Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
26 September 2022 – 4 October 2022
6 October 2022

Virtual Hearing

Name of registrant:	**Wendy June Sanderson**
NMC PIN:	76Y2519E
Part(s) of the register:	Registered Nurse Adult Nursing – April 1980 Children Nurse – October 1989 Registered Midwife Midwifery – July 1986
Relevant Location:	Wolverhampton
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Laura Wallbank (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Madeline Deasy, Case Presenter
Mrs Sanderson:	Not present and not represented
No case to answer:	**Charges 5a, 5b, 5c**
Facts proved:	Charges 1ai,1aii, 1b, 1c, 2, 3a, 3bi, 3bii, 3biii, 3c, 3d, 4, 6c, 7a and 7b
Facts not proved:	Charges 6a, 6b
Fitness to practise:	Impaired

Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Sanderson was not in attendance, nor was she represented in her absence. Notice of this hearing had been sent via email to an email address held for Mrs Sanderson on the NMC register on 22 August 2022.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the notice of hearing provided details of the date and time of the hearing and that it was to be held virtually. In addition it contained information about Mrs Sanderson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Sanderson

The panel next considered whether it should proceed in the absence of Mrs Sanderson. It had regard to Rule 21 and heard the submissions of Ms Deasy. She informed the panel that Mrs Sanderson's engagement with the NMC has been limited. She drew the panel's attention to an email from an NMC Case Officer to Mrs Sanderson, dated 1 August 2022. In this email, Mrs Sanderson was asked to confirm if the hearing could proceed in her absence. In response Mrs Sanderson, in an email dated 1 August 2022, confirmed that the hearing could proceed in her absence.

Ms Deasy submitted that Mrs Sanderson's reasons for non-attendance are clear and she does not wish to engage. She submitted that there is a public interest in the expeditious disposal of the case as it concerns discriminatory behaviour, failure to treat people with kindness and respect, failures to undertake observations and deliver care without delay.

Ms Deasy submitted that there are six witnesses due to attend and not proceeding could cause them inconvenience. Ms Deasy acknowledged that a registrant who does not attend and is without representation will be prejudiced in these proceedings. However, the overriding factor in prejudicing Mrs Sanderson is her own lack of engagement and decision to voluntarily absent herself. The unfairness to her is therefore limited.

Ms Deasy invited the panel to continue in the absence of Mrs Sanderson.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Sanderson. In reaching this decision, the panel has considered the submissions of Ms Deasy and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Sanderson received an email and telephone call from the NMC Case Officer and she confirmed that the hearing could proceed in her absence.
- No application for an adjournment has been made by Mrs Sanderson;
- There is no reason to suppose that adjourning the case would secure her attendance at a future date;

- Two of witnesses are available to give live evidence virtually, others are due to attend on subsequent days;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Some of the charges relate to events that occurred in 2017;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Sanderson. The panel recognised that there is some disadvantage to Mrs Sanderson in proceeding in her absence. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's view this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The panel will draw no adverse inference from her absence in its findings of fact.

Details of charge

That you, a registered midwife:

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;

    a. Described henna on their hands as;
        i. '*awful black tar*', or words to that effect;
        ii. '*horrible black stuff*', or words to that effect;

b. Said to Patient A, in respect of the henna on their hands, '*this is really stupid, why have you done this, we need to get this off*', or words to that effect;

c. Said to a colleague that you could tell where a woman was from just by looking at them, and that Patient A was too short to be from Somalia;

2. Your conduct at charge 1c was racially discriminatory;

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;

a. Failed to introduce yourself to Patient B;

b. Asked Patient B;

i. '*How long have you been in this country*', or words to that effect;

ii. '*Don't you speak any English*', or words to that effect;

iii. '*Why did you come to this country when there's lots of countries that speak French*', or words to that effect;

c. Told Patient B to '*put your bum on the bed*', or words to that effect;

d. When Patient B did understand the instruction at charge 3c, said '*you know, derriere, bed, haha, see I do remember some French, but that's where it stops*', or words to that effect;

4. Your conduct at charge 3b was racially discriminatory;

Over the course of 2 and 3 December 2017:

5. Failed to treat Patient A and her husband with kindness and respect, in that you:

a. Told Patient A to "*get off the floor you don't know what's been there*", or words to that effect;
b. Did not provide any support to Patient A;
c. In response to Patient A's husband querying the lack of medical treatment, said "*let's be honest, she wouldn't be here if she wasn't pregnant, she'd be at home sitting it out like the rest of us*", or words to that effect;

6. Failed to provide adequate care for Patient A, in that you failed to;

    a. Clean Patient A after she had vomited;
    b. Administer IV antibiotics to Patient A in a timely manner;
    c. At 21:45 on 2 December 2017, accurately record Patient A's pulse rate;

7. Failed to record that you:

    a. Asked a HCA to repeat Patient A's observations;
    b. Informed the obstetric registrar of the MEOWS score of 4 recorded at 21:45;

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

The panel of its own volition invited submissions from Ms Deasy to amend the wording of charge 3d. As the charges were being read it noted a typographical error within this charge.

The panel heard an application made by Ms Deasy, on behalf of the NMC, to amend the wording of charge 3d.

The proposed amendment was to correct a typographical error and add the word 'not' to the wording of the charge. Further, the proposed amendment does not change the nature

of the charge or the case Mrs Sanderson has to answer. The panel consider there is no injustice against Mrs Sanderson.

It was submitted by Ms Deasy that the proposed amendment would provide clarity and more accurately reflect the evidence.

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;

    d. When Patient B did **not** understand the instruction at charge 3c, said '*you know, derriere, bed, haha, see I do remember some French, but that's where it stops*', or words to that effect;

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Sanderson 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.

Mrs Sanderson was informed of this amendment by email.

Background

During the course of the investigation into charges 5 to 7, an updated employment reference was obtained from the Acting Chief Nurse at the Royal Wolverhampton NHS Trust (the Trust), where Mrs Sanderson was employed as a Band 6 midwife.

From the updated employment reference, dated 2 June 2021, the NMC was advised that Mrs Sanderson had been suspended pending investigation due to concerns about her

professional conduct and behaviour. The NMC therefore made a referral in relation to these concerns.

Charge 1 and 2, are in respect of Patient A, which is now referenced in this determination as Patient A1 (not the same patient referenced in charges 5 to 7).

On 25 March 2021, it is alleged that during a night shift, Mrs Sanderson made unacceptable comments regarding a patient of African descent. The patient, Patient A1, had dark henna painted on her hands, which Mrs Sanderson thought made monitoring, using the oxygen saturation probe, difficult. Mrs Sanderson allegedly described this as 'awful black tar' on the patient's hands and allegedly made repeated comments about this in front of colleagues.

Later, Mrs Sanderson was allegedly overheard again commenting about the 'horrible black stuff' on Patient A1's hands. This was subsequently followed by a conversation regarding the patient's ethnic origin during which Mrs Sanderson allegedly said that she was 'too short to be from Somalia.' It is alleged that this comment regarding the patient was racially discriminatory.

Evidence in respect of this charge is from Ms 1, the Matron for Gynaecology services at the Trust, Ms 2, a Band 6 Midwife at the Trust, and Dr 3 who at the concerning time was a ST4 trainee obstetrics and gynaecology registrar.

Mrs Sanderson has not provided a formal response to these charges. During an investigation undertaken by Ms 1, Mrs Sanderson accepted that she told Patient A1 that it was 'silly' to have henna on her hands and that it was a poor choice of words. She did accept using the term 'black tar'. In relation to charge 1a, Mrs Sanderson, in her local statement, has accepted saying the term 'black tar' but indicated that she was merely repeating a phrase which had been used by a female healthcare assistant when describing the henna to her. In relation to charge 1c, Mrs Sanderson accepted, in her local

statement, making these comments about Patient A1's height but did not intend them to be insulting but merely observational.

On 20 April 2021, in respect of charges 3 and 4, it is said that comments were made towards Patient B which were inappropriate.

Mrs Sanderson was overheard by Ms 4 talking to Patient B who was of African descent and spoke French. It is alleged that Mrs Sanderson asked the patient inappropriate questions regarding where she was from and why she did not go to a country that spoke French. It is also alleged that Mrs Sanderson also asked the patient to 'put their bum on the bed,' and said 'you know, your derrière.' These comments were also overheard by the patient in the next bed who was a midwife in a neighbouring Trust.

Evidence in respect of this charge is from Ms 1 and Ms 4 a Band 6 midwife at the Trust.

