, by documenting that Patient C was happy with the lithotomy position, you misrepresented the true position as you would have been clearly aware that Patient C was not happy. In the view of the panel, right minded people would view deliberately misrepresenting the facts in medical notes as dishonest behaviour. Therefore, the panel determined that there was evidence that you were dishonest in recording in Patient C's labour notes that she was happy with the lithotomy positon when she was not.

Therefore, having considered all the evidence the panel was satisfied that the NMC has shown, on the balance of probabilities that you acted dishonestly. It therefore found charge 25 proved.

Charge 26:

26. Did not provide practical support in relation to pushing.

This charge is found not proved.

In reaching its decision the panel had regard to Patient C's evidence that: "I was directed to grip my thighs and put my chin to my chest during contractions, holding my breath and pushing hard. This again, went against the advice and information I had previously been given regarding perineal tearing, but my concerns about this were dismissed when I raised them with Dinah." In her evidence to the panel, Patient C said "I was told to hold my breath and push whilst [Dinah] counted, I found it very difficult under strain which felt unnatural".

The panel considered that this in itself could be described as practical support in relation to pushing notwithstanding that Patient C felt it was inappropriate.

The panel had regard to your evidence that you did provide practical support in relation to pushing. Having had careful regard to Patient C's labour notes, the panel determined that there was clear documentation demonstrating that you had provided practical support in relation to pushing. In all the circumstances the panel has concluded that it is unable to find this allegation proved on the balance of probabilities. It therefore found charge 26 not proved.

Charge 28:

28. Left patient C covered in blood waiting to be taken down to theatre

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient C, following her delivery, that: "I was then left alone for several hours with very little idea what was happening, and with me feeling very weak and covered in blood. The blood was all over my arms, legs and clothes; my legs and feet were particularly bad."

Your evidence on this changed during the course of the hearing. In cross examination it was put to patient C that there was no changing of sheets, but the laying of a clean sheet over bloodied sheets. Your evidence to this panel was that, despite Patient C

refusing to have her bed sheets changed, you did clean the blood off her and sought to preserve her dignity by covering her up and partly changing the bed sheets. However, the panel noted that it was not documented anywhere in Patient C's notes that she refused to have her bed sheets changed and there was no documentation of the measures you took to consider or to mitigate the risk of infection.

In response to the assertion that she refused to have her bed sheets changed, Patient C said such an assertion was "laughable and insane, I was sat in a puddle of blood, no one wants that". The panel found Patient C's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient C. It therefore found the facts alleged in charge 28 proved on the balance of probabilities.

In relation to Patient D on 22 September 2016 you;

Charge 30:

30. Did not stop suturing when you were asked to do so by Patient D.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient D which was admitted as her evidence in chief and supplemented with oral evidence. In her witness statement Patient D stated: "Dinah injected the anaesthetic and started to stitch and when I explained to her that I could feel it, she ignored me. I know that she heard me because there were only four of us in the room and she was standing really close to me between my legs. I thought that maybe she didn't hear me so I shouted out that I could feel the stitches to ensure that she heard me but she continued to stitch which was very unsettling. I shouted loudly and clear 'Please stop. You're hurting me' but she continued and never spoke."

Your evidence on this was not clear, initially you stated that after that you administered the local anaesthetic and as you finished tying up the stitch on the 'apex' of the tear/wound, Patient D asked you to stop as she could feel the needle. You said you immediately stopped at that point. In cross examination you stated that you had gone further than making an anchor stitch at the apex, although you insisted that you stopped when Patient D asked you to.

However, in her evidence to the panel Patient D reiterated that she could feel you carry on even after she had asked you to stop. She said: "I could feel her continuing to suture…the whole time I was shouting she was suturing…It didn't feel like she stopped very shortly after I asked her to." In her complaint letter to the Hospital dated 14 March 2017, Patient D wrote: "She was hurting my body. I was powerless to stop her. It was at this point that my husband spoke and said he thought she should stop…" The panel found Patient D's evidence compelling consistent and credible in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient D. It therefore found the facts alleged in charge 30 proved on the balance of probabilities.

Charge 31:

31. Continued to suture when you were asked to stop by Colleague A.

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Colleague A and Patient D which were admitted as their evidence in chief and supplemented with oral evidence. In her witness statement Colleague A stated: "Despite having assured the patient that the suturing would stop and in the process gaining her trust, Dinah

attempted to put another stitch in so I had to ask her to stop again. I know that Dinah had attempted to put another stitch in because I saw her take the needle out of the skin and back into the other side of the tear instead of removing it and tying off the knot…I was in very close proximity to the patient so I could clearly see what Dinah was doing. It was obvious that the patient recognised that another stitch had been started because she became distressed again."

