Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

12 – 18 February 2019

7 – 10 May 2019

20 – 22 May 2019

12 – 15 August 2019

2 – 5 September 2019

Nursing and Midwifery Council, 114-116 George Street, Edinburgh, EH2 4LH

Name of registrant:	Louise Ann Kennedy
NMC PIN:	05I1785S
Part(s) of the register:	Registered Midwife (November 2008)
Area of registered address:	Scotland
Type of case:	Misconduct
Panel members:	Anne Asher (Chair, Registrant member) Christina McKenzie (Registrant member) (12 – 14 February 2019) Jude Bayly (Registrant member) (18 February 2019 onwards) Alex Forsyth (Lay member)
Legal Assessor:	Peter McLuckie (12-18 February 2019) Graeme Henderson (7 May 2019 onwards)
Panel Secretary:	Elaine Stewart (12 – 18 February 2019) Tara Hoole (7 – 9 & 20 – 22 May 2019) Susan Curnow (10 May 2019) Caroline Pringle (12 – 16 August 2019)

	Philip Austin (2 – 5 September 2019)
Mrs Kennedy:	Present and represented by David Adams (12-20 February 2019) and David Cobb (7 May 2019 onwards)
Nursing and Midwifery Council:	Represented by Samantha Forsyth, Case Presenter
Facts proved:	1.1(a), 1.2(a), 1.2(b)(i), 1.2(b)(ii), 1.2(c), 1.2(d)(i), 1.2(d)(ii), 1.2(e), 1.2(f), 1.2(g), 1.2(i), 1.3, 2.1(b), 2.1(d), 2.1(e), 2.1(h), 2.1(j), 2.1(k), 2.2(a), 2.2(b), 2.2(c), 2.3(a), 2.3(b), 2.3(c), 2.4, 2.5, 3.1(a), 3.1(b), 3.1(c), 3.1(e), 3.1(g), 3.1(i), 3.2(a), 3.2(c), 3.2(d), 3.2(e), 3.2(f), 3.4, 4.2(b), 4.2(c), 4.2(d), 4.3 and 6 (in relation to 1.2(g) and 3.4
Facts proved by admission:	1.1(b), 1.1(c), 1.4, 2.1(a), 2.1(c), 2.1(g), 3.1(d), 3.1(f), 3.1(h), 3.3, 4.1, 4.2(a), 5 and 7
Facts not proved:	1.2(h), 2.1(f), 2.1(i) and 3.2(b)
Fitness to practise:	Currently impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order – 18 months

Submission and application on adjournment

At the start of the hearing and prior to the reading of the charges, Mr Adams, on your behalf, made an application to adjourn the hearing.

He told the panel that you had been represented by Thompsons Solicitors throughout the NMC investigation of your case and that they had instructed him as counsel on 11 January 2019. He told the panel that he received the interim hearing bundle on 14 January 2019 and the final bundle on 4 February 2019. He said his first consultation with you was on 8 February 2019 and he met you yesterday on 11 February 2019. Mr Adams explained that, during these consultations, you made him aware that there were documents missing from the hearing bundle that had been in the Case Examiners bundle. Mr Adams said that you believed they were necessary for the proper exploration of your case. Further to that, Mr Adams said that you had identified a number of medical records that you would have expected to be in the hearing documents that were not present in either the hearing bundle or the Case Examiners bundle.

Mr Adams submitted that in order to present your case properly and be able to cross examine witnesses thoroughly, he required time to review the documentation available from the Case Examiners bundle and then take instruction from you.

He told the panel he would have expected a number of records relating to Patients A, B and C. Specifically:

- Patient A
    - digital record for magnesium sulphate syringe driver pump
    - ICE records
- Patient B
    - Triage notes taken prior to Patient B being handed over to your care
    - TPAR (Kardex)
    - Fluid Balance Chart

    - Maternity assessment record and continuation sheet (it is expected that this would contain the blood pH results)

- Patient C
    - Notes regarding the stillborn confirmation

He submitted that requests were made for the full records for Patients A, B and C prior to the hearing and would have expected the documents above to be included in the document bundle.

With regard to Patient D, Mr Adams acknowledged that no specific request had been made prior to the hearing for the full notes for Patient D and he said it was unclear why this had not been requested. He told the panel that he had now requested that the instructing solicitor attends the hearing today to assist on this matter. However, he submitted that he now requires the full record of the care provided to Patient D in order to properly present your case.

Mr Adams then told the panel he would also be making a further application to adjourn the hearing in order to obtain and admit the evidence of an expert witness. He told the panel that he had only been made aware yesterday that an expert witness had been instructed, who had produced an interim report. He submitted that, as this was only an interim report, it was not sufficient to present as evidence at this time and that he had yet to take instruction on its contents. Mr Adams told the panel that he accepted that an adjournment to finalise the expert evidence and also secure the attendance of the expert would take a considerable amount of time that would exceed the time allocated to this hearing.

Ms Forsyth, on behalf of the NMC, opposed both the application for disclosure of further documents and the adjournment application relating to an expert witness.

Ms Forsyth told the panel that the NMC has requested all the documents it deemed necessary to present its case and that four witnesses were being called in support of its case. Ms Forsyth submitted that any gaps in the evidence can be dealt with by the witnesses.

Ms Forsyth submitted that the Case Management Form was returned to the NMC on 23 November 2018 and the form was clearly marked that you would not be relying on any expert evidence. She further submitted that there was no mention of an expert witness at the case conference on 20 December 2018. She said she had not seen the report and had no information about what this expert would address. For these reasons, Ms Forsyth indicated she would oppose any application to adjourn relating to an expert witness.

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

The panel invited both parties to agree the specificity of the documentation requested and to make full submissions following the arrival of the instructing solicitor, Ms Osborne.

The hearing reconvened later on day one with Ms Osborne in attendance.

Mr Adams informed the panel that he was now making a formal application for adjournment in respect of documentation disclosure only. He told the panel that you would not now be relying on any expert evidence.

Mr Adams then gave further submissions that reiterated his earlier position on the necessity for all the relevant documentation to be made available. He submitted that this was essential to allow him to prepare your case fully. He submitted that the documentation requested was relevant and that he would then require time to consider each item requested and take your instructions on this. He invited to panel to allow an adjournment in the interest of fairness to you.

Ms Forsyth invited the panel to reject the application on the basis that the NMC has requested all the documents it deemed relevant to present the case, and that you have had sufficient time prior to the hearing to request any additional documents. Ms Forsyth further submitted that the documents are exhibited by witnesses who have been called to give evidence and any insufficiencies can be addressed with these witnesses. Ms Forsyth told the panel that the documents now requested are not relevant and would not assist further in addressing the charges in this case.

The panel gave careful consideration to the submissions of both parties and noted that, as the charges have yet to be read, the panel have yet to see the hearing bundles and assess the necessity of any further documentation. The panel considered the fairness to you to allow you to be satisfied that the panel had access to all the relevant documentation in its consideration of your case. The panel also considered the public interest in the expeditious disposal of this case, and that witnesses had been called and were in attendance to give evidence. The panel, in balancing fairness, decided to adjourn the hearing until the morning of day two to allow time for NHS Tayside to be contacted and a request made for them to supply missing documentation.

On day two, the panel was informed by Ms Forsyth that all the documentation requested had been identified by Ms 2 and that the process of scanning and emailing it to the NMC had begun. Ms Forsyth told the panel that some documents had already been received, and sent on to Mr Adams, and that the remaining available documents would be sent in as they were collated over the coming hours.

Ms Forsyth invited the panel to have the charges read and then, while the outstanding documentation is being received, the panel can read the main hearing bundles. She submitted that this would allow progress to be made with the hearing, and allow Mr Adams time to take instruction as the documents are received.

Mr Adams made a further application for adjournment at this time. He told the panel that some of the documentation now provided by NHS Tayside had previously been said not to exist. He expressed concerns about the 'piecemeal' disclosure of documentation and said that he required time to consider the entirety of the documentation before he could take full instructions and present your response to the charges in your case.

He submitted that it was in the interests of fairness to you that you had sufficient time to review this new information and formulate your response.

Ms Forsyth opposed this further application. She submitted that you had already provided a response to the charges in the Case Management Form and that, as the documentation refers only to a small number of the charges, it would be possible for you to deny the charges at this time in relation to those charges and that you would have the opportunity to change your position on receipt of the evidence.

Ms Forsyth submitted that a further delay would severely inconvenience the witnesses called and that it was not in the public interest to delay the hearing further.

The panel again balanced fairness to you with the public interest in the expeditious disposal of the case. The panel considered that, with regard to Patient D, there may be considerable information to be reviewed as the full records had not previously been requested. It found that, having been assured that the documentation was available and would be provided today, it was fair to allow you time to consider this properly.

The panel was mindful of the further inconvenience to the witnesses and sought assurances from parties that, following time to consider the requested documentation, there were no further issues that would delay the hearing. The panel requested an agreed schedule of the requested documents together with assurances from key NHS Tayside personnel where such documents were not held.

Mr Adams raised a concern regarding Ms 1's eligibility to give evidence at that time but it was agreed by parties that it was a matter for her.

Having heard that there were no other outstanding issues, the panel adjourned the hearing for the remainder of day two.

On day three of the hearing, Ms Forsyth told the panel that all documentation had been served and Mr Adams confirmed that you had considered the documentation provided.

Prior to the reading of the charges, Mr Adams raised an objection to the admissibility of the evidence of Ms 2.

Ms Forsyth, on behalf of the NMC, told the panel that no issue had been raised regarding Ms 2's evidence prior to this morning. She said that it was a matter for the panel to determine what evidence it should take into account and invited the panel to proceed with the case without further delay.

The panel heard and accepted the advice of the legal assessor who reminded them of their wide discretion as to how they direct proceedings and the balance to be had against prejudice to you.

The panel therefore determined that they would hear submissions relating to admissibility at a later point in proceedings without any prejudice to you and proceeding with the hearing at this time would meet the public interest in dealing with hearings in a timely manner.

Details of charge (as amended):

That you, a registered midwife:

1. When caring for Patient A between 9 and 11 June 2016:

1.1 Did not communicate adequately with Patient A in that you:

a. Did not discuss infant feeding with Patient A when you took over her care and/or document the discussion in Patient A's notes; **Proved**
b. During the night shift of 9 to 10 June 2016, did not document that you had any conversation with Patient A regarding the baby's care; **Proved by admission**
c. On one or more occasion called the patient "sweetheart" as opposed to calling her by her name. **Proved by admission**

1.2. Did not sufficiently document Patient A's care in that you:

a. Between 21.30 and 23.54 on 9 June did not observe the blood pressure of Patient A but retrospectively sought this information from the blood pressure monitor; **Proved**
b. Between 20.00 and 23.54 on 9 June failed to observe and/or record:
   i. Patient A's respiratory rate; **Proved**
   ii. The cumulative fluid balance; **Proved**
c. ~~Recorded observations in the notes without making it clear these entries were retrospective;~~ Between 21.00 and 23.54 on 9 June , recorded observations in the MAR chart and/or labour record without making it clear these entries were retrospective; **Proved**
d. In relation to commencing the labelatol and/or magnesium sulphate infusions:
   i. Did not obtain consent and/or document that consent had been obtained; **Proved**
   ii. Did not explain to the patient and/or document that you had discussed with her why the infusions were being recommended; **Proved**

e. Did not carry out and/or document adequate observations for the first 30 minutes of the magnesium sulphate infusion; **Proved**
f. Did not make sufficient entries in the notes in relation to Patient A's on-going care needs, analgesia, emotional support and wellbeing; **Proved**
g. Wrote an entry in the notes stating that you had previously discussed breast feeding with Patient A when this discussion had not taken place; **Proved**
h. Wrote an entry in the notes to say that you helped with hand expressing when it was in fact a colleague who assisted; **Not proved**
i. Did not ensure that the information recorded in the maternal notes corresponded with the observations in the MEWS chart. **Proved**

1.3. Failed to escalate a MEWS trigger to the medical staff or senior charge midwife on one or more occasion. **Proved**

1.4. On 10 June failed to follow a written instruction from the doctor with respect to the discontinuation of magnesium sulphate IV infusion. **Proved by admission**

2. When caring for Patient B on 6 and 7 September 2016:

2.1. Did not sufficiently document Patient B's care in that you:
a. Documented the fundal height measurement in weeks as opposed to centimetres; **Proved by admission**
b. ~~Did not document the fetal heart rate in the maternal record~~; Between 20.40 and 22.05 on 6 September 2016, and/or during the second stage of labour did not document the fetal heart rate in the maternal record and/or on the CTG; **Proved**
c. Did not document that the patient was accompanied by her mother and partner; **Proved by admission**
d. Did not document sufficient details in relation to the birth; **Proved**
e. Incorrectly documented the administration of the oxytocin; **Proved**
f. Documented that you had given the oxytocin when this was not the case; **Not proved**

g. Did not document the position of fundus following the birth of the placenta and membranes; **Proved by admission**

h. ~~Did not adequately complete the postnatal documentation~~. Did not adequately complete the postnatal documentation in the maternal notes, in that you did not document any post-natal advice and/or that a complete assessment of the genital tract had been carried out; **Proved**

i. Recorded the incorrect dose of Vitamin K which was provided to the baby; **Not proved**

j. Did not adequately complete the fluid balance chart; **Proved**

k. Did not ensure that the information recorded in the maternal notes and corresponded with the observations in the MEWS chart. **Proved**

2.2. Did not adequately provide care to Patient B in that you:

a. Did not obtain consent and/or document the consent for examining the perineum; **Proved**

b. Did not take and/or recognise that pH samples had not been taken following the birth. **Proved**

c. Did not conduct further observations at 1.30am on 7 September 2016. **Proved**

