Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

12 November – 23 November 2018

1 – 5 April, 23– 26 July, 31 October – 5 November and 7-8 November 2019

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

Name of registrant:	Dorisilla Khamsali Adolwa
NMC PIN:	89J0027O
Part(s) of the register:	RN1, Registered Nurse (sub part 1) Adult (5 October 1989) RM, Registered Midwife (17 May 1992)
Area of registered address:	England
Type of case:	Misconduct
Panel members:	Alexander Coleman (Chair, Lay member) Jude Bayly (Registrant member) Florence Mitchell (Registrant member)
Legal Assessor:	Simon Walsh
Panel Secretary:	Deepan Jaddoo (12 November 2018 - 26 July 2019) Kathleen Picketts (19 November 2018) Lucy Eames (31 October – 7 November 2019) Sam Headley (8 November 2019)

Mrs Adolwa:	Present and not represented (12-23 November 2018) Not present and not represented (1-5 April 2019) Present and not represented (23-25 July 2019) Present and not represented (31 October – 8 November 2019)
Nursing and Midwifery Council:	Neil Jeffs, Case Presenter (12 November 2018 – 5 April 2019 and 31 October – 8 November 2019) Leeann Mohamed, Case Presenter (23 – 26 July 2019)
Facts proved:	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.14, 1.16, 1.17, 1.19(a), 1.19(b), 1.21, 1.22(a-d), 1.24, 1.25, 2.1, 2.2, 2.4, 2.5(a), 2.5(b), 2.5(d), 2.6, 2.7, 2.8(a), 2.8(b), 2.9(a-d), 2.11, 2.12, 2.13
Facts not proved:	1.13(a), 1.13(b), 1.15, 1.18, 1.20, 1.23, 2.3 2.5(c), 2.10
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order (18 months)

Details of charge:

That you, a Registered Midwife:

1 Whilst working at Croydon Hospital on 23 February 2015 and in respect of Woman B and/or her baby:

1.1 Failed to recognise that Woman B was in labour at approximately 15:05 **[PROVED]**

1.2 Failed to recognise that Woman B was in established labour at approximately 15:50. **[PROVED]**

1.3 Failed to undertake and/or document closer monitoring of maternal observations given Woman B's known medical history. **[PROVED]**

1.4 Failed to risk assess and/or document the risk assessment of Woman B's condition. **[PROVED]**

1.5 Failed to escalate to the appropriate medical professional that Woman B wished to open her bowels **[PROVED]**

1.6 Did not advise and/or document the advice given to Woman B about the risks of her being disconnected from the CTG monitor while she went to the bathroom. **[PROVED]**

1.7 Failed to escalate the CTG reading which you knew or ought to have known was abnormal to the appropriate medical professional. **[PROVED]**

1.8 Did not recognise and/or interpret the presence of a fetal heart deceleration in the CTG trace. **[PROVED]**

1.9 *Failed to challenge and/or document a challenge to the Consultant's interpretation of the CTG.* **[PROVED]**

1.10 *Failed to document the justification for administering IV paracetamol to Woman B at approximately 16:00.* **[PROVED]**

1.11 *Failed to recognise that the baby became bradycardic with a heart rate of 40 beats per minute.* **[PROVED]**

1.12 *Failed to pull the emergency buzzer until approximately 10 minutes after the baby became bradycardic with a heart rate of 40 beats per minute* **[PROVED]**

1.13 *Failed to conduct and/or record the required fetal heart monitoring following an epidural been provided to Woman B*

a. *Every 15 mins* **[NOT PROVED]**
b. *Every 5 mins following transition into 2nd stage of labour* **[NOT PROVED]**

1.14 *Failed to seek hourly 2nd checks of the CTG trace.* **[PROVED]**

1.15 *Failed to document any concern or escalation* **[NOT PROVED]**

1.16 *Failed to comment or complete a partogram.* **[PROVED]**

1.17 *Failed to fully analyse and/or interpret the fetal heart rate.* **[PROVED]**

1.18 *Completed page 1 of the Antenatal notes rather than completing the relevant sections of the Birth Notes.* **[NOT PROVED]**

1.19 *Failed to contemporaneously document:*

a. *Care provided* **[PROVED]**

b. *Maternal observations of pulse and blood pressure.* **[PROVED]**

1.20 *Failed to undertake and/or document observations for Woman B following her anaesthesia/epidural.* **[NOT PROVED]**

1.21 *Failed to investigate and/or escalate appropriately when Woman B became tachycardic.* **[PROVED]**

1.22 *Failed to properly complete Woman's B's records in that you:*

a) *Did not complete the Patient Identifying Information on page 5 and 9-11* **[PROVED]**
b) *Did not complete and/or record the risk assessment in Woman B's notes at page 2.* **[PROVED]**
c) *Did not complete and/or record the general examination on page 3 of Woman B's birth notes.* **[PROVED]**
d) *Did not conduct and/or record the 'agreed plan' section on page 3 of Woman B's notes.* **[PROVED]**

1.23 *Failed to escalate Woman B's distress of the situation to appropriate medical professionals.* **[NOT PROVED]**

1.24 *Failed to challenge the Doctor's decision to delay delivering the baby.* **[PROVED]**

1.25 *Failed to clearly mark where entries in Woman's B's records are retrospective.* **[PROVED]**

2 On 11-12 September 2016 while working at Kings College Hospital and in respect of Woman A and/or her baby:

2.1 Failed to recognise that Woman A was in established labour. **[PROVED]**

2.2 Failed to carry out the expected assessments for a woman in established labour. **[PROVED]**

2.3 When Woman A was in the latent stage of labour, failed to conduct or record the fetal heart rate **[NOT PROVED]**

2.4 Failed to take the fetal heart rate at least every 15 minutes once Woman A was in established labour and in any event from 23:30. **[PROVED]**

2.5 Failed to support Woman A in her intrapartum pain relief choices in that you:

a) *Did not provide Woman A with all the options as to the pain relief available* **[PROVED]**

b) *Did not take into consideration that the non-pharmacological methods had already been tried when assessing and advising Woman A on pain relief.* **[PROVED]**

c) *Failed to prepare Woman A for an epidural* **[NOT PROVED]**

d) *Failed to listen and/or respond appropriately to Woman A's description of her pain.* **[PROVED]**

2.6 *Failed to date and/or time all recordings in real time and/or in chronological order.* **[PROVED]**

2.7 *Failed to clearly mark which notes were retrospective and/or the rationale for doing so.* **[PROVED]**

2.8 *Failed to document how long you auscultated the fetal heart rate and/or what equipment was used and/or the method employed at*

a) *21:40* **[PROVED]**
b) *00:00* **[PROVED]**

2.9 *After assessing at 21:40 that Woman A was having a prolonged latent phase failed to auscultate the fetal heart rate at each further assessment and/or failed to document that assessment and/or document rationale for not listening to the fetal heart rate.*

a) *22:00 when making an assessment for pain relief* **[PROVED]**
b) *23:00* **[PROVED]**
c) *23:30* **[PROVED]**
d) *23:45* **[PROVED]**

2.10 *Failed to auscultate and/or document the fetal heart rate between 21:40 and midnight.* **[NOT PROVED]**

2.11 *Failed to auscultate and/or document the fetal heart rate at least every 15 minutes from approximately 23:30 to midnight.* **[PROVED]**

2.12 *Failed to continuously monitor the fetal heart rate from approximately midnight onwards.* **[PROVED]**

2.13 *Failed to document the time that the CTG was started.* **[PROVED]**

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

Background:

The allegations against you came to light as a result of the detailed investigations into the tragic deaths of two babies at two different hospitals. You were closely involved in the care of each mother but it is not alleged that you were in any way directly responsible for the death of either baby. Nevertheless this panel cannot ignore how painful these baby deaths must have been for the two mothers and the wider families involved. The panel wished to express their profound sympathies to the families involved and especially to Woman A who came to give evidence to the panel. With Woman A's permission the panel referred to her baby by name during the hearing although this name has not been used in the transcript of the hearing. The panel wished to make it clear that is has not allowed these sad deaths to influence its assessment of the evidence about your actions and are sure the families involved will understand this.

<u>First set of allegations – Woman B and her baby</u>

The first set of allegations arose whilst you were working as an Agency Midwife at Croydon University Hospital ("the Croydon Hospital"), part of Croydon Health Services NHS Trust ("the Croydon Trust"). The allegations concern your standard of care provided to Woman B and her unborn baby, on the day shift of 23 February 2015.

Woman B arrived at the delivery suite by ambulance with a temperature of 37.7 degrees.

The concerns regarding the midwifery care you provided include:

- Failure to recognise established labour
- Failure to document
- Failure to interpret/escalate concerns regarding CTG readings
- Failure to pull emergency buzzer until approximately 10 minutes after the baby became bradycardic

- Failure to fully analyse and/or interpret fetal heart rate
- Failure to investigate and/or escalate appropriately when Woman B became tachycardic
- Failure to challenge Doctor's decision to delay delivering the baby

Ms 1, the Local Supervising Authority Supervisor of Midwives (SOM) at the time, was asked to carry out an investigation from a SOM perspective. The report alleged that you failed to communicate effectively and did not fulfil your duties in caring for Woman B. The report set out your alleged failings and your alleged lack of insight following the incident.

Ms 2, the Maternity Risk Manager at the time of the incident was a member of the Investigation panel and the author of the Trust's Root Cause Analysis investigation report, dated 5 May 2015. The report provides a chronological background of how the incidents allegedly took place and the actions taken by staff members at the time, including yourself.

Second set of allegations – Woman A and her baby

The second set of allegations arose whilst you were working as a Band 6 Midwife, working in the Nightingale Birth Centre ("Labour Ward"), at Kings College Hospital, part of King's College Hospital NHS Foundation Trust ("the Trust").

On the night shift of 11/12 September 2016, you were allocated to Woman A, to provide intrapartum care. Woman A was in early labour and it was her first baby. Woman A had self-referred to the labour ward on the morning of 11 September 2016 and was found to be in early labour. She was advised to go home and await the onset of established labour. Woman A returned later that day distressed with contractions which were irregular and required opiate analgesia to help her cope.

Care was handed over to you at 19:45 and the concerns regarding the midwifery care you provided include:

- Failure to recognise established labour
- Failure to increase surveillance of fetal heart rate as labour progressed
- Failure to support a woman in her intrapartum pain relief choices

Ms 4 was appointed as the Investigating Officer for the incident which occurred on the night shift of 11/12 September 2016. The investigation report contains statements from both yourself and other colleagues involved in the incident. Amongst other documents, it also contains the Serious Investigation Report.

Admissions

At the outset of this hearing, you told the panel that you admitted some of the charges. However, since you were unrepresented the panel noted your admissions but deferred accepting them under Rule 24(5) until it had heard all of the evidence.

Decision and reasons on application under Rule 19

Mr Jeffs made a request that parts of the hearing of your case be held in private on the basis that proper exploration of your case involves private matters relating to your health and personal life. The application was made pursuant to Rule 19 of the Rules.

You supported this application.

The panel accepted the advice of the legal assessor.

Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) provides that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to your health and personal life the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session as and when such issues are raised.

Decision and Reasons on applications pursuant to Rule 31:

On day 1 of the proceedings, Mr Jeffs made an application under Rule 31 to introduce into evidence a clear and annotated copy of the CTG printout, labelled Exhibit ML/6.

On day 2 of the proceedings, during the evidence of Ms 2, she indicated that a fuller and better CTG printout was available. She made arrangements for this to be sent to the NMC. Subsequently, Mr Jeffs made a further application under Rule 31 for this to be introduced into evidence.

You agreed this fuller and better CTG printout would be helpful. It was therefore admitted into evidence. This fuller and better version was then shown to every subsequent witness.

Decision and reasons on application pursuant to Rule 31 in relation to Ms 1's evidence via video-link (Webex)

The panel heard an application made on day 5 of proceedings by Mr Jeffs under Rule 31 to allow Ms 1 to provide further evidence in relation to the fuller and better CTG printout to the panel on day 6 of proceedings via Webex. Mr Jeffs submitted that this application was being made due to Ms 1's professional commitments which prevented her from physically attending the hearing for a second time. Mr Jeffs reminded the panel that Ms 1 had attended on both day 2 and 3 of proceedings, despite originally only being warned to attend for day 2, and that this had already had an impact on her professional commitments and working schedule. Mr Jeffs therefore submitted that

given the above, it would be fair and appropriate for Ms 1 to give her evidence via Webex.

You opposed this application and told the panel that the evidence to which Ms 1 speaks to will have to be analysed, and that this is something which cannot be achieved via video or telephone. You told the panel that Ms 1 had to be physically present in order for you to challenge her evidence.

The panel accepted the advice of the legal assessor.