Mrs Sanderson again has provided no formal response. It is said that during Ms 1's investigation, Mrs Sanderson said she used the word 'derrière' in order for the patient to understand and only as communication. She further admitted to asking the patient questions about how long they had been in the country. Mrs Sanderson is said to have done so in order to determine Patient B's level of English for communication purposes. It is said that Mrs Sanderson could see how it could be interpreted and regretted saying it at the time.

The NMC received a referral on 2 September 2019 from the father of baby A, who was the partner of Patient A (who will now be referred to in this determination as Patient A2). Patient A2 had been admitted to New Cross Hospital (the Hospital), Royal Wolverhampton NHS Trust on 2 December 2017.

Evidence in respect of charges 5 to 7 is from Mr 6, the father of baby A and partner of Patient A2. Contained within Mr 6's evidence is an expert witness report of Mr 10. There is also evidence from Ms 5, the Director of Midwifery at Royal Wolverhampton.

Patient A2 (not the same patient referenced in charges 1 to 4) was 25 weeks pregnant at the time. Following her admission to the hospital, Patient A give birth to baby A who a short time later tragically passed away. It should be noted that the death of baby A has not been attributed to Mrs Sanderson.

Patient A2 attended the hospital with severe abdominal pain around 04:30 on 2 December 2017. Within a witness statement, Patient A2 describes arriving at the hospital, her pain increasing and slumping on the floor in agony. It is alleged that she was approached by a midwife, Mrs Sanderson, who told her to “get up off the floor you don’t know what’s been there”. It is then said that Mrs Sanderson failed to provide any support to the patient in assisting her from getting up off the floor.

Having seen Patient A2 upon arrival, it is alleged that Mrs Sanderson responded to a patient call bell. On this occasion the father of baby A, asked whether more pain relief could be provided to Patient A2 and questioned why no medical treatment, plan or review had been undertaken.

It is alleged that Mrs Sanderson responded “No, there’s nothing we can do. Its just a bit of pregnancy pain, lets be honest, she wouldn’t be here if she was pregnant, she’d be at home sitting it out like the rest of us.” [sic]

It is alleged in respect of charge 6a, that Mrs Sanderson attended Patient A2 at a time when she had vomited on herself and in her bedding. Mrs Sanderson is said to have sought to provide no assistance or to clean up Patient A2 and ensure she was clean and comfortable. This resulted in Patient A2’s partner, Mr 6, attempting to find cleaning supplies around the ward to clean up patient A2.

Mrs Sanderson in a local statement stated that she completed Patient A2's observations at 21:45 and, as her MEOWS was 4, and asked an HCA to repeat them. This was done at 22:15, when the MEOWS remained 4.

Mrs Sanderson's evidence is that she informed the obstetric registrar of the MEOWS of 4 at 21:45 and a further review was undertaken. This is evidenced within Patient A2's medical records. In her local statement, the registrant accepted that she failed to document that she asked an HCA to repeat Patients A2 observations or that she informed the obstetric registrar that the score was 4 at 21:45.

Mr 10, an expert witness on behalf of Mr 6, addresses the incorrect calculation of Patient A2's MEOWS at 21:45 and the alleged failure to comply with the requirements of the Trust MEOWS protocol. Mrs Sanderson's local evidence is that she completed the observations documented at 21:45. These included a maternal pulse rate of 63. Mr 10 suggests that this recording is an error.

According to her medical records Patient A2's pulse was consistently 96 or above and increased steadily following her admission. The entry made by Mrs Sanderson at 21:45 would appear to be an anomaly. Patient A2 was also reviewed by an obstetrician at 21:36, when her pulse was said to be 144. As such, it is alleged that Mrs Sanderson made an error in her estimation of Patient A2's pulse rate, and her MEOWS score.

Additionally, a delay in administering antibiotics was noted because no midwife was available to check them with Mrs Sanderson until 23:45, shortly before Patient A2 was transferred to the Surgical Assessment Unit.

Decision and reasons on application of no case to answer

During the proceedings, the panel received a partially unredacted version of the rota which showed that Mrs Sanderson was not working on the morning of the 2 December 2017.

The panel of its own volition invited submissions from Ms Deasy in relation to whether there is no case to answer in respect of charges 5a, 5b and 5c. This application was made under Rule 24(7).

Ms Deasy accepted that there is no case to answer in respect of these charges.

The panel took account of the submissions and accepted the advice of the legal assessor which included reference to *R v Galbraith [1981] 1 WLR 1039.*

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. It considered the evidence at its highest, taking into account its strength and its weaknesses. The panel was solely considering whether sufficient evidence had been presented, such that a properly directed panel could find the charge proved and therefore whether Mrs Sanderson had a case to answer.

The panel took account of the partially unredacted rota. It was satisfied that it demonstrated that Mrs Sanderson was not working the night shift on 1 December 2017 and therefore was not present in the morning of the 2 December 2017. It was of the view that this is inconsistent with the evidence of Mr 6 regarding the events on that day.

In light of this, the panel was of the view that there is insufficient evidence to support a charge based on a duty to treat Patient A2 and her husband with kindness and respect. Applying the second limb of *Galbraith*, the panel concluded that no panel, properly directed, could find that such a duty existed.

In these circumstances, a charge based on such a duty could not be made out and Mrs Sanderson has no case to answer in respect of this charge.

Decision and reasons on application to amend the charge

The panel of its own volition invited submissions from Ms Deasy to amend the wording of charge 6c. During its deliberation of this charge, it noted that the MEOWS chart shows a recording of '63' being made at '21:40'. It also noted that the expert report refers to a time of '21:45' in respect of the pulse rate forming part of the rationale and reasons as to why a MEOW score of 4 was made.

6. Failed to provide adequate care for Patient A, in that you failed to;
    c. At 21:45~~5~~**0** on 2 December 2017, accurately record Patient A's pulse rate;

Ms Deasy submitted that on the basis of the documentation and the interpretation from Ms 6 of the MEOWS chart, an amendment to reflect the time of 21:40 would provide clarity and more accurately reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Sanderson 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.

Mrs Sanderson was informed of the amendment by email.

Details of charge (as amended)

That you, a registered midwife:

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;

a. Described henna on their hands as;
    i. '*awful black tar*', or words to that effect;
    ii. '*horrible black stuff*', or words to that effect;

b. Said to Patient A, in respect of the henna on their hands, '*this is really stupid, why have you done this, we need to get this off*', or words to that effect;

c. Said to a colleague that you could tell where a woman was from just by looking at them, and that Patient A was too short to be from Somalia;

2. Your conduct at charge 1c was racially discriminatory;

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;

a. Failed to introduce yourself to Patient B;

b. Asked Patient B;
    i. '*How long have you been in this country*', or words to that effect;
    ii. '*Don't you speak any English*', or words to that effect;
    iii. '*Why did you come to this country when there's lots of countries that speak French*', or words to that effect;

c. Told Patient B to '*put your bum on the bed*', or words to that effect;

d. When Patient B did not understand the instruction at charge 3c, said '*you know, derriere, bed, haha, see I do remember some French, but that's where it stops*', or words to that effect;

4. Your conduct at charge 3b was racially discriminatory;

Over the course of 2 and 3 December 2017:

5. Failed to treat Patient A and her husband with kindness and respect, in that you:

    a. Told Patient A to "*get off the floor you don't know what's been there*", or words to that effect;
    b. Did not provide any support to Patient A;
    c. In response to Patient A's husband querying the lack of medical treatment, said "*let's be honest, she wouldn't be here if she wasn't pregnant, she'd be at home sitting it out like the rest of us*", or words to that effect;

6. Failed to provide adequate care for Patient A, in that you failed to;

    a. Clean Patient A after she had vomited;
    b. Administer IV antibiotics to Patient A in a timely manner;
    c. At 21:40 on 2 December 2017, accurately record Patient A's pulse rate;

7. Failed to record that you:

    a. Asked a HCA to repeat Patient A's observations;
    b. Informed the obstetric registrar of the MEOWS score of 4 recorded at 21:45;

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Deasy on behalf of the NMC and written representations by Mrs Sanderson.

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

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

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

- Ms 1: The Matron for Gynaecology services at the Trust;
- Ms 2: Band 6 Midwife at the Trust;
- Dr 3: At the concerning time, an ST4 Trainee obstetrics and gynaecology registrar;
- Ms 4: Band 6 Midwife at the Trust;
- Ms 5: At the concerning time a Band 6 Midwife at the Trust;
- Mr 6: Patient A2's (charges 5-7) partner.