2.3. After commencing the CTG at around 20:40 on 6 September 2016 did not:

a. Assess the CTG directly for the first 5 minutes; **Proved**

b. Review and sign the CTG at 15 and/or 30 minutes; **Proved**

c. Provide sufficient reasons for stopping the CTG. **Proved**

2.4. Did not provide Patient B with appropriate pain relief. **Proved**

2.5. Inappropriately transferred Patient B to the antenatal ward. **Proved**

3. When caring for Patient C on 10 and 11 September 2016:

3.1. Did not adequately document Patient C's care in that you:

a. ~~Did not note her physical and/or psychological wellbeing~~ Between 20.00 and 22.00 on 10 September 2016, did not note her physical and/or psychological wellbeing in the maternal notes; **Proved**

b. Failed to make any entry in the notes between 20.15 and 20.55 on 10 September 2016; **Proved**

c. Did not document any attempts to deliver the placenta and membranes; **Proved**

d. Incorrectly documented that the placenta was manually removed; **Proved by admission**

e. Did not document the position of the baby at birth and/or whether the neuchal cord was around the baby's neck; **Proved**

f. Did not record whether the neuchal cord was clamped and cut prior to birth or after birth; **Proved by admission**

g. Did not document the liquor around the baby and/or if the baby had passed meconium; **Proved**

h. Did not use the partogram; **Proved by admission**

i. Incorrectly documented the administration of the oxytocin. **Proved**

3.2. Did not adequately provide care to the patient in that you:

a. Did not discuss and/or document that you had discussed bladder care with the patient; **Proved**

b. Made no assessment of maternal bleeding immediately post birth; **Not proved**

c. Did not give oxytocin in a timely manner; **Proved**

d. Did not ask and/or document whether Patient C wanted a translator; **Proved**

e. Did not carry out maternal observations every 15 minutes and/or document them whilst awaiting the delivery of the placenta and membranes; **Proved**

f. Did not offer and/or document that you had offered analgesia. **Proved**

3.3 Failed to fill out a datix in relation to the stillbirth. **Proved by admission**

3.4. Recorded in the notes that you had discharged Patient C when this was not the case. **Proved**

4. When caring for Patient D on 7 September 2016 you:

4.1 Provided a fresh eyes review when you had allowed your CTG training to lapse. **Proved by admission**

4.2 Did not ~~sufficient~~ [sufficiently] document Patient D's care in that you:

a. Incorrectly documented details of the perineal tear; **Proved by admission**
b. Did not document any advice or information given regarding the healing of a perineal wound and/or the reasons for recommending suturing; **Proved**
c. Did not document anything in relation to analgesia; **Proved**
d. Did not document anything in relation to the vagina or cervix. **Proved**

4.3 Did not obtain consent and/or document the consent for examining the perineum. **Proved**

5. Between 2 July 2016 and 11 September 2016 had allowed your CTG training to lapse. **Proved by admission**

6. Your actions at charges 1.2g and/or 1.2h and/or 2.1f and/or 3.4 were dishonest in that you sought to represent that you had carried out certain tasks when you had not. **Proved in relation to charges 1.2(g) and 3.4 only**

7. On one or more occasion(s) between 1 September 2017 and 4 January 2018 provided midwifery services without being under the direct supervision of a registered midwife. **Proved by admission**

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

Decision and reasons on application to amend the charge

On day three of the hearing, after the charges had been read, Mr Adams raised an objection to four of the charges on the grounds of specificity. He submitted that charges 1c, 2.1b, 2.1h and 3.1a were vague and lacked specific detail as to the time frames involved or expected information to be recorded.

Ms Forsyth gave suggested amendments to the charges to provide clarity and more accurately reflect the evidence.

<u>Original charges</u>

1.2. Did not sufficiently document Patient A's care in that you:

c. Recorded observations in the notes without making it clear these entries were retrospective;

2.1. Did not sufficiently document Patient B's care in that you:

b. Did not document the fetal heart rate in the maternal record;

h. Did not adequately complete the postnatal documentation.

3.1. Did not adequately document Patient C's care in that you:

a. Did not note her physical and/or psychological wellbeing;

<u>Amended charges</u>

1.2. Did not sufficiently document Patient A's care in that you:

c. Between 21.00 and 23.54 on 9 June, recorded observations in the MAR chart and/or labour record without making it clear these entries were retrospective;

2.1. Did not sufficiently document Patient B's care in that you:

b. Between 20.40 and 22.05 on 6 September 2016, and/or during the second stage of labour did not document the fetal heart rate in the maternal record and/or on the CTG;

h. Did not adequately complete the postnatal documentation in the maternal notes, in that you did not document any post-natal advice and/or that a complete assessment of the genital tract had been carried out;

3.1. Did not adequately document Patient C's care in that you:

a. Between 20.00 and 22.00 on 10 September 2016, did not note her physical and/or psychological wellbeing in the maternal notes;

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> 28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—
>
> (a) the charge set out in the notice of hearing; or
>
> (b) the facts set out in the charge, on which the allegation is based,
>
> unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.
>
> (2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel noted that these amendments were agreed by both parties and was of the view that the amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision on Recusal

On receipt of the hearing documents, the panel became aware of the name of the hospital involved in these charges, Ninewells Hospital (the Hospital). The registrant panellist made it known that she has had a prior relationship with this Hospital as she was the midwife member of an invited review group by the Royal College of Obstetricians and Gynaecologists (RCOG) in November 2012. This review examined the quality of care of midwifery services at the Hospital and a report was provided to NHS Tayside.

Whilst the registrant midwife panellist was not aware of you personally, or the witnesses, many of them were employed in the service at that time.

The panel found that there was a risk that the public may perceive that the conclusions of the registrant midwife panellist may be influenced by her prior knowledge of the Hospital.

The panel was clear that there was no suggestion of any actual bias on the part of the registrant midwife panellist, but it could not be satisfied that there would not be a possibility of perceived bias should the hearing of your case be allowed to continue with the current registrant midwife panel member.

Accordingly, the registrant midwife panellist recused herself.

The hearing resumed on day five with a new registrant panellist.

Submissions were invited from both parties regarding the substitution of the new panellist but both Ms Forsyth and Mr Adams confirmed they had no submissions to make and were content to proceed with the newly constituted panel.

Adjournment

At the close of day three of the hearing, Mr Adams indicated that he would be withdrawing as your counsel to allow a new advocate to be instructed to represent you who would have availability to conclude the hearing. Mr Adams had told the panel that he would have difficulty in attending resuming dates for the hearing as it would not now conclude in the time allocated.

It was confirmed toward the end of day four that Mr Adams would continue with the case and it was anticipated that the hearing would recommence at 09:30 on day five.

In dealing with preliminary matters on day five, resuming dates for the hearing were discussed and it was apparent that finding dates when all essential hearing parties were available was proving to be extremely difficult.

Mr Adams made an application to adjourn the hearing to allow new counsel to be sought as, despite the best efforts of all parties, he acknowledged that his limited availability was causing difficulty. He submitted that it was in your interest that you had one representative throughout the course of the hearing and that it was unreasonable for your case to be heard in part by one advocate who would have to hand over to another.

Mr Adams acknowledged the considerable cost and inconvenience involved in bringing all parties here today and the further inconvenience to the witnesses. However, he submitted that it was both fair and reasonable to allow you to present your case in the best way possible.

Ms Forsyth acknowledged the difficulties in your situation regarding representation but submitted that she had been in contact with the instructing solicitor on Friday and was of the understanding that the case would proceed this morning. She provided the panel with an email exchange in support of this.

Ms Forsyth submitted that she opposed the application on the grounds of the public interest in the expeditious disposal of the case and the further inconvenience to witnesses who have now been warned and stood down on a number of occasions now. Ms Forsyth indicated that she expected to be able to conclude her case in the time remaining but accepted that this may not now be possible.

The panel gave careful consideration to both parties' submissions and determined to adjourn the hearing at this time to allow new counsel to be sought. The panel weighed up carefully the balance in allowing you to present your case in a way that is fair to you, with the public interest in the expeditious disposal of the case.

The panel determined that while some progress could be made this week, it looked probable that, if Mr Adams remained as counsel, it would be the autumn before the case would be concluded. The panel considered that, should a new advocate be instructed, seven days were available in April in which it would be possible to make considerable progress with your case.

Accordingly, the panel determined that it was both in your interest and in the public interest to adjourn the hearing and resume on 8 April 2019 for seven days.

Ms Forsyth raised a concern regarding witness availability in April. On further discussion, it was agreed that the hearing would resume on 7, 8, 9 and 10 May and again on 20, 21 and 22 May.

Hearing resumed on 7 May 2019 (Day six)

The panel formally opened the hearing on 7 May 2019. At this point you were afforded the opportunity to respond to the charges which were read into the record prior to the hearing adjourning in February. You made admissions to charges 1.1(b), 1.1(c), 1.4, 2.1(a), 2.1(c), 2.1(g), 3.1(d), 3.1(f), 3.1(h), 3.3, 4.1, 4.2(a), 5 and 7. The chair announced these charges proved by admission.

During the evidence of Ms 2 on day seven, it became apparent that there may be further documentation in existence which would assist the panel. During her evidence Ms 2 made reference to a notebook belonging to you which you had produced during the course of an appeal hearing before your employers. During the course of proceedings elsewhere you produced the notebook into evidence. Mr Cobb, on your behalf, raised objections to mention of this notebook as he had no prior knowledge of it. Proceedings were adjourned to allow Mr Cobb to take instructions.

On returning to the hearing Mr Cobb submitted that the notebook should be admitted into evidence. The panel requested that Ms Forsyth make enquiries as to whether a copy of the notebook could be produced for this hearing.

On day eight, the panel requested an update regarding any progress on the notebook. Ms Forsyth told the panel that she had not received any further information regarding the notebook. She told the panel that she had advised Mr Cobb that, if the notebook forms part of your case, that it may be more available to you. Mr Cobb advised that you have contacted the person who represented you in the previous internal proceedings to request a copy of the notebook.

Decisions and reasons on applications to hear evidence from witnesses via video link pursuant to Rule 31

On day six, Ms Forsyth made an application to allow Ms 3 and Ms 4 to give their evidence via video link. Ms Forsyth told the panel this had been provisionally agreed between the parties. Ms Forsyth reminded the panel that Ms 3 had attended the hearing in person in February to give evidence and had not been heard. She told the panel that a provisional agreement had been reached between the parties to allow Ms 3 and Ms 4 to give video evidence rather than requiring them to attend in person to avoid further inconveniencing these witnesses.

Ms Forsyth told the panel that both Ms 3 and Ms 4 speak to a charge which has been admitted.

Mr Cobb told the panel he was not aware of any agreement reached to hear Ms 3 and Ms 4 by video link. However, he had no objections to hearing their evidence in this manner.

The panel accepted the advice of the legal assessor, who referred the panel to Rule 31(1). He reminded the panel that it was first required to consider whether the proposed evidence was relevant and, if so, whether in all the circumstances it would be fair to allow the evidence by video link. He further reminded the panel that whilst the witnesses would not be in attendance in person that they would still be able to view the witnesses via the video link. He drew the panel's attention to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and the decision to allow remote evidence was not a routine matter.

The panel decided to allow the application to hearing Ms 3's and Ms 4's evidence via video link. It was satisfied that their evidence is relevant and that no unfairness would be caused by allowing the application. It noted that the witnesses in this case were inconvenienced by the delays at the previous hearing in February. The panel considered it will be able to see and hear their evidence in a similar way as if they were

physically present in the room, and their evidence can still be tested by cross-examination. In these circumstances, the panel was satisfied that it would be fair to allow Ms 3 and Ms 4 to give evidence by video link and therefore allowed the application.

On day eight, Ms Forsyth updated the panel as to Ms 4's availability to provide evidence to the hearing. Ms Forsyth told the panel that Ms 4 was available to give telephone evidence today between her appointments but that, as Ms 4 was out of the office she was not able to give evidence via video link today. Ms Forsyth informed the panel that Ms 4 would be available tomorrow (day nine) at 13:00 to provide evidence via video link. Ms Forsyth said it was a matter for the panel as to when and by what method they determined to hear Ms 4's evidence.

Mr Cobb submitted that it would be his preference to hear Ms 4's evidence via video link rather than by telephone. Mr Cobb told the panel he would object to Ms 4 giving telephone evidence.

The panel accepted the advice of the legal assessor who reminded the panel that it required a good and cogent reason to proceed with telephone evidence today rather than video link tomorrow given the objections made by Mr Cobb and the neutral position of the NMC.

The panel determined that, whilst there was a time pressure to ensure the hearing completes in as timely a manner as possible, it did not justify proceeding today with telephone evidence rather than postpone until tomorrow for video evidence. The panel considered that it would be preferable for all parties for Ms 4 to give her evidence via video link. In addition the panel considered the convenience of the witness. Ms 4 would be providing her evidence by mobile phone in a car park. Ms 4 would likely be more comfortable giving her evidence from her office rather than being out of the office and between appointments. The panel therefore determined to adjourn the hearing until Ms 4 was available to attend via video link on day nine.

Decision and reasons on application under Rule 19

Prior to hearing witness evidence it was noted that it was likely that there would be reference to your health during the course of the hearing.

Ms Forsyth submitted that it would be appropriate that any reference to your health be heard in private under Rule 19 of the Rules. Ms Forsyth submitted that it was not necessary to hold the entirety of the hearing in private.

Mr Cobb indicated that he agreed that any reference to your health conditions should be heard in private.

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

Having heard that there will be reference to your health, 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 in connection with your health condition as and when such issues are raised.

Decision and reasons to amend the charge

During closing submissions on the facts by Ms Forsyth and Mr Cobb, the legal assessor noted a grammatical error in charge 4.2.

It was proposed that the word “sufficient” in the charge be amended to “sufficiently” to correct the error.

Both Ms Forsyth and Mr Cobb agreed that it would be appropriate to make such an amendment for the purposes of clarity.

The panel was satisfied that this was an obvious grammatical error and therefore decided to amend the charge.

Background

The charges arose whilst you were employed by NHS Tayside (the Board). You were initially employed as a temporary Band 6 Registered Midwife in August 2011 and then as a permanent employee from February 2012. You moved from Arbroath Midwifery Unit to Ninewells Hospital (the Hospital) in October 2012.

The Board received a complaint on 30 August 2016 from Patient A who had been in your care from 9 – 11 June 2016. A review of the care provided to Patient A was conducted. Following this the Board investigated a further two instances, involving Patient B and Patient C, relating to care you provided on 6 – 7 September 2016 and 10 – 11 September 2016 respectively.

In total it is alleged that you failed to provide an appropriate standard of midwifery care to four patients for whom you were the named midwife. The allegations in this case are wide-ranging and relate to fundamental midwifery care including: inaccurate recording of and failure to undertake observations, failures to follow correct procedures and policies, lack of knowledge and falsification of records.

A disciplinary hearing was held on 13 February 2017 following which you were dismissed.

Decision on the findings on facts and reasons

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

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 was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel heard oral evidence from four witnesses tendered on behalf of the NMC:

- Ms 1 – Clinical Services Manager at the Hospital at the time of the allegation;
- Ms 2 – Midwifery Team Manager for in-patient services at the Hospital at the time of the allegation;
- Ms 3 – Office Manager for Private Midwives at time of the allegation;
- Ms 4 – Midwife and Team Co-Ordinator at Private Midwives at time of the allegation;

The panel was also provided with the written witness statement of Mr 6, Investigation Manager at the NMC.

The panel also heard oral evidence from you and from Ms 5, called on your behalf, who was a registered midwife at the Hospital at time of the allegations.