The panel gave consideration to the application. Given that a new copy of the CTG printout had now been obtained, and given that Ms 1's NMC statement speaks to this, her evidence on this matter is clearly relevant.
You would be in a position to cross examine this witness. The panel also noted that Ms 1 would have a physical copy of the the new CTG printout in front of her whilst giving her evidence via video-link, and that the document had clearly defined timings and letterings which were easily visible and clear to follow. Given that Ms 1 has been physically present previously, and the lengthy extent of her evidence, the panel did not consider it unfair to call this witness again via video-link, given that the issue in contention simply related to the new CTG printout which had been recently obtained by the NMC. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be appropriate for Ms 1 to give evidence to the panel by Webex, or if this was not possible by way of telephone.

Further application pursuant to Rule 31

The panel heard an application made by Mr Jeffs under Rule 31 of the Rules to allow the written statement of Ms 6 into evidence. Mr Jeffs informed the panel that Ms 6's evidence insofar as it related to matters under consideration was not being disputed by

you, and that you were in agreement with the NMC that it would not be necessary for Ms 6 to attend to give oral 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 of the Rules provides that, so far as it is '*fair and relevant,'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel noted that Ms 6's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph 'This statement is true to the best of my information, knowledge and belief' and was signed by her.

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 Ms 6 to that of a written statement. The panel was mindful of Mr Jeffs' submission that this application was beneficial to both parties, and that you also agreed to the application.

In these circumstances, the panel came to the view that it would be fair to accept into evidence the written statement of Ms 6 but would give this statement the appropriate weight.

Application to adjourn

Following the closure of the NMC's case you made a request to adjourn proceedings for the following day, namely 20 November 2018. You told the panel that you were undertaking a podiatry course and had an assessment scheduled on 20 November 2018. You had missed time on your course the previous week as a result of these proceedings, and explained to the panel that you may fail your assessment if you do not attend and may not be able to reschedule an assessment at a later date. When asked about when you were notified about this assessment, you told the panel that you had been made aware on Thursday 15 November 2018, although you later accepted that

this date had been on your course calendar since September. You told the panel that you are extremely sorry and that you were unaware of the consequences of these proceedings overlapping with this day on your course.

Mr Jeffs did not oppose the application and was neutral on this issue.

The panel accepted the advice of the legal assessor.

The panel bore in mind that there are no more NMC witnesses, thus no witness inconvenience would be caused by an adjournment. The panel also considered that, despite indicating on your case management form that you did not wish to attend these proceedings, you have attended and fully engaged, and wished to give evidence to the panel.

The panel considered the public interest in the expeditious disposal of your case and was of the view that this does not outweigh your interest in this matter. Bearing in mind that the NMC is neutral in respect of this application, the panel determined that it would be an injustice to you not to accept your application for adjournment until 21 November 2018, at which time you will give your evidence to the panel. The panel considered it significant that if no adjournment were granted in these specific circumstances, the panel would move on to fact finding without hearing any evidence from you. Such a way forward would not be fair to you. Further, there was also a public interest in a panel being fully informed of all the evidence before making any decision.

In consequence, the panel grants your application to adjourn the hearing until 9am on 21 November 2018.

Amendment to charge pursuant to Rule 28 of the Nursing and Midwifery Fitness to Practise Rules 2004 (“the Rules”)

On 14 November 2018 Mr Jeffs made an application to amend charge 2.5 (c).

The proposed amendment to charge 2.5 (c) was as follows:

2.5 Failed to support Woman A in her intrapartum pain relief choices in that you:

c) Failed to prepare Woman A for an epidural **when requested at 19:45**

In support of his application, Mr Jeffs told the panel that it had become clear, through hearing the oral evidence of Woman A, that her evidence in respect of the time she had requested an epidural, corroborated Ms 4's written evidence as contained in her NMC witness statement. As such, Mr Jeffs told the panel that the amendment sought would better reflect and clarify the time the alleged concerns arose and thus better reflect the charge. Mr Jeffs submitted that no injustice would be caused to you if this amendment were to be allowed.

You told the panel that you objected to this amendment and that you didn't think 19:45 was an accurate time.

The panel accepted the advice of the legal assessor.

Rule 28 of 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.

In relation to the proposed amendment, the panel determined that to change this charge at this late stage by adding a specific time would significantly change the nature of the charge and would not be fair nor in the wider public interest. The panel also noted that there is evidence that you did indeed prepare Woman A for an epidural at 19:45.

The panel therefore rejected the proposed amendment to charge 2.5 (c).

Adjournment

On day 10 of proceedings, after answering questions during cross examination for an hour, Mrs Adolwa was afforded a break. Upon resumption of the hearing Mrs Adolwa suddenly indicated to the panel that she felt unable to continue. The chair asked why she was unable to continue, she indicated she had reasons but she did not feel able to share them with the panel. Mrs Adolwa gathered her papers, left the hearing room and left the building.

The chair considered it would be inappropriate to continue in Mrs Adolwa's absence. The case was therefore adjourned to a later date. In any event the overall hearing was going to be adjourned part-heard as this was the last day of the current listing.

Mr Jeffs informed the panel that the public would remain suitably protected by the interim suspension order already in force.

Resuming 1 April 2019

Decision on service of Notice of Hearing:

Mrs Adolwa was not in attendance or represented in her absence at the hearing. The panel noted that written notice of this resuming hearing had been sent to Mrs Adolwa's registered address by recorded delivery and by first class post on 18 December 2018.

The panel took into account that the notice of the resuming hearing provided the time, dates and venue of today's hearing.

In the circumstances, Mr Jeffs submitted that the NMC had complied with the requirements of Rule 32(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended ("the Rules").

In the light of all of the information available and the advice of the legal assessor which the panel accepted, the panel was satisfied that Mrs Adolwa has been properly notified of this resumed hearing.

Decision on proceeding in the absence of Mrs Adolwa:

Mr Jeffs invited the panel to continue in the absence of Mrs Adolwa on the basis that she had voluntarily absented herself.

Mr Jeffs referred the panel to a letter from Mr David Welch, a Barrister at Alexander Chambers dated 15 January 2019, who wrote to the NMC, on behalf of Mrs Adolwa. In this letter, Mr Welch confirmed, on behalf of Mrs Adolwa, that she was aware that the case was currently part heard and enclosed a statement from her, in which she stated:

"As the NMC are fully aware I was unable to continue to answer questions at the substantive hearing. I am not… able to face the trauma of resuming my evidence or attending any further part of the FTP process. Even if the scheduled resumed hearing was adjourned I would not be able to face any further dealings with the NMC."

Mr Jeffs also informed the panel that the NMC had received a further e-mail from Mr Welch dated 20 March 2019, in which he notified the NMC that he was no longer instructed but confirmed that Mrs Adolwa would not be attending the resuming hearing.

Given the above, Mr Jeffs submitted that there was no reason to believe that an adjournment would secure Mrs Adolwa's attendance on some future occasion.

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

The panel noted the correspondence from Mr Welch, on behalf of Mrs Adolwa. The panel also noted Mrs Adolwa's statement enclosed within the letter and the recent e-mail from Mr Welch notifying the NMC, on Mrs Adolwa's behalf, that he was no longer instructed and that she would not be attending the hearing.

The panel decided to proceed in the absence of Mrs Adolwa. In reaching this decision, the panel considered that whilst Mrs Adolwa has not communicated directly with the NMC, she has provided very clear reasons, through the instruction of Mr Welch, a barrister, as to why she would not attend. The panel noted that there are a significant amount of allegations, that they are of a serious nature and that there is a strong public interest in having these matters heard. The panel noted that Mrs Adolwa has sought legal advice, has made it clear that she will not be able to participate in proceedings and has no intention of doing so in the future. As such, the panel determined that an adjournment would not serve any useful purpose.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Adolwa.

Adjournment

The panel completed its deliberations on facts at 17:00, on the fourth day (4 April 2019). The chair determined that there was insufficient time to conclude the case, given that full written reasons would need to be drafted, reviewed and finalised. Day 5 will be used as a drafting day.

The panel have requested a further four days to conclude the hearing.

The case will therefore be adjourned and re-listed for four days.

All parties present have agreed to the following resuming dates: 23 – 26 July 2019. These dates will have to be canvassed with Mrs Adolwa.

Mr Jeffs informed the panel that the public would remain suitably protected by the interim suspension order already in force.

Resumed 23-26 July and 31 October-8 November 2019

Decision on the findings on facts and reasons

In reaching its decision on the charges, the panel took account of all of the evidence, oral and documentary, adduced in this case, including the accounts given by you, together with the submissions made by Mr Jeffs on behalf of the NMC and submissions made by you.

In order to assist the panel Mr Jeffs produced a very helpful document at the hearing on 1 April 2019. This document, entitled 'NMC outline submissions on facts' consists of 198 paragraphs over 39 pages. You were not present when Mr Jeffs took the panel through this document. You first saw it on 23 July 2019 and referred to it at length and in detail in your submission on 24-25 July 2019. You were very critical of the way in which this document had been produced but the panel considered these criticisms, of a wholly private document produced for the panel's assistance, to be ill-founded.

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

The NMC's live witness evidence came from:

- Woman A;
- Ms 1, Band 7 Midwife on the delivery suite at the time, at the Croydon Trust;
- Ms 2, Maternity Risk Manager at the time, at the Croydon Trust;
- Ms 3, Band 7 Sister at the Nightingale Birth Centre, at the Trust;
- Ms 4, Consultant Midwife at the time, at the Trust;
- Ms 5, Director of Midwifery at the time, at the Trust.

The panel also heard live evidence from you and the Reverend 7, on her behalf.

The panel considered Woman A's evidence. The panel found that Woman A gave her evidence in a dignified way, notwithstanding how painful it may have been to recall events. The panel found her to be both credible and reliable. There was no evidence before the panel to support your assertion regarding woman A being "…dragged in here" and "forced" to give evidence by the NMC.
The panel considered Ms 1's evidence. Ms 1 was clear, focused and logical. Her oral evidence was supported by documentation. Ms 1 had a good recollection of the investigation and remained consistent throughout cross examination. The panel noted that Ms 1 was an experienced midwife and found her to be a reliable witness. The panel noted that you repeatedly and vitriolicly accused Ms 1 of writing her report and giving her evidence "to further her own ego", the panel found no evidence to support this and found your assertions without merit.

The panel considered Ms 2's evidence. The panel found Ms 2 to be an experienced midwife who sought to be helpful to the panel.

The panel found Ms 3's evidence consistent with her written statement. Ms 3 was able to speak to events referred to in charge 1 because she was present at the time. The

panel found her to be a clear, credible and reliable witness, as well as an experienced midwife.

The panel considered the evidence of Ms 4, a consultant midwife at the time at the Trust. Ms 4 answered all questions in an open manner. The panel found her to be a reliable witness.

The panel considered the evidence of Ms 5. Ms 5 was clear, focused and logical. Her oral evidence was supported by documentation. Ms 5 had a good recollection of the investigation and remained consistent throughout cross examination. The panel noted that Ms 5 was an experienced midwife and found her to be a reliable witness. The panel noted that you asserted, in your submissions on facts that Ms 5 was biased against you, the panel found no evidence to support this and found your assertions without merit.

The panel noted that Ms 6's (LSA Support Midwife) evidence was agreed by both parties and accepted it as correct.

In your submissions on facts you repeatedly asserted that the only reason that you were investigated by your employers was that you were "a black midwife". For example you said 'most of the agency midwives are black midwives because they are not lazy; they are the ones who are working. When you go on the ground, every unit there are black midwives; why? The managers are the white midwives but the black ones are working and I'm stressing that very much, because they work collectively'. There is no evidence before the panel of any racial bias by any of the NMC witnesses towards you.

The panel considered your evidence. Your oral evidence lacked consistency and the panel found that you changed your version of events in an attempt to provide explanations for your actions at the time. The panel found large parts of your evidence to lack any credibility whatsoever and found that at times you tended to display idiosyncratic beliefs and impressions including exaggerated expressions of self-importance, for example you stated in the hearing on 22 November 2018 'then I told her

[the mother] another thing is I'm like a famous midwife'. Also at the hearing on 24 July 2018 you stated 'I'm one of the best midwives in the UK really' and 'especially very good in intensive care I think and really very good as a natural midwife…so I praise myself and recommend myself to know that I'm really the best'. 'I'm one of the best water birth midwives in the UK… so I will not stop bragging about myself but I am a very good nurse and good midwife and patients really like me as long I have practised.' Further, you said 'because I know I'm famous in a way the patients comment about me and the comments they write they attest to my knowledge, the letters they send to the Trust'. On 25 July 2019 at the hearing you stated 'these managers who are talking about these things, do they have enough experience to really know that this is a labour ward; its hard going, so you have to act very fast, very, fast' and 'You want to see a water birth; the queen is in King's, and I had that kind of popularity'.