In her oral evidence Colleague A said as she was very familiar with suturing she could see that you had started again and the patient could tell. She added "It wasn't just being tied off…the procedure was being carried on, not what we agreed."

The panel had regard to Patient D's evidence that: "[Colleague A] instructed Dinah to stop stitching and when I was ready, it could be completed. I was still shaking and crying as she spoke to me. I agreed to this plan and thanked her…Dinah who was still in a stitching position said "I'll just finish". I was horrified that she was now not listening to her superior either. I had just agreed with the Band 7 Coordinator that Dinah needed to stop. The Band 7 Coordinator said "No" and had to again explain the plan to Dinah that she needed to stop stitching now."

The panel noted your evidence that you did not carry on with the suturing and that when you said 'I'll just finish', you meant tying off the stitch which you had started to avoid leaving the needle and stitch unsecured.

The panel noted that Patient D was adamant that you continued suturing even after Colleague A had told you to stop, something she was clear about in her complaint letter to the Hospital dated 14 March 2017. The panel found Patient D and Colleague A's evidence consistent, credible and reliable in relation to this incident.

The panel also noted the labour notes where you wrote: "Colleague A attended and tried to asked (sic) Patient D to allow me to tie the suture and cut the needle off so the

suturing can be later when she is settled. Patient D agreed and I did another suture and tied it."

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient D and Colleague A. It therefore found the facts alleged in charge 31 proved on the balance of probabilities.

Charge 32:

32. Left Patient D while she was in the lithotomy positon and with a needle in situ.

This charge is found proved.

In reaching its decision, the panel considered the evidence from Colleague A that: "I went with Dinah to the patient's room and it was clear that the patient was very distressed as she was breathing very quickly. Her partner was also very upset. The patient was still in lithotomy and the suturing needle was still in situ which I was concerned with because this is not normal practice…I was concerned because the patient had been left in lithotomy while Dinah came and escalated her concerns which meant there was a risk of the patient causing injury to herself should she have tried to take her legs out of the stirrups."

The panel had regard to your evidence that needle was not left in situ in that it was not anywhere close to the patient. You said that the needle was secured with forceps lying on top of a sterile sheet on a bowl. However, the panel accepted Colleague A's evidence that when she arrived Patient A was in lithotomy, holding the baby, she did not see any forceps/needle holder attached to the needle and that she could see it in the sterile area between Patient D's legs. The panel found Colleague A's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Colleague A. It therefore found the facts alleged in charge 32 proved on the balance of probabilities.

Charge 33.1:

33**.** Did not adequately communicate with Patient D in that you;

33.1 Did not explain to Patient D how to increase the strength of contractions.

This charge is found proved.

In reaching its decision, the panel considered the evidence from Patient D that: “I was very concerned about Dinah’s cold demeanour from the very beginning. I remember when Dinah took over my care she told me that my contractions were not strong enough and then looked down at me with her arms folded and asked “What are you going to do about it?”

The panel had regard to your evidence that you explained to Patient D that her contractions were very low and told her what to do to get them going as per your entry in Patient D’s labour notes. However, you said you could not advise on increasing the strength of contractions as it is something the body does naturally and cannot be taught.

The panel accepted your rationale for not explaining to Patient D how to increase the strength of her contractions. In those circumstances, the panel determined that you did not explain to Patient D how to increase the strength of contractions. The panel therefore found charge 33.1 proved on the balance of probabilities.

Charge 33.2:

33.2 Did not explain why you were rubbing her abdomen.

This charge is found not proved.

In reaching this decision, the panel noted that the only direct evidence in support of this charge came from Patient D, where she stated: “Very soon after the placenta had been delivered, I was on my back holding my son to my chest. It was at this point that Dinah began rubbing my abdomen and pressing down onto my belly. As I was lying down I couldn’t see what Dinah was doing with her hands, I just felt her pushing really far down into my abdomen and rubbing it which really hurt and scared me. I therefore asked Dinah to stop but she didn’t.”

The panel noted your evidence that you noticed clots were coming out which suggested that Patient D was suffering from post-partum haemorrhage. You said in your clinical judgement, you deemed the incident an emergency and started rubbing the placenta to contract without first gaining Patient D’s consent. However, you later explained to Patient D why you were rubbing her abdomen.

Having had careful regard to Patient D’s labour notes and the entry at 1106, the panel noted that there was some documentary evidence supporting your position. In the absence of any further evidence the panel has concluded that it had insufficient evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find this charge proved on the balance of probabilities. Accordingly, the panel found charge 33.2 not proved.

Charge 33.3:

33.3 Did not explain how to deliver the placenta.

This charge is found proved.