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

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

Charge 1

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;
    a. Described henna on their hands as;
        i. '*awful black tar*', or words to that effect;

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 2, Dr 3, Ms 5 and Mrs Sanderson.

When considering this charge, the panel bore in mind that evidence is required to establish a duty upon Mrs Sanderson to treat Patient A1 with kindness and respect.

The panel took account of Mrs Sanderson's job description as a Band 6 Midwife, provided by Ms 5. The panel noted that under the title "Kind & Caring" it states, "We will act in the best interest of others at all times". It also took account of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) which states:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion'

In light of the above, the panel was satisfied that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient A1 or any patient under her care with kindness and respect.

The panel moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient A1 with kindness and respect by describing the henna on her hands as '*awful black tar'.*

The panel took account of the witness statement of Ms 2, which stated:

> *"…Wendy took over the handover then started talking about the henna on Patient A[1]'s hands and described the henna as awful black tar. Both [Dr 3] and [Dr 7] looked horrified at this comment…"*

Ms 2 reaffirmed this in her oral evidence. She stated that during a ward round, attended by Dr 3 and Dr 7 (a fellow doctor), Mrs Sanderson was not present initially. Patient A1 was Mrs Sanderson's patient but as she was not present Ms 2 began the handover presentation. Ms 2 said that this is when Mrs Sanderson entered and started talking about Patient A1. According to Ms 2, Mrs Sanderson stated that "Patient A[1] has this awful black tar on her hands" and that she had been looking for acetone but could not find any. Ms 2 stated that Mrs Sanderson appeared irritated giving this report. Further, both doctors looked uncomfortable and in disbelief at what was being said.

Ms 2 also stated that when Dr 7 attempted to clarify whether Mrs Sanderson was describing henna, she repeated the phrase saying "yes, that awful black tar".

The panel also took account of the witness statement of Dr 3 which stated:

> *"…Whilst going through the patients I heard Wendy make comments about a patient of African descent who had attended her induction with dark henna on her hands, which made monitoring her with the sats probe difficult. I will hereafter refer to this patient as Patient A.*
>
> *Wendy described Patient A has having 'awful black tar' on her hands and made repeated comments about this during the handover. At the time during this handover I said 'this was not a very nice thing to say'…"*

Dr 3 reaffirmed this in her oral evidence.

The panel took account of Ms 1's witness statement. It bore in mind that she was commissioned to undertake an investigation into the incident. The witness statement stated:

> *"…Wendy accepted that she told Patient A[1] that it was silly to have the henna on her hands and on reflection this was a poor choice of words. She also accepted using the term black tar…"*

Mrs Sanderson, in her local statement, stated that she was repeating what she was told by a female healthcare assistant.

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel preferred the evidence of Ms 2 and Dr 3. It noted that both Ms 2 and Dr 3 are direct witnesses to the incident. It was of the view that both were consistent with each other and their respective witness statements.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 25 March 2021, Mrs Sanderson failed to treat Patient A1 with kindness or respect, in that she described henna on their hands as 'awful black tar' or words to that effect.

Therefore, this sub-charge is found proved.

Charge 1

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;
    a. Described henna on their hands as;

ii. ‘*horrible black stuff*’, or words to that effect;

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Dr 3 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient A1 with kindness and respect. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient A1 with kindness or respect by describing the henna on her hands as ‘*horrible black stuff*’*.*

The panel took account of the witness statement of Dr 3 which stated:

> *“…Later during the shift I returned to the Induction Suite to review another patient. I was sat in the office when I overheard Wendy handing Patient A[1] over to midwife [Ms 8]. Also present was a student midwife.*
>
> *I again heard Wendy saying to Julie that Patient A[1] had 'horrible black stuff on her hands', which prompted [Ms 8] to ask where this patient was from…”*

Dr 3 reiterated this in her oral evidence. She stated that she heard Mrs Sanderson say this during a handover, when Patient A1 was due to be moved from induction to the delivery suite. Dr 3 stated she was concerned by the fact that a similar phrase had been used again when she had pointed out already it was not a nice thing to say. Further, Dr 3 also stated that it was not relevant to the clinical care of the patient.

Mrs Sanderson, in her local statement, stated:

> *“…At handover of care to the next shift I would have referred to the patient wearing henna on her fingers as this was relevant to the provision of care, and whilst I*

would not knowingly make derogatory comments about a patient, I cannot recall my specific wording given the passage of time…"

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel preferred the evidence of Dr 3. It noted that she was a direct witness to the incident. Additionally, it was of the view that her oral evidence was consistent with her witness statement.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 25 March 2021, Mrs Sanderson failed to treat Patient A1 with kindness or respect, in that she described henna on their hands as '*horrible black stuff*', or words to that effect.

Therefore, this sub-charge is found proved.

Charge 1

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;
    b. Said to Patient A, in respect of the henna on their hands, '*this is really stupid, why have you done this, we need to get this off*', or words to that effect;

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 2 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient A1 with kindness and respect. It moved on to consider if, on the

balance of probabilities, Mrs Sanderson failed in her duty to treat Patient A1 with kindness or respect by saying '*this is really stupid, why have you done this, we need to get this off*', or words to that effect in respect of the henna on her hands.

The panel took account of the witness statement of Ms 2 which stated:

> *"…I have never known a pulse oximetry probe not to work because of henna on a patient hands. However, I trusted that [Mr 9] had tried a different machine and had also tried her toes but this also did not work as she also had henna there. I advised [Mr 9] to check Patient A[1]'s pulse manually and reassured him that her saturation levels were not an urgent concern as she was walking around, talking and has no signs of cyanosis. [Mr 9] agreed to this.*
>
> *Wendy then came passed me and grabbed Patient A[1]'s hands. I cannot remember the exact wording but said words to the effect of this is really stupid why have you done this we need to get this off…" [sic]*

Ms 2 reiterated this in her oral evidence. She stated that she and Mrs Sanderson were in the office when Mr 9, a healthcare assistant, brought Patient A1 to the office with a concern. He was struggling to take his observations because of the henna on Patient A1's hands. Ms 2 stated that she knew it was henna and it was something she was reasonably familiar with and, in her clinical experience, should not cause a problem. Ms 2 described Mrs Sanderson pushing past her, grabbing Patient A1's hands in a way that surprised Ms 2. Ms 2 stated that she would not expect anyone to grab anybody like that in the hospital.

Ms 2 described Mrs Sanderson's demeanour as irritated saying "this is silly, why have you done this". Ms 2 stated she tried to explain to Mrs Sanderson how henna is a cultural symbol of celebration but received no response.

Mrs Sanderson, in her local statement, stated:

"…It was only when I went to check if the HCA had managed to remove the substance that I and my fellow midwifery colleague realised that her hands had been decorated with henna, which I am aware cannot be removed by washing or acetone. I do recall saying to the patient that I thought that this was silly, which I can appreciate was a poor choice of words, but my concern was that the wearing of henna could prevent us from monitoring her saturation levels which would become increasingly important should she become ill during her labour or require an operative delivery.

At no time did the midwife who accompanied me make any comment or raise any concerns with me regarding my poor choice of words and we continued to work through the shift without issue.…"

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel preferred the evidence of Ms 2. It noted that she was a direct witness to the incident. Additionally, it was of the view that her oral evidence was consistent with her witness statement.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 25 March 2021, Mrs Sanderson failed to treat Patient A1 with kindness or respect, in that she said to Patient A1, in respect of the henna on their hands, 'this is really stupid, why have you done this, we need to get this off', or words to that effect.

Therefore, this sub-charge is found proved.

Charge 1

1. On 25 March 2021, failed to treat Patient A with kindness or respect, in that you;
    c. Said to a colleague that you could tell where a woman was from just by looking at them, and that Patient A was too short to be from Somalia;

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2, Dr 3 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient A1 with kindness and respect. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient A1 with kindness or respect by saying to a colleague that she could tell where a woman was from just by looking at them, and that Patient A1 was too short to be from Somalia.

Ms 2 in her witness statement stated:

> *Whilst in the office Wendy went through Patient A[1]'s medical history. Wendy then spoke about the henna again and saying how she could not get the probe to work. Wendy again said it looked like black tar and would not come off.*
>
> *[Ms 8] asked where Patient A[1] was from. I cannot recall verbatim what Wendy said but if was words to the effect that she usually knows where a woman is from just from looking at them however Patient A[1] was too short to be from Somalia and that she was not sure where she was from.*
>
> *At this point [Dr 3] had stopped what she was doing to look at me, notably uncomfortable with conversation…"*

Ms 2 reiterated this in her oral evidence. She also stated that Mrs Sanderson provided other examples of knowing where people are from. Ms 2 stated that Mrs Sanderson probably thought she was being funny and does not think she realised how shocking her comment was. Ms 2 also stated herself and Dr 3 were using the computers and she could feel Dr 3 staring at her.

