Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 13 February 2023 - Thursday 23 February 2023
and
Monday 14 August 2023 - Thursday 17 August 2023

Virtual Hearing

Name of Registrant:	**Yvonne Margaret Tasker**
NMC PIN	85B0313E
Part(s) of the register:	Registered Nurse – RN1 Adult Nursing – May 2000 Registered Midwife – May 2000
Relevant Location:	North Lincolnshire
Type of case:	Misconduct
Panel members:	Darren Robert Shenton (Chair, Lay member) Sue Davie (Lay member) Laura Wallbank (Registrant member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Berivan Genc
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter (13 – 23 February 2023) Represented by Matthew Kewley, Case Presenter (14 – 17 August 2023)
Ms Tasker:	Not present and not represented
Facts proved:	Charges 1d to 6 and 8 to 21
Facts not proved:	Charges 1a, 1b, 1c and 7

Fitness to practise:	Impaired
Sanction:	**Suspension Order (12 months)**
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 Ms Tasker was not in attendance and that the Notice of Hearing letter had been sent to Ms Tasker's registered address by recorded delivery and by first class post on 11 January 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was sent to Ms Tasker's registered address on 11 January 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Tasker's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel noted that the Rules do not require evidence that the notice was actually received. It is the responsibility of any registrant to maintain an effective and up-to-date registered address and email address.

In the light of all of the information available, the panel was satisfied that Ms Tasker 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 Ms Tasker

The panel next considered whether it should proceed in the absence of Ms Tasker. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to continue in the absence of Ms Tasker. He submitted that there had been no engagement at all by Ms Tasker with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Mr Kennedy referred the panel to the case law of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 in that the panel should proceed with "utmost care and caution" and there is a duty incumbent on Ms Tasker to engage with the NMC. Therefore, Mr Kennedy submitted that the panel should proceed in the absence of Ms Tasker.

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'* as referred to in the case of *R* v *Jones* and *General Medical Council v Adeogba.*

The panel has decided to proceed in the absence of Ms Tasker. In reaching this decision, the panel has considered the submissions of Mr Kennedy, 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* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Tasker;
- Ms Tasker has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;

- Ms Tasker has not informed the NMC that she has received the Notice of Hearing and has not confirmed that she is content for the hearing to proceed in her absence;
- Ms Tasker has not provided the NMC with details of how she may be contacted other than her registered address and her NHS email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The number of witnesses that are due to attend this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred on 1 October 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.

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

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

Details of charge

That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;

1) At around 19:15:
   a) Following Patient A's second elevated blood pressure/proteinuria reading did not escalate/refer Patient A to consultant led care.
   b) Did not record Patient A's blood pressure reading in the Trust's computer system.
   c) Did not escalate/refer Patient A's second reading of elevated blood pressure/proteinuria reading to;
      i) A Central Delivery Suite Co-ordinator
      ii) An Obstetric doctor.Did not provide/communicate to Patient A, information regarding the necessity of referring her to consultant led care.
   d) Did not record that you had communicated to Patient A, information about the necessity of referring her to consultant led care.

2) Did not record an SBAR review of potential Pre-eclampsia in Patient A's records.

3) Did not record:
   a) A plan of care for/from the Obstetric Team.
   b) A date/time of the intrapartum assessment.

4) Did not record a risk assessment for the appropriate professional lead, in Patient A's records.
5) Before commencing the CTG at around 19:45:
   a) Did not document the fetal heart rate following an assessment with;
      i) A pinnard.
      ii) A handheld dopplex.

6) Prior to discontinuing the cardiotocography (CTG) at around 21:37;
    a) Did not have the CTG assessed by the Obstetric Team.
    b) Did not have the CTG assessed by a Senior Midwife.

7) Did not ensure that the CTG was reviewed by a colleague/a fresh eyes check was conducted for Patient A at around 20:40.

8) Did not document an assessment when discontinuing the CTG at 21:37.

9) After discontinuing the CTG at 21:37 you worked outside the scope of your practice in that you:
    a) Incorrectly categorised Patient A as being low risk.
    b) Did not request a suitable member of the Obstetric Team to review/categorise Patient A.

10) Did not inform Patient A that she had suffered from a minor antepartum haemorrhage.

11) Did not adequately explain to Patient A why you decided to break Patient A's waters.

12) Did not obtain/record that you had obtained, informed consent from Patient A before breaking Patient A's waters/performing an artificial rupture of membranes.

13) Did not discuss a plan of care with Patient A.

14) Did not explain to Patient A, that Patient A's baby was 'back to back'.

15) Did not conduct/record that you had undertaken, intermittent auscultation at 15 minute intervals once Patient A was confirmed to be in the first stage labour.

16) Did not escalate the absence of a fetal heart rate to the Obstetric Consultant Team within a timely manner.

17) At around 22:15;

a) Did not escalate/discuss Patient A's fresh blood/ante partum haemorrhaging with the Registrar.
b) Did not escalate/discuss Patient A's raised blood pressure with the Registrar.
c) Did not immediately commence a continuous CTG following Patient A's fresh blood/ante partum haemorrhaging.
d) Performed an inappropriate vaginal examination on Patient A.
e) Did not perform an abdominal palpation, prior to the vaginal examination on Patient A.

18) Incorrectly performed an artificial rupture of membranes.

19) Performed an artificial rupture of membranes outside the scope of your practice.

20) Did not press/raise the emergency buzzer when you could not detect a fetal heart rate, in a timely manner.

21) Did not press/raise the emergency buzzer at around 22:15 when Patient A suffered from bleeding/ante partum haemorrhaging.

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

Background

Ms Tasker was registered as a midwife in 1991 and employed by North Lincolnshire & Goole NHS Foundation Trust ("the Trust") where the incidents which led to these charges arose in 2017. Ms Tasker subsequently retired from the Trust in 2019.

Ms Tasker was referred to the NMC by a member of public, (Patient A) following the loss of her baby daughter, who was stillborn on 2 October 2017 at Scunthorpe Hospital. Patient A was booked for midwife led care and following an uneventful pregnancy, without any complication or cause for concern, was admitted at 18:30 on 1 October 2017 for a labour assessment at 40 weeks and 1 day gestation. Patient A was hoping to use hypnobirthing and to have a water birth.

On admission, Patient A was found to be in established labour, but her blood pressure was elevated at 150/100. At the first appointment with a midwife at the start of her pregnancy, her blood pressure was 110/64. On admission, another midwife admitted Patient A at 18:30. She recorded the elevated blood pressure (BP) of 150/100 and detected proteinuria on urinalysis. It is alleged that the presence of these risk factors meant that the labour should have been consultant, rather than midwife led and a care plan should have been documented by the Obstetric Team (OT). Transfer of care of Patient A to Ms Tasker took place at 19:15.

At 19:15 hrs, a second elevated blood pressure (BP) reading of 135/95 was recorded by Ms Tasker. It is alleged that Patient A's condition was not escalated, as it should have been in that the identified risks were not reported to the OT in accordance with the Trust Guidelines. It is alleged the OT should have reviewed Patient A and documented a plan of care for her, which should have been discussed with Patient A and a transfer to consultant led care should have taken place. It is alleged that the method of monitoring fetal wellbeing should have been determined by the OT.