In closing submissions, objection was taken to some of the evidence of Ms 2 on the basis that she was providing expert evidence. Although it sought to challenge the admissibility of her evidence, the evidence had already been adduced. It was suggested by the legal assessor that the issues raised in the case of *Kennedy v Cordia Services LLP* [2016] SC (UKSC) 59 involved the issue of what weight could be given to her evidence. No comment was made on this advice.

The panel first considered the overall credibility and reliability of all of the live witnesses.

The panel found Ms 1 to be credible and reliable. She did her best to assist the panel and acknowledged the limits of her own knowledge and recall.

The panel found Ms 2 to be a credible and reliable witness. Her evidence was balanced, fair and consistent, even under cross-examination. She demonstrated a high level of professionalism, appeared very familiar with the documentation in use at the Hospital, was an experienced midwife, and gave evidence regarding the Hospital's midwifery standards and practices. Although Ms 2 worked in an operational management role at the time, she is a registered midwife and continued to support the team clinically when necessary. The panel was therefore of the view that Ms 2 was well placed to give evidence regarding your conduct and the standards of care expected from a midwife at the Hospital. The panel did not accept all of her evidence. For example, it considered that to expect the recording of consent for the examination of the perineum in the intrapartum period was perhaps a 'platinum' standard of recording and the panel was aware of current midwifery practice in today's busy NHS.

The panel found Ms 3 to be a credible and honest witness. Although her evidence was limited to your employment with Private Midwives, she was able to assist the panel with the dates of your employment in various roles.

The panel found Ms 4 to be a credible and reliable witness. She did her best to assist the panel and acknowledged the limits of her own knowledge and recall.

The panel found you to be an unreliable witness. Your evidence was inconsistent and contradictory and the panel found that your explanations, at times, lacked credibility. In some cases you attempted to shift the blame onto others or blamed pressure of work.

The panel found Ms 5, who gave evidence on your behalf, to be a credible and honest witness. Her evidence was clear and focused and she had a good recollection of events.

At the start of this resumed hearing you admitted the following charges: 1.1(b), 1.1(c), 1.4, 2.1(a), 2.1(c), 2.1(g), 3.1(d), 3.1(f), 3.1(h), 3.3, 4.1, 4.2(a), 5 and 7.

These were therefore announced as proved.

The panel then went on to consider the remaining charges and made the following findings:

Charge 1.1 (a)

1. When caring for Patient A between 9 and 11 June 2016:

1.1 Did not communicate adequately with Patient A in that you:

a. Did not discuss infant feeding with Patient A when you took over her care and/or document the discussion in Patient A's notes;

This charge is found proved.

The panel was provided with a copy of Patient A's maternal records from 9 – 11 June 2019. In these notes there is no record made by you of a discussion with Patient A regarding infant feeding.

The panel noted that, in your interview with Ms 2 on 16 September 2016, you were asked if it was your normal practice to speak with your patients regarding their feeding intentions. You replied that you "would have but it was handed over to me twice that she didn't want to breast feed".

In your oral evidence you confirmed that you did not discuss infant feeding with Patient A when you took over her care.

For these reasons the panel was satisfied that you did not discuss infant feeding with Patient A when you took over her care and/or document the discussion in Patient A's notes.

Accordingly, charge 1.1(a) is found proved.

Charge 1.1(b)

b. During the night shift of 9 to 10 June 2016, did not document that you had any conversation with Patient A regarding the baby's care;

This charge is found proved by way of your admission.

Charge 1.1(c)

c. On one or more occasion called the patient "sweetheart" as opposed to calling her by her name.

This charge is found proved by way of your admission.

Charge 1.2 (a)

1.2. Did not sufficiently document Patient A's care in that you:

a. Between 21.30 and 23.54 on 9 June did not observe the blood pressure of Patient A but retrospectively sought this information from the blood pressure monitor;

This charge is found proved.

The panel had regard to the notes of the disciplinary hearing, dated 13 February 2017. In these notes, you are recorded as saying that the entries made by you on Patient A's MEWS chart between 21:30 and 23:54 on 9 June 2019 were recorded retrospectively.

In your oral evidence to this panel you denied saying this at the disciplinary hearing. However Ms 2, who was also present at the disciplinary hearing, was adamant that you had.

The panel preferred the evidence of Ms 2. Her evidence was clearer and more consistent than yours. It was also supported by the contemporaneous notes of the disciplinary hearing which, in the panel's view, were likely to be more reliable having been made closer to the time.

For these reasons the panel was satisfied on the balance of probabilities that between 21:30 and 23:54 on 9 June 2016 you did not observe the blood pressure of Patient A but retrospectively sought this information from the blood pressure monitor.

Accordingly, charge 1.2(a) is found proved.

Charge 1.2 (b)(i)

b. Between 20.00 and 23.54 on 9 June failed to observe and/or record:
   i. Patient A's respiratory rate;

This charge is found proved.

The panel had regard to Patient A's MEWS charts from 9 June 2016. This showed no recorded observations of Patient A's respiratory rate between 20:00 and 23:54. In your evidence to the panel you stated that you had Patient A regularly in your sight during this time and were watching for signs of respiratory concern. However, the panel considered that your evidence on this point was inconsistent and unreliable. It also had no other evidence, in the absence of recorded observations, to support your assertion that you were observing Patient A.

For these reasons, the panel was satisfied on the balance of probabilities that between 20:00 and 23:54 on 9 June 2016 you failed to observe and record Patient A's respiratory rate.

Accordingly, charge 1.2(b)(i) is found proved.

Charge 1.2(b)(ii)

b. Between 20.00 and 23.54 on 9 June failed to observe and/or record:
   i. …
   ii. The cumulative fluid balance;

This charge is found proved.

The panel had regard to Patient A's fluid balance chart from 9 June 2016. On this chart, the cumulative totals at the bottom of the page were incomplete. In your oral evidence you accepted that it would have been your responsibility, as the midwife caring for Patient A, to calculate these totals and you did not.

The panel was therefore satisfied on the balance of probabilities that between 20:00 and 23:54 on 9 June 2016 you failed to observe and record Patient A's cumulative fluid balance.

Accordingly, this charge is found proved.

Charge 1.2 (c)

c. Between 21.00 and 23.54 on 9 June, recorded observations in the MAR chart and/or labour record without making it clear these entries were retrospective;

This charge is found proved.

The panel had already found charge 1.2(a) found, namely that you retrospectively entered blood pressure readings on Patient A's MAR chart. The panel had copies of the relevant records and was satisfied that they contained no indication that these observations had been completed retrospectively.

The panel was therefore satisfied on the balance of probabilities that between 21:00 and 23:54 on 9 June 2016 you recorded observations in Patient A's MAR chart and/or labour record without making it clear that these entries were retrospective.

Accordingly, charge 1.2(c) is found proved.

Charge 1.2 (d)

d. In relation to commencing the labelatol and/or magnesium sulphate infusions:
   i. Did not obtain consent and/or document that consent had been obtained;
   ii. Did not explain to the patient and/or document that you had discussed with her why the infusions were being recommended;

This charge is found proved in its entirety.

The panel had a copy of the relevant sections of Patient A's notes. It noted that you had not documented consent for the labelatol or magnesium sulphate. Nor had you documented any discussion with the patient as to why the infusions were being recommended. It remains to be seen whether, in light of these findings, there is a finding of misconduct at a later stage.

Accordingly, charges 1.2(d)(i) and 1.2(d)(ii) are found proved.

Charge 1.2(e)

e. Did not carry out and/or document adequate observations for the first 30 minutes of the magnesium sulphate infusion;

This charge is found proved.

The panel had regard to Patient A's records. On 9 July 2016 at 23:30 you documented that you had commenced the magnesium sulphate infusion and started five minute observations. Patient A's MEWS chart records observations at 23:43, 23:45 and 23:54. From 00:00 onwards observations are recorded on a different chart (the High Dependency chart) every 15 minutes.

Patient A required five minute observations for the first 30 minutes of the magnesium sulphate infusion. This means that you should have recorded six sets of observations between 23:30 (when the infusion was started) and 00:00. However, Patient A's MEWS charts only shows three sets.

For these reasons, the panel was satisfied that you did not carry out or document adequate observations for the first 30 minutes of the magnesium sulphate infusion.

Accordingly, charge 1.2(e) is found proved.

Charge 1.2(f)

f. Did not make sufficient entries in the notes in relation to Patient A's on-going care needs, analgesia, emotional support and wellbeing;

This charge is found proved.

The panel had regard to Patient A's records and noted that you had made no entries regarding Patient A's ongoing care needs, analgesia, emotional support or wellbeing. You accepted this but stated in your oral evidence that your main focus at the time had been caring for the woman's ill health.

The panel was therefore satisfied that you did not make sufficient entries in the notes in relation to Patient A's ongoing care needs, analgesia, emotional support and wellbeing.

Accordingly, charge 1.2(f) is found proved.

Charge 1.2(g)

g. Wrote an entry in the notes stating that you had previously discussed breast feeding with Patient A when this discussion had not taken place;

This charge is found proved.

The panel had regard to Patient A's notes. In these notes you made the following entry at 20:30 on 10 June 2016: 'discussed with Patient A with regard to breast feeding as she previously mentioned she did not wish to do so. Would now like to.'

The panel had already found charge 1.1(a) proved, namely that you did not discuss infant feeding with Patient A when you took over her care. In your evidence you said that you wrote this because you had had a discussion with Patient A's partner in the presence of Patient A where, according to you, he had said that the babies were receiving SMA. When questioned on this point, the panel found your evidence to be inconsistent and confused.

The panel therefore concluded that it was more likely that you did not have a previous conversation with Patient A regarding breast feeding and that the entry that you made in her notes at 20:30 on 10 June 2016 regarding her previously mentioning that she did not wish to breast feed was untrue.

For these reasons the panel was satisfied on the balance of probabilities that you wrote an entry in the notes stating that you had previously discussed breast feeding with Patient A when this discussion had not taken place.

Accordingly, charge 1.2(g) is found proved.

Charge 1.2(h)

h. Wrote an entry in the notes to say that you helped with hand expressing when it was in fact a colleague who assisted;

This charge is found NOT proved.

The panel had regard to Patient A's notes. In these you had made an entry at 22:10 on 10 June 2016 which read: 'Helped with hand expressing. Patient A felt it was uncomfortable, therefore I stopped helping with the hand expressing and advised Patient A to continue'.

The panel noted that the charge originates from the meeting held between you and Ms 2 on 16 September 2016 when you were asked whether you assisted Patient A with hand expressing and you allegedly denied this. However, in your oral evidence to this panel you stated that you did assist Patient A. Furthermore, Patient A's complaint states that Mrs Kennedy sent in a healthcare assistant who started setting up the breast pump but, when Patient A asked if she could get advice on hand expressing first, she sent the midwife back in.

The panel had regard to all of the evidence and came to the conclusion, having particular regard to the entry made by you in Patient A's notes, that it was more likely than not that it was you who assisted Patient A with hand expressing, rather than a colleague.

Accordingly, charge 1.2(h) is found not proved.

Charge 1.2 (i)

i. Did not ensure that the information recorded in the maternal notes corresponded with the observations in the MEWS chart.

This charge is found proved.

The panel had regard to Patient A's notes. At 05:45 on 11 June 2016 you recorded that Patient A's blood pressure was 'beginning to creep up'. However, this did not accord with the observations recorded by you on Patent A's MEWS chart; the blood pressure reading you recorded on the MEWS chart at 05:40 was lower than the previous recording made at 05:00. The panel considered that you were under a duty to ensure that you recorded consistent entries in both documents.

The panel was therefore satisfied on the balance of probabilities that you did not ensure that the information recorded in the maternal notes corresponded with the observations in the MEWS chart.

Accordingly, charge 1.2(i) is found proved.

Charge 1.3

1.3. Failed to escalate a MEWS trigger to the medical staff or senior charge midwife on one or more occasion.

This charge is found proved.

The panel had regard to Patient A's MEWS chart. This showed that between 21:00 and 23:15 Patient A's observations triggered a 'red score' on the MEWS chart, necessitating escalation. The panel heard evidence from you that at approximately 21:00 you escalated this to medical staff by bleeping the medical team and also going into theatre to speak with Dr 8, who advised giving oral labetalol. This was consistent with the entry you made in Patient A's notes at 21:00 on 9 June 2016.

However, once the labetalol had been administered Patient A's MEWS scores continued to trigger a red score which required escalation. Despite this, there is no evidence of any further action being taken until 23:10 when Patient A was reviewed by Dr 7. The panel therefore had no evidence that, during the two hours after the

administration of labetalol, you took any action to escalate a MEWS trigger regarding Patient A.

For these reasons, the panel was satisfied on the balance of probabilities that you failed to escalate a MEWS trigger to the medical staff or senior charge midwife on one or more occasions.

Accordingly, charge 1.3 is found proved.

Charge 1.4

1.4. On 10 June failed to follow a written instruction from the doctor with respect to the discontinuation of magnesium sulphate IV infusion.

This charge is found proved by way of your admission.

Charge 2.1 (a)

2. When caring for Patient B on 6 and 7 September 2016:

2.1. Did not sufficiently document Patient B's care in that you:

a. Documented the fundal height measurement in weeks as opposed to centimetres;

This charge is found proved by way of your admission.

Charge 2.1(b)

b. Between 20.40 and 22.05 on 6 September 2016, and/or during the second stage of labour did not document the fetal heart rate in the maternal record and/or on the CTG;

This charge is found proved.

It was not disputed that you were responsible for the care of Patient B on 6 September 2016 during the relevant time. The panel heard evidence that you admitted her from triage and put her on the CTG.

The panel heard evidence from Ms 2 that, upon starting a CTG, it should be observed and signed after five minutes and then regularly observed and marked every 15 minutes. The panel noted that Patient B's CTG had no observation lines drawn onto it. The panel noted that the only entry in Patient B's notes regarding the CTG was made by Dr 9 at 21:50. There were no entries made by you.

The panel was therefore satisfied on the balance of probabilities that between 20:40 and 22:05 on 6 September 2016 and/or during the second stage of labour you did not document the fetal heart in Patient B's maternal record and/or on the CTG.

Accordingly, charge 2.1(b) is found proved.

Charge 2.1(c)

c. Did not document that the patient was accompanied by her mother and partner;

This charge is found proved by way of your admission.

Charge 2.1(d)

d. Did not document sufficient details in relation to the birth;

This charge is found proved.

The panel heard evidence from Ms 2 regarding the level of detail which she would expect to be recorded. This included whether the birth was preterm, the baby's position at birth, whether the cord was around the neck, whether the cord required to be clamped and cut prior to or after birth, and noting the presence or absence of liquor at birth. The records you made regarding Patient B's birth contained none of these details.