In reaching this decision, the panel noted that the only direct evidence in support of this charge came from Patient D, where she stated: “I felt lost as I didn’t understand what she wanted me to do and I felt that she was angry at me for making things difficult. It was as though I was slowing down her list of jobs that she wanted to do. I therefore pushed and the placenta came out…I would have liked her to have explained to me what she was expecting me to do…I wanted Dinah to communicate with me about what was happening and tell me what to do in order to deliver the placenta. This poor communication and lack of information or guidance exacerbated the situation.”

The panel noted your evidence that patient D wanted to deliver the placenta herself. You said you explained the active management of the third stage of labour to Patient D and your colleague who saw her before you had also explained and documented that explanation in the labour notes. However, Patient D declined controlled cord contraction as part of the active management of the third stage of labour as she wanted to deliver the placenta naturally, which she did eventually.

Having had careful regard to Patient D’s labour notes at 0450 on 22 September 2016, the panel noted that there was some documentation that a discussion had taken place when Patient D first arrived and confirmation that she would accept active management in the event that she suffered any bleeding in the third stage of labour. The panel noted that you gave Patient D an injection when she started bleeding. However, there were no entries in the labour notes suggesting that you explained how delivery of the placenta would be managed in light of the post-partum bleeding.

The panel considered that there was some confusion on the part of Patient D not understanding the need for controlled contraction as part of the active management of her third stage of labour. The panel noted Patient D’s evidence that she remembered having an injection, however, there was no explanation on how to deliver the placenta.

The panel found Patient D’s evidence consistent, credible and reliable in relation to this incident. Having weighed all the evidence in relation to this allegation, the panel

preferred and accepted the evidence of Patient D. It therefore found the facts alleged in charge 33.3 proved on the balance of probabilities.

Charge 33.4:

33.4 Did not explain what the injection for the placenta was for.

This charge is found not proved.

As highlighted above, the panel determined that having had careful regard to Patient D's labour notes, there was some documentation that a discussion had taken place when Patient D first arrived and that she would accept active management in the event that she suffered any bleeding in the third stage of labour. The panel noted your evidence that you and a colleague who had seen Patient D before you, would have explained the process and as part of that discussion, including what the injection for the placenta was for. The panel noted the entries in Patient D's labour notes at 0450 and 1052 in relation to this incident. The panel determined there was insufficient evidence to support the allegation that you did not explain what the injection for the placenta was for. The panel therefore found charge 33.4 not proved.

In relation to Patient E on 9 September 2016 you;

Charge 34.1:

34. Did not communicate adequately with Patient E in that you;

34.1 Did not explain different positions Patient E could take.

This charge is found not proved.

In reaching this decision, the panel noted that the evidence in support of this charge came from Patient E. In her witness statement Patient E stated: “I felt I had lost control because I didn’t know what position to put myself in and didn’t know what to do. There were no instructions or calming words from Dinah so I would know what was happening. I tried to get on my side but I couldn’t because I was connected to so many different wires. Dinah didn’t speak to me much and she was in and out of the room but I wasn’t sure why or where she was going.”

The panel took into account your evidence that you did explain and support Patient E in relation to different positions she could take. The panel had careful regard to Patient E’s labour notes for 9 September 2016, noting the entries where you had discussions in relation to alternative positions. The panel noted references in the labour notes to Patient E using a birthing ball, walking and being advised to mobilise between 1900 and 2015 hours.

The panel determined that in the absence of any further evidence, in particular evidence which would corroborate the accounts given by Patient E, it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not did not explain different positions Patient E could take. Accordingly, the panel found charge 34.1 not proved.

Charge 34.2:

34.2 Did not explain alternative pain relief to the epidural

This charge is found not proved.

In reaching this decision, the panel noted that the evidence in support of this charge came from Patient E. In her witness statement Patient E stated: “Even though I didn’t want an epidural, I felt I had no choice because no other alternative was provided.”

The panel took into account your evidence that you did explain alternatives to pain relief. The panel had careful regard to Patient E's labour notes for 9 September 2016, noting the entries that you had discussions in relation to Entonox, epidural and offering Patient E a bath. The panel also had regard to the evidence that Patient E would have been given an explanation by the anaesthetist who prepared her for the epidural.

The panel determined that in the absence of any further evidence, in particular evidence which would corroborate the accounts given by Patient E, it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not did not explain different positions Patient E could take. Accordingly, the panel found charge 34.2 not proved.

Charge 34.3:

34.3 Did not explain that you were going to touch her abdomen.

This charge is found not proved.

In reaching this decision, the panel noted that the evidence in support of this charge came from Patient E. In her witness statement Patient E stated: "I was in the bath at time when Dinah walked in and she introduced herself. She then came over to the bath, put her hand on my tummy and looked at the clock. I assumed this was to count my contractions but she didn't explain to me what she was going to do or why she was doing it."

The panel took into account your evidence that you did explain why you were touching Patient E's abdomen during your introductory discussion.