Ms Tasker commenced a Cardio-Tocograph (CTG) at 19:45. The Central Delivery Suite Coordinator (CDSC) reviewed Patient A at 19:45 and documented an agreed plan of care, recording that the Doctors were aware of the plan. It is alleged that the OT had not reviewed Patient A as per the Trust guideline. Although Patient A 's blood pressure had reduced to 123/80 by 19.45, it is alleged that she was not assessed by the OT and therefore the OT did not confirm if Patient A was suitable to be treated as low risk and be transferred back to midwife led care.

At 21:37, the CTG was discontinued by Ms Tasker and it is alleged that she re-categorised Patient A as low risk. The fetal heart rate (FHR) was auscultated at 22:00. Ms Tasker recorded at 22:15 the presence of a small trickle of fresh blood from the vagina (antepartum haemorrhage) (APH). She then undertook a vaginal examination (VE) to assess progress of labour and performed an artificial rupture of membranes (ARM). She stated verbal consent was given for the ARM, but this is refuted by Patient A.

It is alleged that Ms Tasker did not escalate the APH. It is alleged that at this stage an ARM was not clinically indicated. Prior to the VE or ARM Ms Tasker was required to palpate the abdomen and assess FHR, but allegedly failed to do so.

Following the ARM, Ms Tasker was unable to detect Patient A's baby's FHR around 22:15. It is alleged that this should have been considered as an obstetric emergency and the emergency call bell in the delivery room should have been used to summon immediate assistance. It is alleged that Ms Tasker failed to recognise this as an obstetric emergency and delayed for 15 minutes before she sought assistance from the CDSC at 22:30.

At 23:02, the Consultant Obstetrician confirmed that Patient A's baby had died in utero.

The Trust undertook a Serious Incident Investigation (SII) and Root Cause Analysis (RCA) following the death of Patient A's baby.

Decision and reasons on facts

In the absence of Ms Tasker, the panel received no admissions to the charges and as such required the NMC to present its case in respect of all the charges. The panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy on behalf of the NMC.

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:

- Patient A: Patient at Scunthorpe General Hospital (Mother)
- Person B: Husband of Patient A (Father)
- Witness 1: Locum Registrar
- Witness 2: Matron of Obstetrics
- Witness 3: Obstetric Doctor
- Expert Witness: Senior Midwifery Lecturer

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

In dealing with the charges, the panel were mindful of looking at the context of the circumstances of the tragic death of Patient A's baby and were aware that there were other healthcare professionals involved in Patient A's care whose actions or omissions could be called into question in a Trust whose performance was in Special Measures. However, this panel were only concerned with the actions or omissions of Ms Tasker.

The panel considered, what in the circumstances of this case, was meant by the term 'consultant led care'. It had regard to the Trust's "Care of Women in Labour guidelines in all care settings; first, second and third stages". In appendix A of that document, the panel noted the section "Concerns Refer to appropriate medical personnel" which sets out indications for escalating matters to a medical professional.

In the circumstances, therefore the panel understood the term 'consultant led care' to mean a midwife escalating concerns to an appropriate medical professional. This definition which the panel has adopted for itself received support from the evidence provided by Witness 2. During panel questions when asked what you would see in patient records to know if the consultant led care was in place, she replied:

> *"…discussed with registrar and assessment as they got the involvement of the doctor."*

Therefore, whenever there was a reference to consultant led care, obstetric doctor, obstetric team, Registrar or to obstetric consultant team, the panel took this to mean escalation by a midwife to appropriate medical professional i.e., an obstetric doctor, and therefore considered this to be consultant led care.

The panel were assisted by the expert witness evidence. It considered her evidence to be clear, helpful, and consistent and that she had the appropriate credentials to give her expert evidence. The panel broadly accepted her evidence. During the course of her oral evidence, the expert accepted that she was applying the "gold standard approach" to her assessments and the criticisms that she made.

Her evidence in the main was an interpretation of policy and standards in a generic manner. The panel also accepted the evidence of Witness 2 who, although not an expert in her own right, was able to provide the local context in which this Trust operated.

The evidence of the expert witness was that if something was not documented, "*it did not happen".* The panel considered that, whilst an action may not be documented to a required standard, there may have been other evidence of the matter to enable it to determine that the action had taken place.

The panel noted that significant time has passed since October 2017. Where there was conflicting evidence from the same witness, the panel generally placed more weight on evidence that was the most contemporaneous (e.g., Patient A's records and the statements made to the Trust by those involved in the care of Patient A and her baby soon after the event), than it did on later evidence, recognising how time affects memory and recall.

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

Charge 1a

> "That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;
>
> 1) At around 19:15:
>
> a) Following Patient A's second elevated blood pressure/proteinuria reading, did not escalate/refer Patient A to consultant led care"

In reaching it decision, the panel took into account all of the evidence before it and noted that Ms Tasker came on duty at 19:15 taking over the care of Patient A from the midwife who had booked Patient A into the labour ward.

The medical records clearly indicate two consecutive raised BP readings, the second BP reading of 135/95 was recorded at 19:15 by Ms Tasker and documented in Patient A's notes. There was evidence in Patient A's notes that when admitted onto the labour ward at 18:30hrs, that she had proteinuria. The evidence of the expert witness was that the second consecutive high blood pressure reading in conjunction with proteinuria should have led to a referral to the OT.

In considering the totality of Witness 1's oral evidence and the statements she had made during the trust investigation and latterly to the NMC, the panel identified an inconsistency in her written accounts in respect of the blood pressure readings. In her statement to the NMC, and her oral evidence to the panel, there was mention of only the high blood pressure reading of Patient A on admission. However, in her Trust Statement dated 28 October 2017, Witness 1 acknowledged the references to Patient A's two high blood pressure readings and stated that she was aware of the issues concerned.

Witness 1's Trust Statement contained the following:

> *"I was informed about Patient A at around 19.30 of 1 October 2017. I was told by the midwife she was 40+1/40 primigravida. …….Her admission blood pressure was 150/100 at 18:30. On abdominal examination by the midwife, strong contraction was palpated. On vaginal examination (VE), her cervix was 6cm dilated with bulging membrane. Rpeated blood pressure at 19:30 was 135/95. There was 1+ proteinuria. I verbally told the midwife to insert a cannula and perform blood tests to exclude pre-ecamlampsia. I also verbally told the midwife that if the blood pressure remained raised she would need an artificial rupture of membrane (ARM). She had a repeated blood pressure at around 20:09. It was 123/80. The midwife informed me and I verbally told her that as it seemed to have settled down we did not have to proceed to ARM at this stage…she had another blood pressure reading checked at 20:55. It was 132/84. I had reviewed her blood results then which did not suggest pre-eclampsia."*

The panel noted that the CDSC had written in the patient records at 19.45:

"*Coordinator review by myself [CDSC]*"

and references raised blood pressure and proteinuria. She also adds information about the plan which reflected what was contained in Witness 1's Trust Statement.

The panel also noted in CDSC's Trust Statement dated 28 October 2017, the entry at 19:45 where she states that:

> *"[Witness 1] was aware of the situation as informed by Ms Tasker, the plan for ARM if BP does not settle or abnormal blood results or CTG concerns".*

The panel considered the evidence provided by the expert witness who stated that:

…" Midwife B should have recognised that the identified risk of raised BP and proteinuria required appropriate referral as per national guidelines (NICE 2014… and Trust guidelines) to an obstetric doctor for review of care, and that transfer of care was required to Consultant led care and that this should be documented in the records."