You accepted in your oral evidence that your notes lacked detail. You explained that you had started to write your notes but then had to go on a break. When you returned, the notes had been taken by the paediatric team and you were unable to complete your records.

However, Patient B's records showed that the notes had been available to you for at least two hours as you had been able to make entries from the time Patient B gave birth at 00:28 until she took a shower at 02:15. The panel found your explanation that you took a break in the middle of writing your notes to be implausible, and considered it more likely that you had completed all of the notes you intended to make, but that they lacked sufficient detail. In your oral evidence you stated that you had continued your documentation on a continuation sheet as the maternal notes were unavailable to you. However as the panel had no sight of this continuation sheet (despite strenuous efforts made to locate it) and is of the view that it is the named midwife's responsibility to ensure that any documentation pertaining to patients should be married up with the main maternal notes.

For these reasons, the panel was satisfied on the balance of probabilities that you did not document sufficient details in relation to Patient B's birth.

Accordingly, charge 2.1(d) is found proved.

Charge 2.1(e)

e. Incorrectly documented the administration of the oxytocin;

This charge is found proved.

The panel had regard to Patient B's notes. At 00:30 on 7 September 2016 you recorded that you had administered 'Syntometrine 5iu'. You recorded the same on Patient B's birth summary.

However, Ms 2 gave evidence that this should have been recorded as ‘Syntometrine 1ml’ as it does contain 5iu of syntocinon but also 500 micrograms of ergometrine. This evidence was confirmed by NHS Tayside’s ‘Labour and Birth Guidance’ policy which states that 1 ampoule (equivalent to 1ml) of syntometrine should be administered.

The panel was therefore satisfied on the balance of probabilities that you incorrectly documented the administration of oxytocin to Patient B.

Accordingly, charge 2.1(e) is found proved.

Charge 2.1(f)

f. Documented that you had given the oxytocin when this was not the case;

This charge is found NOT proved.

The panel noted that in Patient B’s records you have documented ‘Syntometrine 5iu given I/M’ at 00:30 on 7 September 2016. However, Ms 2 gave evidence that in your meeting with her on 16 September 2016 you denied that it was you who had actually given the drug, and stated that it had been administered by a colleague. The panel noted that the entry made by you in Patient B’s notes does not specify who had given the drug and it was plausible that, as there were two midwives at Patient B’s delivery, either one of you could have given the syntometrine. It was also plausible that the midwife who administered the drug would not necessarily be the one to record it in the notes.

Having regard to all of the evidence, the panel was not satisfied that the NMC had established, on the balance of probabilities, that you had not administered the oxytocin to Patient B. In the alternative, it was not satisfied that your entry in Patient B’s records established that you had been the one to administer the medication, and not your colleague.

In these circumstances, the panel was not satisfied on the balance of probabilities that you had documented that you had given oxytocin when this was not the case.

Accordingly, charge 2.1(f) is found not proved.

Charge 2.1(g)

g. Did not document the position of fundus following the birth of the placenta and membranes;

This charge is found proved by way of your admission.

Charge 2.1(h)

h. Did not adequately complete the postnatal documentation in the maternal notes, in that you did not document any post-natal advice and/or that a complete assessment of the genital tract had been carried out;

This charge is found proved.

The panel had a copy of Patient B's notes. In these it could find no documentation made by you regarding post-natal advice or an assessment of the genital tract.

In your evidence you told the panel that you were unable to document this information as you went on a break and, when you returned, Patient B's notes had been taken by the paediatric team. You told the panel that you completed your notes on a continuation sheet.

However, the panel had already rejected this explanation for the reasons given in charge 2.1(d). Furthermore, it had no evidence of the continuation sheet on which you claim to have documented this information as this sheet couldn't be found during the local investigation.

It was therefore satisfied that on the balance of probabilities you did not adequately complete the postnatal documentation in Patient B's maternal notes, in that you did not document any post-natal advice and/or that a complete assessment of the genital tract had been carried out.

Accordingly, charge 2.1(h) is found proved.

Charge 2.1(i)

i. Recorded the incorrect dose of Vitamin K which was provided to the baby;

This charge is found NOT proved.

The panel noted that you recorded that the paediatric team had administered 'Konalion *(sic)* 1ml' to Patient B's baby on 7 September 2016. You told the panel that you made this record after speaking on the phone with Paediatrics.

According to the evidence of Ms 2, this dose is incorrect as the baby, being pre-term, would usually only have been administered 750 micrograms.

However, the panel was mindful that it had no evidence regarding the dose that was prescribed and administered by the paediatric team. It therefore had no way of assessing whether the dose recorded by you was actually the dose prescribed, or a recording error on your part.

In these circumstances, the panel could not be satisfied on the balance of probabilities that you recorded the incorrect dose of vitamin K which was provided to the baby.

Accordingly, charge 2.1(i) is found not proved.

Charge 2.1(j)

j. Did not adequately complete the fluid balance chart;

This charge is found proved.

The panel had regard to Patient B's fluid balance chart from 6 September 2016. This chart had only one entry one it. You accepted in your oral evidence that the completion of the fluid balance chart for Patient B had been your responsibility. You further accepted that only making one entry during your shift was poor practice.

The panel was satisfied on the balance of probabilities that you did not adequately complete Patient B's fluid balance chart.

Accordingly, charge 2.1(j) is found proved.

Charge 2.1(k)

k. Did not ensure that the information recorded in the maternal notes and corresponded with the observations in the MEWS chart.

This charge is found proved.

The panel had a copy of both Patient B's maternal notes and her MEWS chart. In her notes you made an entry on 6 September 2016 at 20:40 stating that Patient B's blood pressure was 120/74. However on her MEWS chart you recorded her blood pressure at 20:45 as 126/68. The panel found that you were under a duty to ensure consistent recording in both documents.

The panel was therefore satisfied on the balance of probabilities that you did not ensure that the information you recorded in Patient B's maternal notes corresponded with the observations in the MEWS chart.

Accordingly, charge 2.1(k) is found proved.

Charge 2.2 (a)

2.2. Did not adequately provide care to Patient B in that you:

a. Did not obtain consent and/or document the consent for examining the perineum;

This charge is found proved.

The panel had regard to Patient B's notes. At 00:33 on 7 September 2016 you documented 'perineum intact'. However the notes contain no record of you seeking or obtaining Patient B's consent for this examination.

In your oral evidence you accepted that there was no consent documented. However you stated that you had implied consent when delivering the baby as the examination is part of the intrapartum care provided.

The panel accepted your evidence. It was satisfied that a visual examination of the perineum was a routine part of the intrapartum care provided to women and, as the midwife who delivered Patient B's baby, you would have had implied consent to perform this visual examination as part of the delivery.

The panel therefore decided that although there was no consent documented in Patient B's records, it was satisfied on the balance of probabilities that you did have implied consent for examining the perineum.

Therefore the charge is found proved on the basis that although you obtained consent, you did not document this.

Accordingly, charge 2.2(a) is found proved.

Charge 2.2 (b)

b. Did not take and/or recognise that pH samples had not been taken following the birth.

This charge is found proved.

In your oral evidence you accepted that you yourself did not take pH samples following Patient B's delivery but you were adamant that samples had been taken by one of your colleagues.

Extensive enquiries were made with the testing laboratories both before and during this hearing. The panel had email correspondence from the Senior Biomedical Scientist at the laboratory who confirmed that she had 'searched the laboratory information systems and cannot see any evidence of a Blood Gas being run on the patient on the day in question'.

Having regard to the evidence, the panel concluded that it was more likely than not that samples had not been taken at all. It was therefore satisfied on the balance of probabilities that you did not take and/or recognise that pH samples had not been taken following the birth.

Accordingly, charge 2.2(b) is found proved.

Charge 2.2 (c)

c. Did not conduct further observations at 1.30am on 7 September 2016

This charge is found proved.

The panel had regard to Patient B's records. These showed that she gave birth at 00:28 on 7 September 2016. She also lost 570mls of blood which, according to NHS Tayside's 'Labour and Birth Guidance', is classified as a postpartum haemorrhage.

Ms 2 gave evidence that following a delivery she would expect a midwife to carry out a full assessment of the patient including analgesia needs, fundal palpitation, bladder care and a full set of physiological observations.

However, Patient B's records show that you took no observations between 00:28, when Patient B gave birth, and 03:00 when she was transferred to the postnatal ward. The only clinical entry made by you during this time is at 01:30 when you document that Patient B had lost a further 150mls of blood, bringing her total estimated blood loss to 570mls. No further observations are recorded. You accepted in your oral evidence that you did not conduct further observations on Patient B because, on visualising and speaking to her, she gave no indication that she was unwell.

The panel was therefore satisfied on the balance of probabilities that you did not conduct further observations at 01:30 on 7 September 2016.

Accordingly, charge 2.2(c) is found proved.

Charge 2.3 (a)

2.3. After commencing the CTG at around 20:40 on 6 September 2016 did not:

a. Assess the CTG directly for the first 5 minutes;

This charge is found proved.

The panel heard evidence from Ms 2 that, upon starting a CTG, it should be reviewed and signed after five minutes and then further lines should be drawn on to the CTG to confirm when it was observed. The panel noted that Patient B's CTG had no observation lines drawn onto it. The panel noted that the only entry in Patient B's notes regarding the CTG was made by Dr 9 at 21:50. There were no entries made by you.

The panel was therefore satisfied on the balance of probabilities that after commencing the CTG at around 20:40 on 6 September 2016 you did not assess the CTG directly for the first five minutes.

Accordingly, charge 2.3(a) is found proved.

Charge 2.3 (b)

b. Review and sign the CTG at 15 and/or 30 minutes;

This charge is found proved.

The panel heard evidence from Ms 2 that, upon starting a CTG, it should be reviewed and signed after five minutes and then further lines should be drawn on to the CTG to confirm when it was observed. The panel noted that Patient B's CTG had no observation lines drawn onto it. The panel noted that the only entry in Patient B's notes regarding the CTG was made by Dr 9 at 21:50. There were no entries made by you.

The panel was therefore satisfied on the balance of probabilities that after commencing the CTG at around 20:40 on 6 September 2016 you did not review and sign the CTG at 15 and/or 30 minutes.

Accordingly, charge 2.3(b) is found proved.

Charge 2.3 (c)

c. Provide sufficient reasons for stopping the CTG.

This charge is found proved.

The panel had regard to Patient B's notes. It noted that you had recorded 'CTG discontinued for transfer to ward for observations'.

According to Ms 2's evidence, there were insufficient reasons documented for why you had stopped the CTG and despite Dr 9 confirming that the patient 'may return to the ward', you did not record what the plan was or why Patient B was being transferred back.

In your oral evidence to the panel you stated that a plan had already been put in place for Patient B to be transferred to the ward so you didn't need to write anything else.

The panel was of the view that, as Dr 9's note only states that Patient B *may* return to the ward, there was no definite plan for Patient B to return and therefore further details should have been provided as to why the CTG was being discontinued.

The panel was therefore satisfied that on the balance of probabilities you did not provide sufficient reasons for stopping the CTG.

Charge 2.4

2.4. Did not provide Patient B with appropriate pain relief.

This charge is found proved.

The panel had regard to Patient B's notes. Ms 5's entry on 6 September 2016 at 22:30 confirms that when Patient B arrived on the antenatal ward she was 'clearly distressed leaning over the side of the bed'. Ms 5 confirmed in her oral evidence that Patient B was complaining of pain and it was only once she was transferred to the antenatal ward that you gave her any pain relief.

In your oral evidence to the panel you said that you had been advised by the midwifery team leader that once Patient B was transferred to the antenatal ward she should be provided with pain relief. However, it was the evidence of Ms 2 that pain relief would normally be given before a patient is transferred between wards.

The panel considered that it was the responsibility of a midwife to respond to a patient's complaint of pain and provide pain relief without delay. The panel was of the view that by not providing Patient B with pain relief on the labour ward, and waiting until she was transferred to the antenatal ward, you failed to provide her with appropriate pain relief.

Accordingly, charge 2.4 is found proved.

Charge 2.5

2.5. Inappropriately transferred Patient B to the antenatal ward.

This charge is found proved.

The panel noted that Patient B was assessed by Dr 9 at 21:50 on 6 September 2016. At this point, Dr 9 wrote that Patient B 'may return to the ward' as she did not appear to be in established labour. However, it was a further 40 minutes before Patient B was actually transferred. During this time Patient B's labour progressed and, when she arrived back on the antenatal ward, she was distressed and in considerable pain.

Ms 5 was so concerned about Patient B's condition when she was transferred to the antenatal ward that she submitted a Datix form in which she reported that Patient B had been transferred to the antenatal ward from the labour suite despite appearing to be in established preterm labour.

The panel considered that you, as the midwife responsible for Patient B's care on the labour ward, had a duty to support and advocate for your patient. Patient B's condition changed between Dr 9's assessment and her transfer 40 minutes later and yet you did not escalate the change in her condition or take steps to ensure that she remained on the labour suite. Instead you allowed a woman in established preterm labour to be inappropriately transferred to the antenatal ward.

Accordingly, charge 2.5 is found proved.

Charge 3.1 (a)

3. When caring for Patient C on 10 and 11 September 2016:

3.1. Did not adequately document Patient C's care in that you:

a. Between 20.00 and 22.00 on 10 September 2016, did not note her physical and/or psychological wellbeing in the maternal notes;

This charge is found proved.

The panel had regard to Patient C's notes from 10 September 2016. You took over Patient C's care at 20:00 but the panel could find no documentation within her notes by you regarding Patient C's physical and/or psychological wellbeing. Patient C had suffered an unexpected intrauterine death at full term. You accepted in your oral evidence that Patient C's physical and psychological wellbeing were not fully described in the notes.

The panel was therefore satisfied on the balance of probabilities that between 20:00 and 22:00 on 10 September 2016 you did not note Patient C's physical and/or psychological wellbeing in her maternal notes.

Accordingly, charge 3.1a is found proved.

Charge 3.1(b)

b. Failed to make any entry in the notes between 20.15 and 20.55 on 10 September 2016;

This charge is found proved.

The panel had regard to Patient C's notes. You had made entries on 10 September 2016 at 20:15 and 20:55. There were no entries in between. The panel was satisfied that you were under a duty to make entries during this critical period.

The panel was therefore satisfied on the balance of probabilities that you failed to make any entry in Patient C's notes between 20:15 and 20:55 on 10 September 2019.

Accordingly, charge 3.1(b) is found proved.

Charge 3.1(c)

c. Did not document any attempts to deliver the placenta and membranes;

This charge is found proved.