The panel determined that in the absence of any further evidence, in particular evidence which would corroborate the account given by Patient E, it had insufficient clear evidence upon which it could rely to safely reach a fully informed conclusion on this allegation. In all the circumstances the panel has concluded that it is unable to find, on the balance of probabilities, that you did not did not explain that you were going to touch Patient E's abdomen. Accordingly, the panel found charge 34.3 not proved.

Charge 35.1:

35. Did not provide adequate guidance and/or support during labour in that you

35.1 Did not explain how to push.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement evidence of Patient E and Ms 2 which were admitted as their evidence in chief and supplemented with oral evidence. In her witness statement Patient E stated: "I was then told by Dinah that I couldn't push until 05:00 so as soon as the clock turned 05:00, I pushed. Dinah did not explain to me why I couldn't push until 05:00. Every time I felt pressure I pushed and as this was my first labour I had no idea what I had to do or what was coming…I was expecting her to guide me more such as telling when to push…"

In her oral evidence to the panel Patient E stated: "She said I couldn't push until 5:00am, looking back that was probably when I was fully dilated but that was not explained at the time".

The panel noted your evidence that you did provide adequate guidance and support in relation to pushing. However, Patient E was adamant that you did not support her. The panel also noted Ms 2's evidence that: "Patient E recalled that when she was in the second stage there was some confusion around when she should push but that Dinah 'was no help at all' telling her when she was pushing that she 'shouldn't be pushing."

The panel found Patient E and Ms 2's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient E and Ms 2. It therefore found the facts alleged in charge 35.1 proved on the balance of probabilities.

Charge 35.2:

35. Did not provide adequate guidance and/or support during labour in that you

35.2 Did not provide adequate direction throughout the process.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement evidence of Patient E and Ms 2 which were admitted as their evidence in chief and supplemented with oral evidence. The panel accepted Patient E's evidence as highlighted above and that there was no explanation as to why things were happening saying "it was abrupt more than anything."

Your evidence was that you did provide adequate direction throughout the process. However, the panel found Patient E's evidence consistent, credible and reliable in relation to this incident.

Having weighed all the evidence in relation to this allegation, the panel preferred and accepted the evidence of Patient E. It therefore found the facts alleged in charge 35.2 proved on the balance of probabilities.

Charge 35.3:

35. Did not provide adequate guidance and/or support during labour in that you

35.3 Told Patient E to look at the CTG monitor to know when she was having a contraction.

This charge is found not proved.

In reaching its decision, the panel accepted the evidence that based on her position on the bed, the CTG screen would not have been visible to Patient E. It also noted your evidence and the evidence of Patient E. In those circumstances, the panel determined that it had insufficient clear evidence upon which it would accept the assertion that you told Patient E to look at the CTG monitor to know when she was having a contraction. The panel therefore found charge 35.3 not proved.

Charge 36:

36. At around 0140-0145 increased syntocinon infusion which was not clinically justified.

This charge is found not proved.

The panel had careful regard to Patient E's notes with regard to the administration of syntocinon infusion. The panel took into account your evidence that you raised the dosage in line with local guidelines and the levels prescribed, using your clinical judgement. The panel accepted your evidence that you only increased the syntocinon infusion when you felt Patient E's contractions were diminishing. The panel considered that there was no evidence to suggest Patient E suffered over- stimulation as a result of your actions. The panel noted that this charge was specific to the time between 0140-0145. In those circumstances, the panel determined that it had insufficient clear evidence upon which it could prove that at around 0140-0145 you increased syntocinon infusion when it was not clinically justified. The panel therefore found charge 36 not proved.

Charge 37:

37. Did not adequately and/or accurately record the increase of syntocinon.

This charge is found not proved.

In reaching its decision, the panel had careful regard to Patient E's labour notes and your oral evidence and noted that you made clear entries of the times syntocinon was increased at 0115, 0145 and 0345 hours. The panel therefore found charge 37 not proved.

Charge 38:

38. Said to Patient E that she would be unable to cope or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient E. In her witness statement Patient E stated: "As Dinah was about to finish her shift she said goodbye to me and I thanked her but only out of politeness, not because I was actually thankful. Dinah then said I wouldn't have lasted in the birthing pool just on gas and air. I didn't really take this in at the time but having reflected on it, I didn't think this was a very nice thing to say which made me feel a bit weak."

The panel noted your evidence that you did say something to the effect of Patient E would not have been unable to cope. However, you claim that you did not say it in a sarcastic manner, but that you had said it in the course of a supportive debrief at the end of your shift.

In light of the above, and having weighed all the evidence in relation to this allegation, the panel found charge 38 proved on the balance of probabilities.

Charge 39:

39. At the following times you incorrectly counted Patient E's contractions

39.1 0215

39.2 0330

39.3 0530.