Based on the information before the panel, it is satisfied that Ms Tasker did escalate the second elevated blood pressure and proteinuria to the relevant doctor, Witness 1, at around 19:30. The panel carefully considered the wording of the charge which alleges, "*At around 19:15…."* and it determined that, in the context of moving Patient A to Room 3 between 19:15 and 19:30, escalating to Witness 1 at 19:30 was reasonable.

In the circumstances, the panel were satisfied on the balance of probabilities that Ms Tasker did escalate the elevated blood pressure and proteinuria to both the coordinator and appropriate medical personnel (doctor) adopting the panel's interpretation of the definition of "consultant led care".

What was not clear from the medical records, nor from the Trust investigation, was the formal status of Patient A at any time during her care in labour as being under ‘consultant led care’.

This charge is found NOT proved.

Charge 1b)

> “That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;
>
> 1) At around 19:15:
>
> b) Did not record Patient A’s blood pressure reading in the Trust’s computer system.”

Based on the information before the panel, it determined that the charge relates to blood pressure readings but the evidence all referred to blood test results being entered on a computer system.

The panel heard evidence from Witness 2 that the local electronic record system was called Web V where patients’ blood test results would be recorded and Modified Early Warning Score (MEWS) charts would be used to record the blood pressure. Witness 2 told the panel that the paper MEWS charts were uploaded to WEB V at a later date following the discharge of the patient.

As there is no evidence of a requirement to record blood pressure in the Trust’s computer system, the panel found this charge not proved.

This charge is found NOT proved.

Charge 1c

"That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;

1) At around 19:15:

c) Did not escalate/refer Patient A's second reading of elevated blood pressure/proteinuria reading to;

i) A Central Delivery Suite Co-ordinator
ii) An Obstetric doctor.

The panel had regard to the evidence it considered and its decision in relation to charge 1a. It determined for the reasons contained within its decision on 1a, that Ms Tasker did escalate Patient A's blood pressure reading and proteinuria to the CDSC and an obstetric doctor. Therefore, the panel determined that this charge was not proved.

This charge is found NOT proved.

Charge 1d)

"That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;

1) At around 19:15:

d) Did not provide/communicate to Patient A, information regarding the necessity of referring her to consultant led care."

The panel considered that Ms Tasker had a requirement to communicate with Patient A about the necessity of referring her to consultant led care, based on the evidence of both the expert witness and Witness 2. Both witnesses were clear that any patient should be made aware of any risk factors and the fact that this had been escalated to the OT.

The panel considered Patient A's evidence that the only information she was provided by Ms Tasker was that she could not enter the birthing pool as her blood pressure was raised. The panel also considered Person B's evidence who stated that there was little discussion between them, and Ms Tasker did not make them aware of any concerns. Both Patient A and Person B stated that if they knew there were any concerns, they would have changed their birthing plan immediately. There was no entry in the medical record to indicate that Patient A had been made aware of the necessity to raise her care to being 'consultant led'.

Both witnesses provided consistent accounts in that the environment was "calm" and there appeared to be no cause for concern apart from the elevated blood pressure which prevented Patient A having a waterbirth. When asked directly in evidence, they said they were not told about the necessity to refer Patient A to consultant led care. The panel noted that the medical records indicate that a plan of care was discussed between Ms Tasker and Witness 1 before the cannula had been sited and blood tests taken.

The panel noted that Ms Tasker does not comment in her Trust statement about the necessity of referring Patient A for consultant led care.

It was clear to the panel that there must have been some type of discussion in relation to the plan of care, what was going to take place and the proposed actions by Ms Tasker, particularly as patient had a cannula inserted. However, the panel found that there was no evidence of direct conversation with Patient A about the requirement for consultant led care. When asked directly, Patient A and Person B were clear that they had not received the communication regarding the necessity of consultant led care and they were unaware of any increased risk.

The panel relied on the accounts of Patient A and Person B whose evidence was tested on oath and so the panel determined on the balance of probabilities that the information specific to the charge of 1d was not communicated.

This charge is found proved.

Charge 1e)

> "That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;
>
> 1) At around 19:15:
>
> e) Did not record that you had communicated to Patient A, information about the necessity of referring her to consultant led care.

The panel noted the evidence of Witness 2 and the expert witness that clear, accurate and complete documentation in patient records was a requirement of both national and local guidelines and policies. In this instance, the documented record would need to include information about the risks, reasons why Patient A had been referred to consultant led care and confirmation that Patient A has been fully informed of this.

Having considered the patient records, and taking into account its determination in charge 1d, the panel found that there was no record of communication to Patient A specifically about necessity of referring her to consultant led care.

This charge is found proved.

Charge 2

"Did not record an SBAR review of potential Pre-eclampsia in Patient A's records."

The panel was informed by the expert witness that a Situation Background Assessment Recommendation (SBAR) was "an easy to use, structured form of communication that enables information to be transferred accurately between individuals." In oral evidence, the expert witness confirmed that there was no SBAR review in Patient A's records. However, she also stated that what is important is that some form of review is recorded even if it is not an SBAR and there is no evidence of any such review within Patient A's records.

The panel also received evidence from Witness 2 that at the Trust, the SBAR review is recorded by way of a sticker, which should be documented in the medical records, in order to evidence the concise and accurate assessment that has been undertaken in accordance with NICE guidelines.

The panel noted that Ms Tasker in her reflective statement to the Trust accepted that she did not use an SBAR sticker for a review of a potential risk of pre-eclampsia.

There was no evidence of the SBAR sticker within the medical records and the panel therefore found this charge proved.

This charge is found proved.

Charge 3a

"Did not record:

a) A plan of care for/from the Obstetric Team."

The requirement for documenting a clear plan of care is stated within the Trust Guideline for Intrapartum Risk Assessment. Section 4.5. states:

"*When a review has taken place by a doctor from the obstetric team an individual plan of care should be documented, and that plan of care implemented.*"

The expert witness and Witness 2 confirmed that it is the midwife's responsibility to ensure that any plan of care is documented.

The panel considered all of the evidence before it and noted the entry in the medical records at that at 19:30 that state:

"*plan discussed after it was arranged with [Witness 1], Registrar*".

The panel also noted that Ms Tasker stated that a plan was discussed in her Trust statement and reflective piece, but she did not record or elaborate what that plan was. However, the panel noted that the CDSC documented further detail regarding the discussion of the plan of care from Witness 1 upon her review at 19.45 in the medical record.

It was clear that at the time Ms Tasker came on duty at 19:15 Patient A had already been admitted to hospital in labour and that a review of the care plan for Patient A had taken place following a discussion between Ms Tasker and Witness 1 at 19:30. The panel noted that a discussion with the OT had taken place at the obstetric hand over at 21:00. The CDSC but not Ms Tasker, was present at the handover and she documented the plan of care in Patient A's records retrospectively.

The panel was not satisfied that the plan of care recorded within the medical records by Ms Tasker was a comprehensive overview of the aspects of care for Patient A as discussed with Witness 1 at 19:30 and therefore found this charge proved.

This charge is found proved

Charge 3b

"Did not record:

b) A date/time of the intrapartum assessment."

The expert witness told the panel that the Intrapartum Risk Assessment Tool should have been timed and dated at the point it was made, and it was not. The panel also considered the evidence provided by Witness 2 who also confirmed that the date and time of the intrapartum assessment was not recorded.