The panel gave careful consideration to your two days of your submissions on facts. Despite following the structure of Mr Jeffs written submissions the panel found your submissions hard to follow. You tended to concentrate on minor unimportant details such as spelling mistakes but failed to address the fundamental basis of the allegations against you.

The panel considered the following charges.

Charge 1.1

That you, a Registered Midwife:

1 Whilst working at Croydon Hospital on 23 February 2015 and in respect of Woman B and/or her baby:

1.1 Failed to recognise that Woman B was in labour at approximately 15:05

This charge is found PROVED.

The panel noted that the evidence in support for this charge came from Woman B, Ms 1 and the antenatal notes produced by Ms 1. The panel also considered your oral evidence.

The panel noted that the antenatal notes contained an entry made by you at 15:05, which stated that Woman B was “distressed, screaming in pain… really uncomfortable on admission”. Further, Mrs Adolwa recorded that Woman B was contracting “5 in 10 minutes”, and that they were “strong”.

Ms 1, in her witness statement stated:

“Page 6 of these notes is Dorisilla's entry when she arrived on shift at 15:05. She has noted that woman B is really uncomfortable on admission. In her interview she said woman B was not in labour at that point and that is why she did not do the observations however she has noted that she is uncomfortable. She did the palpation and recorded that she is contracting 5 in 10 minutes and that they are strong, but she did not recognise that that fits the picture of someone in labour. If you cannot recognise that someone is in labour it is concerning for her to manage intrapartum care because you cannot risk assess and perform adequate monitoring.”

In your oral evidence [paragraph 21 of page 22 of the transcript dated 21 November 2019], you told the panel that you denied this charge “because [Woman B] was already contracting when she came”. You went on to say “I summoned the consultant to come and examine her because she was 33 weeks, she was in pre-term labour… As a midwife you can only do a vaginal examination for a woman who is more than 37 weeks, so a woman less than 37 weeks the consultant has to do vaginal examination”.

In the panel’s view, despite your denial, your observations all support Ms 1’s clinical opinion, that Woman B was in established labour at 15:05. Where your evidence differed to that of Ms 1, the panel preferred the evidence of Ms 1.

The panel noted that it had no evidence before it which suggested that Ms 1 bore any prejudice or ill feeling toward you.

Accordingly, this charge is found proved.

Charge 1.2

1.2 Failed to recognise that Woman B was in established labour at approximately 15:50.

This charge is found PROVED.

In your oral evidence you told the panel that you denied this charge "because the doctor had done a vaginal examination and… found out that this woman's cervix was dilating... She was having contractions and so we have to progress. To progress means I have to start her on the labour ward care. She had ruptured her membranes… And she needed an epidural." [Paragraph 28 of page 22 and paragraph 6 of page 23 of the transcript dated 21 November 2019].

Ms 1, in her witness statement stated:

"At 18:00 Dorisilla notes that the epidural seems to be working. At this point she is not documenting the fetal heart rate every 15 minutes. The fact that the first consultants impression was established labour at 15:50 means the fetal heart rate should have been taken every 15 minutes. The fact that she was given the epidural also means she is in established labour so would be another prompt to take the fetal heart rate every 15 minutes."

The panel had sight of the partogram, which it considered to be pictorial evidence of a woman in labour, as per the 'NICE' guidelines. The panel found these to be very clear about the observations required in established labour.

The panel noted that there was no evidence to suggest that you had carried out the continuing observations required as per the NICE guidelines on Woman B.

The panel noted that there was a clear duty set out within the NICE Guidance which requires that an ongoing assessment of a woman and fetal wellbeing, including observations and recording this on a partogram are made. The panel had no indication that you did this as the partogram had not been completed. Furthermore, the panel noted that the doctor, at 15:50, is recorded as saying that Woman B was in established labour. The panel determined that there was no indication from notes that you carried out the ongoing assessment required as per the NICE guidance and the Croydon Trust's 'Care of Women in Labour Maternity Guidelines'.

You told the panel, in relation to this charge that "to progress means I have to start her on the labour ward care". The panel had no evidence that you did this as there was nothing documented which supported this assertion.

The panel therefore found it more likely than not that you failed to recognise that Woman B was in established labour at approximately 15:50.

Accordingly, this charge is found proved.

Charge 1.3

1.3 Failed to undertake and/or document closer monitoring of maternal observations given Woman B's known medical history.

This charge is found PROVED.

The panel took into account that Woman B's medical history is summarised and can be found in the LSA Supervisory Investigation Report ("LSA Report"). The ambulance transcript records Woman's B temperature as being 37.7 degrees. The panel also noted that you recorded at 15:05 "Obstetric History Noted".

Ms 1, in her written statement stated:

"Dorisilla's notes were all done in retrospect so we cannot be sure whether timings she has recorded are correct and we do not know at what point the notes correlated to. Dorisilla failed to undertake regular maternal observations such as pulse and blood pressure… The ambulance transcript (exhibit ML/3) records that woman B's temperature is 37.7, given her history and the admissions she had prior to this one, it would have prompted closer monitoring of the maternal observations."

You deny this allegation and in evidence in chief and your cross examination told the panel that you used a continuous pulse oximeter monitor to record blood pressure and temperature. You also told the panel that you carried out and recorded the observations, albeit on a small piece of tissue paper.

The panel noted that your introduction of using a pulse oximeter and recording her observations on a small piece of tissue paper were not put to Ms 1 by you during Ms 1's internal investigation shortly after this incident.

In the panel's view, your version of events are undermined due to your late introduction of a "pulse oximeter". Both registrant members of the panel agreed that a pulse oximeter which is attached to a patient's finger does not record blood pressure or temperature. Further, if it is assumed that if such equipment was used, the questions remains as to why you did not immediately seek help, given that you would have been aware that her observations were alarming. The panel also determined that it would be highly unusual and unlikely for you to resort to taking observations on a small piece of

tissue paper, given that it was not an emergency situation at the time. In the panel's view, there would have been every opportunity for you to have written down your observations contemporaneously in the patient notes in the standard way, as carried out by the Doctor at the time.

The panel preferred and accepted the evidence of Ms 1 and on balance, found it more likely than not that you failed to undertake and document closer monitoring of maternal observations on Woman B.

Charge 1.4

1.4 Failed to risk assess and/or document the risk assessment of Woman B's condition.

This charge is found PROVED.

The panel took into account that the evidence in support of this charge came from Ms 1 and the documentary evidence as per Woman B's 'Birth Notes'. The panel noted that the risk assessment section of these notes, which can be found on the second page of the notes, were blank and that no entries had been made.

Ms 1 stated: "Page 2 should be complete for a risk assessment and should have been filled in by Dorisilla. The form is comprised of tick boxes so it should be an easy way for her to record the information but the only part completed on this page is the patient name at the top."

In your oral evidence, you told the panel that you completed and recorded the risk assessment at 15:05, which appears on page 50 of the Antenatal Notes. You confirmed that your written entry of 'PO 33/40 prophylactic antibiotics and steroids x 2 doses' was in fact your recording of the risk assessment.

The panel had sight of the documentary evidence which clearly demonstrated that no risk assessment had been recorded in Woman B's birth notes. The panel preferred the evidence of Ms 1 and determined that your entry on page 50 did not equate to a risk assessment, nor had it been completed in the manner expected. The panel was concerned by the fact that you remained adamant that your entry could be properly considered as a risk assessment. In the panel's view, you had failed to risk assess and/or document this, and it was clear that you did not understand what constituted a risk assessment as per the Trust's policy.

Accordingly, this charge is found proved.

Charge 1.5

1.5 Failed to escalate to the appropriate medical professional that Woman B wished to open her bowels

This charge is found PROVED.

Ms 1, in her written evidence stated: "When Dorisilla let Woman B go to the bathroom, she had expressed an urge to open her bowels, which could indicate a sign that a woman is about to deliver imminently. There was no escalation to a doctor to check whether she was about to deliver. For someone who was in premature labour and already at 3cm dilated, you would want to make sure she had not progressed further before advising her to go to the bathroom."

In your oral evidence you stated "[Woman B] by then she was occipital posterior position and she was feeling a lot like she wants to go to the toilet but there was no signs that she wanted to open her bowels... But because of the pressure of the baby towards her back she wants to go and just sit on the loo, and when she disconnected herself that's what she did. So, again, I had the anaesthetist in the room because we

were going to actually site the epidural and there was no sign that this woman is going to have a baby."

When asked by the panel whether your denial of this allegation was due to your assertion that you had informed the anaesthetist in the room, you answered "yeah" and went on to say: "there was no reason this woman was going to have her baby that time. I could have easily spotted it straightaway. It's just it's continued and she felt the instinct that she wants to go to the toilet. She said, 'Leave me alone. Leave me alone, midwife. Let me just go.' And then when I was trying to explain to her to bring her back, you know, there's just a lot of little things going on in that particular room."

The panel noted your assertion that Woman B did not wish to open her bowels, is contrary to what is set out in the LSA Investigation Report and contrary to Ms 1's evidence. The panel noted that the conclusion made in the LSA Investigation Report supports Ms 1's evidence, that Woman B wishing to open her bowels should have triggered you to escalate this appropriately. The LSA Report confirms that the "Registrar should have been involved" as your decision was an "unsafe decision to take at the time".

The panel noted that there is no record of any such escalation having taken place in the notes at 16:00. It was also was of the view that even if concerns were raised with the anaesthetist, this would not have been the appropriate person to escalate such concerns to.

The panel therefore determined that it was more likely than not that you failed to escalate to the appropriate medical professional that Woman B wished to open her bowels.

Accordingly, this charge is found proved.

Charge 1.6

1.6 Did not advise and/or document the advice given to Woman B about the risks of her being disconnected from the CTG monitor while she went to the bathroom.

This charge is found PROVED.

Ms 1, in her written evidence stated: "The CTG from onset was a non-reassuring CTG, so to discontinue for 10 minutes while [Woman B] went to the bathroom would have posed a risk, as you do not know what is happening in those 10 minutes. Dorisilla should have offered Woman B a bed pan or catheter or explained to woman B so she could asses what she wanted to do."

You denied this charge and in your oral evidence stated: "…What I advised this woman, of course every woman that wants to go you explain everything, so I did explain to her that we need to monitor the baby, but that kind of writing down, coming back to write it, I didn't do it because she was to be on continuous monitoring. So I know as we were going I was telling her 'Woman B, we have to monitor the baby', but she was pushing me away and wanting – I have to just sit there until when she came back to kind of her senses properly and came back and we started monitoring her again."

The panel noted that you accepted that you did not record an entry of your advice given to Woman B. However, the panel had no evidence to dispute your assertion, that you did try to advise Woman B before being pushed away by her.

In all the circumstances, the panel determined that the NMC had failed to discharge its burden in proof in relation to you not advising, but the panel found it proved in relation to your not documenting any advice. The panel noted that this allegation does not begin with an allegation of 'failure', this allegation has been proved as a simple fact and the panel will address at a later stage whether this may amount to misconduct.

Accordingly, this charge is found proved.

Charge 1.7

1.7 Failed to escalate the CTG reading which you knew or ought to have known was abnormal to the appropriate medical professional.

This charge is found PROVED.

Ms 1, in her written evidence stated: “The CTG from onset was a non-reassuring CTG… The crux of the case was the fundamental failure to observe the fetal wellbeing and escalate the concerns about the fetal CTG.” Further “it became apparent that Dorisilla could not escalate because she did not recognise there was a problem. When asked to interpret the same CTG again during the interview and define the fetal heart features she lacked knowledge and could not interpret the trace or define the features.

Any concerns should be escalated to the labour coordinator and the doctors. There always seemed to be a discrepancy in what Dorisilla was saying in interview and what she was doing at the time. She said the CTG was abnormal and that the baby should have been delivered by caesarean section because the baby was infected, but she did not relay that to the doctors or coordinator at the time.

Dorisilla has recorded that the fetal hear rate (FHR) is low, at 102 (it should be above 110), but she has not documented that she is concerned about that, nor has she escalated it. There is no thought process that she was monitoring the maternal heart rate either. At this point as a midwife you would get a doctor’s review. Dorisilla gives IV paracetamol but it is not clear why.”

In your oral evidence, you told the panel that there was a lot happening at the time, stating: “The doctors who are coming the room constantly… The managers came in, the sisters came in, they saw what was going on, they did reassure me they knew, they’d planned for this delivery, if the woman starts to go into labour… So they all knew this. It

is like they come in and they talk, but we are not writing it on the notes… So I wasn't like left alone, and they were so supportive".