This charge is found not proved in its entirety.

The panel had careful regard to Patient E's labour notes together with the CTG trace results. Whilst there may have been some evidence of discrepancies in the number of contractions on the CTG readings and Patient E's labour notes, the panel determined it could not conclude on the basis of the evidence before it that at 0215, 0330 and 0530 you incorrectly counted Patient E's contractions. The panel therefore found charge 39 not proved in its entirety.

Submission on misconduct and impairment:

Having announced its finding on all the facts, the panel moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. The panel considered all the documentary evidence adduced in this case including a bundle of evidence consisting of your reflective statements, professional testimonials and training certificates and records. The panel took into account Ms Mustard's full written and oral submissions on misconduct and impairment and the submission of Ms Molyneux on your behalf.

In summary, Ms Mustard in her written submissions, invited the panel to have regard to the cases of *R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin)* and the case *Roylance v General Medical Council [1999] UKPC 16,* 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. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [nursing] practitioner in the particular circumstances".

She submitted that the misconduct in your case concerns:

- Patient consent;
- Enacting procedures (including intimate procedures) and positions which were not clinically justified;
- Leaving a patient in circumstances where they were at risk of harm;
- Failures in basic midwifery practice (not commencing IV fluids prior to citing an epidural);
- Poor communication (including attitudinal concerns and not respecting patient dignity);
- Inadequate record-keeping and;
- Dishonesty arising from the record keeping in respect of Patient C.

Ms Mustard highlighted the specific parts of the *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* ("the Code") and identified where, in the NMC's view, your actions amounted to misconduct. These were paragraphs 1.1, 1.2, 1.3, 2.4, 2.5, 2.6, 4.1, 4.2, 7.2, 7.4, 10.2, 10.3, 10.4, 11.3, 20.1, 20.2, 20.3, 20.5 and 20.8 of the Code. Ms Mustard noted that dishonesty is a grave regulatory concern as it goes against the core principles of acting with honesty and integrity in order to uphold the reputation of the profession. She submitted that the misconduct in your case comes under a lot of categories and each on their own are sufficiently serious to amount to misconduct. Ms Mustard submitted that given the wide-ranging concerns and number of patients affected, your conduct falls short of what would be expected in the circumstances and therefore amounts to misconduct. In all the

circumstances, she submitted that your actions represent a sufficiently serious departure from proper standards as to result in a finding of misconduct.

With regards to the question of impairment, Ms Mustard referred the panel to the cases of *Cohen v General Medical Council [2008] EWHC 581 (Admin); Zgymunt v General Medical Council [2008] EWHC 2643 (Admin)* and the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*, particularly paragraph 76 of Mrs Justice Cox's judgement, where she endorsed the questions formulated by Dame Janet Smith in her Fifth Shipman Report. Ms Mustard submitted that the four parts of the question in paragraph 76 of Mrs Justice Cox's judgement can be answered in the affirmative in your case in relation to past conduct. Due to your lack of insight there is also a continuing risk that you may be liable to act in the same way in future.

Ms Mustard invited the panel to have regard to the level of your insight, remorse and remediation. She submitted that you have taken no responsibility for your actions and have therefore demonstrated only limited insight into your dishonesty. She further noted that true remediation has not taken place and therefore the risk of future repetition which would place patients at risk of harm remains. Ms Mustard further submitted that your actions were so serious that a finding of current impairment is required in order to maintain public confidence in the professions and to uphold proper professional standards.

Mr Molyneux on your behalf submitted that you accept that the matters found proved amounted to misconduct.

With regards to impairment, Ms Molyneux submitted that whilst it is accepted that your past actions were sufficient to justify a finding of impairment, a finding of current impairment could not be made in light of your current circumstances. She referred the panel to the case of *Meadow v General Medical Council [2006] EWHC 146 (Admin)* and submitted that considering impairment was a forward looking exercise, to consider

current impairment as of today and not punishing a practitioner for past deeds. Ms Molyneux submitted that apart from the incidents in question, which occurred within a short period of your midwifery practice and covered a narrow area of that practice, you had an unblemished career. She submitted that for the panel to find impairment on public protection grounds your practice has to be manifestly unsafe. However, in your case the main concerns highlighted relate to poor communication and lack of support, but the other concerns relate to subjective issues based on a lack of clinical justification.

Ms Molyneux submitted that you have continuously worked in healthcare settings, providing valuable, effective and safe practice, including in your current role as a registered nurse without any concerns. She referred the panel to positive testimonials from a range of health care professionals, attesting to your compassionate and good practice, noting that the authors were aware of the allegations you faced. She submitted that you have undertaken a large amount of training to improve your practice and to address the concerns identified. Ms Molyneux submitted that there is no real risk of harm to the public, therefore public protection is not engaged.