The panel had regard to Patient C's notes. Patient C delivered her stillborn baby at 20:15. At 20:55 you documented 'placenta and membranes remain in situ. Syntometrine 5iu given I/M'. The next entry at 21:10 is 'placenta and membranes remain in situ. For medical review'. The next entry at 21:40 is 'placenta and membranes removed manually by [Dr 10]'.

There were no entries regarding any attempts you made to actively manage the delivery of the placenta and membranes.

In a meeting with NHS Tayside on 15 November 2016 you stated that you documented notes regarding Patient C in your own notebook, rather than Patient C's maternal records. The panel did not have a copy of your notebook, nor did you produce it during evidence.

In your evidence to this panel you stated that there were no external signs of the placenta being separated and you did not want to attempt to deliver it as Patient C was holding her baby in her arms. However, there is no note to this effect in Patient C's records.

In the circumstances, the panel was satisfied on the balance of probabilities that you did not document any attempts to deliver the placenta and membranes.

Accordingly, charge 3.1(c) is found proved.

Charge 3.1(d)

d. Incorrectly documented that the placenta was manually removed;

This charge is found proved by way of your admission.

Charge 3.1(e)

e. Did not document the position of the baby at birth and/or whether the neuchal cord was around the baby's neck;

This charge is found proved.

The panel noted that you had recorded the presentation of Patient C's baby as 'cephalic' on the birth summary. However, there was no documentation regarding the baby's position at birth or the neuchal cord in Patient C's notes.

The panel was therefore satisfied on the balance of probabilities that you did not document the position of Patient C's baby at birth and/or whether the neuchal cord was around the baby's neck or that there was any abnormality of the neuchal cord.

Accordingly, charge 3.1(e) is found proved.

Charge 3.1(f)

f. Did not record whether the neuchal cord was clamped and cut prior to birth or after birth;

This charge is found proved by way of your admission.

Charge 3.1(g)

g. Did not document the liquor around the baby and/or if the baby had passed meconium;

This charge is found proved.

The panel had regard to Patient C's notes and could find no entries made by you regarding the colour of the liquor or any evidence of the presentation of meconium.

The panel was therefore satisfied that you did not document the liquor around the baby and/or if the baby had passed meconium.

Accordingly, charge 3.1(g) is found proved.

Charge 3.1(h)

h. Did not use the partogram;

This charge is found proved by way of your admission.

Charge 3.1 (i)

i. Incorrectly documented the administration of the oxytocin.

This charge is found proved.

The panel had regard to Patient C's notes. At 20:55 on 10 September 2016 you recorded that you had administered 'Syntometrine 5iu'.

However, Ms 2 gave evidence that this should have been recorded as 'Syntometrine 1ml' as it does contain 5iu of syntocinon but also 500 micrograms of ergometrine. This

evidence was confirmed by NHS Tayside's 'Labour and Birth Guidance' policy which states that 1 ampoule (equivalent to 1ml) of syntometrine should be administered.

The panel was therefore satisfied on the balance of probabilities that you incorrectly documented the administration of oxytocin to Patient C.

Accordingly, charge 3.1(fi) is found proved.

Charge 3.2(a)

3.2. Did not adequately provide care to the patient in that you:

a. Did not discuss and/or document that you had discussed bladder care with the patient;

This charge is found proved.

The panel had regard to Patient C's maternal records and noted that they contained no documentation to indicate that you had discussed bladder care with Patient C. The panel also had regard to the oral evidence of Ms 2.

In your oral evidence to the panel you accepted that you had not made any such documentation but stated that you and Dr 10 did have a discussion with Patient C regarding bladder care.

However the panel noted that both you and Dr 10 made notes in Patient C's records between 20:00 and 01:15, but there is no mention in these of bladder care.

The panel therefore concluded that it was more likely than not that no such discussion took place.

It was therefore satisfied on the balance of probabilities that you did not discuss bladder care with Patient C or document this.

Accordingly, charge 3.2(a) is found proved.

Charge 3.2(b)

b. Made no assessment of maternal bleeding immediately post birth;

This charge is found NOT proved.

The panel had regard to Patient C's records and noted that at 22:00 you had documented 'lochia ave'. The panel considered that this did constitute an assessment of maternal bleeding and therefore found the charge not proved.

Accordingly, charge 3.2(b) is found not proved.

Charge 3.2(c)

c. Did not give oxytocin in a timely manner;

This charge is found proved.

Ms 2 gave evidence that oxytocin should be administered with the birth of the baby or as soon as possible thereafter as per NHS Tayside's 'Labour and Birth guidance'.

The panel noted from Patient C's records that she gave birth at 20:15 but you did not administer the oxytocin until 20:55, some 40 minutes later.

The panel was therefore satisfied that you did not give oxytocin in a timely manner as per NHS Tayside guidance.

Accordingly, charge 3.2(c) is found proved.

Charge 3.2 (d)

d. Did not ask and/or document whether Patient C wanted a translator;

This charge is found proved.

The panel had regard to the NHS Tayside 'Interpretation and Translation' policy which states that staff will always have to book an interpreter for discussions about preferred discharge arrangements and should not use family members or friends unless in emergency situations, and then only to obtain basic and immediate information until an interpreter can be accessed. It also had regard to the evidence of Ms 2. It was left in little doubt that it was proper practice to obtain an interpreter (even if over the telephone). The issue of whether an interpreter was required was also something that should only have been canvassed through an interpreter.

You accepted in your oral evidence that you did not ask Patient C if she wanted a translator because it had been previously documented in her notes that she did not want one, and preferred to use her friend who was with her. There was also another midwife on duty elsewhere in the unit who spoke Bulgarian and was able to translate for Patient C.

However, the panel heard evidence that Patient C's friend left at some point during the evening. The evidence about when she left, and whether she returned, was also very confused and unclear. The panel also heard evidence that the Bulgarian midwife finished her shift and went home, so was not present for much of your interaction with Patient C.

The panel also bore in mind the change in circumstances which Patient C experienced. Although she may have declined a translator earlier, when you took over her care at approximately 20:00 she had experienced an unexpected intrauterine death and was about to deliver a still born baby. Notwithstanding her earlier declination of a translator before she was in labour, the panel considered that you had a responsibility to ask

again when you took over her care. Given the significant lapse of time since the first offer of a translator was made and the fact that both her friend and the Bulgarian colleague had left the unit this was an opportunity again to re-open this discussion.

The panel was therefore satisfied that you did not ask whether Patient C wanted a translator. There was also no documentation to this effect in Patient C's notes.

Accordingly, charge 3.2(d) is found proved.

Charge 3.2(e)

e. Did not carry out maternal observations every 15 minutes and/or document them whilst awaiting the delivery of the placenta and membranes;

This charge is found proved.

Ms 2 gave evidence that after the baby was born it would be reasonable to allow the placenta some time to separate but within half an hour there should be some observations documented. She told the panel that from the time the midwife declares the placenta as not delivered, observations should be recorded every 15 minutes.

The panel had regard to Patient C's records. It noted that the baby was delivered at 20:15. You recorded the placenta as not delivered at 20:55. The placenta and membranes were finally delivered at 21:40. The panel could find no record of 15 minute maternal observations being carried out by you between 20:55 and 21:40.

In your oral evidence you accepted that you did not take 15 minute maternal observations, as you felt it was inappropriate due to Patient C's distress.

It was therefore satisfied that you did not carry out maternal observations every 15 minutes and/or document them whilst awaiting the delivery of the placenta and membranes.

Accordingly, charge 3.2(e) is found proved.

Charge 3.2(f)

f. Did not offer and/or document that you had offered analgesia.

This charge is found proved.

The panel noted that at 22:00 you documented that Patient C was ‘not requesting any pain relief’. You accepted in your oral evidence that you had not specifically offered Patient C any pain relief, but did not think it necessary to do so as she judged Patient C not to require any.

The panel bore in mind the communication difficulties with Patient C and considered that, in light of these, it was even more important that you specifically offered pain relief, rather than relying on Patient C to request it.

In these circumstances the panel was satisfied on the balance of probabilities that you did not offer and/or document that you had offered analgesia.

Accordingly, charge 3.2(f) is found proved.

Charge 3.3

3.3 Failed to fill out a datix in relation to the stillbirth.

This charge is found proved by way of your admission.

Charge 3.4

3.4. Recorded in the notes that you had discharged Patient C when this was not the case.

This charge is found proved.

The panel had regard to Patient C's notes. At 01:15 on 10 September 2016 you documented the following:

> 'Maternal observations all within normal limits. Happy to discharge home – phone number of ward given – knows to contact us if any concerns. Advised … (friend) if she begins to have any flashbacks herself then to contact her GP. Condolences given again to Patient C and [her partner]. Has left the ward.'

This entry appears to relate to you discharging Patient C. However, you told Ms 2 during the local investigations that you "later went back to the room and the woman had gone. Thankfully I had given her the memory box. She had been desperate to leave". Ms 2 confirmed that during the investigation you had stated that Patient C's friend who had been interpreting for her left at approximately 22:30 because she had to work the next day. At the Appeal Hearing on 11 May 2017, you confirmed that Patient C's friend left a few hours after the delivery and about half an hour after the Bulgarian midwife had been brought in to interpret the post mortem paperwork. The post-mortem discussion is documented as having taken place at 22.30, which would suggest that Patient C's friend left at approximately 23:00. This is over two hours before you have documented discharging Patient C. If the discharge occurred as you have documented it, then you did so without the assistance of an interpreter.

In your evidence you accepted that Patient C left the ward without your knowledge but your documentation at 01:15 is written in such a way which suggests that you formally discharged Patient C at 01:15 and were present when she left the ward. The note makes no mention of Patient C leaving the ward without your knowledge. Similarly, the sentence within the entry "Advised ... (friend) if she begins to have any flashbacks herself then to contact her GP" cannot be correct as, by your evidence, the friend left over two hours before.

The note also states that you took maternal observations but there is no record of the results of these within Patient C's notes. The entry also lacks any specific information or advice for the discharge of a woman following a stillbirth.

Having regard to all the evidence, the panel considered it more likely that Patient C had left the ward without your knowledge before you had the opportunity to discharge her, and you subsequently made the entry in her notes at 01:15 once you had discovered that Patient C had already left the ward.

The panel was therefore satisfied that you recorded in the notes that you had discharged Patient C when this was not the case.

Accordingly, charge 3.4 is found proved.

Charge 4.1

4. When caring for Patient D on 7 September 2016 you:

4.1 Provided a fresh eyes review when you had allowed your CTG training to lapse.

This charge is found proved by way of your admission.

Charge 4.2(a)

4.2 Did not sufficiently document Patient D's care in that you:

a. Incorrectly documented details of the perineal tear;

This charge is found proved by way of your admission.

Charge 4.2(b)

b. Did not document any advice or information given regarding the healing of a perineal wound and/or the reasons for recommending suturing;

This charge is found proved.

The panel had regard to Patient D's notes. You confirmed in your oral evidence that there was only one entry in the notes made by you; this was the entry at 03:40. In this entry you record that Patient D has a second degree tear and does not want stiches. It does not contain any advice or information regarding the healing of the wound or why sutures would be recommended.

According to Ms 2, the expectation would be that a midwife should record information on hygiene, signs of infection and delayed healing if not sutured, and information on hydration and diet for healing. Your entry contains none of this information.

The panel was therefore satisfied that you did not document any advice or information given regarding the healing of a perineal wound and/or the reasons for recommending suturing.

Accordingly, charge 4.2(b) is found proved.

Charge 4.2(c)

c. Did not document anything in relation to analgesia;

This charge is found proved.

Ms 2 gave evidence that she would expect your entry regarding Patient D's care to include documentation about any pain relief provided and its effectiveness. Your entry does not contain these details.

The panel was therefore satisfied that you did not document anything in relation to analgesia.

Accordingly, charge 4.2(c) is found proved.

Charge 4.2 (d)

d. Did not document anything in relation to the vagina or cervix.

This charge is found proved.

Ms 2 gave evidence that she would expect your entry regarding Patient D's care to include documentation relating to the vagina and cervix. Your entry does not contain these details.

The panel was therefore satisfied that you did not document anything in relation to the vagina or cervix.

Accordingly, charge 4.2(d) is found proved.

Charge 4.3

4.3 Did not obtain consent and/or document the consent for examining the perineum.

This charge is found proved.

In reaching its decision on this charge, the panel bore in mind its earlier findings in relation to charge 2.2(a). In respect of charge 2.2(a) the panel accepted your evidence that, as the midwife delivering the baby, you had implied consent to examine the patient's perineum as part of the intrapartum care you were providing to her.

Your evidence to the panel as regards Patient D was the same; you stated that you had implied consent to examine the perineum.

However, the panel noted that you were the second midwife at Patient D's delivery and did not, on this occasion, actually deliver the baby. The panel was therefore of the view that you would not have had this implied consent. In response to questions from the

panel, you stated that you had not explicitly asked Patient D for consent but stated that the patient did not say no when you began to examine her.

In these circumstances, the panel was satisfied that you had a duty to obtain consent from Patient D to examine her perineum and did not do so. There was also no consent documented in Patient D's records.

The panel was therefore satisfied that you did not obtain consent or document the consent for examining the perineum.

Accordingly, charge 4.3 is found proved.

Charge 5

5. Between 2 July 2016 and 11 September 2016 had allowed your CTG training to lapse.

This charge is found proved by way of your admission.

Charge 6

6. Your actions at charges 1.2g and/or 1.2h and/or 2.1f and/or 3.4 were dishonest in that you sought to represent that you had carried out certain tasks when you had not.

This charge is found proved in relation to charges 1.2(g) and 3.4.

The panel had already found charges 1.2(h) and 2.1(f) not proved and therefore did not consider dishonesty in relation to these two charges.

The panel bore in mind the advice of the legal assessor and the test for dishonesty, as set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

The panel first considered dishonesty in relation to charge 1.2(g). The panel had found proved that you wrote an entry in Patient A's notes stating that you had previously discussed breast feeding with Patient A. However, the panel had also found proved that this previous discussion had not taken place. The panel inferred that your purpose in making this entry was to give the impression that you had delivered a fuller programme of care to Patient A than was actually the case. The panel was of the view that creating a false entry about an event which had not taken place was untrue and inherently dishonest. It therefore found charge 6 proved in relation to charge 1.2(g).

The panel then moved on to consider dishonesty in relation to charge 3.4. The panel had found proved that, upon discovering that Patient C had left the ward without your knowledge and before you had discharged her, you wrote an entry in her notes which gave the impression that you had formally discharged her and that Patient C had left the ward following this and with your full knowledge. The panel was of the view that creating a false entry in a patient's record documenting a conversation which you knew had not taken place was inherently dishonest. It therefore found charge 6 proved in relation to charge 3.4.