Dr 3 in her witness statement stated:

> *"…Later during the shift I returned to the Induction Suite to review another patient. I was sat in the office when I overheard Wendy handing Patient A[1] over to midwife [Ms 8]. Also present was a student midwife…I heard Wendy say that Patient A[1] was 'too short to be from Somalia but she could not be sure if she was from Sudan…"*

Dr 3 in her oral evidence stated that she felt she had already addressed the situation with the henna. She stated she said nothing until this incident. She said that Ms 8 (a delivery suite midwife) had attended the induction of labour suite and was in the office to take handover of Patient A1's care. She stated that Mrs Sanderson referenced the henna again and alluded to trying to use cleaning products to remove it. She then stated that both Ms 8 and Mrs Sanderson enquired into where Patient A1 was from which is when Mrs Sanderson stated Patient A1 was too short to be from Somalia. Dr 3 stated she was shocked and appalled at the comment.

Mrs Sanderson, in her local statement, stated:

> *"…I do recall making a reference that the patient was of short stature..."*

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel preferred the evidence of Ms 2 and Dr 3. It noted that both Ms 2 and Dr 3 are direct witnesses to the incident. It was of the view that both were consistent with each other and their respective witness statements. It also bore in mind that Ms 1, Ms 2 and Dr 3 all stated that talking about a person's nationality or height was not appropriate and usually not relevant to care. Further, it was of the view that in the context of the whole conversation including reference to Patient A1's henna, the comments made by Mrs Sanderson were not appropriate. It was of the view that it was not respectful and not needed for a clinical assessment to be made.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 25 March 2021, Mrs Sanderson failed to treat Patient A1 with kindness or respect, by saying to a colleague that she could tell where a woman was from just by looking at them, and that Patient A1 was too short to be from Somalia.

Therefore, this sub-charge is found proved

Charge 2

2. Your conduct at charge 1c was racially discriminatory;

This charge is found proved.

In considering this charge the panel bore in mind the legal definition of racial discrimination was "Any discrimination against any individual on the basis of their skin colour or racial, or ethnic origin."

The panel noted that Mrs Sanderson in her local statement had stated:

"…I do recall making a reference that the patient was of short stature. This was an

observation and not intended as an insult. In my experience of the women of Somalian descent whom I have previously cared for, it is my recollection that all been much taller than me at just under five feet tall, which would explain the origins of my comment....”

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel determined that Mrs Sanderson’s comment to a colleague indicating that she could tell where a woman was from by looking at them and that Patient A1 was too short to be from Somalia is discrimination based on Patient A1’s ethnic origin. It was satisfied that Mrs Sanderson was referring to the characteristic of someone based on their ethnic origin.

The panel noted that Patient A1 was not present when this comment was made, nor did she overhear it. However it was of the view that Mrs Sanderson’s comment, as a professional midwife, caring for Patient A1 which had no bearing on any clinical care for the patient, constitute racial discrimination.

The panel also took account of the impact that Mrs Sanderson’s comments had on Ms 2 and Dr 3. Dr 3 stated that this incident including the wider context of the events caused her to make a complaint to her education supervisor, college tutor and the medical director.

In light of the above the panel found that, on the balance of probabilities, Mrs Sanderson’s conduct at charge 1c was racially discriminatory.

Therefore this sub-charge was found proved.

Charge 3

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;
    a. Failed to introduce yourself to Patient B;

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1 and Ms 4.

As Patient B was under Mrs Sanderson's care, the panel was satisfied that, as a registered Band 6 midwife, Mrs Sanderson had the same duty to treat Patient B with kindness and respect that she did with Patient B. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient B with kindness or respect by failing to introduce herself to Patient B.

Ms 4 in her witness statement stated:

> *"…I was in the bay with my woman when Wendy entered Patient B's bay at around 22.00. As they bays were next to each other you could overhear the interaction clearly.*
>
> *Wendy did not say hello or introduce herself she went straight into asking Patient B lots of questions…"*

Ms 4 reiterated this in her oral evidence that she noticed the exchange as Mrs Sanderson went over and began questioning Patient B without making any introductions. She stated that this was far from the standard she would have expected as a midwife as the usual process would be introductions, then making sure the patient was comfortable and then proceeding with the plan of care.

The panel noted that Mrs Sanderson, in her local statement, while referring to this incident does not mention introducing herself to Patient B at all. However, in Ms 1's investigation interview, dated 5 August 2021, Mrs Sanderson stated:

> *"…I was late going to see this patient due to other reasons and she needed to get on the monitor…"*

The panel was of the view that this was consistent with the evidence of Ms 4 in that this was the first time Mrs Sanderson had seen Patient B and did not introduce herself.

The panel preferred the evidence of Ms 4. It noted that Ms 4 was a direct witness to the incident. Further, it was of the view that her oral evidence was consistent with her witness statement.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 20 April 2021, Mrs Sanderson failed to treat Patient B with kindness or respect by failing to introduce herself to Patient B.

Therefore, this sub-charge is found proved

Charge 3

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;
    b. Asked Patient B;
        i. '*How long have you been in this country*', or words to that effect;
        ii. '*Don't you speak any English*', or words to that effect;
        iii. '*Why did you come to this country when there's lots of countries that speak French*', or words to that effect;

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 1, Ms 4 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient B with kindness and respect. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient B with kindness or respect of the questions described in charges 1b(i), 1b(ii) and 1b(iii).

Ms 4 in her witness statement stated:

> *"…I was in the bay with my woman when Wendy entered Patient B's bay at around 22.00. As they bays were next to each other you could overhear the interaction clearly.*
>
> *Wendy did not say hello or introduce herself she went straight into asking Patient B lots of questions including "How long have you been in this country? Don't you speak any English? Why did you come to this country when there's lot of countries that speak French?".*
>
> *I was mortified as was my patient, we both just looked at each other…"*

Ms 4 reiterated this in her oral evidence. She stated she was nearby and could hear everything that was said. She also stated that Mrs Sanderson asked why Patient B came to this country as there are a lot of French speaking countries. Ms 4 stated that Mrs Sanderson said this in an uncomfortable tone with no kindness in her voice. She further stated that while Patient B may not have understood what Mrs Sanderson was saying, she would have understood the tone.

Ms 4 stated that she was stunned by this inappropriate line of questioning.

Mrs Sanderson, in her local statement, stated:

"…With regards to the third allegation, I can recall that I was looking after this patient on a night shift. At handover of care, it was explained that the patient did not understand or speak any English. It is my experience, having cared for numerous patients from overseas, that many have a better understanding of English as a second language than first thought, and there are obvious implications and challenges in the delivery of care for those who speak no English at all… I did ask the patient for her country of origin as a point of interest of her and her country. I also asked how long she had been here. It helps me to ascertain if she understands me, and if she has been in England long enough to have a grasp of the language. She told me she was from the Congo and had been here a year, therefore establishing she understood a little basic English language. I did ask why she hadn't chosen to live in a French speaking country, not something I had asked a patient before, but I think it was borne of the apprehension of expecting difficulty in establishing a dialogue with the patient…"

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

Additionally, the panel also bore in mind that Ms 1 in her oral evidence stated that Patient B's language needs would have been assessed earlier in her pregnancy, at her booking appointment and if an interpreter was required then this would have been arranged. As a result, the panel was satisfied that Mrs Sanderson's line of questioning was inappropriate and unnecessary.

The panel preferred the evidence of Ms 4. It noted that Ms 4 was a direct witness to the incident. Further, it was of the view that her oral evidence was consistent with her witness statement.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 20 April 2021, Mrs Sanderson failed to treat Patient B with kindness or respect by asking the questions described in charges 1b(i), 1b(ii) and 1b(iii).

Therefore, these sub-charges are found proved

Charge 3.

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;
    c. Told Patient B to '*put your bum on the bed*', or words to that effect;

This sub-charge is found proved.

In reaching this decision, the panel took account of Ms 4 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient B with kindness and respect. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient B with kindness or respect by telling Patient B to '*put your bum on the bed*', or words to that effect.

Ms 4 in her witness statement stated:

> *"…I then heard Wendy ask Patient B to "Put your bum on the bed", to which Patient B did not reply..."*

Ms 4 reiterated this in her oral evidence. She stated that Mrs Sanderson had only just met Patient B and whilst you can sometimes gauge with certain patients to take a more relaxed approach, in her view it was unprofessional. She stated that Mrs Sanderson's tone was lacking in respect.