With regard to the public interest, Ms Molyneux submitted that a fully informed member of the public with full knowledge of the circumstances of your case and the regulatory process you have engaged in, would not be concerned if a finding of impairment were not made. She submitted that there is a public interest in retaining an otherwise safe practitioner and allowing her to practice in a role she is passionate about. Ms Molyneux submitted that a finding of misconduct in itself does mark the matters found proved as unacceptable. Therefore, a finding of no current impairment is not tantamount to a comprehensive acquittal. She referred the panel to the case of *PSA v NMC [2017] CSIH 29* and invited it to find that your fitness to practice is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to the cases of: *Roylance, Grant; Cohen; Zygmunt; Saha-v-GMC [2009] EHWC 1907 Admin Cheatle-v- GMC [2009] EHWC 645 Admin; Ashton v GMC [2013] EHWC 943* in relation to the factors the panel should into account when considering misconduct and impairment. The legal assessor further advised that the case of the *PSA v NMC [2017] CSIH 29* may be distinguishable on its facts.

The panel adopted a two-stage process in its consideration, as advised. 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 then decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct:

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

The panel, in reaching its decision, had regard to public protection and the wider public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel determined that your actions fell short of the standards expected of a registered midwife, and that these actions amounted to breaches of the following parts of the Code:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.3 avoid making assumptions and recognise diversity and individual choice.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action.

7 Communicate clearly

To achieve this, you must:

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum.

10 Keep clear and accurate records relevant to your practice.

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 act with honesty and integrity at all times…

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to.

The panel bore in mind that breaches of the Code do not automatically equate to a finding of misconduct. However, the panel determined that the overwhelming majority of matters found proved, which related to lack of informed consent, inadequate communication, patient safety, and dishonesty in a clinical setting, taken individually and collectively, are sufficiently serious to amount to misconduct. In the panel's view, the failings which were wide ranging demonstrated a lack of support, care and compassion towards women in your care on five separate occasions, and each would be deemed deplorable by fellow professionals. The panel concluded that your actions in relation to the matters found proved fell significantly below the standard required of a registered midwife and therefore amounted to misconduct.

The panel considered that whilst the matters found proved in relation to charges 16, 18, 33.1 and 27, do engage the Code and represented poor midwifery practice, they were not, taken by themselves, sufficiently serious to amount to misconduct.

Decision on impairment:

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

The panel had regard to the guidance given in the judgment of Mrs Justice Cox in the case of *Grant*. At paragraph 74 of that judgment, 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.

Mrs Justice Cox went on to say in Paragraph 76, quoting from Dame Janet Smith in her Fifth Shipman Report at 25.67:

> *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. has in the past acted dishonestly and/or is liable to act dishonestly in the future".*

The panel considered that your actions had engaged all of the questions quoted above. The panel noted that you failed to terminate intimate procedures when asked to do so, failed to support women in their birth choices and left Patient C covered in blood waiting to be taken down to theatre, leaving her at potential risk of infection. Furthermore, you failed to stop suturing when asked to do so by both Patient D and Colleague A and placed that patient at risk when you left her unattended in a lithotomy position, with her legs in stirrups and with the end of the bed having been removed. The panel therefore determined that by the misconduct found you had acted so as to place patients at unwarranted risk of harm.

The panel was satisfied that your actions, in particular with regard to your failure to communicate with patients, your actions conducted without obtaining consent, and your dishonesty had brought the midwifery profession into disrepute.

The panel had regard to the fact that patients and the public place trust in the midwifery profession, and that midwives are expected to act in a way which justifies that trust. It is fundamental to maintaining that trust that midwives make it a priority to deliver safe and effective care to their patients. The panel considered that these were fundamental tenets of the profession. The panel therefore considered that your actions, in respect of the charges found proved breached fundamental tenets of the profession identified above.

You also acted dishonestly.

The panel bore in mind that the issue it had to determine was that of current impairment. It therefore had to look to the future and consider whether you are still liable to act in such a way as to put patients at unwarranted risk of harm, breach fundamental tenets of the profession, bring the midwifery profession into disrepute or act dishonestly. The decision about the risk of repetition in your case would be informed by consideration of the level of insight and remorse you have demonstrated and by whether your misconduct has been or is capable of being remedied.

The panel had careful regard to your reflective accounts and took into account the evidence you gave earlier in these proceedings.

The panel first considered your insight into your shortcomings. The panel took into account your engagement with the regulatory process and the fact that you made admissions to some of the charges from the outset. The panel considered that you have reflected on your failings and sought to demonstrate remorse in your reflective accounts. It noted your apology in your reflection and that you sought to apologise to the patients involved during the local investigation. The panel determined that you have

expressed remorse in your reflection and in the course of these proceedings. However, the panel considered that whilst there was some evidence of reflection in relation to the concerns highlighted and the broader impact of your misconduct, it was not satisfied that you have demonstrated the requisite level of insight.