The panel considered the medical records and noted that there was no date or time of the entry on the Intrapartum Risk Assessment Tool completed by Ms Tasker nor is there any reference made to a risk assessment in the free text records.

This charge is found proved.

Charge 4

"Did not record a risk assessment for the appropriate professional lead, in Patient A's records."

The panel acknowledged the expert witness report referring to the guideline of 'Maternity And Children's Health Records Policy And Procedure For the Completion and Filing Of All Documentation' which states:

'*risk assessment is an ongoing process performed at each contact with a health care professional'.*

The panel also noted within that report under the subheading: 'Failure to escalate to Consultant led care when the clinical signs indicated this was necessary' states that:

…*'there is a need for an ongoing process of risk assessment in terms of who is the lead professional and that this must be documented. There is no documentation within Patient A's records that such a risk assessment had been considered by midwife B [Ms Tasker]'.*

The panel noted that Witness 1 was the appropriate medical professional at that time, following the escalation to her by Ms Tasker at 19.30. The panel determined that as soon as Ms Tasker had the discussion with Witness 1, there was a requirement for a risk assessment to be carried out and documented.

The panel also noted that there was no SBAR review and no plan of care, which suggests no risk assessment was carried out by Ms Tasker as it should have been. There was neither the appropriate professional lead recorded in the notes nor the risk assessment. Therefore, the panel determined that Ms Tasker's omissions were a failure to follow Trust guidance.

The panel considered that this charge was poorly worded and not clear. It went on to consider whether the requirement to record a risk assessment was to identify an appropriate professional lead or to record a risk assessment on behalf of the appropriate professional lead. Irrespective of the intention of the charge as drafted, the panel determined that in either case there was no adequate risk assessment recorded and, on that basis, found the charge proved.

This charge is found proved

Charge 5a

"Before commencing the CTG at around 19:45:

a) Did not document the fetal heart rate following an assessment with;

i) A pinnard.

ii) A handheld dopplex."

The expert witness explained to the panel the importance of a pinnard or dopplex being used prior to commencing a CTG to ensure that it is the fetal heart rate is being recorded and not, for example, the maternal pulse. This was reiterated in Trust guidelines for CTG Monitoring and confirmed by Witness 2.

The panel noted in Patient A's records that an entry at 19.40 states:

"CTG commenced with Patient A's verbal consent. FH 145bpm" and is signed by Ms Tasker. It does not state how the heartbeat was obtained and reads as if it was from the CTG. The CTG print out shows the starting heartbeat reading at approx. 145bpm.

The expert witness and Witness 2 stated that there was no evidence of a fetal heart rate being assessed with a pinnard or a dopplex prior to starting the CTG.

The panel noted that Ms Tasker had manually recorded the maternal pulse on the first page of the CTG trace. However, the panel determined that this alone was not in accordance with Trust guidelines, which required that the fetal heart rate was also recorded using a pinnard or dopplex before commencing the CTG. The panel determined that there was no evidence that Ms Tasker had assessed the fetal heart rate with a pinnard or dopplex prior to commencing the CTG.

The panel considered Ms Tasker's reflection that she carried out an abdominal palpation and noted that one would normally record with a pinnard and then start the CTG, but there is no evidence of this as there is no entry within the medical records as to when the palpation commenced.

Patient A and Person B provided evidence consistent with their statements to the NMC. They were unable to recall the use of any other piece of equipment prior to the CTG being applied.

In the absence of evidence to indicate how the FHR had been obtained before commencing the CTG, the panel determined that on balance, this allegation was found proved.

This charge is found proved.

Charge 6

"Prior to discontinuing the cardiotocography (CTG) at around 21:37;

a) Did not have the CTG assessed by the Obstetric Team.

b) Did not have the CTG assessed by a Senior Midwife."

In reaching its decision in respect of this charge, the panel considered both charges 6a and 6b together as the evidence presented to it related to both.

The panel noted that the OT had been made aware of Patient A's high blood pressure readings and proteinuria initially at 19.30, as evidenced by Witness 1's Trust statement and Patient A's records and then again at the time of the obstetric handover at 21.00 as evidenced by the Trust statements of Witness 1, Witness 3 and the CDSC and Patient A's records. Adopting its interpretation of Consultant Led Care, the panel determined that Patient A was still under consultant led care at 21:37.

Witness 2 gave evidence to the panel that, due to the risk factors with Patient A and the fact that she should have been under consultant led care, there should have been an assessment of the CTG prior to discontinuation by the coordinator and then, if necessary, the doctor.

The expert witness informed the panel why it would have been important for Patient A's CTG to be assessed by a doctor prior to discontinuing the CTG, recognising that the CTG readings must be considered in the context of a holistic view of the patient and this patient should have been considered as high risk recognising the raised blood pressure and proteinuria. She also informed the panel that you can have different interpretations of CTG readings by different people.

The panel heard evidence from Witness 3 who was on duty from 21.00 and present at the obstetric handover from Witness 1 at that time. Witness 3 stated that after the obstetric handover, she had no contact with the patient until 22:35 when she was bleeped by CDSC, because Ms Tasker was unable to detect Patient A's baby's fetal heartbeat.

The panel noted that Patient A's records show that at 21.37:

> *"CTG discontinued as blood result normal"*

and this is signed by Ms Tasker. In addition, the panel noted the entry in Patient A's record by the CDSC at 21.00, when the obstetric handover took place with the CDSC present (written in retrospect at 04.00 on 2 October 2017) which stated:

> *"PLAN – advised a further BP reading in 30 mins if remains normal and CTG remains normal PLAN to discontinue CTG ….."*

The panel noted the evidence in the Trust statement of the CDSC, dated 28 October 2017. Timed at 21.45, she states that:

> "*At approximately 21.45 discontinued CTG shown to me….".*

The panel determined that there was evidence that Witness 3 was not consulted prior to the CTG being discontinued recognising she had no involvement with Patient A until 22.40 and the CTG was discontinued at around 21:37. This is supported by there being no reference in Patient A's records to an assessment being undertaken by the OT, nor on the CTG print out itself which is only signed by Ms Tasker.

The panel also determined that the CTG was not assessed by the CDSC (the Senior Midwife who was the Central Delivery Suite Coordinator). There is evidence in Patient A's records that the CDSC was shown the report after the CTG was discontinued but not before. There is no evidence in Patient A's records of any assessment being undertaken.

The panel considered that the evidence from Patient A and Person B, that no-one else was in the room around the time of the CTG being stopped, supported the panel's determination.

The panel took into account that there was a discussion at the obstetric handover at 21.00 and this included consideration of discontinuing the CTG. However, it was clear from the evidence of Witness 2 and the expert witness that this did not mean that an assessment was not required by a doctor or the CDSC prior to it being discontinued. In addition, the panel considered the evidence of the expert witness highlighting the variability of the CTG between 21.00 and when it was discontinued. She stated that this non reassuring feature on the CTG, combined with the previous high blood pressure and proteinuria meant that the CTG should have been reviewed by a doctor and continued. This was supported in evidence from Witness 2 and Witness 3 who both said the CTG should have been continued, even if stopped temporarily to enable a toilet break.

The panel found this charge proved as to both 6a and 6b, there was no evidence that Ms Tasker had the CTG assessed by either the Registrar or the CDSC prior to discontinuing it at 21:37.