The panel had sight of the patient notes which did not support your version of events. In particular, the patient notes do not support your assertion that there were many doctors in the room. At 17:00 the notes simply refer to doctors on the ward round. At 15:40 and 15:50 Dr 1 attends, but at 16:00 Woman B returns from the toilet and her FHR is recorded at 102. At 17:30 Dr 2 attends.

The panel was of the view that even if Dr 3 was in the room at the time, there was no evidence to support that you had escalated this to him or to any other medical professional. The panel also noted that by your own assertion, you knew that the CTG reading was abnormal.

The panel preferred the evidence of Ms 1 and found that on balance, it was more likely than not that you failed to escalate the CTG reading which you knew or ought to have known was abnormal to the appropriate medical professional.

Accordingly, this charge is found proved.

Charge 1.8

1.8 Did not recognise and/or interpret the presence of a fetal heart deceleration in the CTG trace.

This charge is found PROVED.

The panel asked you during your oral evidence whether, at the time of looking at the CTG, you noticed any decelerations. You responded by saying that doctors were constantly coming in and referencing problems monitoring. You went on to say "By that time when I was doing that there wasn't decelerations".

You then went on to say that when you did notice decelerations, you called the doctors and that you recorded these decelerations on “stickers” which are now not in Woman B’s notes.

Ms 1 stated: “Mrs Adolwa could not define what the acceleration or decelerations was, or identify the baseline… if you cannot do those things, then you cannot interpret the CTG correctly and escalate any concerns.”.

This evidence is supported by the evidence of Ms 2 who stated: “The criticism of Dorisilla is that she did not recognise that between 17:30 and 18:30 there was a problem and did not call for help during that time. After this, the woman is referred to the Obstetrician.”

The panel had sight of the CTG which clearly indicated fetal deceleration at 16:30. In the panel’s view, you clearly were unable to recognise decelerations. As a consequence of this, you were unable to interpret the CTG. The panel was concerned that you still denied this despite clear evidence to show that there were in fact decelerations in the CTG trace.

Accordingly, this charge is found proved.

Charge 1.9

1.9 Failed to challenge and/or document a challenge to the Consultant’s interpretation of the CTG.

This charge is found PROVED.

Ms 1, in her written statement at paragraph 6, stated: “Dorisilla failed to communicate effectively and did not fulfil her duties in caring for woman B because she did not

challenge the doctor's interpretation of a CTG and their decision. During the interview Dorisilla said she completely disagreed with the consultant's interpretation of the CTG but she did not escalate her concerns to the doctor or any other colleagues".

Ms 1 goes on to say at paragraph 10 of her statement that although you had worked at the hospital on many occasions before and did not have issues with staff, your response as to why you did not challenge the consultant's interpretation of the CTG was because you felt that you had no say in the consultant's opinion.

The LSA Investigation report states:

"From the consultant's statement, he stated that he had not been handed over any concerns with the CTG by his colleague and so did not look at the entire trace. The section he looked and described as "normal" was the time of the epidural insertion, which at that point appeared to have been recording maternal pulse.

The report criticises Mrs Adolwa and states that she: "failed to challenge the consultant's classification of the trace on the ward round despite reporting during the interview that she disagreed with him".

It sets out in more detail by what is meant by this, by stating that you "reported disagreeing with this classification and remarked "it was suspicious and this baby should have been delivered as soon as she came in by C-section". [You] failed to vocalise this disagreement with the team and when asked why, [you] responded with "I didn't because Woman B needed me" [you] then went on to say that [you] "had no say, although I thought it was suspicious, he was the consultant".

Ms 1, in her written statement at paragraph 56 stated: "It is documented that there was a decision to postpone forceps delivery and continue with active pushing. This was written in retrospect at 21:00. The delivery should have been expedited; there was an

extra delay on the part of the doctors and Dorisilla had not questioned that decision. Her accountability, advocation (sic) for the woman and care was missing."

In your oral evidence you told the panel: "When he looked at it it was a very normal trace according to the NICE guidelines, so there was nothing for me to have challenged this doctor." and "Who am I to go and start challenging and start now quarrelling? No, I don't work like that, we work together. We looked at it, it was all perfect and we stuck with that point".

The panel concluded that the decision of the consultant did not override your personal accountability as a midwife for the safety of Woman B. You could have challenged him directly or challenge his decision with the co-ordinator. Your evidence is contradictory, you said in your statement to the Croydon Trust 'an epidural top up was given and CTG was reassuring' but Ms 1's written statement says you 'completely disagreed with the consultants interpretation of the CTG but she did not escalate her concerns to the doctor or any other colleagues.'

In your submissions you said 'I am not going to be here and critical what is happening, and this particular time, the consultant is in that room, we are working as a team. I cannot isolate, I cannot go there, I did not go to do an agency shift as a poor little black midwife to go and start criticising all the doctors; we were working in a team and I say that we were working in a team. So, whatever we were doing, we were so collective. If a little manager can go there and try to criticise the consultant, criticise Dorisilla, make sure that this care is absolute; no.'

The panel found this charge proved.

Charge 1.10

1.10 Failed to document the justification for administering IV paracetamol to Woman B at approximately 16:00.

This charge is found PROVED.

The panel considered the written evidence of Ms 1 who stated:

“Dorisilla has recorded that the fetal heart rate (FHR) is low, at 102 (it should be above 110), but she has not documented that she is concerned about that, nor has she escalated it. There is no thought process that she was monitoring the maternal heart rate either. At this point as a midwife you would get a doctor's review. Dorisilla then gives IV paracetamol but it is not clear why.”

Whilst you accept that you administered paracetamol to Woman B, you told the panel this had been prescribed by a doctor. You therefore told the panel that there was no need to document the justification in administering this to Woman B. In your closing submissions on facts you informed the panel that the consultant had administered the paracetamol.

In the panel’s view, as your entry at 16:00 for IV paracetamol contained no other information, the panel determined that you had failed to document the clinical justification for administering this medication.

Accordingly, this charge is found proved.

Charge 1.11

1.11 Failed to recognise that the baby became bradycardic with a heart rate of 40 beats per minute.

This charge is found PROVED.

Ms 1, in her written statement stated:

“With the fetal monitoring, Dorisilla failed to recognise that the baby became bradycardic with a heart rate of 40 beats per minute and she pulled the emergency buzzer 10 minutes later.

During the interview Dorisilla was still adamant that the baby had not become bradycardic and that it was just a loss of contact on the trace with the transducer.. Until she could not auscultate the fetal heart at all, that is what triggered her to pull the emergency buzzer or summon help.”

She later goes on to say:

“The fetal heart rate was recorded at 40bpm but there was no recognition of bradycardia from Dorisilla and even at the interview she denied it being a bradycardia. She said the emergency buzzer was called at 18:29 and so either her entry at 18:20 was the wrong time, or it was written in retrospect and she had written the wrong timing.”

In your oral evidence you told the panel that you denied this charge and explained that at the time of the incident, following administering a catheter to Woman B, you were trying to make room enough for the baby to “move right down into the pelvis”. The panel noted that you, at an interview shortly after the incident, denied that Baby B had become bradycardic. Ms 1 in paragraph 19 of her witness statement states ‘during the interview Dorisilla was still adamant that the baby had not become bradycardic.’

The panel further noted that your reaction to Ms 1, as to why you said you pulled the emergency bell was not related to the baby’s heart rate, but because of the position of the baby’s head: “So when I eventually found it was low right down in the pelvis. It was low and that's how I called the emergency.” The panel noted that this version of events supported your previous denial to Ms 1, that Baby B was not bradycardic.

The panel also took into account that Ms 1's evidence was largely supported by Ms 2's evidence, in which she stated: "There was a bradycardia at 18:20hrs the Midwife documented that there was a loss of contact and did not escalate her concerns until 18:30hrs. The panel felt that a bradycardia was evident".

The panel noted that the documentary evidence, contained in Woman B's notes shows that at 18:20 you record a 'Loss of contact with transducer… head low in the pelvic area". The panel noted that there was no record of any heart rate taken at this time by you.

In all the circumstances, the panel preferred the evidence of both Ms 1 and Ms 2 and found that it was more likely than not, that you failed to recognise that Baby A had become bradycardic with a heart rate of 40 beats per minute.

Accordingly, this charge is found proved.

Charge 1.12

Failed to pull the emergency buzzer until approximately 10 minutes after the baby became bradycardic with a heart rate of 40 beats per minute

This charge is found PROVED.

The panel noted that your position is that you pulled the emergency buzzer at 18:20. If that were the case, this evidence conflicts with the account given by the labour ward co-ordinator, as Ms 3 confirms that the buzzer was pulled at 18:30. Indeed, Ms 3 attends the room at 18:30 and claims that she "buzzes" the registrar. The panel noted that the registrar records the timing of his arrival as being at 18:33. The panel took into account that he therefore appears to arrive promptly, shortly after the 18:30 emergency buzzer is pulled. In the panel's view, the version of events given by Ms 3 are more likely to have occurred. In support of this, Ms 3 never refers to an emergency buzzer being sounded at 18:20, either in her contemporaneous record or witness statement. Further, Ms 3 was

the labour ward co-ordinator and would have been expected to arrive promptly to any emergency buzzer. Your account is made even more unlikely, as if this were to be believed, the doctor would have arrived 13 minutes after emergency buzzer, and in the panel's view this was implausible.

The panel noted that the doctor's retrospective entry of his arrival time of 18:33 on page 81 of the notes supports Ms 3's timeline and version of events.

The panel preferred the evidence of Ms 3 and found it more likely than not that you failed to pull the emergency buzzer at 18:20, but rather at 18:30.

Accordingly, this charge is found proved.

Charge 1.13

1.13 Failed to conduct and/or record the required fetal heart monitoring following an epidural been provided to Woman B

a. *Every 15 mins*
b. *Every 5 mins following transition into 2nd stage of labour*

These charges are found NOT PROVED.

The panel took into account that the relevant policy in relation to this charge was the 'Care of Women in Labour Maternity Guidelines' which state that following a patient being administered an epidural, the FHR of the baby should be taken every 15 minutes and then every 5 minutes in the second stage of labour. Ms 1 also confirms this in her written statement.

The panel noted that the antenatal notes show that at 16:43, the epidural was started and at 18:00 it is recorded that the epidural appears to be working.

During your evidence to the panel, you told it that you recorded the FHR in Woman B's epidural chart. You maintain that you monitored this appropriately and at the correct time intervals.

The panel noted that there are one of two places where such recordings would be recorded, Woman B's birth notes or the epidural chart. The NMC has not produced the epidural chart, in which you claim to have recorded these observations. Whilst the birth notes do not contain any information in relation to these observations, and whilst the partogram is blank, the panel had no evidence to refute your assertions.

In all the circumstances, the panel determined that the NMC had not discharged its evidential burden of proof in relation to these charges.

Accordingly, these charges were not found proved.

Charge 1.14

1.14 Failed to seek hourly 2nd checks of the CTG trace.

This charge is found PROVED.

The panel noted that the Trust's Guidance in relation to this charge was found in the 'Continuous Electronic Fetal Monitoring' Guidance, version 1.4, section 5.4, which states:

"A "fresh eyes" approach to CTG interpretation ensures that the trace is interpreted by more than one person. This recognises that factors such as fatigue and familiarity can lead to a lack of objectivity, thus impeding accurate interpretation of the CTG trace…

The previous 30 minutes of the trace should be assessed and categorised every hour. The categorisation should be documented (then pre-printed sticker may be used)

defined as either normal, suspicious or pathological based on NICE definitions and classifications."

You deny this charge and told the panel that "doctors were with [her] in the room and they were checking the CTG… They would assess with me the CTG".

The panel noted that you had not recorded any information relating to the fresh eyes guidance (above) in the birth notes.

The panel found your assertion, that someone carried out this procedure and that she then recorded this on "stickers", undermined by the fact that the LSA investigation shows that the labour ward coordinator was not present at the time you told the panel she had carried this out with you. There was also nothing about this procedure contained in the partogram or in the notes that the doctor had recorded. There was also no evidence to suggest that the labour ward coordinator had carried this out. The panel noted that you were unable, in your oral evidence, to tell the panel who, specifically, had undertaken the fresh eyes procedure. The panel further noted that Ms 1 could not find anyone during her internal investigation who confirmed carrying out this procedure.

In all the circumstances, the panel found that it was more likely than not that you had failed to seek hourly 2nd checks of the CTG trace.

Accordingly, this charge is found proved.

Charge 1.15

1.15 Failed to document any concern or escalation

This charge is found NOT PROVED.

The panel considered its earlier findings and took into account that whilst you failed to pull the emergency buzzer promptly at 18:20, you had at some stage pulled the emergency buzzer and documented this at a later time. It therefore cannot be said that there was a failure to document any concern or escalation.

Accordingly, this charge is not found proved.

Charge 1.16

1.16 Failed to comment or complete a partogram.

This charge is found PROVED.