Ms 4 in her local statement stated:

"…As the patient returned from the toilet, I did ask her to put her 'bum on the bed'. As she looked puzzled by my request I patted the bed, indicating for her to sit down.."

In Ms 1's investigation interview, dated 5 August 2021, Mrs Sanderson stated:

"…she knew I wanted to examine her tummy she knew I wanted to listen to baby, and she needed to go to the toilet before I put her on the monitor, she went to the toilet I sorted the bed out for her while she was gone and then when she returned I said ''Pop your bum on the bed'' because I say that to nearly everybody, it did not occur to me that she would not understand…"

The panel also noted that Ms 1 and Ms 4, both stated in their oral evidence that there may be situations where such language is appropriate. However, Ms 1 stated that she did not find this phrase particularly concerning but it would be appropriate if it was used correctly.

The panel considered that the context in which the phrase "put your bum on the bed" was said is important to establish if this charge is found proved. It was of the view that the words of the charge in themselves do not necessarily establish that Mrs Sanderson did not show kindness or respect.

However, the panel took into account the evidence of Ms 4 who stated that the conversation between Mrs Sanderson and Patient B from start to finish was wholly inappropriate and disrespectful. The panel preferred the evidence of Ms 4. It noted that Ms 4 was a direct witness to the incident. Further, it was of the view that her oral evidence was consistent with her witness statement.

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the

veracity of the local statement or the comments she made during the investigation with Ms 1.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 20 April 2021, Mrs Sanderson failed to treat Patient B with kindness or respect by telling Patient B to '*put your bum on the bed*', or words to that effect.

Therefore, this sub-charge is found proved.

Charge 3

3. On 20 April 2021, failed to treat Patient B with kindness or respect, in that you;
    d. When Patient B did understand the instruction at charge 3c, said '*you know, derriere, bed, haha, see I do remember some French, but that's where it stops*', or words to that effect;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4 and Mrs Sanderson.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to treat Patient B with kindness and respect. It moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to treat Patient B with kindness or respect by saying '*you know, derriere, bed, haha, see I do remember some French, but that's where it stops*' when Patient B did not understand the instruction at charge 3c.

Ms 4 in her oral evidence stated:

> *"…I then heard Wendy ask Patient B to "Put your bum on the bed", to which Patient B did not reply. Wendy went on to say "you know… Derriere, bed, haha, see I do*

remember some French, but that's where it stops". She then tapped the bed and laughed…"

Ms 4 reiterated this in her oral evidence. She described the whole conversation as sarcastic, derogatory and disrespectful.

Mrs Sanderson in her local statement stated:

"…I said ''Pop your bum on the bed'' because I say that to nearly everybody, it did not occur to me that she would not understand, she gave me a quizzical look and then I said ''derriere'' and patted the bed and she smiled at me and she got on the bed, then I apologised and said 'my school girl French is terrible I can't speak French at all'' and she just nodded and smiled at me…"

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

Ms 4 stated that the conversation between Mrs Sanderson and Patient B from start to finish was wholly inappropriate and disrespectful. The panel preferred the evidence of Ms 4. It noted that Ms 4 was a direct witness to the incident. Further, it was of the view that her oral evidence was consistent with her witness statement.

Additionally, the panel also bore in mind that Ms 1 in her oral evidence stated that Patient B's language needs would have been assessed earlier in her pregnancy and if an interpreter was required then this would have been arranged. As a result, the panel was satisfied that Mrs Sanderson's comments were inappropriate and unnecessary.

Having found the stem of the charge proved, the panel was satisfied that, on the balance of probabilities, on 20 April 2021, Mrs Sanderson failed to treat Patient B with kindness or respect by saying to Patient B '*you know, derriere, bed, haha, see I do remember some*

French, but that's where it stops' when Patient B did not understand the instruction at charge 3c.

Therefore, this sub-charge is found proved.

Charge 4

4. Your conduct at charge 3b was racially discriminatory;

This charge is found proved.

In considering this charge the panel bore in mind the legal definition of racial discrimination was "Any discrimination against any individual on the basis of their skin colour or racial, or ethnic origin."

The panel noted that Mrs Sanderson in her local statement had stated:

> *"…With regards to the third allegation, I can recall that I was looking after this patient on a night shift. At handover of care, it was explained that the patient did not understand or speak any English. It is my experience, having cared for numerous patients from overseas, that many have a better understanding of English as a second language than first thought, and there are obvious implications and challenges in the delivery of care for those who speak no English at all…I did ask the patient for her country of origin as a point of interest of her and her country. I also asked how long she had been here. It helps me to ascertain if she understands me, and if she has been in England long enough to have a grasp of the language. She told me she was from the Congo and had been here a year, therefore establishing she understood a little basic English language. I did ask why she hadn't chosen to live in a French speaking country, not something I had asked a patient before, but I think it was borne of the apprehension of expecting difficulty in establishing a dialogue with the patient. However, this was not the case, as she*

understood more than she spoke. She had experienced all the procedures previously, so the language line was not required....."

The panel bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of the local statement.

The panel was of the view that the questions asked by Mrs Sanderson were wholly inappropriate and unnecessary. It was of the view that it would never be appropriate to ask a patient why she came to this country when there are other French speaking countries.

The panel also bore in mind that Ms 1 in her oral evidence stated that Patient B's language needs would have been assessed earlier in her pregnancy and if an interpreter was required then this would have been arranged.

Additionally, Ms 4 stated in her oral evidence that information regarding Patient B's level of English was passed to Mrs Sanderson during handover. As a result, the panel was satisfied that Mrs Sanderson's line of questioning was inappropriate, was irrelevant to the care of Patient B and was unnecessary.

The panel also particularly noted that Ms 4 stated that when she went home and reflected, she felt if she did not take action regarding this incident, then it would have been as if she had made the remarks herself. The panel bore in mind that Ms 4 was a direct witness to the incident and her oral evidence was consistent with her witness statement.

The panel was satisfied that Mrs Sanderson was treating Patient B differently based on her ethnic origin.

The panel was of the view that Mrs Sanderson's comment, as a professional midwife, caring for Patient B which had no bearing on any clinical care for the patient, constitute racial discrimination.

In light of the above the panel found that, on the balance of probabilities, Mrs Sanderson's conduct at charge 1c was racially discriminatory.

Therefore this sub-charge was found proved.

Charge 6

6. Failed to provide adequate care for Patient A, in that you failed to;
    a. Clean Patient A after she had vomited;

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 5 and Mr 6.

The panel took account of the witness statement of Mr 5 which stated:

> *"…Patient A was covered in vomit and in a lot of pain when Wendy came into the room but she just ignored this and did not attend to any personal care despite their being vomit on 's clothes and bedding…"*

Mr 5 reiterated this in his oral evidence. He also stated that Patient A2 was vomiting around the time of her admission into the Hospital.

Ms 6 in her witness statement stated:

> "…Patient A[2]…she was one of these patients who was admitted on 2 December 2017 at 4:55 am…."

Ms 6 confirmed this in her oral evidence. It also took account of Patient A2's patient care records and noted that at 19:30, there is an entry that states:

"…Has been vomiting all day…last vomited an hour ago…"

However, the panel took account of the rota for 2 December 2017 and noted that Mrs Sanderson would have started her shift at 21:30. She has made an entry in the patient notes at 21:45 stating:

"…last vomited @ 2 hours ago…"

The panel bore in mind that Ms 5 confirmed that this entry at 21:45 was the handwriting of Mrs Sanderson. This is consistent with the evidence of the rota which shows she started her shift at 21:30 on 2 December 2017.

Mrs Sanderson in an email to the NMC, dated 22 August 2022, stated:

"…I'm not lying when I say I was not in attendance when a patient was allegedly mistreated…"

When considering this charge, the panel bore in mind that evidence is required to establish a duty upon Mrs Sanderson to provide care for Patient A2. It bore in mind that Mrs Sanderson had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of her statement.

However, there is corroborating evidence that suggests that Mrs Sanderson was not on duty when Patient A2 was admitted. Therefore, she could not have had a duty to provide any care for Patient A2.