This charge is found proved

Charge 7

> **"**Did not ensure that the CTG was reviewed by a colleague/a fresh eyes check was conducted for Patient A at around 20:40."

The expert witness in her report referred to the NICE guidelines and the Trust Guidelines which state that a systematic assessment of the CTG should be made every hour.

She also included an extract from the Trust Guidelines "Cardiotacograph (CTG) for continuous electronic fetal monitoring (EFM) Guideline" dated 28/6/17:

> *"Every 2 hours the practitioner providing the care must seek the assistance of a colleague (midwife or doctor) to systematically review the CTG trace with them. This must be documented as "Fresh Eyes" on the CTG interpretation sticker."*

The expert witness told the Panel that a ‘fresh eyes’ review is a second assessment of the interpretation of the CTG independent of the attending midwife’s review, that provides reassurance that the interpretation is correct, and it is considered to be an important part of maintaining the safety of the unborn baby in labour.

In her oral evidence, the expert witness stated that a ‘fresh eyes’ review should have taken place at 20:40 hours however, the first entry within the medical records of a CTG review taking place occurred at 20:55 and is contained in the form of a risk assessment sticker. The expert witness informed the panel that the facility to indicate that a ‘fresh eyes’ review has taken place is for a second signature to be made in the relevant box on the sticker or in a time specific entry in the medical records. She informed the panel that, in this case, neither appear.

Witness 2, in her NMC statement said:

> “…*it does not appear as though a fresh eyes check was conducted for Patient A. This should have occurred approximately 20.40”*

In oral evidence, Witness 2 confirmed that ‘fresh eyes’ was part of the Trust policy and that Ms Tasker should have had fresh eyes on the CTG trace every hour.

The panel considered the Trust CTG Guidelines in effect at the time of the charge. From these, it was clear that a ‘fresh eyes’ review is required every 2 hours as stated in the extract from the Trust CTG Guidelines in the expert witness report.

The panel also considered the evidence of Witness 2 in her NMC statement and in her oral evidence which differed from the Trust CTG Guideline in force at the time. It determined that as her NMC statement was made on 1 February 2021 and her oral evidence was given in this hearing, it is possible that Trust CTG Guidelines have been updated since the version in place at the time and therefore the panel preferred to rely on the Trust CTG Guidelines in force at the time.

The panel noted there is a CTG review sticker entry documented by Ms Tasker at 20:55. In the process of what is otherwise continuous monitoring of the CTG, the panel determined that it is likely that the review of the CTG is 15 minutes late. It noted that the "fresh eyes" box on the sticker had not been signed but the panel determined that as the CTG was commenced at 19.40, following the Trust CTG Guidelines, Ms Tasker did not have a duty to have "fresh eyes" until 21.40, 2 hours after the CTG was commenced.

The panel therefore found this charge not proved.

This charge is found NOT proved.

Charge 8

"Did not document an assessment when discontinuing the CTG at 21:37."

The panel considered its findings in Charge 6 where it determined that there had been no assessment by the OT or CDSC prior to discontinuing the CTG. For this charge, it went on to consider whether Ms Tasker had documented any assessment she had completed.

The panel heard from both Witness 2 and the expert witness who were clear that there is a requirement to document a full systematic assessment of the CTG before it is discontinued.

The panel noted that the free text entry documented in the patient records at the time of the discontinuation of the CTG (at 21.37) was:

"*CTG discontinued as blood results normal*" and this entry was made by Ms Tasker.

Additionally, the panel noted the handwritten entry by Ms Tasker on the CTG trace at it its conclusion which stated:

"*discontinued as now in low risk category*".

The evidence of the expert witness and Witness 2 was that neither of these constituted a systematic assessment of the CTG when it was discontinued, when one should have taken place.

The panel determined that this charge is found proved.

This charge is found proved.

Charge 9a

"After discontinuing the CTG at 21:37 you worked outside the scope of your practice in that you:

a) Incorrectly categorised Patient A as being low risk.

The panel heard evidence from the expert witness and from Witness 2 that Patient A should have been considered high risk and, therefore, any decision relating to Patient A's care should be in consultation with the OT.

The panel took into account its view at the start of Charge 6, that Patient A was under consultant led care.

The evidence from the expert witness, supported by Witness 2, was that the decision to reclassify a patient from high to low risk should be taken by the appropriate medical professional and not by the treating midwife. In doing so, Ms Tasker was acting outside the scope of her practice. Both the expert witness and Witness 2 confirmed that, in any event that Patient A should not be considered 'low risk', due to the associated risk factors of blood pressure, proteinuria and ketones in the urine.

The panel noted that at the conclusion of the CTG, Ms Tasker wrote and signed an entry on the trace which simply stated:

> '*discontinued as now in low risk category'*.

The panel considered the retrospective entry made at 04:00 hrs in Patient A's records timed at 21:00 of CDSC, which states at the end:

> '*plan discussed at handover with [Witness 3] and [the Consultant] agree with plan'*.

There is no entry that indicates that Patient A was categorised as 'Low risk'.

The panel considered the evidence of Witness 3. In her Trust statement, she stated:

> "*I was aware that the patient was in labour but as she was low risk, I was not required to see her*".

In oral evidence, Witness 3 said when questioned that, when receiving handover:

> "*we are dependent on the information given*"

Witness 3 went on to tell the panel that the OT would decide who to see depending on the handover from the previous shift. In further questioning, Witness 3 stated that she was only aware of one high blood pressure reading although she acknowledged it was a long time ago. When asked if two high blood pressure readings and proteinuria being present would make it appropriate for this patient to be on consultant led care, she said "*yes*".

The panel considered that there is a clear distinction between midwife and consultant led care, which is dependent on the presence of risk factors. It was evident from the history of Patient A and the evidence of the expert witness and Witness 2 that Patient A was high risk. To re-categorise a patient from high risk to low risk, is a significant event, which requires a review by the OT and a clear documented rationale.

The entry at 21:37 by Ms Tasker contains no such reference other than confirming the discontinuance of the CTG.

The panel noted in the CDSC's retrospective entry that although a plan was discussed at 21:00 by the doctors and the CDSC and no concerns were identified, this was not documented by Ms Tasker and she should have referred to the doctor on duty to agree a change of risk status and subsequent change in responsibility of care. The panel accepted the RCA Report where it sets out that whilst this was a verbal plan, this should have been documented and include the method of monitoring fetal wellbeing.

The panel noted that although there was a discussion of the plan of care between Ms Tasker and the CDSC, the panel determined that because it was a plan agreed by the OT, the OT should have been involved in the assessment, the decision to re-categorise Patient A's risk level and the decision to discontinue the CTG.

Additionally, Witness 3 stated that had the plan been brought to her, her advice would have been to continue the CTG. The evidence of Witness 3 was that no such discussion took place. It was clear that that there would have been a cause for concern regarding the CTG being discontinued due to the risk factors involved. It was made clear to the panel that a normal labour would be suited for midwife led care, and any deviation from the 'normal' should be referred to consultant led care. Therefore, the panel determined that Ms Tasker had incorrectly categorised Patient A as low risk and that she should have reported back to the OT to make sure that the plan was still appropriate.

Having considered all of the evidence, the panel determined that it was an obstetric role to assess a patient who is high risk with a view to re-categorise to low risk. Therefore, Ms Tasker acted outside the scope of her practice by re-categorising Patient A as low risk herself. In addition, the panel determined that, in light of all the risk factors associated with Patient A, this re-categorisation was incorrect.