In the panel's judgement, you have failed to take full responsibility and professional accountability for your failings. The panel noted that even in your most recent reflection you continued to interpret your failings as misunderstandings by patients, constantly deflected your failings and sought to put them down to the expectations of the patients. In the panel's view, your reflection demonstrated a lack of insight into the seriousness of your failings and the impact they had on the five patients, in what was a vulnerable stage in their lives. The panel further determined that it had no evidence of insight in relation to its finding of dishonesty, therefore it was not satisfied that you have demonstrated that you will not be dishonest in the future. The panel therefore concluded that you demonstrated very limited insight into your misconduct.

With regard to remediation, the panel noted the learning you have undertaken to address deficiencies identified in your practice. The panel took into account that you have been practicing as a nurse since the incidents, and noted the positive testimonials submitted on your behalf. However, the panel considered that you have not practiced as a midwife for some two and a half years and in the absence of evidence of current good midwifery practice, the panel determined that it could not be satisfied that the concerns highlighted in relation to your midwifery practice have been remediated.

In all the circumstances, the panel concluded that in the absence of full insight, together with the fact that shortcomings have not been remedied, there is a high risk of repetition. The panel determined that in these circumstances, a finding of impairment is necessary on the grounds of public protection.

The panel went on to consider whether a finding of impairment is also necessary to uphold proper professional standards and public confidence in the profession. The panel determined that findings of acting without consent and dishonesty in a clinical

setting are particularly serious. Informed members of the public with knowledge of the circumstances of this case would be alarmed if a finding of impairment were not made and public confidence would be undermined as a result. In view of these considerations, the panel determined that a finding of impairment on public interest grounds was required to uphold public confidence in the profession and the NMC as its regulator.

Having regard to all of the above, the panel concluded that your fitness to practise is currently impaired on both public protection and public interest grounds.

Determination on sanction:

The panel has considered this case very carefully and decided to make a striking-off order. The effect of this order is that the NMC register will show that your name 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, together with the submissions of Ms Mustard on behalf of the NMC and those of Ms Molyneux on your behalf.

Ms Mustard addressed the panel on the aggravating and mitigating features of your case and made submissions in relation to the approach the panel should take at the sanction stage. She invited the panel to have regard to the NMC's Sanctions Guidance (SG) at this stage. She submitted that the NMC's sanction bid in the circumstances of your case was that of a striking off order.

Ms Molyneux on your behalf submitted that a striking off order or suspension order would be a manifestly disproportionate and punitive response in the circumstances of your case. She addressed the panel on the mitigating features of your case and made submissions as to how a conditions of practice order would be the most appropriate and proportionate sanction. In relation to the finding of dishonesty, Ms Molyneux submitted that the NMC's guidance makes it clear that not all dishonesty is equally serious. She submitted that the dishonesty in your case was not premeditated and it related to a one

off incident of spontaneous conduct. She further submitted that no patients came to harm as a result and your dishonesty was not influenced by financial gain, nor was it systematic. Ms Molyneux therefore submitted that your behaviour was at the lower end of the spectrum of dishonest conduct. Ms Molyneux referred the panel to the SG in relation to factors to be taken into account in relation to a conditions of practice order and stated that they are engaged in your case. She submitted that taking all the circumstances of your case, the proportionate and appropriate sanction is that of a conditions of practice order.

The panel accepted the advice of the legal assessor.

The panel bore in mind that any sanction imposed must be reasonable, appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel first considered the mitigating and aggravating factors in your case. The panel identified the following as aggravating factors in your case:

- Your lack of insight into your misconduct;
- Your misconduct placed all five patients at unwarranted risk of harm;
- Patient C was hearing impaired and therefore particularly vulnerable;
- The dishonesty found proved was in a clinical setting;
- Your misconduct was not isolated as it related to five patients during five different episodes of midwifery care and demonstrated a pattern of failings over a period of seven months;
- Your misconduct related to a failure to provide basic midwifery care and a breach of local policies and guidelines.

The panel identified the following as mitigating factors in this case:

- There was some evidence of remorse for your misconduct in your reflective accounts and you offered an apology to the patients at the local investigation;
- Evidence of keeping up to date with nursing practice;
- Evidence of an attempt to remediate some of the midwifery concerns through training;
- You have practised since the incidents without repetition of your misconduct, albeit, as a nurse and not a midwife;
- Positive professional testimonials.

The panel then turned to the question of which sanction, if any, to impose. It considered each available sanction in turn, starting with the least restrictive sanction and moving upwards.