The panel noted that during the internal investigation and according to Ms 1, when asked about the partogram, you laughed and said that you did not have time to complete it.
In your oral evidence, when referring to the partogram, you told the panel “and this partogram you can only start to fill it in when you have time to fill it in and when it’s a long labour”. You made reference to Woman B progressing very quickly, i.e. two hours. You told the panel that she made entries in the obstetric notes and that there was “no time to go to fill the partogram”.

The panel determined that there was no documentary evidence to support your assertion. The panel had before it the blank partogram which can be found in the antenatal notes. Given that the partogram would be the appropriate place to make entries, it found your version of events not credible.

The only conclusion the panel was able to draw, is that you failed to comment or complete a partogram.

Accordingly, this charge is found proved.

Charge 1.17

1.17 Failed to fully analyse and/or interpret the fetal heart rate

This charge is found PROVED.

As the panel has earlier concluded, there were concerns regarding the CTG and your ability to interpret and understand this. Additionally, the panel has accepted that there were concerns regarding the doctor's interpretation of the CTG and FHR.

However, given that you were the allocated midwife to Woman B, the responsibility fell on you to continuously monitor the FHR and act as the advocate for Woman B.

The panel noted that Ms 1's evidence was that the "CTG from the onset was a non-reassuring CTG". In contrast, your position is that only after 18:00, when you realised the FHR was 40, you pressed the emergency buzzer.

The panel preferred the evidence of Ms 1, and was of the view that you should have realised from the outset that the CTG was non-reassuring. The panel concluded therefore that you did not fully analyse or interpret the fetal heart rate.

Accordingly, this charge was found proved.

Charge 1.18

1.18 Completed page 1 of the Antenatal notes rather than completing the relevant sections of the Birth Notes.

This charge is found NOT PROVED.

The panel noted that you denied this charge and told the panel that you did not write the entry contained on page 1. The panel has had sight of other entries, which were undisputedly yours and accepted that the entry on page 1 bore no similarity. The panel therefore accepted your evidence in relation to this charge and determined that the NMC had not discharged its evidential burden of proof.

Accordingly, the panel found this charge not proved.

Charge 1.19

1.19 Failed to contemporaneously document:

a. Care provided

b. Maternal observations of pulse and blood pressure.

This charge is found PROVED.

The panel noted that you denied these charges despite appearing to accept that your performance was unacceptable during the LSA investigation, in which it is recorded:

“

- What standard did the midwife fail to uphold and where is the evidence to support the allegation?

Mrs Adolwa failed to complete her records at the time of care and did not record the times that she had made the entries in the notes. There were multiple entries not signed or dated and some sheets did not have patient identifiable information. Mrs Adolwa reported that there were two CTG stickers that had been filled but were not found in the notes so she failed to ensure that the notes were kept securely to provide evidence of her care. There was incomplete documented evidence of routine care observations and assessments and no evidence of any care discussions or advice by Mrs Adolwa to either members of the obstetric team or to Woman B.

- What was the standard of care that you would expect from a reasonable responsible midwife?

The NMC Rules and Codes of conduct are clear that a midwife must keep accurate and contemporaneous records and state clearly when recording the time when the notes were documented, if not at the time of care. Ensuring all entries were signed dated and notes kept securely stored. All conversations should have been accurately recorded to show evidence of the care and advice that she provided. Mrs Adolwa recognised she was unable to complete her documentation and so should have escalated to the labour ward coordinator that she was unable to fulfil her duty of care."

The panel noted that it was accepted that you made retrospective entries in Woman B's notes. The panel also noted that the entries made by you in relation to the care provided to Woman B were sporadic and that there was no evidence of contemporaneous maternal observations of blood pressure.

In the panel's view, your denial of these charges is undermined by your previous acceptance that your documentation was not fully completed or to the requisite standard. The panel also noted that you made admissions to these charges on the first day of the hearing, despite changing your position during your oral evidence.

Accordingly, the panel found these charges proved.

Charge 1.20

1.20 Failed to undertake and/or document observations for Woman B following her anaesthesia/epidural.

This charge is found NOT PROVED.

The panel noted that you did undertake and did record some of the observations for Woman B following her anaesthesia/epidural, as evidenced on page 53 of the NMC Exhibit Bundle. The panel was therefore not satisfied that the NMC had discharged its burden of proof for this charge.

Accordingly, this charge was not found proved.

Charge 1.21

1.21 Failed to investigate and/or escalate appropriately when Woman B became tachycardic.

This charge is found PROVED.

Ms 1, in support of this charge stated: “Woman B was tachycardic, her heart rate was not too high but it still warranted further investigations”. The LSA Investigation Report also refers to the entry at 16:43 when the epidural is sited and states: “It appears on CTG that it was maternal pulse being recorded between 16:43 – 17:15 and this was not identified or questioned by Mrs Adolwa despite a maternal tachycardia of 105bpm”. The same report also records that there was “no escalation to the registrar when noting a moderately high maternal pulse of 105bpm” and “Mrs Adolwa did not report ongoing maternal tachycardia despite documenting a low fetal heart rate and failed to consider that she may have been recording the maternal pulse”

In your oral evidence, you appeared to suggest that Woman B did not become tachycardic because the anaesthetist would not have done an epidural if this was the case. However, in the maternal notes there is evidence of maternal tachycardia prior to epidural siting.

The panel preferred the evidence of Ms 1, which was supported by the documentary evidence contained in the LSA Investigation Report.

Accordingly, this charge is found proved.

Charge 1.22a

1.22 Failed to properly complete Woman's B's records in that you:

a) Did not complete the Patient Identifying Information on page 5 and 9-11

This charge is found PROVED.

The panel noted that neither your name nor signature was contained on page 5 and pages 9-11. The panel considered that, despite other health care professionals being responsible for Woman B's care, you had a parallel responsibility to make sure that the correct details were recorded on Woman B's records. The panel did not accept your explanation, that "whoever got to the page fills it in". Ms 1 stated: "Whilst the doctor also had an obligation to ensure that their own documentation is correct, as the case midwife, it was the Registrant's responsibility to complete this information". The panel accepted the evidence of Ms 1 in this regard.

Accordingly, this charge is found proved.

Charge 1.22b

b) Did not complete and/or record the risk assessment in Woman B's notes at page 2.

This charge is found PROVED.

Ms 1 stated: "The Registrant should have completed a risk assessment on page 2 of the birth notes. The form is comprised of 'tick boxes', which is an easy way to record the

information. The only information completed is the patients name in the top left hand corner".

The panel had sight of the risk assessment on page 140 and 146 of the NMC Exhibit Bundle. The panel noted that in her oral evidence, you accepted that you did not follow the correct policy, but that you did in fact carry out the risk assessment by making an entry on Page 50. The panel noted that this did not contain the information required as set out in the local policy. The panel therefore rejected your explanation and preferred the evidence of Ms 1 in this regard.

Accordingly, this charge is found proved.

Charge 1.22c

c) *Did not complete and/or record the general examination on page 3 of Woman B's birth notes.*

This charge is found PROVED.

Ms 1 stated: "Similarly, page 3 of the birth notes is completely blank. The vaginal examination should have been completed by the consultant, but the general examination section should have been completed by the Registrant. Again, the 'tick boxes' should make the process really quick and are there to prompt the midwife to check all the components. The Registrant should also have signed the document".

In your oral evidence, you told the panel that she completed this documentation but not in the correct place, namely Woman B's notes. You told the panel that you did not have time to "go and copy all what I had written here onto that page… I had to go and copy all these ones, replicate and put it there, but I have written it here on page 50".

The panel noted that there is partial evidence in support of your explanation, in that Woman B is recorded by you as having blood pressure, pulse, presenting history.

However, the panel noted that by your own admission, as contained in the LSA Investigation report, you "accepted that [your] performance in relation to [your] documentation was unacceptable and evident of poor practice. [You] remarked that it was not [your] usual standard of documentation; [you] demonstrated that [you are] aware of good practices in relation to good record keeping but struggled to provide this on the day of the incident as [you] reported that Woman B required a lot of emotional support and so [you] did not have the time to keep contemporaneous records."

Accordingly, this charge is found proved.

Charge 1.22d

d) Did not conduct and/or record the 'agreed plan' section on page 3 of Woman B's notes.

This charge is found PROVED.

Ms 1 stated: "The Registrant would have been expected to complete the 'agreed plan' section on page 3 noting any risk factors including that IV paracetamol had been given in response to managing temperature and a plan to check the temperature again"

You told the panel "I have a plan on page 50. I've got a plan on page 51. I've got even a doctor's plan on page 52. I have another plan on page 53. "

The panel had sight of the relevant documentation, which contained a blank initial assessment, despite your assertions to the panel. The panel therefore determined that it was more likely than not that you did not conduct and/or record the 'agreed plan'.

Accordingly, this charge is found proved.

Charge 1.23

1.23 Failed to escalate Woman B's distress of the situation to appropriate medical professionals.

This charge is found NOT PROVED.

The panel noted that you told the panel "I had to go and call the other senior anaesthetist from the Intensive Care Unit and he's the one we were working together with."

The panel took into account that there was evidence that the doctor attended Woman B at 15:40 and that an epidural for pain relief had been requested at that time and was in transit. The panel also noted that there was evidence to show that you had found another consultant to attend to Woman B. You told the panel that the doctor was present, that pain relief was forthcoming and that an epidural had been provided. The documentary evidence supports this.

The panel was therefore of the view that there was sufficient evidence to show that you had escalated Woman B's distress to an appropriate medical professional, and that the NMC had failed to discharge its burden of proof in relation to this charge.

Charge 1.24

1.24 Failed to challenge the Doctor's decision to delay delivering the baby.

This charge is found PROVED.

The LSA Investigation report stated: "The concerns include the Registrant's failure to

advocate on behalf of Woman B. More specifically, there was a decision to postpone forceps delivery and continue with active pushing, a decision which was written in retrospect at 21:00".

Ms 1, in her written statement, stated: "It is documented that there was a decision to postpone forceps delivery and continue with active pushing. This was written in retrospect at 21:00. The delivery should have been expedited; there was an extra delay on the part of the doctors and Dorisilla had not questioned that decision. Her accountability, advocation for the woman and care was missing".

Ms 2 supports Ms 1's evidence and stated: "The registrant would have been expected to challenge more, but also that the reference to the Consultant's overall involvement".

You deny this charge.

The panel preferred the evidence of Ms 1, and accepted that you had a duty to ensure that Baby A's delivery should have been expedited, despite the discrepancies in decision between medical staff. In the panel's view, you should have challenged the doctor, given that Baby B's foetal heart readings were "pathological".

Accordingly, this charge is found proved.

Charge 1.25

1.25 Failed to clearly mark where entries in Woman's B's records are retrospective.

This charge is found PROVED.

The panel considered the documentary evidence before it, namely Woman B's patient notes.

You told the panel that you had to stay late to write your notes and that another midwife had been making entries at the time due to you providing care to Woman B. You accepted that you then made further entries after this, including entries that were made after your shift had ended. These can be found in the continuation sheet, in the antenatal notes from 21:50 onwards.

The panel noted that it was clear that a number of entries made in Woman B's patient notes were identical to those made by you in Woman B's continuation sheet, specifically four entries made at the following times: 18:50, 18:54, 18:56 and 18:57.

The panel took into account that it is accepted best practice to make contemporaneous entries and that if entries are made retrospectively, that they are clearly marked/labelled as being 'retrospective'. This ensures that anyone else viewing the document will know that these entries had been retrospectively.

For the reasons above, the panel found it was more likely than not that you made retrospective entries at 18:50, 18:54, 18:56 and 18:57 and failed to clearly mark that they were retrospective.

Accordingly, this charge is found proved.

Charge 2.1

2.1 Failed to recognise that Woman A was in established labour.

This charge is found PROVED.

The panel considered the evidence of Ms 5, who stated: "Once we diagnose that a woman is in established labour, our guidance for care would be that we would do regular maternal and fetal assessments, provide one to one care and stay with the

woman. Until we diagnose the woman is in established labour, one to one care, staying with the woman, is unlikely to happen…

When I spoke to…the shift co-coordinator, she was genuinely shocked to see how advanced Woman A was in labour when she found her on the toilet bearing down at 23:30."

She went on further to say:

"I went and spoke to woman A and asked her questions. I was shocked by her description of what happened to her. From what she was describing to me, I had a high suspicion that had been in established labour or there was something wrong because to experience the amount of pain she was describing is not normal. She described 'thrashing and thumping the walls' in pain. She apologised for this and any damage she may have done to the walls.

When I pieced it together I questioned where the midwife was during the labour. If woman A was contracting as strongly as described."

Ms 5 reaffirmed these views in her oral evidence to the panel.