The panel considered that your behaviour in respect of these charges would be regarded as dishonest by right thinking ordinary people.

Accordingly, charge 6 is found proved in relation to charges 1.2(g) and 3.4.

Charge 7

7. On one or more occasion(s) between 1 September 2017 and 4 January 2018 provided midwifery services without being under the direct supervision of a registered midwife.

This charge is found proved by way of your admission.

Decision to adjourn the hearing on 15 August 2019

The panel handed down its decision on facts at 14:00 on 15 August 2019. The hearing was listed to run until 16 August 2019.

Ms Forsyth reminded the panel that she would not be available on 16 August 2019, due to pre-existing personal commitments. She had first informed the panel of this when the August dates were set in May. At the time, it was hoped that the hearing would be at a stage where a colleague could step in for Ms Forsyth on behalf of the NMC.

However, both Mr Cobb and Ms Forsyth were in agreement that there was no realistic prospect of completing your evidence on impairment and hearing submissions on misconduct and impairment today. The panel's decision on facts is over 60 pages long and Mr Cobb informed the panel that he would need considerable time to go through this decision with you and take instructions, before you could begin giving your evidence. It was agreed that, realistically, you would not be in a position to do this until tomorrow morning.

This would mean that Ms Forsyth's colleague would have to cross-examine you with no prior knowledge of this large case and little time to prepare.

In these circumstances, Mr Cobb made an application to adjourn the hearing at this stage. This application was supported by Ms Forsyth.

The panel accepted the advice of the legal assessor. It was mindful that its determination on facts was lengthy and you required time to address these findings. It accepted Mr Cobb's submissions that there was no realistic prospect of you being in a position to give evidence today, and considered that it would be unfair to compel you to do so. It was also of the view that it would be unfair to the NMC to make another case presenter step in to this case tomorrow at the point when you were giving your evidence, given the large number of charges found proved and the complex nature of the evidence.

The panel bore in mind the public interest in the expeditious disposal of cases, not to mention your understandable wish to conclude this case quickly. However, it was mindful that, even if you were in a position to commence your evidence immediately, this hearing was still highly unlikely to conclude in the allocated time remaining. Therefore adjourning at this stage would not significantly increase the delay in the conclusion of this case.

The panel therefore decided, in all the circumstances, to adjourn the hearing.

Dates were canvassed with the parties and the resuming dates of 2 – 5 September 2019 were agreed upon.

Ms Forsyth confirmed on the record that the panel did not need to consider an interim order.

The hearing adjourned on 15 August 2019. It will resume on 2 September 2019.

Hearing Resumed, 2 September 2019

On 2 September 2019, the panel reconvened to consider the next stage of the hearing, namely, misconduct and impairment.

The NMC was represented by Ms Forsyth.

You were in attendance and represented by Mr Cobb.

You gave evidence to the panel by way of affirmation at the start of the resumed hearing.

The panel did not consider your account delivered in live evidence and your reflective piece to be credible or reliable. For example, it was unable to accept your explanation that you were not in breach of your interim conditions of practice order. You claimed that you did not perform midwifery services once an interim conditions of practice order was imposed upon you. This is contradictory to the position adopted by you in live evidence at the interim order review hearing on 4 January 2018. At this substantive hearing, Ms 4 also gave evidence that was consistent with your earlier position. The panel considered it more likely that you agreed with your employers that a telephone call be made before and after a visit to the patient, which you thought would allow you to comply with your interim conditions of practice order. This arrangement was however in breach of the direct supervision requirement.

You also told the panel that if your supervisor was not directly present in the room with you, you would facetime her during midwifery procedures so she could monitor your practice. However, the panel did not believe this explanation. It was of the view that supervision via facetime would not meet the requirements specified in charge 2 of your previous interim conditions of practice order in any event.

The panel did not accept this explanation and regarded it as another attempt to tailor your evidence. You further told the panel, at the resumed hearing that the unit you

worked in was a good place to work. In particular, you told the panel that there was a good social mix and good working relationships between doctors and midwives. This contradicted the earlier evidence provided by you to the effect that you were forced to work extra shifts, and that members of the medical staff were uncommunicative, and you felt unable to challenge them.

Submission 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 it as a registrant's suitability to remain on the register unrestricted.

In her submissions, Ms Forsyth invited the panel to take the view that your actions amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Forsyth 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'*.

Ms Forsyth invited the panel to find that all of the charges found proved amount to misconduct. She submitted that your clinical failings were contrary to safe and effective midwifery practice, as your record keeping fell far below the standards expected of a registered midwife in the circumstances of this case. In particular, Ms Forsyth submitted that allowing your CTG training to lapse was particularly dangerous, and that you could have exposed patients to a real risk of significant harm. Furthermore, your record keeping could have misled other professionals.

Ms Forsyth submitted that the charges which have been found proved are serious, in particular, the charges of dishonesty which occurred in a clinical context. She submitted that you had made a false entry to disguise an error you had made in not properly discharging Patient C.

Ms Forsyth further submitted that practicing as a midwife without the required level of supervision is very serious, and that it was clear that your midwifery practice was to be directly supervised at all times. She submitted that this was a necessary requirement to ensure that the public were sufficiently protected from the risk of harm you posed. Ms Forsyth informed the panel that you had attended the interim order hearing on 15 March 2017, where an interim conditions of practice order was first imposed on your practice, and subsequently attended the interim order review hearing on 12 June 2017, where the conditions were varied.

Ms Forsyth submitted that it was your responsibility to adhere to your interim conditions of practice order and inform your employer of the particular conditions you were subjected to. She reminded the panel that Ms 4, in her oral evidence, had stated that she did not remember seeing your interim conditions of practice order, but she did recall discussing a need for you to be supervised with you. However, Ms 4 confirmed that had she been aware of the condition involving your midwifery practice to be directly supervised, she would have approached matters differently.

Ms Forsyth then moved on to the issue of impairment, and addressed the panel on the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*.

Ms Forsyth submitted that you had put patients at a clear risk of harm as a result of your actions. In particular, with regard to Patient A, Patient B and Patient C, in not documenting things correctly, failing to escalate, failing to follow a written instruction from a doctor, not monitoring the CTG correctly, not carrying out maternal observations

when required and not providing drugs in a timely manner, you failed to carry out basic midwifery tasks.

Ms Forsyth also submitted that you had brought the midwifery profession into disrepute by breaching your interim conditions of practice order, by acting dishonestly, and by not providing the level of care expected to four patients. She submitted that public confidence in the profession and in the NMC as a regulator would be undermined should a finding of impairment not be made.

Ms Forsyth submitted that you had breached a fundamental tenet of the midwifery profession, as you had not provided the best possible care to patients in your care, and you had acted dishonestly. She submitted that you had attempted to create a false impression by indicating that care had been delivered to patients, when it had not. Ms Forsyth reminded the panel that honesty, integrity and trustworthiness are considered to be the bedrock of the midwifery profession, and that members of the public expect registered midwives to adhere to these values.

Ms Forsyth invited the panel to have regard to the case of *Cohen v GMC [2008] EWHC 581 (Admin)*, in considering whether your conduct is capable of remediation, whether it has been remediated, and whether there is a likelihood of repetition. She submitted that despite there being a wide-range of concerns, the failures identified could be capable of remediation.

However, Ms Forsyth submitted that you have not shown a sufficient level of insight into the charges found proved by the panel, nor recognised the potential implications your actions had on the reputation of the profession. She submitted that you denied the majority of the charges and you also deny that your fitness to practise is currently impaired. Ms Forsyth submitted that a finding of dishonesty is often more difficult to remediate, particularly when you do not accept that you have acted in a dishonest manner.

Ms Forsyth submitted that whilst you have raised your personal health circumstances in defence of your conduct, there is no link to suggest that your health impacted on your midwifery practice.

Ms Forsyth submitted that you have not yet provided sufficient evidence of having remediated your midwifery practice, and that your conduct is likely to be repeated.

Ms Forsyth invited the panel to have regard to the public interest elements of this case. She submitted that a fully informed member of the public would be shocked by a registered midwife acting in the way that you did, both clinically and in your behaviour.

In light of the above, Ms Forsyth invited the panel to find that your fitness to practise as a registered midwife is currently impaired on the grounds of public protection and it is also in the public interest.

Mr Cobb submitted that, in conducting its analysis of whether misconduct has occurred, the charges proved can be encapsulated under five separate headings: A failure to obtain consent, inadequate documentation of treatment and observations, inadequate performance of professional duty, a failure in performance of professional duty and dishonesty.

In respect of charges 1.2(d) and 4.3, Mr Cobb submitted that your failure to obtain consent speaks more to a lack of clarity on your part about when consent is and is not implied and that the matter is now more fully understood by you.

In respect of charges 1.1(b), 1.2(a),1.2(b)(i) & (ii), 1.2(c), 2.1(d), 2.1(f), 2.1(h), 2.1(j), 2.1(b), 2.2(a) (found as a failure to document), 2.3(b), 3.1(a), 3.1(c), 3.1(d), 3.1(e), 3.1(f), 3.1(g), 3.1(h), 3.1(i), 4.2(a), 4.2(b), 4.2(c), Mr Cobb submitted you understand the need for accurate and complete documentation to allow the treatment and condition of a patient to be understood by anyone examining them. Further, it also provides confirmation of what a professional has done at various stages in a patient's treatment.

He submitted that you now recognise that you compromised patient safety by failing to document fully the care you delivered. He further referred the panel to the oral evidence of Ms 4, who was able to confirm that you now fully appreciate the risks involved.

In respect of charges 1.1(a), 1.2(e), 1.2(f), 1.2(i), 1.3, 2.1(e), 2.2(c), 2.1(g), 2.1(k), 2.2(c), 2.3(c), 2.4, 2.5, 3.2(d), 3.2(e), 4.2(a), 4.2(b), 4.2(c) and 4.2(d), Mr Cobb submitted that these involved inadequate performance of professional duty. He invited the panel to have regard to all of the factors in each of the charges.

In respect of charges 1.1(a), 1.2(g), 2.2(b), 3.3, 3.4, 4 and 5, Mr Cobb made a number of submissions, placing each charge in context, and invited the panel to assess the prospect of recurrence.

In respect of charges 1.2(g) and 3.4, Mr Cobb submitted that your conduct does not lie at the serious end of the spectrum for dishonesty. In relation to Patient C, he accepted that the writing of the note left itself open to interpretation and reasonably might have sought to avoid expressly accepting that Patient C had left unnoticed.

Mr Cobb invited the panel to consider the seriousness of some of the charges to see whether they pass the threshold of misconduct.

In his submissions on impairment, Mr Cobb submitted that you have demonstrated genuine remorse for your conduct, and accepted during your oral evidence and in your reflective piece that your practice fell short of the standards expected of a registered midwife at the time of the events. [PRIVATE]

Mr Cobb submitted that you are not the same person you were at the time of the events in 2016. He submitted that these proceedings have taught you a salutary lesson. The three years you have spent away from the hospital environment has provided you with the opportunity to reflect on your conduct, accept responsibility, identify where you went wrong, and improve your midwifery practice. He submitted that you have been able to

demonstrate what steps you would take in future, should a similar set of circumstances arise in respect of your clinical concerns.

Mr Cobb submitted that you have provided a commitment to the public in a volunteering capacity, and that you are now fit to practise as a midwife in a safe and proper manner. He submitted that the concerns encapsulate a fairly short period in which your midwifery practice fell below the standards of a registered midwife, and there have been no previous concerns raised prior to these events. He reminded the panel that you became a registered midwife in 2008, and submitted that it would be unjust for the panel to make a finding of impairment based on a particularly difficult period of your life.

Mr Cobb stated that your health and personal circumstances are different now to what they were, and that you recognise the seriousness of the charges found proved. He submitted that you have continued to maintain an interest in the midwifery profession since the imposition of the interim suspension order, and you have used this time effectively to develop soft skills to further develop your midwifery practice. Mr Cobb submitted that your willingness to retrain and your continuous professional development have put you on the right path in attempting to remediate the concerns identified. He submitted that ultimately, impairment is a matter for the panel to determine. Mr Cobb invited the panel to consider carefully whether your fitness to practise is currently impaired.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant, these included: *Roylance*, *Grant* and *Cohen*.

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 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 midwife, and considered you to have breached multiple provisions of the Code. Specifically:

"**1 Treat people as individuals and uphold their dignity**

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.3 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,

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people…

4 Act in the best interests of people at all times

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice.

7 Communicate clearly

To achieve this, you must:

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

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

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

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges individually in determining whether your actions were so serious so as to amount to misconduct in the circumstances of this case.

The panel had regard to the various policies of NHS Tayside, which you had departed from. It also had regard to the NMC's guidance on the standards of competency for registered midwives.

In respect of charge 1.1(a), the panel noted that Patient A had been consistent in her position that she wanted to breastfeed her baby when infant feeding was discussed with her prior to labour. You had previously told the panel that it had been communicated to you on two occasions that Patient A did not want to breastfeed her baby, and therefore, you did not discuss this directly with her. You ultimately denied Patient A's wishes. The panel noted that Patient A was recovering from a caesarean section and that you had acted as a go-between for Patient A, her husband and the neo-natal unit who were caring for her premature twin babies. In these circumstances, the panel considered it to have been appropriate for you to have discussed infant feeding with Patient A yourself, and to have documented such a discussion in the patient's notes. The panel determined that the facts found proved in charge 1.1(a) amounted to misconduct.

Similarly, the panel considered that by not documenting that you had a conversation with Patient A regarding her baby's care on the night shift of 9 – 10 June 2016, you had not delivered the appropriate level of care. The panel determined that the facts found proved in charge 1.1(b) amounted to misconduct.

However, in respect of charge 1.1(c), the panel determined that in calling the patient "sweetheart" as opposed to calling her by her real name was not serious enough to amount to misconduct. It considered that whilst this was not good practice, your conduct did not fall significantly short of the standards expected of a registered midwife in this regard, as your actions did not cross the threshold for misconduct.

In respect of charge 1.2(a), the panel noted that it had found that you did not observe the blood pressure of Patient A between 21:30 hours and 23:54 hours on 9 June 2016, but you had retrospectively sought this information from the blood pressure monitor. The panel was of the view that retrospectively monitoring Patient A's blood pressure would not have served the purpose of the observations as you would not have identified any deterioration in her condition at real time. The panel determined that the facts found proved in charge 1.2(a) amounted to misconduct.