In light of this, the panel reminded itself that it is for the NMC to prove the charge. It noted that the NMC has provided the panel with insufficient evidence to establish that Mrs Sanderson was on shift when Patient A2 was admitted and began vomiting and therefore had a duty to provide adequate care. It reminded itself that the NMC relied solely on the

evidence of Mr 5. The panel does not believe that he was trying to mislead the panel. However, the panel noted that the NMC had not provided the panel with sufficient information that demonstrated that Mrs Sanderson had failed to provide adequate care for Patient A by failing to clean her after she had vomited. This charge is not supported by any other documentation before the panel.

Therefore, the panel finds this sub-charge not proved.

Charge 6

6. Failed to provide adequate care for Patient A, in that you failed to;
    b. Administer IV antibiotics to Patient A in a timely manner;

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 5 and Mrs Sanderson.

When considering this charge, the panel bore in mind that evidence is required to establish a duty upon Mrs Sanderson to provide care for Patient A2.

The panel took account of Mrs Sanderson's job description as a Band 6 Midwife, provided by Ms 5. The panel noted that under the title "Kind & Caring" it states, "We will act in the best interest of others at all times". It also took account of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) which states:

'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'

In light of the above, the panel was satisfied that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to provide adequate care to Patient A2 or any patient under her care

The panel moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to provide adequate care to Patient A2 by failing to administer Intravenous (IV) antibiotics to Patient A2 in a timely manner.

Ms 5 in her oral evidence drew the panel's attention to Patient A2's patient care records. At 23:00 on 2 December 2017, a doctor prescribes an IV for Patient A2 noting *"…Advised to give IV…".*

Within the same patient records for Patient A2 Mrs Sanderson, at 23:30 has noted "…Busy Triage…delayed in giving…". As a result administering IV antibiotics was delayed as another registered member was not available to do a two person check. Ms 6 stated that the triage would have been busy as 20 patients were admitted around this time.

Ms 6 advised the panel of the national standard referred to as the "golden hour". She stated that on the initial decision that Patient A2 could have been septic, the sepsis care pathway commences. Ms 6 informed the panel that the national standard indicated that IV antibiotics should be administered within an hour of the diagnosis of sepsis.

The panel noted that Mrs Sanderson, at 23:45, has made a note stating that antibiotic IV has commenced. It was satisfied that this was done within 45 mins of the diagnosis of sepsis and the IV antibiotics being prescribed.

In light of this, the panel reminded itself that it is for the NMC to prove the charge. It noted that the NMC has not provided the panel with any evidence to establish that Mrs Sanderson failed in her duty to administer IV antibiotics to Patient A2 in a timely manner. This charge is not supported by any other documentation before the panel.

Therefore, the panel finds this sub-charge not proved.

Charge 6

6. Failed to provide adequate care for Patient A, in that you failed to;
    c. At 21:40 on 2 December 2017, accurately record Patient A's pulse rate;

This charge is found proved.

In reaching this decision, the panel took account of the evidence of the expert report provided by Mr 5.

The panel had already established that Mrs Sanderson, as a registered Band 6 Midwife, had a duty to provide adequate care to Patient A2 It moved on to consider if, on the balance of probabilities, Mrs Sanderson in her duty provide adequate care to Patient A2 at 21:40 failed to accurately record Patient A's pulse rate.

The expert report stated:

> *"…At 21.45 the MEOWS was noted as 4, but the figures quoted by the Registrar would make the score 7 – it appears that the pulse was recorded as 63 at 21.45, which is unexpected and does not fit with the trend in the other observation parameters; in my opinion it is likely an error…"*

The panel noted that there appears to be typographical error within the experts report. It took account of Patient A2's records and noted that Mrs Sanderson has recorded a pulse rate of "63" at 21:40.

The panel noted that Mrs Sanderson assumed care of Patient A2 at 21:30. While there is no signature from Mrs Sanderson on the MEOWS chart, it was satisfied that it was more likely than not that the entry made at 21:40 was made by her.

The panel noted that the pulse rate has been identified in the expert report as an anomaly as Patient A had been reviewed by an obstetrician at 21:36 and her pulse was “144”. Upon Patient A2’s admission into the hospital at 04:55, the panel noted that her pulse rate was recorded as “96” and had been steadily increasing.

The panel was of the view that this entry was recorded in respect of a MEOWS score of 4 which would have been calculated and based on a number of factors including the pulse rate. However, based on the expert report, the pulse recording of “63” would appear to be an inaccurate reading. This is because the previous reading recorded at 18:25 as “144” and the subsequent reading of “152” at 22:15.

Ms 5 in her oral evidence suggested that Patient A2 may have been asleep at this time which might explain the drop in her pulse rate at 21:40.

However, the expert report stated that the MEOWS score should have been 7 based on the information recorded before Mrs Sanderson at the time which included the pulse rate of ‘63’. The panel therefore concluded that Mrs Sanderson’s entry of “63” was an error.

In light of the above the panel, on the balance of probabilities, determined that Mrs Sanderson failed to provide adequate care for Patient A2 in that she failed to accurately record Patient A2’s pulse rate at 21:40.

Therefore this sub-charge is found proved.

Charge 7

7. Failed to record that you:
    a. Asked a HCA to repeat Patient A’s observations;
    b. Informed the obstetric registrar of the MEOWS score of 4 recorded at 21:45;

These sub-charges are both found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 5 and Mrs Sanderson.

When considering these charges, the panel bore in mind that evidence is required to establish a duty upon Mrs Sanderson record that she asked a HCA to repeat Patient A2's observations and inform the obstetric registrar of the MEOWS score of 4.

The panel took account of MEOWS flow chart provided by Ms 5. It shows what should be done depending on the MEOWS score. In this case, the MEOWS score for Patient A2 was recorded as 4. According to the flow chart, Mrs Sanderson had a duty to call the obstetric registrar and continue hourly observations until Patient A2 was stable.

In light of the above, the panel was satisfied that Mrs Sanderson, as a registered Band 6 Midwife, had a duty in relation to this charge.

The panel moved on to consider if, on the balance of probabilities, Mrs Sanderson failed in her duty to record that she asked a HCA to repeat Patient A's observations.

Ms 5, in her oral evidence, stated that she would have expected Mrs Sanderson to record that she asked an HCA to repeat Patient A's observations.

The panel noted that a MEOWS score of 4 has been recorded at 21:45. The guidance contained with the MEOWS flowchart indicated that as a result of the MEOWS score of 4, observations should be continued hourly until Patient A2 was stable and the obstetric registrar should have been informed.

The panel took account of Mrs Sanderson's written response where she stated:

> "…I am aware that my documentation in the notes are brief and succinct…"

In Mrs Sanderson's local statement referred to by Ms 5, she stated:

> "…When I took over care at 21:45, [Patient A] appeared quite ill, with a low grade pyrexia and tachycardia. Her MEOWS was 4. I asked HCA…to repeat her observation in half hour. I did inform the obstetric staff of the above, although I omitted to document this…"

The panel noted that Mrs Sanderson has accepted she has failed to record that she had asked the HCA to repeat Patient A2's observations or inform the obstetric registrar of the MEOWS score of 4.

The panel therefore finds these sub-charges proved.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

Submissions on misconduct and impairment

Ms Deasy invited the panel to take the view that the facts found proved amount to misconduct as Mrs Sanderson's actions fell below the standards expected of a registered midwife.

With regards to charges 1 to 4, Ms Deasy submitted that racially discriminatory comments to and about patients is a serious concern, falling far below the standards expected of a midwife. She submitted that there is a clear expectation that nurses, midwifes and nursing associates will behave in an inclusive, respectful and non-discriminatory way. 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) sets out these expectations. She submitted that the conduct found proved is a clear breach of the code and the NMC takes concerns about discrimination very seriously and has made it clear that racism and discrimination should not be tolerated within healthcare. She referred the panel the NMC Guidance "How we determine seriousness" (reference FTP-3).

Ms Deasy submitted that Mrs Sanderson has not submitted any substantive response in respect of these proceedings, and therefore it is difficult to assess any insight into the conduct. She submitted that there is no evidence before the panel that Mrs Sanderson has taken any action to ensure that similar comments or discriminatory language are not used again, or to understand why such comments and language is problematic and perceived as discriminatory.

Ms Deasy submitted that Mrs Sanderson has provided no evidence to the panel of comprehensive insight, remorse or strengthened practice. She further submitted that the panel cannot be satisfied that the views and behaviours had been addressed and are not still present. She submitted that Mrs Sanderson remains currently impaired in this way and public confidence in the profession would be undermined if a finding of impairment were not made.

With regards to charges 6c and 7, Ms Deasy submitted that there is no evidence of any actual physical harm having been caused purely as a result of Mrs Sanderson's conduct. However, there was a potential for harm.