This evidence is largely supported by the evidence of Ms 3, who stated:

"I saw [Woman] A at 21:00 after her Mum asked for help. At this stage she was uncomfortable and needed to be assessed. Mother A looked like someone who was going in to labour and she was breathing through contractions. I spent approximately 5 minutes talking with Mother A and her Mum about the latent phase of labour and explained it can take a long time to get in to established labour. Mother A's Mum asked me if it was normal, and I explained that was, and that it can be exhausting..."

You deny this charge and although your evidence is somewhat confused, the panel recognise the thrust of your defence is that you did recognise the onset labour as you took or were at least party to the decision to move Mother A to a more appropriate room for a woman in labour.

The panel do not accept your explanation because on the evidence before it, it was Ms 3 who identified the onset of labour when she entered the room at the request of the mother of Patient A. The panel's judgment is further reinforced by the handwritten statement signed by you, dated 21 November 2016, where you stated "while helping the midwife in theatre [Ms 3] came to call me that woman A was distressed and I should attend to her immediately."

There is documentary evidence to show that Woman A was moved to Room 5 at 00:15 - this is on any view 45 minutes after the latest time at which the registrant should have recognised that she was in established labour.

In consequence the panel found this charge proved.

Charge 2.2

2.2 Failed to carry out the expected assessments for a woman in established labour.

This charge is found PROVED.

The panel noted that the policy in relation to this charge can be found in the NICE guideline 'Intrapartum care for healthy women and babies'.

The panel noted that up until 23:30 you failed to diagnose established labour, and that established labour was diagnosed by Ms 3.

In your oral evidence to the panel, you took the panel to page 265 of the NMC exhibit bundle, and to the observations you recorded on this page. You recorded at 22:00 “Await labour”. However, the panel noted that this would have been at 21:40, when Woman A was in the latent phase of labour.

The panel therefore determined that you had failed to carry out the expected assessments for Woman A whilst she was in established labour.

Accordingly, this charge is found proved.

Charge 2.3

2.3 *When Woman A was in the latent stage of labour, failed to conduct or record the fetal heart rate*

This charge is found NOT PROVED.

Given the timings established, the panel adopted the position that the latent phase of labour finished at 23:30.

The panel saw in the maternal clinical notes for Woman A, that you had documented a fetal heart rate at 21:40. A sticker on the notes showed that you had recorded a further fetal heart rate at 21:45. It was clear that you had carried out some recording of the fetal heart.

Ms 4, in her written statement stated: “At 21:40 Dorisilla makes the assessment that woman A is having a prolonged latent phase. In the King's College Hospital Care in Labour guidelines (exhibit CG/24, page 6), for a woman who is in a latent phase, the fetal heart should be auscultated at the first contact with the woman and at each further assessment to determine whether labour has become established, and auscultate the fetal heart for a minimum of 1 minute.

Therefore every entry in the notes of when Dorisilla comes back into the room should contain a recording of the fetal heart rate. I would consider that potentially every time Dorisilla went back in to the room (given the lapses in time), it would be regarded as a new assessment, so Dorisilla should review and assess woman A's behaviour. As a midwife you may make a decision not to listen to the fetal heart every time you go back into the room; however that should be documented in the patient notes, e.g. your rationale. By Dorisilla's omission to record the fetal heart rate or record why she has not, we are assuming she would not be following policy because she has not stated why she had not."

Ms 5, in her statement stated: "I think Dorisilla left woman A alone and was distracted by things she should not have been. Therefore there was no opportunity for regular assessments to pick up any fetal heart monitoring which would have led to increased monitoring and involvement of the wider team."

In response, in your oral evidence you told the panel: 'Yeah, there is a foetal heart rate on that sticker. Thank you. I deny the charge.'

The panel concluded that you monitored the fetal heart rate on two occasions at 21:40 and 21:45, and in the panel's view the NMC has not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 2.4

2.4 Failed to take the fetal heart rate at least every 15 minutes once Woman A was in established labour and in any event from 23:30.

This charge is found PROVED.

Ms 4, in relation to this charge, stated: “It is hard to say from the notes at what stage Woman As labour established, but if it is assumed it was at 23:30 (because woman A was wanting to push), it would have been reasonable to monitor the fetal heart at least every 15 minutes, but potentially every 5 minutes, from 23:30. Dorisilla does not listen in at 23:30 or at 23:45 when she assesses woman A. In my professional opinion, Dorisilla's plan for a Vaginal Examination at 23:30 assessment also suggests that woman A was in established labour.”

The panel noted that the relevant policy at the time can be found in the NICE Guidance, Section 1.10.2.

You appeared to assert that was undertaken at 00:00. The panel noted that the fetal heart seemed to be recorded at 00:00 and at one other later time, but that the 15 minute time line was breached.

The panel noted that in principle, the fetal heart rate should have been taken at the following time intervals: 23:30, 23:45, 00:00, 00:15, 00:30 and 00:45.

The panel noted that you had recorded foetal heart rate on four occasions, but apart from the recording taken at 00:00, all the rest were untimed.

The panel also noted that the doctors were called in at 00:45 because of Baby A’s bradycardia.

The panel noted that you said that these observations were done at the appropriate time intervals. The panel took into account that whilst the Trust investigation only cites one reading at midnight, in the handwritten notes provided, there are single entries made at 00:00 and three other untimed recordings of the fetal heart (127bpm, 89bpm and 79bpm). The panel considered that even if there were four fetal heart recordings taken, they were still not compliant with the NICE guidelines.

Accordingly, this charge is found proved.

Charge 2.5

2.5 Failed to support Woman A in her intrapartum pain relief choices in that you:

a) Did not provide Woman A with all the options as to the pain relief available

This charge is found PROVED.

Ms 5, in the Trust's Serious Incident Report states: "Ms X repeatedly asks for an epidural. Unfortunately Mrs Adolwa appears to have not taken Ms X's request for an epidural analgesia seriously and imposed her own attitudes, values and beliefs regarding coping with pain in labour, without due regard to a woman's choice. An early epidural should be available to comply with a women's request as NICE CG 190 suggests that this should be available to women with severe pain in the latent phase of labour. Although the labour ward and anaesthetist (sic) was busy on this evening it was not so busy that an epidural service was not available and it would have been appropriate for Mrs Adolwa to highlight the request for epidural to the co-ordinator and anaesthetist (sic) on duty early in the evening."

Ms 5 maintained this position in her oral evidence to the panel.

The panel noted that Woman A's birth notes indicate that Mrs Adolwa recorded "birth plan discussed, wants epidural, stay in bed."

The panel noted the NICE guidance (Section 1.9.3) on page 354 on the NMC Exhibit Bundle which states: "If a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent first stage of labour."

During Woman A's evidence to the panel, you asked her whether she could remember whether she discussed "all the pain relief, epidural, any other analgesia before [Mrs Adolwa] left the room". Woman A answered "no".

During panel questions, Woman A, with regard to being asked whether she could recall any discussion about what types of pain relief were available to her, stated:

"Dorisilla, she made it clear that it was my first child and I was young, and basically that she was just saying that I can do it, I can brave through it. When it comes to epidurals, I think she told me that it was too early to take an epidural. She knew I was in pain."

You denied this charge and indicated that you had discussed with Woman A all the options of pain relief.

The panel preferred the evidence of Woman A, who gave a clear, consistent and measured account of events, and who was clear in telling that panel that all the available options for pain relief had not been provided to her at the time by you. The panel noted that Woman A told the panel that she attended this hearing so that lessons would be learned and that this would not happen to another woman in labour. The panel was of the view that she did not seek to apportion blame or seek a sanction against any particular person.

In the panel's judgement, its conclusion on this is supported by your submissions in which you said 'I offer them other alternatives before I go onto the pharmaceutical drugs. I don't believe in that, but when we need to give them, we give them'.

Accordingly, this charge is found proved.

Charge 2.5b

b) Did not take into consideration that the non-pharmacological methods had already been tried when assessing and advising Woman A on pain relief.

This charge is found PROVED.

Ms 5, in support of this charge, stated: "[Woman A] said she kept asking for an epidural. Dorisilla kept going over other techniques such as soaking in the bath and walking around but woman A had been doing that all day. Dorisilla failed to take into consideration that the nonpharmacological methods had already been tried and that woman A wanted something more to help her with labour pains."

The panel noted that the Serious Incident Report stated: "It is some professional concern that [Mrs Adolwa] appears to have failed to support a young woman in labour, be it latent or established, [Woman B] was in severe discomfort, experiencing regular painful contractions and [Mrs Adolwa] appears to have actively chosen to be distracted by other activities within the labour ward rather than attending and 'being with woman'. It is hard to understand how a young woman's request for an epidural was ignored and the package of non-pharmalogical, message, mobility and hydrotherapy focussed upon when an opioid injection had not been fully effective and especially when the request for an epidural was so clearly stated. It is with regret that it appears that Mrs Adolwa had a 'musketeer approach' to promoting physiological birth against the expressed wishes of the woman. Her birth partners tried to advocate her choice but they too were not able to persuade Mrs Adolwa to facilitate her choice of an epidural earlier in the evening."

You denied this charge.

The panel preferred the evidence of Woman A for the same reasons stated on the previous charge and accepted the evidence of Ms 5 on the issue.

Charge 2.5c

c) Failed to prepare Woman A for an epidural

This charge is found NOT PROVED.

The panel noted that there is documentary evidence which demonstrates that at some point during the shift you prepared Woman A for an epidural. This was accepted by the NMC. The panel noted that whilst it remains unclear as to when exactly this occurred, whether this actually had occurred was not in dispute.

The panel therefore found this charge not proved.

Charge 2.5d

d) Failed to listen and/or respond appropriately to Woman A's description of her pain.

This charge is found PROVED.

As with Charge 2.5(b), the panel considered Ms 5's evidence in which she stated: "[Woman A] said she kept asking for an epidural. Dorisilla kept going over other techniques such as soaking in the bath and walking around but woman A had been doing that all day. Dorisilla failed to take into consideration that the nonpharmacological methods had already been tried and that woman A wanted something more to help her with labour pains."

Ms 5 also went on to provide more context into the above, by stating:

"It also appeared that Dorisilla was unable to move away from her normal, low-risk approach. Unless the woman is saying she will give the previous techniques another go, you do not go back to them unless it is in partnership with trying alternatives. It was

Dorisilla's partnership with woman A that was not coming across when I spoke to her. It seemed it was Dorisilla's way of doing things and she was not listening to woman A."

Woman A, in her oral evidence told the panel:

""I felt like my screams were going unheard for what felt like hours. I felt like she didn't recognise there was a problem, and she didn't anticipate that the problem would be so big. Whatever happened within my body, what was going on, I was the only one feeling it and if someone is not listening to what you are saying, and keeps on saying that it's your first child, and they're reassuring you that, 'This is your first child, you are young', it made me feel like, 'Okay, let me to suppress it. I was suppressing pain I shouldn't have been suppressing, I was – I shouldn't have gone through that that amount of pain for that that period of time. It wasn't normal and I feel like if I was heard quicker, that I would have been out of pain and – I would have been out of pain."

You denied this charge and stated: "Again, as she had talked about the pain I was listening to her. … There is no time I argued with her that I will not give her epidural. I listened to this woman and we had a very good rapport …"

The panel preferred Woman A's evidence which was clear and consistent on this matter and supported by the Serious Investigation Report.

Accordingly, this charge is found proved.

Charge 2.6

2.6 Failed to date and/or time all recordings in real time and/or in chronological order.

This charge is found PROVED.

The panel noted that in the patient notes before it, you had signed and dated some entries and note others, in particular, there were no signatures or time stamps for the entries made for 11 September 2016.

The panel therefore found this charge proved.

Charge 2.7

2.7 Failed to clearly mark which notes were retrospective and/or the rationale for doing so.

This charge is found PROVED.

In your oral evidence, you denied this charge and stated: ““you are looking after a woman, you are scrubbed up in scrubs, you could not be writing.”

The panel noted that this would appear to refer to when Woman A was in theatre. In your notes the theatre decision is timed at 00:45, by contrast at page 273 the theatre decision is timed at 00:55 and is signed and dated by the attending doctor, by the specialist registrar and senior house officer.

The panel therefore determined that there would appear to have been sufficient opportunity for you to make notes between 23:00 and 00:45, or more likely 00:55. You have not provided any rationale for making retrospective notes between these times.

Accordingly, this charge is found proved.

Charge 2.8

2.8 Failed to document how long you auscultated the fetal heart rate and/or what equipment was used and/or the method employed at

a) 21:40

This charge is found PROVED.