In respect of charges 1.2(b)(i) and (ii), the panel noted that there was no documentary evidence to support your assertion that you had been monitoring Patient A on 9 June 2016, between 20:00 hours and 23:54 hours. It had regard to its decision at the fact finding stage of this hearing, in which it was satisfied that in the absence of any recordings stipulating Patient A's respiratory rate and cumulative fluid balance, it could not be certain that you made any observations of Patient A at this time. The panel considered it to be important to observe and record the respiratory rate and to maintain an accurate record of the cumulative fluid balance totals for Patient A during 20:00 hours and 23:54 hours on 9 June 2016. The panel determined that the facts found proved in charges 1.2(b)(i) and (ii) amounted to misconduct.

In respect of charge 1.2(c), the panel considered that completing entries of observations without indicating that they had been made retrospectively could have misled other professionals as to the accurate level of midwifery care that had been provided to Patient A. The panel determined that the facts found proved in charge 1.2(c) amounted to misconduct.

In respect of charges 1.2(d)(i) and (ii), the panel noted that a doctor had a discussion with Patient A in respect of commencing labetalol and/or magnesium sulphate infusions. It had evidence before it to suggest that it would have been the doctor's responsibility to seek consent for this level of treatment to be provided to Patient A, not yours. Therefore, the panel determined that your actions in respect of charge 1.2(d)(i) and (ii) did not amount to misconduct.

In respect of charge 1.2(e), the panel noted that you did not follow NHS Tayside's guidelines on caring for a woman within the first 30 minutes of commencing a magnesium sulphate infusion, as you did not document or record the required observations during this period of time. The panel was of the view that in failing to follow these guidelines, you had exposed Patient A to a real risk of harm, as it recognised that magnesium sulphate could have a severe effect on a patient. The panel determined that

the facts found proved in charge 1.2(e) amounted to misconduct as there are guidelines in place to maintain patient safety.

In respect of charge 1.2(f), the panel noted that you were the midwife responsible for Patient A's care, and that you had not made an entry in her notes for some two hours, in relation to ongoing care needs, analgesia, emotional support and wellbeing. It noted that Patient A was acutely ill by this point in time. The panel considered this to have been a significant period of time in which you did not document vital observations in relation to Patient A's care. The panel determined that the facts found proved in charge 1.2(f) amounted to misconduct.

In respect of charge 1.2(g), the panel considered your entry to have been misleading as it had given the impression that you had previously discussed breastfeeding with Patient A, when this discussion had not taken place. The panel was concerned by this entry as it could have resulted in other professionals responsible for the care of Patient A to have relied on this information, which could have impacted on further care delivered to her. The panel determined that the facts found proved in charge 1.2(g) amounted to misconduct.

In respect of charge 1.2(i), the panel was of the view that in not ensuring that the information recorded in the maternal notes corresponded with the observations in the MEWS chart could have been misleading for the continuity of care delivered to Patient A. The panel considered you to have demonstrated unsafe practice, as the inconsistencies in these observations could have exposed Patient A to a real risk of significant harm, and impacted on her future care. The panel determined that the facts found proved in charge 1.2(i) amounted to misconduct.

In respect of charge 1.3, the panel considered there to be clear guidelines in escalating MEWS triggers to medical staff or a senior charge midwife. The panel considered there to be some evidence to suggest that Patient A had triggered a 'red score' on the MEWS several times, and that this required escalation. The panel had no evidence before it to

suggest that you attempted to escalate Patient A's condition after 21:00 hours. It considered you to have exposed Patient A to a significant risk of harm by failing to escalate the MEWS triggers to the medical staff or a senior charge midwife. The panel determined that the facts found proved in charge 1.3 amounted to misconduct.

In respect of charge 1.4, the panel did not consider your failing to follow a written instruction from a doctor with respect to the discontinuation of magnesium sulphate IV infusion to be so serious so as to amount to misconduct in the circumstances of this case. The panel noted that you had only a short timescale in which to act after having received this instruction, and that your failure to discontinue magnesium sulphate IV infusion would not have adversely impacted upon the patient by this time. The panel determined that the facts found proved in charge 1.4 did not amount to misconduct.

In respect of charge 2.1(a), the panel did not consider your actions in documenting the fundal height measurement in weeks as opposed to centimetres to be sufficiently serious so as to amount to misconduct. The panel received evidence to suggest that this had been accepted practice at the Hospital at the time. The panel determined that charge 2.1(a) did not amount to misconduct.

In respect of charge 2.1(b), the panel considered your conduct in not documenting the foetal heart rate in the maternal record and/or the CTG between 20:40 hours and 22:05 hours, and/or during the second stage of labour to be very serious. By not documenting these recordings, you could have compromised the foetal outcome, particularly as Patient B's baby was premature. The panel was of the view that there was a need for you to have been more vigilant to ensure that Patient B's baby was not compromised, given that it was a challenging stage of labour. The panel determined that the facts found proved in charge 2.1(b) amounted to misconduct.

In respect of charge 2.1(c), the panel considered it to be good practice for you to have documented that Patient B was accompanied by her mother and her partner, but it did not consider your actions in not documenting this information to be sufficiently serious to

meet threshold for misconduct. The panel determined that the facts found proved in charge 2.1(c) did not amount to misconduct.

In respect of charge 2.1(d), the panel noted that you had stated that you had continued to document details relating to the birth of Patient B's baby on a separate continuation sheet. If such a document had been completed, it was your responsibility to ensure that this additional record was reconciled with the maternal notes. However, the panel did not have sight of these notes, so it had no evidence before it to suggest that this was the case. The panel considered it to be important for you to have provided sufficient information, as it could have impacted on Patient B's ongoing care needs. In the absence of further information relating to the birth of Patient B's baby, the panel considered there to have been a gap in the maternal notes for Patient B and her baby, as there was no information relating to what had occurred around the time of Patient B giving birth. The panel determined that the facts found proved in charge 2.1(d) amounted to misconduct.

In respect of charge 2.1(e), you incorrectly documented the administration of oxytocin. Whilst the information you entered was incorrect, the panel received evidence to suggest that a number of other midwives recorded this information in this manner. Although contrary to policy, this information was accepted practice in the unit. The panel determined that charge 2.1(e) did not amount to misconduct.

In respect of charge 2.1(g), the panel considered your actions to be serious in not documenting the position of the fundus following the birth of the placenta and membranes. The panel was of the view that this could have prevented other medical practitioners from checking for certain complications involved in the birth of Patient B's baby. The panel determined that the facts found proved in charge 2.1(g) amounted to misconduct.

In respect of charge 2.1(h), the panel had no evidence before it to suggest that you had given Patient B any post-natal advice and/or that a complete assessment of the genital

tract had been carried out. The panel considered this to be a fundamental part of midwifery care, and in so doing, determined that you did not adequately complete the postnatal documentation in Patient B's maternal notes. The panel considered it to have been your responsibility to attach any additional documentation to Patient B's original notes, had you completed any further documentation when providing her with midwifery care. The panel determined that the facts found proved in charge 2.1(h) amounted to misconduct.

In respect of charge 2.1(j), whilst the panel considered that your actions in not adequately completing the fluid balance chart to be contrary to good midwifery practice, it was of the view that your conduct would not be regarded to have been sufficiently serious to amount to misconduct.

In respect of charge 2.1(k), in not ensuring that the information recorded in the maternal notes corresponded with the observations in the MEWS chart, your midwifery practice fell below the standards expected of a registered midwife. The panel considered this to be an example of poor documentation. It noted that there was clear guidance around documenting recordings set out in the Code, and considered you to be in breach of these provisions. The panel determined that the facts found proved in charge 2.1(k) amounted to misconduct.

In respect of charge 2.2(a), the panel determined that your actions in not documenting the consent for examining Patient B's perineum following you delivering her baby was not sufficiently serious enough to amount to misconduct.

In respect of charge 2.2(b), the panel considered your conduct to be serious in that you did not take and/or recognise that PH samples had not been taken following the birth of Patient B's baby. The panel noted that you denied this charge, and that you had informed it that a colleague had taken the PH samples following the birth of Patient B's baby. However, in the absence of any documentary evidence to confirm this, the panel was satisfied on the balance of probabilities that you had not completed this task. The

email from the senior bio-medical scientist to Ms 2 confirmed that there had been no trace of the PH samples being taken. The panel determined that the facts found proved in charge 2.2(b) amounted to misconduct.

In respect of charge 2.2(c), the panel was of the view that by not conducting further observations of Patient B at 01:30 hours on 7 September 2016, you failed to follow the guidelines set by NHS Tayside. The panel noted that Patient B was supposed to be on one-to-one care at this point, and had been bleeding. You had told the panel that you had spoken to Patient B, and that she had appeared fine. However, the panel was of the view that it was entirely possible that a patient who was presenting well, could in fact be deteriorating. It considered Patient B to have been exposed to a significant risk of harm as a result of you not conducting further physical observations given the significant amount of blood loss she had suffered. The panel determined that the facts found proved in charge 2.2(c) amounted to misconduct.

In respect of charges 2.3(a), 2.3(b), and 2.3(c), the panel was of the view that Patient B and her unborn baby were exposed to a significant risk of harm as on 6 September 2016, after commencing the CTG at around 20:40 hours, you did not assess the CTG directly for the first five minutes after setting it up, you did not review and sign the CTG at 15 and/or 30 minutes, and nor did you provide sufficient reasons for stopping the CTG. The panel noted that after the first five minutes of the CTG being set up, the only entry that had been made was by a doctor. This led the panel to conclude that you had not been monitoring the CTG at all, as you would have been aware of your requirement to assess the CTG and document accurate recordings. The panel noted that as Patient B was in premature labour, this increased the need for you to be hypervigilant in these circumstances. You failed to follow NHS Tayside's guidelines when it came to reviewing and signing as per the guidance. With regard to stopping the CTG, the panel was of the view that it would have been important for you to have documented the ongoing observations of the foetal wellbeing, given that the unborn baby was premature, and there is no evidence of you having done so. The panel determined that the facts found proved in charges 2.3(a), 2.3(b) and 2.3(c) amounted to misconduct.

In respect of charge 2.4, by not providing Patient B with appropriate pain relief, you failed to provide her with the appropriate standards of care at the time. The panel considered this to be counter-intuitive to you advocating patient centred care as a registered midwife. The panel determined that the facts found proved in charge 2.4 amounted to misconduct.

In respect of charge 2.5, you did not reassess Patient B prior to inappropriately transferring her to the antenatal ward, despite there having been a period of delay since the original decision to transfer her had been made. As a result of you making this decision, Patient B could have given birth in the wrong environment on an ante-natal ward, where one-to-one care is unable to be provided. The panel determined that the facts found proved in charge 2.5 amounted to misconduct.

In respect of charge 3.1(a), the panel considered it important for you to have noted Patient C's physical and/or psychological wellbeing in the maternal notes on 10 September 2016, between 20:00 hours and 22:00 hours for the purposes of her ongoing care needs. You appeared to prioritise the distress caused to you in your role as a registered midwife above the stress of a non-English speaking patient who was expecting her first child – a full term fresh stillbirth. The panel determined that the facts found proved in charge 3.1(a) amounted to misconduct.

In respect of charge 3.1(b), in failing to make any entry in Patient C's notes between 20:15 hours and 20:55 hours on 10 September 2016, you did not provide the appropriate level of care at a critical period of time. The panel noted that the placenta was still in situ between 20:15 hours and 20:55 hours. The panel considered your failure in this respect to have related to a fundamental aspect of midwifery care for a patient during intra-partum care. The panel determined that the facts found proved in charge 3.1(b) amounted to misconduct.

In respect of charge 3.1(c), in not documenting any attempt to deliver the placenta and membranes relates to a fundamental aspect of midwifery practice during intra-partum care, at a critical period of time. The panel determined that the facts found proved in charge 3.1(c) amounted to misconduct.

In respect of charge 3.1(d), by incorrectly documenting that the placenta was manually removed could have caused professionals associated with Patient C's care to have been misled. Again, the panel considered the importance of this to relate to a fundamental aspect of midwifery practice. The panel determined that the facts found proved in charge 3.1(d) amounted to misconduct.

In respect of charge 3.1(e), the panel noted that you did provide some information regarding delivery of Patient C's baby in her notes. However, the panel considered it to have been important for you to have documented the position of the baby at birth and/or whether the neuchal cord was around the baby's neck, which you failed to do. The panel determined that the facts found proved in charge 3.1(e) amounted to misconduct.

In respect of charge 3.1(f), the panel considered it to be vitally important to document whether the neuchal cord was clamped and cut prior to birth or after birth in Patient C's notes, which you did not do. The panel determined that the facts found proved in charge 3.1(f) amounted to misconduct.

In respect of charge 3.1(g), the panel considered it to have been of the utmost importance for you to have documented the liquor around the baby and/or if the baby had passed meconium. It was of the view that this would have provided helpful information for the family and clinicians in establishing the possible cause of an unexplained stillbirth. The panel determined that the facts found proved in charge 3.1(g) amounted to misconduct.

In respect of charge 3.1(h), the panel was of the view that your failure in not completing a partogram, Patient C could have been exposed to a significant risk of harm during this

period, and could have easily deteriorated. The partogram allows the patient's condition to be monitored over time and can demonstrate patient deterioration more easily. The panel determined that the facts found proved in charge 3.1(h) amounted to misconduct.

In respect of charge 3.1(i), you incorrectly documented the administration of oxytocin. Despite your entry being incorrect, the panel had evidence before it to suggest that the method you used was recognised as being accepted practice at the Hospital. Whilst the panel did not consider your approach to be good practice, it did not consider your conduct to have fallen so far below the standards expected of a registered midwife so as to justify a finding of misconduct. The panel determined that charge 3.1(i) did not amount to misconduct.

In respect of charge 3.2(a), in not discussing and/or documenting that you discussed bladder care with Patient C, you did not provide her with the adequate level of care expected. The panel considered this aspect of midwifery to be fundamental to patient safety, especially when there was going to be an early discharge of this patient. The panel determined that the facts found proved in charge 3.2(a) amounted to misconduct.

In respect of charge 3.2(c), in not giving Patient C oxytocin in a timely manner, you failed to adhere to NHS Tayside's guidance, as this states that oxytocin should be given with the birth of the baby, or as soon as possible thereafter. The panel noted that in these circumstances, there was a time delay in administering this medication of about 40 minutes, and you did not offer any explanation for this lengthy delay. The panel was of the view that Patient C could have been exposed to a significant risk of harm as a result of your delayed action in administering oxytocin, particularly after having given birth to a stillborn baby. The panel determined that the facts found proved in charge 3.2(c) amounted to misconduct.