This charge is found proved

Charge 9b

> "Did not request a suitable member of the Obstetric Team to review/categorise Patient A."

The panel noted its determination in Charge 9a. The panel had found proved that Ms Tasker had acted outside her scope of practice by independently categorising Patient A as low risk. Therefore, it determined that it followed that she had not requested a suitable member of the OT to review or categorise Patient A when discontinuing the CTG, and therefore acted outside the scope of her practice.

This is charge is found proved.

Charge 10

> "Did not inform Patient A that she had suffered from a minor antepartum haemorrhage."

The panel considered written and oral evidence from Patient A and were of the view that it remained consistent in relation to only finding out about the minor antepartum haemorrhage after reading the Investigation Review. The panel noted the evidence of Person B that he was not informed.

The panel noted the record made in the patient records at 22.15 by Ms Tasker:

> "*Small trickle of fresh blood from vagina seen*. *Discussed with Patient A VE to assess progress of labour. ? for ARM if slow progress – verbal consent obtained – onto back for VE"*

The panel determined that the record, as written, indicates that it was the VE that was discussed and not the APH. This interpretation was supported by Ms Tasker's Trust statement which only referenced her discussing the VE and ARM.

The panel determined that with the record in the patient note and consistency of Patient A and Person B's evidence, it is more likely than not that Patient A was not informed about the APH. Therefore, the panel determined that this charge is found proved.

This charge is found proved

Charge 11

> **"**Did not adequately explain to Patient A why you decided to break Patient A's waters."

The expert witness informed the panel that a patient has a right to have an ARM fully explained to enable the patient to give informed consent, recognising that it is the patient's body and this procedure does increase pain and can increase the risk of complications.

The panel considered the evidence of Patient A and Person B who provided consistent evidence. In her oral evidence, Patient A stated that the decision to break her waters was not explained to her, and she just went along with what Ms Tasker had told her was going to happen. There was no discussion regarding increased pain or the increased risk from complications from performing the ARM. Evidence from Patient A and Person B was that they simply understood it was something that was going to be done as Ms Tasker stated that she:

'was not happy with how things were going' as Patient A's cervix had only dilated by 1cm since admission. They described "*going along*" with the actions of Ms Tasker who did not explain what she was doing.

The panel considered the medical records in relation to this episode of care which were made retrospectively. There is no clear evidence in those records that an explanation was given to Patient A regarding the increased pain and possible increased risk associated with the decision to break her waters nor was there clear evidence in the account given by Ms Tasker in her Trust Statement.

The panel determined that there was no evidence of an explanation to Patient A regarding the ARM and found this charge proved.

This charge is found proved

Charge 12

> "Did not obtain/record that you had obtained, informed consent from Patient A before breaking Patient A's waters/performing an artificial rupture of membranes."

The panel noted its findings in Charge 11. As it had found proved that Ms Tasker did not adequately explain to Patient A why she decided to break Patient A's waters and explain the associated risks, it was clear that consent, even if given, was not informed.

The panel was taken to the medical records by the expert witness who in evidence criticised the entry at 22:15 in Patient A's records as being "insufficient" and not detailing any discussion about the associated risks of an ARM with Patient A prior to the procedure.

The panel therefore found this charge proved in that Ms Tasker had neither obtained nor recorded that she had informed consent from Patient A prior to the ARM.

This charge is found proved

Charge 13

> "Did not discuss a plan of care with Patient A."

Due to the sequence of the charges, the panel considered this charge to relate to a plan of care around the time of the VE and ARM approximately 22:15.

The expert witness outlined to the panel the importance of a plan being explained to a patient and documented in the records. Ms Tasker was planning to do a VE and an ARM and a patient should understand both why and what will happen afterwards, including any associated risk.

The panel considered the medical records and noted that there was no evidence of a plan being documented nor discussed with Patient A by Ms Tasker. Both Patient A and Person B provided consistent evidence in that regard. The panel determined that in the absence of an explanation from Ms Tasker and a detailed record of what took place, the panel accepted the evidence of Patient A and Person B, that a plan of care had not been discussed with Patient A, and therefore found this charge proved.

This charge is found proved

Charge 14

"Did not explain to Patient A, that Patient A's baby was 'back to back'."

The panel noted that there was evidence in the medical records that Patient A's baby was 'back to back' and that Ms Tasker was aware – in the Intrapartum Book 2 completed by Ms Tasker when she took over the care of Patient A, and on the VE sticker in Patient A's records signed by Ms Tasker at 22.15. In the entries, the term "OP" and "ROP" are used respectively, meaning "Occiput-Posterior" and "Right Occiput-Posterior" i.e., 'back to back'.

Witness 2 informed the panel that a baby being 'back to back' can cause slower cervical dilation and more backache and should be discussed with the patient.

Patient A's oral evidence was consistent with her NMC Statement in that she was never informed that the baby was 'back to back'. In her oral evidence, she explained that she had only became aware of what it meant from either the internet or TV programmes.

The panel noted that there is no evidence in Patient A's records of a discussion informing Patient A of the fact that her baby is 'back to back' and what that means. Patient A's evidence was that she still doesn't know what it means but understands that labour can be more difficult.

The panel accepted the evidence of Patient A and therefore found this charge proved.

This charge is found proved

Charge 15

> "Did not conduct/record that you had undertaken, intermittent auscultation at 15 minute intervals once Patient A was confirmed to be in the first stage labour."

In considering this charge, the panel were mindful of Witness 2's evidence referring to the Trusts' intermittent auscultation guidelines and the requirement to record the baby's baseline heart rate every 15 minutes in the first stage of labour.

The guidelines also state that whilst a CTG was applied, it was not necessary for intermittent auscultation to occur at the same time. The panel therefore determined that the times referenced in Witness 2's NMC statement were whilst Patient A was subject to CTG monitoring and therefore not pertinent to this charge.

The panel determined that once the CTG had ceased at 21:37, it was then necessary for intermittent auscultation to occur every 15 minutes as Patient A was still in the first stage of labour. Review of Patient A's records show that the next intermittent auscultation occurred at 22:00 which was 23 minutes after the discontinuance of the CTG. Therefore, it was beyond the 15 minute period required for the intermittent auscultation to have taken place. The panel therefore finds this charge proved.

The panel noted the criticism of the timing of the auscultations in the RCA report and the subsequent criticism by the expert witness who adopted the findings of the RCA report in which it was identified that there were no auscultations for a for a period of 27 minutes. The panel considered this period to be an error as 23 minutes was the actual gap in time according to Patient A's records.

This charge is found proved

Charge 16

> "Did not escalate the absence of a fetal heart rate to the Obstetric Consultant Team within a timely manner."

The panel considered the consistent evidence of the expert witness, Witness 2 and Witness 3. They all stated that, where a FH that could not be detected, this should be considered an obstetric emergency which required immediate escalation and intervention. The panel was informed that emergency buzzers were placed in every birthing room to enable midwives facing such an emergency to call for immediate assistance without the need to leave the patient.

The evidence contained within the medical records written by Ms Tasker retrospectively indicates that at 22:15 hours she was unable to auscultate a FH and at 22.30 she:

> "*Informed [CDSC] of difficulty in obtaining FH*".