The panel first considered whether to take no action. The panel bore in mind that it had identified at the impairment stage that there remained a high risk of repetition in your case. Any repetition would bring with it a risk of harm to patients. To take no action would therefore not provide protection to the public. In addition, the panel considered that to take no further action would be inadequate to mark the seriousness of your misconduct and it would therefore not address the public interest considerations of this case.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution is only appropriate "…if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the…midwife's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again." The panel was satisfied that your impairment was not at the lower end of the spectrum. The panel decided that a caution order would be insufficient to protect the

public, mark the seriousness of your misconduct or to maintain public confidence in the profession and the NMC as its regulator.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel considered that it had found that your misconduct arose from wide ranging concerns relating to basic midwifery practice, including poor communication and sustained inability to appropriately communicate with women during labour. In the panel's view, your misconduct was indicative of general incompetence. The panel also considered that there was evidence of attitudinal problems in your failure to listen and respond to what the women in your care had clearly requested orally and in their birth plans. Whilst there was some evidence of a willingness to address concerns through training on your part, the panel concluded that it was not possible to formulate conditions which would address the matters emanating from the findings of dishonesty. In light of these considerations, the panel determined that a conditions of practice order would not be an appropriate or proportionate sanction. The panel further determined that a conditions of practice order would not adequately satisfy the public interest considerations arising from your misconduct.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order may be appropriate where:

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel took into account that in your reflective statements and oral evidence, you demonstrated some remorse for your misconduct. However, the panel considered that your misconduct which included dishonesty in a clinical setting, had placed patients at unwarranted risk of harm, breached fundamental tenets of the profession and brought the profession into disrepute. It considered that it had found that acting without consent, and dishonestly in a clinical setting, was particularly serious and that your other failings were not isolated, involving five patients during five different episodes of midwifery care over seven months. The panel also bore in mind its findings that there is a high risk of your misconduct and dishonesty being repeated, due to your very limited insight in failing to take full responsibility and professional accountability for your failings and the impact your misconduct had on the women in your care. The panel determined that there was a lack of acknowledgement of the patients' distress on your part.

The panel carefully considered the dishonest conduct in your case. It noted that it occurred in September 2016, thus it was after an investigation meeting with Ms 1 in February 2016 in relation to the concerns around Patient A's care. In the panel's view, you deliberately documented that Patient C was 'happy' with the lithotomy position when that was not the case, to protect yourself from a further complaint or a fresh investigation. In the panel's judgement your dishonesty, which involved the falsification of patient records, which are legal documents, was very serious.

In these circumstances, the panel determined that the seriousness of your misconduct, as highlighted by the facts found proved was a significant departure from the standards expected of a registered midwife. The panel concluded that the behaviour demonstrated a serious breach of the fundamental tenets of the profession.

Balancing all of these factors, the panel determined that a suspension order would not be an appropriate or proportionate sanction to protect the public and address the public interest considerations.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG;

"*This sanction is likely to be appropriate when what the…midwife has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that the above factors are engaged in your case.

The panel was of the view that the findings in your case demonstrate that your misconduct was very serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel noted and took into account the mitigating factors in your case, but in the panel's view, these were significantly outweighed by the aggravating factors.

Balancing all of these factors and after taking into account all of the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of your actions in placing patients at unwarranted risk of harm, acting dishonestly, bringing the profession into disrepute by adversely affecting the public's view of how registered midwives should conduct themselves, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel concluded that your misconduct demonstrated a significant departure from the standards expected of a registered midwife and was therefore fundamentally incompatible with you remaining on the NMC register.

The panel considered that this order was necessary to protect the public, 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.

Determination on Interim Order:

Ms Mustard, on behalf of the NMC, submitted that an interim suspension order should be imposed on the basis of protection of the public and otherwise in the public interest. She submitted that the interim suspension order, which would take immediate effect, should be for a period of 18 months to cover the possibility of an appeal being lodged by you in the 28 day appeal period.

Ms Molyneux on your behalf submitted that she was neutral as it is expected that the NMC would make such an application in light of the panel's findings.

The panel heard and accepted the advice of the legal assessor.

The panel had regard to the circumstances of your case and the reasons set out in its decision for imposing a striking off order.

The panel decided to make an interim suspension order for a period of 18 months.

The panel had particular regard to its earlier finding that there remained a high risk of repetition of the significant failings identified in your practice. It also bore in mind the seriousness of the matters which it has found proved and concluded that in light of its earlier decisions on impairment and sanction, that an interim order was necessary for the protection of the public and otherwise in the public interest. For the reasons already set out in detail in the decision on sanction, the panel considered that conditions of practice would not be appropriate. The panel therefore concluded that it is necessary for

the whole of your registration to be subject to an interim suspension order on the grounds of public protection and in the public interest. To do otherwise would be inconsistent with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by a striking off order 28 days after the decision of this hearing is sent to you in writing.

That concludes this determination.