In respect of charge 3.2(d), in not asking and/or documenting whether Patient C wanted a translator, you did not provide an appropriate level of midwifery care. The panel considered this charge to be serious, noting as it did, that Patient C did not speak any

English. The panel recognised that there appeared to be some reference to the fact that Patient C did not want a translator earlier in the day, but at that stage, she was emotionally distressed, but was not yet in labour. The panel decided that it would have been your responsibility to check again whether a translator was necessary for Patient C in ensuring that she was provided with the best level of care, in order to breach the language barrier between you, given that the situation had drastically changed. The panel determined that the facts found proved in charge 3.2(d) amounted to misconduct.

In respect of charge 3.2(e), the panel considered you to have exposed Patient C to a significant risk of harm by not carrying out the maternal observations every 15 minutes and/or document them whilst awaiting the delivery of the placenta and membranes. The panel determined that the facts found proved in charge 3.2(e) amounted to misconduct.

In respect of charge 3.2(f), you had documented that Patient C did not request any analgesia to assist with her labour. However, it was unclear to the panel how you had arrived at this assumption as Patient C did not speak any English. The panel determined that the facts found proved in charge 3.2(f) amounted to misconduct.

In respect of charge 3.3, the panel considered that in failing to fill out a datix in relation to Patient C's stillbirth, you had not fulfilled your duty to provide a key element of the patient's risk assessment. The panel was of the view that the information contained within the datix is important as it could be used by other clinicians to assist as to understand why Patient C had an unexpected stillbirth. The absence of such documentation prevents an extra level of scrutiny, which in turn means that a decision could be made without having all the necessary information. The panel determined that the facts found proved in charge 3.3 amounted to misconduct.

In respect of charge 3.4, you recorded in Patient C's notes that you had discharged her when this was not the case. The panel was of the view that you gave an incorrect impression from this entry, which had the potential to mislead other professionals associated with Patient C's care. The panel considered the correct procedure in

discharging a woman with a stillbirth to be extensive, especially taking account of the fact that in these particular circumstances, the patient involved could not speak English. The panel noted that Patient C went home less than six hours after having delivered a stillborn baby, and that she had not been provided with the appropriate support. The panel was very concerned by your actions, as you could have exposed Patient C to a significant risk of physical and emotional harm, taking account of this being the worst possible outcome for a family expecting a healthy baby. The panel found you to have completely failed to care for a patient in your care, at a time in which she was most vulnerable. The panel considered this to be a serious failing, given that you did not offer any advice or aftercare prior to Patient C leaving the maternity department. The panel determined that the facts found proved in charge 3.4 amounted to misconduct.

In respect of charge 4.1, the panel considered your actions to have been dangerous by providing a fresh eyes review when you had allowed your CTG training to lapse. You were aware of the internal procedures in place, but decided not to follow them. The panel considered you to have a professional responsibility to keep your mandatory training up to date. In not being up to date with your CTG training, but by providing a clinical opinion, you exposed Patient D to a significant risk of harm. The panel determined that the facts found proved in charge 4.1 amounted to misconduct.

In respect of charges 4.2(a), 4.2(b), 4.2(c) and 4.2(d), the panel was of the view that Patient D was exposed to a significant risk of harm as a result of you incorrectly documenting details of the perineal tear, not documenting any advice or information given regarding the healing of a perineal wound and/or the reasons for recommending suturing, not documenting anything in regards to analgesia and not documenting anything in relation to the vagina or cervix. The panel was of the view that all of these concerns relate to fundamental aspects of midwifery care which should have been completed and documented appropriately. The panel was most concerned by you not having provided any information as to the analgesia you had provided Patient D after having misrepresented her condition. The panel determined that the facts found proved in charges 4.2(a), 4.2(b), 4.2(c) and 4.2(d) amounted to misconduct.

In respect of charge 4.3, the panel noted that you had not been the primary midwife involved in Patient D's care. Instead, you had operated as a second midwife. The panel determined that by not obtaining consent and/or documenting any consent for examining the perineum, Patient D may have felt as if her privacy had been invaded, thereby exposing her to a risk of emotional harm. The panel determined that the facts found proved in charge 4.3 amounted to misconduct.

In respect of charge 5, the panel considered you to have had a professional responsibility to ensure that your CTG training was up to date, in the proper performance of your role as a registered midwife. The panel noted that you had allowed your CTG training to lapse between 2 July 2016 and 11 September 2016. The panel determined that the facts found proved in charge 5 amounted to misconduct.

In respect of charge 6, the panel noted that it had found that your actions were dishonest in relation to charges 1.2(g) and 3.4. The panel considered your actions to be serious in attempting to create a misleading impression that you had previously discussed breastfeeding with Patient A, and had formally discharged Patient C. The panel noted that honesty, integrity and trustworthiness are the bedrock of the midwifery profession. It further noted that you had breached a fundamental tenet of the nursing profession in documenting this information you knew to be incorrect. The panel determined that the facts found proved in charge 6 amounted to misconduct, in relation to charges 1.2(g) and 3.4.

In respect of charge 7, the panel considered your actions to be of the utmost seriousness as you had ignored a direction from your regulator to work in conjunction with an interim conditions of practice order. The panel noted that an interim order had been considered necessary for the protection of the public and it was otherwise in the public interest. You went on to practise as a registered midwife without the level of supervision required of you, thereby being in breach of your interim conditions of

practice order. The panel determined that the facts found proved in charge 7 amounted to misconduct.

The panel found that your actions in charges 1.1(a), 1.1(b), 1.2(a), 1.2(b)(i), 1.2(b)(ii), 1.2(c), 1.2(e), 1.2(f), 1.2(g), 1.2(i), 1.3, 2.1(b), 2.1(d), 2.1(g), 2.1(h), 2.1(k), 2.2(b), 2.2(c), 2.3(a), 2.3(b), 2.3(c), 2.4, 2.5, 3.1(a), 3.1(b), 3.1(c), 3.1(d), 3.1(e), 3.1(f), 3.1(g), 3.1(h), 3.2(a), 3.2(c), 3.2(d), 3.2(e), 3.2(f), 3.3, 3.4, 4.1, 4.2(a), 4.2(b), 4.2(c), 4.2(d), 4.3, 5, 6, and 7 did fall seriously short of the conduct and standards expected of a registered midwife and amounted to misconduct.

Decision on impairment

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

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 paragraph 76.

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

The panel found that all of the limbs above were engaged in the circumstances of this case.

The panel noted that the concerns identified in this case related to both your clinical midwifery practice, as well as your behaviour. It considered you to have brought the

midwifery profession into disrepute having breached numerous provisions of the Code, on occasions where your actions had fallen far below the standards of a registered midwife in relation to basic areas of practice. Furthermore, it determined that you had breached fundamental tenets of the midwifery profession.

The panel took account of the evidence provided by you at the misconduct and impairment stage of these proceedings. It considered you to have demonstrated limited insight in relation to some of your shortcomings, and in recognising that your fitness to practise as a registered midwife was compromised at the time of the events. However, it considered you to have lacked insight into other areas of your midwifery practice, and in failing to accept that your fitness to practise is currently impaired as of today, the panel was of the view that you failed to appreciate the impact your actions could have had in providing care to patients and their families. Whilst you have expressed genuine remorse and regret for the circumstances which you currently find yourself in, your reflection primarily concentrates on the effect these regulatory proceedings have had on you, and you continue to deflect blame on to other colleagues you were working with.

[PRIVATE]

The panel had regard to the case of *Cohen*, and considered whether the concerns identified in your midwifery practice are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

Whilst the panel noted that you have taken some steps to remediate the clinical concerns identified by way of retraining, it considered you to still be in the early stages of remediating your misconduct. However, the panel was impressed by your commitment to the midwifery profession in your continuous professional development and in the voluntary work that you have undertaken during the imposition of an interim suspension order. It considered you to have taken some steps to keep your midwifery practice up to date by reading midwifery journals and other publications.

The panel considered that a finding of dishonesty is often difficult to remediate. Whilst you did not accept that you were dishonest, you addressed the issues arising from a finding of dishonesty in your reflective piece.

The panel had no evidence before it to demonstrate that you are currently safe to practise as a registered midwife without some form of restriction. The panel had no evidence before it to allay its concerns that you do not currently pose a risk to patient safety and, as such, it considered there to be a real risk of repetition of the incidents found proved, thereby exposing patients in your care to a significant risk of harm. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be seriously concerned by your clinical midwifery failings, as well as the findings of dishonesty and breaching an interim conditions of practice order. Public confidence in the midwifery profession would be seriously undermined were a finding of impairment not made in the circumstances of this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Determination on sanction:

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

In reaching its decision on sanction, the panel considered all of the evidence before it, along with the oral submissions of Ms Forsyth, on behalf of the NMC, and Mr Cobb, on your behalf.

Ms Forsyth took the panel through the aggravating and mitigating factors she considered to be engaged in this case.

Ms Forsyth invited the panel to impose a striking-off order. She submitted that you had deliberately breached your duty of candour in being dishonest on two occasions, and that your conduct was not at the lower end of the spectrum of dishonesty.

Ms Forsyth submitted that a registered midwife who has been found to have acted dishonestly runs a risk of being removed from the NMC register. She submitted that a registered midwife who has demonstrated insight, remorse, or remediation reduces this risk, however, you have not been able to allay the concerns of the panel despite ample opportunity to do so. Furthermore, she submitted that you have not accepted that your actions were dishonest, so the panel cannot be assured that this conduct would not reoccur in future.

Ms Forsyth submitted that your actions are too serious for the consideration of no further action or a caution order. She submitted that these sanctions would not protect patients from the risk of significant harm identified, nor would it satisfy the public interest elements of the case.

Ms Forsyth submitted that whilst the clinical concerns identified are capable of remediation, a conditions of practice order would be insufficient to address the panel's findings of dishonesty. She also reminded the panel that it had found you to have worked in breach of an interim conditions of practice order.

Ms Forsyth submitted that this was not a single incident of misconduct. She submitted that you do not have sufficient insight at this time to suggest that the risk to patient safety has been minimised, and therefore there is a risk of repetition. Ms Forsyth submitted that there is evidence before the panel of a potential attitudinal concern, exacerbated by your oral evidence at this hearing, in which the panel found your accounts to lack credibility, and found that you to have attempted to tailor your evidence.

Ms Forsyth submitted that your actions are serious enough to warrant permanent removal from the NMC register, and that public confidence in the nursing profession would be undermined if this were not done.

Mr Cobb submitted that whilst you have had difficulties in reconciling with the findings of the panel, you have made it abundantly clear that you do not want to find yourself in a similar position to which you now find yourself in. Mr Cobb reminded the panel that it had found you to be in the early stages of attempting to remediate the concerns, and he accepted that the journey back to safe and effective midwifery care may well be a long and difficult one.

However, Mr Cobb invited the panel to have regard to the positive approach you have taken in attempting to develop your skills and keep your midwifery practice up to date, despite being subject to an interim suspension order. He submitted that you have had a change in attitude from the time you gave evidence at the facts stage of this hearing, and that you should now be given a further opportunity to put things right.

Mr Cobb invited the panel to impose a conditions of practice order as, in his submissions, this response was sufficient to adequately manage the concerns identified. He informed the panel that you do not want to return to a hospital setting to practice midwifery, and that should you be given an opportunity to continue to practice, you would only want to work in the private midwifery sector.

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

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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

As regards aggravating factors, the panel has considered the following as relevant:

- The two findings of dishonest conduct occurred in a clinical context in relation to two separate patients.
- You have only demonstrated limited insight, and have focused on how the incidents affected you as opposed to patients, colleagues and the midwifery profession.
- You exposed patients to a risk of significant harm, particularly Patient B and Patient C.
- You worked in breach of an interim conditions of practice order after having received a direct instruction from your professional regulator.

As regards mitigating factors, the panel has considered the following as relevant:

- Testimonials from other midwifery and medical colleagues.

- You have demonstrated some remorse for your conduct.
- You have gone to some effort to keep your midwifery practice up to date, and attempted to address some of the deficiencies in your midwifery practice.

[PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution 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 impose a caution order.

The panel next considered whether placing a conditions of practice order on your midwifery registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case. It noted that there are multiple, serious and wide-ranging concerns in respect of your clinical midwifery practice, as well as serious concerns regarding your attitude and conduct. You had a number of opportunities to assure this panel that your conduct would not be repeated. You failed to satisfy this panel that it would not be. Whilst the panel considered you to have taken some steps to keep your midwifery practice up to date, it determined that this sanction was insufficient given the severity of your misconduct, and your limited

level of insight. The panel had found you to have been dishonest on two occasions, and to have also tailored your evidence before it at this hearing, in attempt to disguise the true nature of events. You had been inconsistent and contradicted the oral evidence you gave at an earlier stage in the proceedings, despite having a longer opportunity to reflect on your actions after receiving the panel's decision on facts.

The panel also took account of its finding that you had breached an interim conditions of practice order, which it considered to be of the utmost seriousness.

The panel was also concerned by Mr Cobb's submission that you did not want to return to a hospital environment, and that you would intend to limit your practice of midwifery, in a community setting. There would be practical difficulties in devising suitable conditions for anywhere other than a hospital.

The panel therefore determined that placing a conditions of practice order on your registration would not adequately address the seriousness of this case, nor would it sufficiently protect the public, or satisfy the public interest considerations.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel noted that this was not a single instance of misconduct and that it had evidence before it of you demonstrating behaviour of a deep-seated attitudinal nature. Further, the panel considered your clinical failings to represent a pattern of poor midwifery practice over a period of time, which had the potential for significant risk of harm.

The panel had found you to have limited insight into your misconduct, despite having had a substantial amount of time to reflect on these incidents. In light of this, the panel had found that there was a real risk of repetition of the events occurring in future.

Taking account of the above, the panel determined that your conduct was a significant departure from the standards expected of a registered midwife, and that the wide-ranging clinical failings, along with a breach in your duty of candour and a breach of fundamental tenets of the midwifery profession, were fundamentally incompatible with you remaining on the NMC register.

The panel was of the view that the findings in this particular case demonstrate that your actions were serious as your misconduct involved four patients, with two instances of dishonesty, and working in breach of an interim conditions of practice order. You had exposed patients in your care to a significant risk of harm and not demonstrated the care and compassion necessary for midwifery practice. The panel considered that in allowing you to maintain NMC registration would put the public at a continued risk of harm, and would undermine public confidence in the profession and in the NMC as a regulatory body.

Considering all of these factors, the panel determined that the 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 this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

Determination on Interim Order

The panel has considered the submissions made by Ms Forsyth that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. She invited the panel to impose an interim suspension order for 18 months.

Mr Cobb did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel had regard to the seriousness of the facts found proved, and the reasons set out in its decision for the substantive order. The panel decided that an interim suspension order is necessary for the protection of the public and it is otherwise in the public interest. To conclude 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.