This was supported by evidence from the Trust Statement of the CDSC that at 22:30 hours, some 15 minutes later at its shortest time, Ms Tasker came out of the room and asked CDSC to contact the on call obstetric doctor. The CDSC bleeped the on-call obstetric doctor, Witness 3 at 2235. Witness 3 received the bleep at 22:35 and attended immediately at 22:40.

In Ms Tasker's Trust statement, having asked the CDSC to bleep the OT, she stated that she went to find a portable ultrasound scanner thereby leaving the patient unattended.

The panel considered whether the escalation that did occur, 15 minutes after not being able to find Patient A's baby's FH, was considered to be within a timely manner. All of the medical professionals, including the expert witness, who provided evidence to the panel were clear that it was not.

The panel also had regard to the retrospective entry timed 22:15 in Patient A's records made by Ms Tasker stating, "FH 145 bpm" and compared this with the entry signed by Ms Tasker at the same time in the FH section, on the VE sticker, where it stated:

"*unable to hear FH*".

The panel were not able to reconcile this contradiction and received no evidence in that regard but preferred the VE sticker because it was the absence of a fetal heart rate that led to the escalation.

The panel determined that the escalation of the absence of Patient A's baby's FH was not escalated in a timely manner and found this charge proved.

This charge is found proved.

Charge 17a

At around 22:15;

a) Did not escalate/discuss Patient A's fresh blood/ante partum haemorrhaging with the Registrar.

The expert witness in her report stated that:

"*frank bleeding per vagina is abnormal. If this occurs, midwife must consult obstetrician*".

The panel considered evidence of Witness 2 and Witness 3 who both confirmed that the antepartum haemorrhage should have been escalated to an appropriate medical professional at the time, especially in the context of the earlier high blood pressure readings and proteinuria. However, they both confirmed that it had not been escalated.

The panel noted from Patient A's records that the bleeding happened prior to Ms Tasker carrying out the VE and the ARM at 22.15. At 22:30, Ms Tasker informed the CDSC of the APH only when she was informing her of her inability to find a FH. The CDSC in turn informed Witness 3. In her evidence, Witness 3 confirmed that she was not aware of the APH and was only contacted at 22.35 by bleeper due to the inability to find Patient A's baby's FH.

From the records, it is clear that Ms Tasker did not escalate this issue to a Registrar as she should have done. Therefore, the panel determined that this charge is found proved.

This charge is found proved

Charge 17b

b) Did not escalate/discuss Patient A's raised blood pressure with the Registrar.

The panel noted from the medical records at 22:15, that there was no evidence that the maternal blood pressure was raised at that point. However, the evidence of the expert witness was that the raised blood pressure earlier in the evening was a factor which heightened the risk of APH for Patient A and therefore should have been escalated to the Doctor when the APH was escalated.

The panel noted that it had found Charge 17a proved as Ms Tasker had not escalated the APH. In addition, the absence of any evidence in the patient records and from the evidence of Witness 3, the panel determined there was no escalation or discussion with the Registrar in respect of Patient A's blood pressure history as there should have been at the time of the APH.

Therefore, the panel found this charge proved.

This charge is found proved

Charge 17c

"Did not immediately commence a continuous CTG following Patient A's fresh blood/ante partum haemorrhaging."

The expert witness referred to national guidelines and stated that:

"*for a suspected APH continuous monitoring should be commenced straightaway*".

She also stated that Trust guidelines for electronic fetal monitoring also supports commencement of CTG if any risk factors, including vaginal bleeding, develop in labour.

Oral evidence from both Witness 2 and Witness 3 also confirmed that a CTG should have been started immediately following the APH.

The panel determined that the medical records did not indicate that a CTG had been commenced. In addition, the panel noted that in the CDSC's Trust statement, she asked Ms Tasker to start the CTG at 22.30, clearly indicating that it had not already been started when Ms Tasker had noted not finding a FH at 22.15. This was a clear requirement and did not occur as it should have done.

The panel found this charge is found proved.

This charge is found proved

Charge 17d

"Performed an inappropriate vaginal examination on Patient A."

The evidence from the expert witness in relation to the appropriateness of the VE by Ms Tasker was critical in three regards. The first was that it was performed 45 minutes before the recommended 4 hour timeframe for considering progress of dilation. Secondly, it was done following an APH. And thirdly, it should not have been done by Ms Tasker without referral to the appropriate medical professional such as an obstetric doctor, recognising the earlier high blood pressure readings, proteinuria and APH.

In Charge 17a, the panel have already found that there was no escalation or discussion with a medical professional after the APH which was shortly before the VE took place. The panel were satisfied that the VE did take place and was conducted by Ms Tasker according to the entry, made retrospectively, relating to 22:15 found within the medical records. There is no record of any escalation or discussion with any medical professional as there should have been. The panel therefore concluded that it was inappropriate for Ms Tasker to have carried out the VE.

This charge is found proved

Charge 17e

> "Did not perform an abdominal palpation, prior to the vaginal examination on Patient A."

The panel considered the evidence from the expert witness which stated that prior to the performance of a VE, it was always necessary to perform an abdominal palpation. She stated in her report:

> "[*Ms Tasker] failed to perform an abdominal palpation prior to the vaginal examination*".

There was no evidence in Patient A's records that an abdominal palpation occurred prior to the VE at 22:15 and in the later undated reflective statement by Ms Tasker, she recognised her failure in this regard. The panel therefore find this charge proved.

This charge is found proved

Charge 18

"Incorrectly performed an artificial rupture of membranes."

In charge 17a, the panel had determined that, at the point that the ARM was performed by Ms Tasker, she should have already escalated the APH to the OT and she had not. The panel acknowledged that there was nothing to show that the procedure itself was incorrectly carried out. However, by performing the ARM when she did, shortly after the APH, and having not escalated the APH to the OT, Ms Tasker was not correct in performing the ARM.

This charge is found proved

Charge 19

"Performed an artificial rupture of membranes outside the scope of your practice."

The expert witness stated in her report:

"*Midwife B [Ms Tasker] performed an artificial rupture of membranes (ARM). This was not required and it was outside her scope of practice to carry out this procedure in a potentially emergency situation, without a review and plan having been made by a Doctor."*

When Witness 3 was asked about the ARM and whether it should have been a midwife decision, she responded that a doctor should have been consulted prior to the ARM taking place particularly in light of Patient A's additional risk factors of previous raised blood pressure, proteinuria and having experienced an APH.

Therefore, having found Charge 18 proved, the panel determined that as Ms Tasker did not escalate the issue to the OT as she should have done, she acted outside the scope of her practice in performing an ARM.

This charge is found proved

Charge 20

"Did not press/raise the emergency buzzer when you could not detect a fetal heart rate, in a timely manner"

The panel received evidence from the expert witness and from Witness 2 that the inability to detect a FH in a timely manner was an emergency obstetric situation. When asked by the panel what a "*timely manner*" would be, they both responded "*immediately*". The panel was informed that there were emergency buzzers in each birthing room which should be used immediately in emergency situations to summon immediate assistance and ensure the patient is not left alone.

In Patient A's records, the first time it is recorded that there is no FH is at 22:15, as recorded on the VE sticker within Patient A's records and signed by Ms Tasker. At 22:30 (written in retrospect by Ms Tasker), the Patient records state:

> *"Informed [CDSC] of difficulty in obtaining FH".* At 22:30 (written in retrospect by the CDSC) the Patient Records state "*[Witness 3] was bleeped at 22:34 to attend Room 3 due to inability to hear FH following small (10-15ml approx.) APH – I was informed by Y Tasker that she was struggling to find FH abdominally and required scanner to locate FH*".