Ms Deasy submitted that Mrs Sanderson made errors in observations of a deteriorating patient and in record keeping. She submitted that such errors clearly expose patients to the risk of harm.

With regards to impairment, Ms Deasy submitted that the panel must consider whether there is a risk that Mrs Sanderson would act in the same way as she did when caring for Patient A2, when caring for patients now. Put simply, whether Mrs Sanderson has put those clinical concerns right or whether there remains a risk of repetition. She submitted that this decision should be considering the context of the conduct at the time.

Ms Deasy invited the panel to find that in the absence of any evidence to the contrary, Mrs Sanderson has failed to put the clinical concerns right and is impaired on the basis of misconduct.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. It considered whether Mrs Sanderson's actions fell significantly short of the standards expected of a registered midwife, and amounted to a breach of the Code.

With regards to charges 1ai and 1aii, the panel considered this to be a serious failing. The panel bore in mind that Ms 2, in her oral evidence, stated that she spoke to Mrs Sanderson. Ms 2 told Mrs Sanderson that her comments were inappropriate and explained the cultural significance of henna. Ms 2 had also explained that midwives at this hospital were well aware of the diversity of the patients and the use of henna would have been familiar to them in this setting. Despite this, Mrs Sanderson continued to make the comments in front of a student midwife, patients and doctors. The panel was of the view that Mrs Sanderson's actions and behaviours fell far short of what is expected of a registered midwife and was serious enough to amount to misconduct.

With regards to charge 1b, the panel considered this to be a serious failing. The panel was of the view that the comments Mrs Sanderson made, while grabbing Patient A1's hands, to be far below the standards expected of a registered midwife. Additionally, it demonstrated Mrs Sanderson's lack of sensitivity to the cultural significance of henna and was serious enough to amount to misconduct.

With regards to charge 1c, the panel considered this to be a serious failing. It bore in mind that Mrs Sanderson's comments were an inappropriate assumption that had nothing to do with Patient A1's clinical care. The panel reminded itself that it had determined this comment to be racially discriminatory and was serious enough to amount to misconduct.

With regards to charge 2, the panel took account of the NMC Guidance "How we determine seriousness". Under the heading "discrimination" it stated:

"…We've made clear that no form of discrimination including, for example, racism, should be tolerated within healthcare. Discriminatory behaviours of any kind can negatively impact public protection and the trust and confidence the public places in nurses, midwives, and nursing associates. We therefore take concerns of this nature seriously regardless of whether they occur in or out of the workplace. These concerns may suggest a deep-seated problem with the nurse, midwife or nursing associate's attitude, even when there's only one reported complaint.

When a professional on the register engages in these types of behaviours, the possible consequences are far-reaching. Members of the public may experience less favourable treatment, or they may feel reluctant to access health and care services in the first place. We know that experiences of discrimination can have a profound effect on those who experience it and that fair treatment of staff is linked to better patient care..."

The panel reminded itself that it had already determined that Mrs Sanderson's comments in charge 1c were racially discriminatory. Mrs Sanderson comments were referring to the characteristics of someone based on their ethnic origin. It was clear to the panel that this was a serious departure of the standards expected of a registered midwife and was serious enough to amount to misconduct.

In considering charge 3, the panel looked at each sub-charge individually. However it bore in mind that collectively the sub-charges formed part of one conversation that took place in the same instance on 20 April 2017.

With regards to charge 3a and 3c the panel was of the view that individually, these comments in different circumstances to this case could be seen as not sufficient to amount to misconduct. However, taking into account the context of the entire conversation with Patient B, the panel also bore in mind the evidence of Ms 4 who was a direct witness. She stated that the tone in which Mrs Sanderson used these comments lacked respect. It also

bore in mind that this was the first time Mrs Sanderson would have met Patient B and did not introduce herself to Patient B and went straight into the questions described in charges 3bi, 3bii and 3biii.

With regards to charge 3bi, 3bii and 3biii the panel considered that the comments made by Mrs Sanderson were inappropriate and unnecessary. It had heard evidence from Ms 1 where she stated that any issues regarding Patient B's language needs would have been addressed at her booking appointment and documented for any midwives involved in her subsequent care.

The panel also took account of the impact the comments had on Ms 4 and her patient who overheard the conversation between Mrs Sanderson and Patient B. Ms 4, in her oral evidence, stated that she was embarrassed by the context, tone and behaviour of Mrs Sanderson's interaction with Patient B. Ms 4 also stated that both her and her patient were stunned by what they overheard. She stated that Patient B may not have understood what Mrs Sanderson was saying to her, but would have understood the tone with which it was said.

Taking into account the context of the entire conversation, it determined that Mrs Sanderson's conduct in charge 3, as a whole and its sub-charges individually, fell far short of the standard expected of a registered midwife. The panel determined that this was serious enough to amount to misconduct.

With regards to charge 4, the panel again took account of the aforementioned, NMC Guidance "How we determine seriousness". The panel reminded itself that it had already determined that Mrs Sanderson's comments in charge 3bi, 3bii and 3biii were racially discriminatory. It was of the view that any nurse or midwife involved in racially discriminatory behaviour clearly has fallen far short of the standard expected.

The panel also took account of the evidence of Ms 4 who stated that if she did not take action regarding this incident, then it would have been as if she had made the remarks

herself. It considered that if this was the impact Mrs Sanderson's conduct had on Ms 4, a registered midwife, then this could have the same effect on other midwives. The panel determined that this was serious enough to amount to misconduct.

The panel considered that when charges 1 to 4 were viewed collectively these instances showed a pattern of a lack of kindness or respect for colleagues and patients, and a lack of professionalism in the workplace. It was mindful that this was a setting where patients were vulnerable, by virtue of their pregnancy, from diverse and varied backgrounds and the comments were made at a time when Mrs Sanderson was a band 6 midwife, and a senior member of staff. Additionally, the comments described in the charges were inappropriate, unnecessary and said in front of colleagues, a student midwife and patients. Viewed both individually and cumulatively, the panel therefore considered that charges 1 to 4 in this case amounted to a significant departure from appropriate standards and was serious enough to amount to misconduct. It also considered that Mrs Sanderson's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.3 avoid making assumptions and recognise diversity and individual choice

1.5 respect and uphold people's human rights

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

To achieve this, you must:

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

7 Communicate clearly

To achieve this, you must:

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

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

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

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

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

The panel then considered charges 6c and 7 which related to clinical care.

With regards to charge 6c the panel reminded itself that Mr 10, in his expert report stated that Mrs Sanderson's recording of a pulse rate of '63' at 21:45 was an anomaly as the previous reading was taken at 18:25 was '144'. As a result, Mrs Sanderson recorded a MEOWS score of 4 when it should have been 7.

In light of this, the panel found that Mrs Sanderson had failed to provide adequate care for Patient A2 by failing to record an accurate pulse rate. In the panel's view, this was a departure from the standard expected of a registered midwife.

The panel reminded itself of Mr Justice Collins in Nandi v GMC [2004] EWHC 2317 (Admin) who stated that:

"the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

The panel bore in mind the contextual background of the situation. It took account of the evidence of Ms 5 who had stated that this shift was very busy and described it as unprecedented with a high number of patients and an inadequate number of staff. It noted that that Mrs Sanderson was the only midwife in this very busy triage. Also, Mrs Sanderson was only responsible for Patient A2's care for a short period of time, just over two hours. Additionally, Patient A2's situation was not a pregnancy related issue. The subsequent referral, to the surgical team, is not a midwife decision but an obstetrician decision. It also noted that as a registered midwife, Mrs Sanderson responsibility was to escalate the anomaly which she did, albeit with the incorrect MEOWS score.

The panel bore in mind that the errors, leading to the tragic circumstances of this case, were perceived by the Trust as being related to obstetric and surgical decision making, rather than that of the midwives involved. The panel took into account that the harm suffered by Patient A2 was not attributed to the failings in Mrs Sanderson's care provision.

Accordingly, whilst the panel considered Mrs Sanderson's actions to be a significant departure from the standards expected of a registered midwife, given the contextual background in this particular charge, it was of the view that her actions would not be considered deplorable by fellow practitioners. This did not amount to misconduct.

With regards to charges 7a and 7b, the panel considered that these are errors which did fall short of the standards expected of a registered midwife. The panel noted that accurate record keeping is an important part of the midwife's role but it noted the context of the shift and Mrs Sanderson's admission at a local level that her records were brief and succinct. Mrs Sanderson was the only midwife in triage, on a very busy shift. Despite this, the observations were completed, the obstetric registrar was informed of the MEOWS score of 4 and the observations were repeated 30 minutes later.