The panel considered the evidence of Ms 4, who stated at paragraphs 12 and 13 of her statement:

"According to the Intrapartum Fetal Monitoring Guidelines (2016)**,** section 5.2 the definition of intermittent auscultation (IA) is 'the auditory technique for sampling and counting the fetal heart rate at particular intervals with the human ear...It is recorded by one number not a range as it would be with Continuous electronic fetal monitoring'. The step by step approach of how it should be taken is explained at section 5.3 of the guidelines.
According to the notes the next time the fetal heart is auscultated (listened in to) is at 21:40 where Dorisilla records it as 114bpm. It is unclear from the notes how long she listened in to the fetal heart, what equipment was used and the method employed. The fetal heart should be assessed as per the Trust's guidelines**.** At step 3 of section 5.3 (page 7), it states that Records should reflect how often IA is to be carried out and the equipment used'."

The panel noted that you initially admitted this charge, but later withdrew this admission and told the panel "so, really to expect me to have written that down – that is expecting too much. I have no further comment on that one."

The panel noted that you had no reasonable explanation when set against the evidence of Ms 4. The panel accepted the evidence of Ms 4.

Accordingly, this charge is found proved.

Charge 2.8b

b) 00:00

You told the panel in your oral evidence that you did listen to the fetal heart rate at this time but failed to document this in the notes. However, the panel determined that you were unable to state what equipment was used, nor the method you assert you had employed.

Given that there is no record of this in the documentary evidence, the panel found it more likely than not that you failed to document how long she had auscultated the fetal heart rate and/or what equipment was used and/or the method employed at 00:00.

Accordingly, this charge is found proved.

Charge 2.9

2.9 After assessing at 21:40 that Woman A was having a prolonged latent phase failed to auscultate the fetal heart rate at each further assessment and/or failed to document that assessment and/or document rationale for not listening to the fetal heart rate.

a) 22:00 when making an assessment for pain relief
b) 23:00
c) 23:30
d) 23:45

These charges are found PROVED.

The panel considered the evidence contained in the Serious Incident Report:

“The recordings at 19:45 of 119 bpm and 21:40 of 114 bpm are 15-20 bpm difference from the other recordings between 11.05 amd (sic) 00:00 overall, there is no

acknowledgement of any difference to previous recordings or a reference to any baseline rate. The fact that Ms X was contracting so strongly and frequently should have initiated a response from the midwife to increase the frequency of intermittant (sic) auscultation as established labour should have been suspected and anticipated. If there had been some consideration to the overall picture and assessement (sic) of the fetal well being then there possibly should have been a commitment to performing additional observations."

Ms 3, in her written statement said: "every entry in the notes of when Dorisilla comes back into the room should contain a recording of the fetal heart rate. I would consider that potentially every time Dorisilla went back in to the room (given the lapses in time), it would be regarded as a new assessment, so Dorisilla should review and assess woman Ns behaviour. As a midwife you may make a decision not to listen to the fetal heart every time you go back into the room; however that should be documented in the patient notes, e.g. your rationale. By Dorisilla's omission to record the fetal…

It would be reasonable at 23:00 to listen to the fetal heart every 15 minutes, as per NICE guidance for the first stage of labour (Section 1.10.2). If she then suspected that woman A needed to push and that second stage was imminent, then she should have started to auscultate more frequently i.e. every 5 minutes as per NICE guidance (section 1.13.2). In this case, the fetal heart is not auscultated between 21:40 and midnight."

You denied this allegation and in your oral evidence said: "because if I keep writing every detail there honestly, it's impractical because of what is going on." The panel noted that you provided no further explanation to the panel and this appeared to be your overall position to all limbs of charge 2.9.

In the panel's view, with regard to all of the times contained within the limbs of charge 2.9, there was no rationale as to why the fetal heart rates were not recorded.

The panel preferred the evidence of Ms 3, whose evidence was supported by documentary evidence contained in Woman A's notes.

Accordingly, this charge is found proved.

Charge 2.10

2.10 Failed to auscultate and/or document the fetal heart rate between 21:40 and midnight.

This charge is found NOT PROVED.

As regards to this charge, the panel noted that there is a sticker on page 265 of the NMC Exhibit Bundle where you did carry out and document what was required at 21:45. This charge is therefore not found proved.

Charge 2.11

2.11 Failed to auscultate and/or document the fetal heart rate at least every 15 minutes from approximately 23:30 to midnight.

This charge is found PROVED.

For the same reasons set out in 2.9 (c) and (d), the panel found this charge proved. Further, the panel noted that there was nothing contained in the notes from you as regards to midnight.

Charge 2.12

2.12 Failed to continuously monitor the fetal heart rate from approximately midnight onwards.

This charge is found PROVED.

The panel noted that in the long note written retrospectively by you, seemingly timed 00:00, the CTG appeared to commence while the anaesthetist was in the room. However the panel found it more likely that the CTG commenced at or around 00:35 where the anaesthetist, at page 299 of the NMC Exhibit Bundle, records that he arrived in the room.

There is no evidence in the notes to suggest that you, as the responsible midwife, monitored the fetal heart continuously. The panel noted that your oral evidence is that you attempted to auscultate the fetal heart: “So, because this woman was a low risk you can do what is called intermittent auscultation of the heartbeat and the nurse guidelines say that. So, if you can see that when I did [VE]’” sic.

The panel considered that, in your oral evidence, you effectively conceded that you did not continue to monitor the fetal heart rate.

Accordingly, this charge is found proved.

Charge 2.13

2.13 Failed to document the time that the CTG was started.

This charge is found PROVED.

In relation to this charge, Ms 3 stated: “It is not clear from the entry what time she started the CTG — she has noted that it was when the anaesthetist was in the room (page 34), however it is unclear whether the fetal heart was normal at that point.”

The panel had sight of part of the retrospective note at 00:00, however as in the charge above, the panel noted that you linked the start of the CTG whilst the anaesthetist was in the room. The anaesthetist times his arrival in the room at 00:35. Therefore, for the reasons referred to above, the panel considered this time (00:35) to be more likely correct. The panel considered that in any event, there was no time on page 275 as to when the CTG was started, as there is no time listed opposite your entry.

Accordingly, this charge is found proved.

Application to admit evidence

During the panel's deliberations on misconduct and impairment you emailed your NMC case officer a very considerable number of documents, totalling 693 pages spread over 135 separate emails. The panel reconvened the hearing and you made an application for these documents to be admitted into evidence. You explained to the panel that the documents were evidence of what you said. You said the documents contained a reflective piece, proof of study days and workshops you have attended and online courses you have undertaken. You added that there were certificates from training courses and proof of which journals you have subscribed to. You told the panel that you have been thinking of other things you can do and want to start an academy. You said that you should have had the documents with you when you were giving evidence but did not know you would need them.

Mr Jeffs submitted that the documents range a variety of subjects including piano lessons. He reminded the panel that it must consider whether the documents are relevant and fair. Mr Jeffs submitted that he could not say if all of them are relevant and the issue of fairness is the panels own discretion. Mr Jeffs told the panel that the documents could contain private matters and invited the panel to consider that they could be redacted after the hearing in order to facilitate an expeditious disposal.

The panel accepted the advice of the legal assessor.

The panel determined to admit the documents into evidence. It noted that you had not realised you would need them at the correct time but have spent time emailing them to your case officer. It further noted that you are representing yourself. The panel decided that it would be fair to admit the documents. With regard to relevance the panel determined that some of the documents may be relevant to your case and decided to read them all and put whatever weight it deemed appropriate to them after they were read.

The panel received a bundle which had been redacted by the NMC case officer and so it did not need to make a decision about redacting after the hearing.

Submissions on misconduct and impairment:

Having announced its finding on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

Mr Jeffs referred the panel to the case of Roylance v GMC (No. 2) [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

In his submissions Mr Jeffs invited the panel to take the view that your actions amount to a breach of *The Code: Standards of conduct, performance and ethics for nurses and midwives 2008* (the 2008 Code) in respect of charge 1 and *The Code: Professional standards of practice and behaviour for nurses and midwives* (the 2015 Code) in respect of charge 2. He then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct. Mr Jeffs added that at the time of the charges there was separate record keeping guidance and Midwifery standards, which your actions also breached.

Mr Jeffs invited the panel to consider that the charges found proved can be grouped in the below categories:

- Failing to recognise various stages of labour
- Failing to undertake appropriate assessments, observations and monitoring
- Failing to escalate concerns
- Failing to act as an advocate for the patients in questions

- Record keeping and documentation concerns

Mr Jeffs submitted that your identified failings in the charges were repeated and they both individually and collectively demonstrate a serious falling short of the standards expected and therefore amount to misconduct.

He then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Jeffs referred the panel to the cases of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

Mr Jeffs submitted that an unwarranted risk of harm arose from your misconduct. He said that there are wide ranging concerns and your actions have the potential to bring the midwifery profession into disrepute. Mr Jeffs invited the panel to consider that you breached fundamental tenets of the profession. He submitted that the panel may find that you have demonstrated some attitudinal concerns and referred the panel to the determination on facts where your assertions of racial bias and a witness being ‘forced’ to give evidence were unfounded.

Mr Jeffs reminded the panel that it must consider your insight and submitted that it may find it lacking. He submitted that the panel must consider whether your actions are remediable and whether they have been remediated. Mr Jeffs invited the panel to consider that there is no evidence that you have yet remedied your practice. He added that the panel should consider your insight and any attitudinal concerns when considering a risk of repetition. Mr Jeffs submitted that the public interest in this case should be at the forefront of the panel’s mind when considering current impairment.

You gave evidence under oath. You said that you feel you gave patients your priority and that you practised effectively. You told the panel that in 2013 you experienced a

number of difficult personal events including health concerns and deaths of family members. Following this, you said you continued to work hard and received an award from King's College Hospital. You told the panel that you are very remorseful that babies died. You said you have been affected by this process and you cannot repeat it. You sated that it has traumatised your life.

You told the panel that you like mothers and their babies to be safe and you were always professional. You said that nursing and midwifery are professions that you were born with and if anything happened in your care you are very remorseful. You said that you loved going to work as you loved to provide care. You told the panel that you miss practising and the only thing you know is to look after people. You told the panel 'my whole career has gone, the skills the knowledge have gone, promotion of natural delivery has gone'. You told the panel that you are writing a book about being a midwife.

You said that you have read a lot about midwifery in journals and have been watching YouTube videos. You told the panel that you would not wish anyone to go through the trauma you did. You said how your life has changed as a result of this process such as losing contact with colleagues and not being able to present at conferences. You said that you have learnt a lot since this hearing started and you may have said things during the hearing you would not usually say. You told the panel that you collaborated well at work and you are very remorseful for what happened, you never intended to cause any problems.

You said that you are currently studying project management, business management and international leadership. You added that the courses have helped you learn how to be a leader, communicate effectively and how to look after people. You said that you dream of nursing and midwifery and you want to be able to give people advice. You told the panel that the situations that the charges arose from were overwhelming as there was so much to be done in a short time. You said that the impact on the mothers involved was traumatic.

You told the panel that you have been writing essays and your computer skills ‘are wonderful’. You said that in future you would know to escalate concerns straight away and explain everything in understandable terms. You told the panel that you have learnt a lot from its determination on facts and you took it as an opportunity to reflect. You said that you do not need further training as a midwife. If you were allowed to practise again you said that you would find a hospital to work in and complete its orientation. You told the panel that you now also have management skills.

The panel read and noted the documents you submitted these were, in general terms:

- Thank you cards from parents going back over some 15 years
- Emails from the library at Kings College Hospital NHS Foundation Trust attaching a wide ranging reading list including midwifery and general medical articles
- Your curriculum vitae (CV)
- A document you called a ‘reflective piece’ dated 11 September 2017, referring to Woman A
- Some communications referring to an academic poster presentation about midwifery
- Some communications concerning your participation in the East African Healthcare forum
- Multiple miscellaneous communications and training certificates covering fields as disparate as beauty therapy, piano lessons, modelling, door supervision and yoga

The panel has accepted the advice of the legal assessor who referred to the cases of Nandi v GMC [2004] EWHC 2317 (Admin), Mallon v GMC [2007] CSIH 17, Holton v GMC [2006] EWHC 2960 (Admin), Meadow v GMC [2007] QB 462, Cohen v GMC [2008] EWHC 581 (Admin), CHRE v (1) NMC (2) Grant [2011] EWHC 927 (Admin).

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 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 2008 Code and the 2015 Code.