In the context of the shift, described by Ms 5 as unprecedently busy, the panel bore in mind that the errors made by Mrs Sanderson did not affect the care provided to Patient A2. The panel was of the view that Mrs Sanderson's actions in relation to charges 7a and 7b individually or collectively would not be considered deplorable by fellow practitioners. This did not amount to misconduct.

Decision and reasons on impairment

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives

and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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) …'

For reasons already set out above in relation to misconduct, the panel considered that limbs a, b and c were engaged by Mrs Sanderson's misconduct in this case.

The panel concluded that Mrs Sanderson had in the past acted so as to put patients at unwarranted risk of harm. It took account of the NMC Guidance "How we determine seriousness" and was of the view that her racially discriminatory comments could have caused patients emotional harm. As a result, clients may take risks with their own health and wellbeing to avoid treatment or care from Mrs Sanderson which could cause physical harm. The panel determined that Mrs Sanderson's failings breached fundamental tenets of midwifery practice. Further her misconduct has brought the midwifery profession into disrepute as the panel has heard evidence of the impact Mrs Sanderson's comments have had on colleagues, doctors and patients. In the panel's judgement, the public do not expect a midwife to act as Mrs Sanderson did as they require midwives to adhere at all times to the appropriate professional standards and to safeguard the health and wellbeing of patients.

The panel however recognised that it had to make a current assessment of Mrs Sanderson's fitness to practice, which involved not only taking account of past misconduct but also what has happened since the misconduct came to light. The panel had regard to the case of *Cohen* and considered whether the concerns identified in her midwifery practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether she had provided evidence of insight and remorse.

Given the nature of the misconduct, it also considered the NMC Guidance "How we determine seriousness". Under the heading "Discrimination, bullying, harassment and victimisation" it states:

"…To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition..."

With regards to insight the panel noted that within Mrs Sanderson's local statement she recognised that calling the use of henna "silly" was a poor choice of words. She further stated that she would not knowingly make derogatory comments about a patient.

With regards to charge 3, Mrs Sanderson stated:

"…I do try to stress the importance upon women the importance of learning the language of their adopted country for their own safety. Depending on others to be their voice may lead to vulnerability through manipulation. It also means their children may have reduced communication skills when commencing school... I did ask why she hadn't chosen to live in a French speaking country, not something I had asked a patient before, but I think it was borne of the apprehension of expecting difficulty in establishing a dialogue with the patient. However, this was not the case, as she understood more than she spoke. She had experienced all the procedures previously, so the language line was not required..."

However, the panel noted that Mrs Sanderson demonstrated very little insight into the effect her comments and the incident had on patients, colleagues or the profession.

The panel considered whether Mrs Sanderson's misconduct is capable of remediation, whether it has been remediated, and whether there is a risk of repetition of similar concerns occurring at some point in the future.

The panel was of the view that racial discrimination was very difficult to remediate. Despite this, it had no evidence before it that Mrs Sanderson had taken steps to strengthen her practice and remediate the concerns identified. It had no evidence of any equality and diversity training undertaken by Mrs Sanderson and no acknowledgement that her comments were racist. It noted that within her local statement, Mrs Sanderson apologised and said her comments were a 'poor choice of words'. However, the panel had no evidence of remorse and no mention of the impact her comments had on patients, colleagues or the profession.

The panel bore in mind that the comments described in charges 1 to 4 were made over a period of time and repeated despite being spoken to by colleagues about the impact they had. It was of the view that this was indicative of deep-seated attitudinal issues.

In the absence of insight, remorse or evidence that Mrs Sanderson has taken any action to ensure that similar comments or discriminatory language will not be used again, or why such comments are discriminatory, the panel is of the view that there is a risk of repetition. The panel therefore 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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel was satisfied that having regard to the nature of the misconduct in this case, "*the need to uphold proper professional standards and public confidence in the profession would be undermined*" if a finding of current impairment were not made. It was of the view that a fully informed member of the public would be seriously concerned for patients in Mrs Sanderson's care due to her racially discriminatory comments should she be permitted to practice as a registered midwife in the future without some form of restriction.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Deasy submitted that it was the view of the NMC, on application of the sanction guidance and severity of the charges found proved, that the most suitable and appropriate sanction in this case is a striking off order.

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

Ms Deasy submitted that the misconduct in this case is too serious to take no action. She also submitted that a caution order would not be suitable as Mrs Sanderson presents an ongoing direct risk to patients due to her attitudinal concerns.

Ms Deasy submitted that the concerns are of a particularly serious and sensitive nature, relating to discrimination, and a failure to treat members of the public with kindness and respect. This raises very serious attitudinal concerns relating to Mrs Sanderson's

professionalism. She submitted that there are no conditions of practice that could address the concerns in this case or satisfy the public interest.

Ms Deasy submitted that a suspension order would not be appropriate. She submitted that Mrs Sanderson's conduct suggests serious attitudinal issues, underpinned by concerns surrounding her professionalism. She submitted that the NMC is clear that discrimination of any form is unacceptable and incompatible with continued registration.

Ms Deasy submitted that a striking off order is the only sanction appropriate in the circumstances. She submitted that there is a substantial concern that public confidence would be drastically undermined by allowing Mrs Sanderson to remain on the register. She also submitted that a striking off order is necessary for the protection of the public.

Decision and reasons on sanction

Having found Mrs Sanderson's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- In the course of 26 days, Mrs Sanderson made racially discriminatory comments to and about two separate patients;
- This pattern of misconduct demonstrates the presence of clear deep-seated attitudinal issues;
- There is evidence of actual distress caused to colleagues due to Mrs Sanderson's behaviour;

- Mrs Sanderson repeated the behaviour a number of times despite being informed of her lack of cultural sensitivity;
- Discriminatory language witnessed by a student midwife and a patient;
- Significant discriminatory language in relation to a different culture and significant failure to show cultural sensitivity which is evidence of a deep-seated attitudinal problem;
- Misconduct which could put patients at risk of harm due to non-attendance because of concerns regarding care from a registered midwife with racially discriminatory views;
- Lack of insight, remorse and evidence of strengthened practice.

In relation to potential mitigating features, the panel also took into account the following:

- Mrs Sanderson acknowledged that some of the words she used were a poor choice and silly, however the panel considered that this did not amount to significant mitigation.

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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Sanderson's practice would not be appropriate in the circumstances. The SG 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 Mrs Sanderson's 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 conditions of practice on Mrs Sanderson's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind that the misconduct identified in this case is not related to clinical concerns. In any event, the panel has no evidence before it of Mrs Sanderson's willingness to undertake training or comply with conditions of practice.

The panel considered that the misconduct identified in this case and the deep-seated attitudinal issues are very difficult to address. Therefore it was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case.

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

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The aggravating factors that the panel took into account were that the misconduct found proved was not an isolated incident. Mrs Sanderson made racially discriminatory comments to and about two separate patients. It was of the view that Mrs Sanderson's

behaviour indicates deep-seated attitudinal problems. Further, Mrs Sanderson lacks insight into her behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Sanderson's actions is fundamentally incompatible with Mrs Sanderson remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took account of the NMC Guidance "Considering sanctions for serious cases". Under the heading "Cases relating to discrimination" it states:

> *"We may need to take restrictive regulatory action against nurses, midwives or nursing associates who've been found to display discriminatory views and behaviours and haven't demonstrated comprehensive insight, remorse and strengthened practice, which addresses the concerns from an early stage.*
>
> *If a nurse, midwife or nursing associate denies the problem or fails to engage with the FtP process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence."*

The panel bore this in mind as it took note of the following paragraphs of the SG:

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

Mrs Sanderson's behaviour was a significant departure from the standards expected of a registered midwife, and is fundamentally incompatible with her remaining on the register.

The panel was of the view that any midwife who displays discriminatory behaviour and a lack of regard to cultural issues raises serious questions about their professionalism. It has found that Mrs Sanderson's behaviour was racially discriminatory, and a serious departure from the standards expected of a registered midwife.

The panel had no evidence before it of any insight from Mrs Sanderson regarding her behaviour or why the comments she made could be discriminatory or harmful to others. The panel found this very concerning considering how long she has been a registered practitioner.

The panel was of the view that the findings in this particular case demonstrate that Mrs Sanderson's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it throughout this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Sanderson's 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 sanction 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.

This will be confirmed to Mrs Sanderson in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Deasy. She submitted that an interim order should be made in order to allow for the possibility of an appeal to be made and determined. She submitted that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.