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

The 2008 Code

8 *You must listen to the people in your care and respond to their concerns and preferences.*
9 *You must support people in caring for themselves to improve and maintain their health.*

26 *You must consult and take advice from colleagues when appropriate.*

28 *You must make a referral to another practitioner when it is in the best interests of someone in your care.*

35 *You must deliver care based on the best available evidence or best practice.*

38 *You must have the knowledge and skills for safe and effective practice when working without direct supervision.*

39 *You must recognise and work within the limits of your competence.*

42 *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*

43 *You must complete records as soon as possible after an event has occurred.*

45 *You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.*

61 *You must uphold the reputation of your profession at all times.*

<u>The 2015 Code</u>

1. Treat people as individuals and uphold their dignity

To achieve this, you must:

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share decisions about their treatment and care

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

2.5 respect, support and document a person's right to accept or refuse care and treatment, and

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk,

10 Keep clear and accurate records relevant to your practice

This 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:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. Looking at charges 1.1 and 1.2, the panel was of the view that recognising when a woman is in labour is a basic and fundamental skill which you

should have been able to carry out as a midwife. The panel considered that your failure in charge 1.3 fell far below the standards expected and you compromised patient safety. Charge 1.4 also fell far below the standards expected as risk assessing and documentation is a basic midwifery skill. The panel noted that your actions in charge 1.5 caused a significant risk of a premature baby being born in a toilet and therefore your actions fell far below the standards expected.

In charge 1.7, your failure to escalate an abnormal CTG reading fell far below the standards expected as escalation of concerns is basic and vital to a patient's care. Your actions in charge 1.8, in that you did not recognise the deceleration of the fetal heart fell far below the standards expected as it is a fundamental midwifery skill. Your actions in charge 1.9 fell far below the standards expected as you were the named midwife responsible for Woman B's care and you did not act as an advocate for her. Further you stated that you were aware that the CTG was 'suspicious' but still did not act to safeguard her or the unborn baby. The panel considered charges 1.11 and 1.12 together as they concerned the same mischief and considered that your actions in both fell far below the standards expected as your actions in failing to recognise that the baby became bradycardic and thus failing to pull the emergency buzzer put the mother and unborn baby at serious risk of harm.

The panel considered that your failure to seek hourly second checks of a CTG trace in charge 1.14 fell far below the standards expected and was a breach of the NICE guidance. Your failure to complete a partogram as set out in charge 1.16 was a breach of the NICE guidance and your actions fell far below the standards expected as a partogram is a live document that provides an accurate record of the progress of labour, so any delay or deviation from normal may be detected quickly and treated accordingly. A midwife should be able to use a partogram when providing care. You failure in charge 1.17 to fully analyse or interpret the fetal heart rate fell far below the standards expected as reading a fetal heart rate is a basic midwifery clinical skill. The fetal heart reading was concerning from the beginning and you failed to recognise this, putting the mother and unborn baby at risk of harm.

Your failure in charges 1.19a and 1.19b fell far below the standards expected as failing to document your actions contemporaneously puts healthcare professionals at risk of not being able to identify a deteriorating patient. Further, failure to document could affect continuity of a patient's care. Your failure to investigate and/or escalate appropriately when Woman B became tachycardic, as set out in charge 1.21, was an inexplicable deviation from normal practice and therefore your actions fell far below the standards expected. The panel considered charge 1.22 as a whole and was of the view that it demonstrated a pattern of substandard maternity care delivered by you. Your failure in charge 1.24 fell far below the standards expected as you were the named midwife responsible for Woman B's care and you did not act as an advocate for her or her unborn baby.

The panel was of the view that your failures in charges 2.1, 2.2 and 2.4 fell far below the standards expected and compromised the mothers and unborn baby's safety. The panel was of the view that the skills set out in these charges are basic and fundamental skills which you should have been able to carry out as a midwife. The panel considered the proved limbs of charge 2.5 together and was of the view that your actions set out in them fell far below the standards expected. It noted that you disregarded the patient's needs in terms of pain relief and put your own beliefs first, rather than the patient.

The panel considered charge 2.9 as a whole and was of the view that your actions fell far below standards expected of a midwife. Fetal heart rates should be auscultated and documented regularly in order to provide appropriate care so an abnormal heart rate may be detected and swift intervention in the birth process instigated. You failed to do this. Further the panel was of the view that your failure in charge 2.11 also fell far below the standards expected. The panel considered your failure in charge 2.12 was very serious and put the mother an unborn baby at serious risk of harm.

The panel was of the view that your actions in charges 1.6, 1.10, 1.25, 2.6, 2.7, 2.8 and 2.13 were poor practice but would not be considered deplorable in the circumstances and therefore did not amount to misconduct.

Overall the panel found that your actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision and reasons on impairment

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said:

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

Mrs Justice Cox went on to say in Paragraph 76:

I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
>
> d. …

The panel finds that limbs a, b and c are engaged in that your actions put patients at unwarranted risk of harm in the past and you are currently liable in the future to do the same. Your actions in the past brought the profession into disrepute and you are currently liable to bring the profession into disrepute in the future. Further you breached and are liable to breach fundamental tenets of the profession.

The panel considered whether your misconduct is remediable and was of the view that, although your practice could be remedied, there has been very little remediation demonstrated by you so far. Indeed, any remediation would be made much more difficult by your attitudinal issues. The panel took into account that you have repeatedly demonstrated an inflated sense of self-importance and a sustained lack of insight into your failings. It was of the view that you saying ‘before I go onto pharmaceutical drugs. I don’t believe in that’ was significant as it demonstrated that you think you know best and would put your own beliefs before a patient’s needs and wishes.

The panel noted that your reflection is focused on the impact these proceedings have had on you and your inability to work. You have not demonstrated any meaningful insight into how your actions impacted on the mothers and families of the babies, your colleagues or the wider midwifery profession. The panel was concerned that you said you do not require any training and could go back to practising straight away. The panel was also disturbed that you asserted that you give people priority and practise effectively. It also took into account that you said you would look for management roles as you now have management skills. The panel determined that this all demonstrated a significant lack of insight.

In respect of the documents you submitted recently, the panel only felt able to give weight to your CV, the document you called a ‘reflective piece’ (referring to only Woman A) and the reading lists from King’s College Hospital. However, the weight the panel gave to these documents was not great. For example, your CV merely sets out your educational career from primary school, through secondary school, and on now to nail technician, beauty therapist and other employments. It makes only the briefest reference to work in the healthcare sector. In the document you called a ‘reflective piece,’ the panel could find no evidence that you have in fact reflected, as that term is understood in the context of regulatory proceedings, on the poor outcome for Woman A and her baby, the family and the wider profession or indeed, on your own professional practice. This apparent lack of understanding was further reinforced by your response

when these omissions were pointed out to you by the panel: you merely repeated the page numbers. The reading lists from Kings College Hospital certainly contained some midwifery material but also contained articles from a wide range of subjects. Further, the panel was unable to assess whether you have in fact learned anything from them.

The panel did not give any weight to the other documents since they did not address any of the panel's concerns about your understanding of the fundamentals of midwifery.

The panel is of the view that there is a significant risk of repetition based on your attitudinal issues, your lack of insight and lack of effective remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind:

'(4) The over-arching objective of the Council in exercising its functions is the protection of the public.
(4A) The pursuit by the Council of its over-arching objective involves the pursuit of the following objectives—
(a) to protect, promote and maintain the health, safety and wellbeing of the public;
(b) to promote and maintain public confidence in the professions regulated under this Order; and
(c) to promote and maintain proper professional standards and conduct for members of those professions.'

The panel was of the view that it would be potentially dangerous for you to practise unrestricted and a member of the public would be alarmed if a midwife who had behaved as you did were not found to be impaired.

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

Submissions on sanction

Mr Jeffs told the panel that the NMC's sanction bid for this case is a striking-off order. He referred the panel to the NMC's Sanctions Guidance (SG) and took it through points to consider for each sanction available. He reminded it of the NMC's over-arching objective and submitted that the sanction must be the least restrictive that would still protect the public.

You told the panel that the hearings process is new to you. You told the panel that you have worked collectively with the hearing parties throughout. You told the panel that you will document your practice better in the future. You said you would keep up to date with guidance and the NMC's code of practice. You said patients are your priority and you will practise effectively. You said you would provide patient safety without prejudice and get help immediately when needed. You said that communication is very important. You said you would seek support for any personal or financial problems. You told the panel that you are passionate about your profession and it makes you happy. You said you have not practised for three years and cannot get a job in a care setting. You said you really feel for the women who lost their babies and accept that maybe you did not do what was expected. You told the panel that the hearing process has been a learning curve and said it would be nice for nurses and midwives to have workshops about the NMC. You said that whatever you do the patient comes first and you want to look after them. You told the panel that you scored 97% on your anatomy and physiology modules whilst studying courses not health related. You said that you want to work with confidence and pride as a nurse and midwife.

You said that lack of insight is a very broad topic but you are aware of treatments and why a patient would want them. You told the panel that you have been active with keeping up with what you have to do. You said that if there is a problem with a patient you would escalate and you can easily find someone to help. You told the panel that you want to have a positive impact on patients and acknowledge, empower and reassure them. You take into account the diversity of patients. You said you have a new

awareness of how to deal with problems. You said that your beauty therapy course was more medical than you thought and it included how to look after yourself. You also said that your work with nails taught you how important it is to look after them. You thanked the panel.

Decision and reasons on sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the Registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register. You will no longer be able to practise as a midwife or a nurse in the United Kingdom.

The panel accepted the advice of the legal assessor, who referred the panel to the cases of CHRE v NMC and Leeper, [2004] EWHC 1850 (Admin); and R (ex p Abrahaem) v GMC [2004] EWHC 279 (Admin).

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had 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 considered that your submissions were unorganised and did not address what sanctions you believe would be appropriate at this stage. You frequently contradicted yourself. The panel has heard you speak at each stage of this process at length and is concerned that you demonstrate the same themes in evidence to it. These are a shocking lack of insight and no real appreciation of your failures or how the poor outcomes in the two incidents in this case impacted on the women and babies concerned or how this could adversely affect the view patients, colleagues and indeed the public in general would have on the profession of midwifery. The panel considers

that you demonstrate such deep seated attitudinal problems that you appear delusional. By this, the panel means that you maintain your idiosyncratic position in response to the seriousness of your midwifery failings despite significant evidence to the contrary.

The panel considered the following factors to be aggravating in your case:

Aggravating factors

- the fundamental nature of the midwifery failings identified. These include, not being able to recognise clearly or at the appropriate times the various stages of labour and being unable to recognise an abnormal fetal heart rate;
- a repeated pattern of misconduct over a period of time which has resulted in extensive and wide ranging breaches of the Code;
- a shocking lack of any insight into your failings which meant that you could not express appropriate remorse;
- deep seated attitudinal concerns, including inflated belief in the quality and safety of your midwifery practice.

The panel could not identify any mitigating circumstances in your case.

The panel first considered whether to take no action or whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to do nothing or impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions

imposed must be relevant, proportionate, measurable and workable. The panel took into account the Sanctions Guidance (SG) and was of the view that there are no practical or workable conditions that could be formulated, given the serious and wide ranging nature of the failings in your case. It considered that there was evidence of harmful deep-seated attitudinal problems as it concluded you were unable to appreciate or respond appropriately to the concerns about your practice.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order would be appropriate in (but not limited to) cases where there was:

- 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 panel is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.

However, none of these apply, as in the panel's view:

- the panel identified over 20 separate findings of misconduct: this was not a single incident;
- there is strong evidence of harmful deep-seated attitudinal problems in your case;
- the first incident in Croydon led to a detailed investigation and resulted in you satisfactorily completing a supervised practice programme. Nevertheless, you were again unable, a year later, to demonstrate fundamental midwifery skills. The panel found that at King's College Hospital, you could still not identify

properly the various stages of labour. There was no further repetition of misconduct but the panel noted you were dismissed and an interim suspension order was in place;

- the panel considers you have a shocking lack of insight and there is a significant risk of you repeating behaviour that could cause unwarranted harm to mothers and babies.

Balancing all of these factors, the panel has determined that a suspension order would not be an appropriate or proportionate sanction.

In conclusion, the panel does not consider that a period of suspension would be sufficient to protect patients, public confidence in midwives or uphold proper professional standards.

Finally, the panel considered a striking-off order. It took note of the following from the SG:

- 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?

Your failings were such significant departures from the standards expected of a registered midwife, that they do raise fundamental questions about your professionalism and, in the panel's view, are fundamentally incompatible with you remaining on the register. Indeed, the panel was of the view that your actions were so far removed from what is expected of a registered midwife in safe and unrestricted practice that it is dangerous for you to work as a midwife. As the findings in this particular case

demonstrate, your actions were so serious that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In considering the principle of proportionality, the panel took into account the financial and other hardship that this will order will have on you. In the circumstances of this case, for the reasons previously identified, the public interest far outweighs your personal interests.

Balancing all of these factors and after taking into account all 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 bringing the profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that a striking-off order is the only sanction that will mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards required of a registered midwife.

Determination on interim order

The panel has considered the submissions made by Mr Jeffs that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest to uphold proper standards of conduct in the nursing profession. You made no comment at this stage.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible 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 the striking-off order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.