Both the expert witness and Witness 3 stated that 15 minutes, between 22:15 and 22:30 was not timely.

Evidence from Witness 3, Patient A and Person B confirmed that the emergency buzzer was not used. Witness 3 confirmed that she was contacted by bleeper.

In Patient A's oral evidence, she stated that when Ms Tasker could not find her baby's heartbeat,

“it seemed really strange as she did not seem concerned so there was no panic, no pulling of the emergency cords, she just went to get the machine and the doctor. There was no rush to say she could not find the fetal heartbeat… the process of confirming there was no fetal heartbeat took a very long time... that’s why we were not panicking as there were no sense of urgency, worry or concern…”

In this case, the panel have found that when Patient A’s baby’s FH could not be detected at 22:15, Ms Tasker undertook a series of actions which took approximately until 22:30 before she left the birthing room to contact the CDSC.

The evidence before the panel was that the emergency button was not activated to summon assistance, as it should have been at 22:15. In these circumstances, the panel determined that a 15 minute gap in seeking assistance is not timely and the emergency buzzer should have been activated as soon as Patient A’s baby’s FH could not be detected at 22:15.

This charge is found proved.

Charge 21

“Did not press/raise the emergency buzzer at around 22:15 when Patient A suffered from bleeding/ante partum haemorrhaging”

In considering this charge, the panel received different views about the use of emergency buzzers when a patient suffers an APH.

The evidence of the expert witness, accepting that she was applying the gold standard, was that this was a medical emergency in light of Patient A’s earlier blood pressure history and Ms Tasker should have sought immediate assistance by pressing the buzzer. On the other hand, the evidence of Witness 2 and Witness 3, who work at the Trust, was that while the APH should have been escalated as the panel had previously determined, they have no expectation that the emergency buzzer would or should have been activated in this specific circumstance.

These views did not affect the findings of the panel that factually Ms Tasker did not press the buzzer around 22:15 following the APH. Both Patient A and Person B stated that at no time was an emergency buzzer activated. Witness 3 confirmed that she was contacted by bleeper at 22:35 and only in relation to the absent FH and not the APH which had occurred at around 22:15.

The issue for consideration was whether the emergency buzzer should have been used when the APH occurred.

The panel found this charge to be factually proved, noting that the consequences of this finding were a consideration for a later stage in these proceedings.

This charge is found proved

Interim order

As this case is being adjourned immediately after the panel has made its findings of facts, the panel went onto consider whether to make an interim order to cover the period until this hearing resumes. 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 Ms Tasker's own interests.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim conditions of practice order may be considered at this stage in case Ms Tasker chooses to return to practice in the intervening period, having retired from the Trust in 2019.

Mr Kennedy submitted that some sort of supervision within an interim conditions of practice order would be appropriate. He submitted that Ms Tasker should be required to undertake training in relation to documentation, escalation, and communication. He submitted that a personal development plan may be necessary to cover these areas with regular reviews by the supervisor.

Lastly, Mr Kennedy submitted that a report may be required for any panel to review the interim order.

The panel heard and accepted the advice of the legal assessor concerning Rule 32(5) of the Rules.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved in reaching the decision to impose an interim order.

The panel noted that there are wide ranging facts found proved, no engagement from Ms Tasker with the NMC throughout this case and no evidence of any recent reflection, remorse or strengthening of Ms Tasker's practice. The panel noted that the reflection provided by Ms Tasker to the Trust near the time of these events in 2017, did not demonstrate an understanding of how her failings affected Patient A and Person B, her colleagues and the wider midwifery profession. On that basis, the panel determined that

the likelihood of repetition is very high and therefore, an interim order is necessary for public protection.

The panel also considered the public interest grounds and determined that a fully informed member of the public would be concerned if they knew that a midwife with these serious charges found proved was allowed to practice without restriction.

The panel also considered the expert witness evidence who stated that most charges found proved were extremely serious.

The panel considered making an interim conditions of practice order but determined that it would not be workable or achievable due to the wide ranging charges found proved, the serious nature of those charges, and total lack of engagement with the NMC. Additionally, the panel determined that it would be difficult to formulate workable conditions.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, on either public protection or public interest grounds. The panel therefore imposed an interim suspension order for a period of 12 months in order to cover the period until this hearing is resumed.

Decision and reasons on service of Notice of Hearing on resuming on 14 August 2023

The panel was informed at the start of this hearing that Ms Tasker was not in attendance and that the resuming Notice of Hearing letter had been sent to Ms Tasker's registered email address by secure email on 15 March 2023.

The panel also had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Ms Tasker's registered address on 13 April 2023.

Mr Kewley, on behalf of the NMC, submitted that although there is no confirmation of whether the delivery was successful, the NMC has taken the appropriate steps to bring the resuming dates of this hearing to Ms Tasker's attention. Therefore, he submitted that the service had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the resuming hearing was to be held virtually, including the transcript of the earlier hearing, instructions on how to join and, amongst other things, information about Ms Tasker's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

In the light of all of the information available, the panel was satisfied that Ms Tasker 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 Ms Tasker

The panel next considered whether it should proceed in the absence of Ms Tasker. It had regard to Rule 21 and heard the submissions of Mr Kewley who invited the panel to continue in the absence of Ms Tasker. He submitted that Ms Tasker had voluntarily absented herself.

Mr Kewley submitted that there has been very little change since the last hearing and that there had been no engagement by Ms Tasker with the NMC in relation to these proceedings. As a consequence, he submitted that there was no reason to believe that an adjournment would secure her attendance on some future occasion. He also submitted that there is no good reason for the panel to not proceed in Ms Tasker's absence particularly when considering the time lapsed since the last hearing.

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'* as referred to in the case of *R* v *Jones* and *General Medical Council v Adeogba.*

The panel has decided to proceed in the absence of Ms Tasker. In reaching this decision, the panel has considered the submissions of Mr Kewley, 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* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Tasker;
- Ms Tasker has still not engaged with the NMC and has not responded to any of the letters sent to her about this resuming hearing;
- Ms Tasker has not informed the NMC that she has received the Notice of Hearing and has not confirmed that she is content for the resuming hearing to proceed in her absence;
- Ms Tasker has not provided the NMC with details of how she may be contacted other than her registered address and her NHS email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred on 1 October 2017; and

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

There is some disadvantage to Ms Tasker in proceeding in her absence. Although the outcome letter from the facts stage from the NMC will have been sent to Ms Tasker at her registered address, she has made no response to the facts found proved. The panel determined that the limited disadvantage is the consequence of Ms Tasker's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide further evidence or make submissions on her own behalf. However, the panel will take into account the information previously provided such as Ms Tasker's reflection to the Trust.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Tasker.

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 Ms Tasker'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.

The panel adopted a two-stage process in its consideration. First, the panel determined whether the facts found proved amounted to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must then decide whether, in all the circumstances, Ms Tasker's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Kewley submitted that misconduct is a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He submitted that this is a matter for the panel to consider whether Ms Tasker's practise amounted to misconduct.

Mr Kewley invited the panel to take the view that the facts found proved amount to misconduct and identified the specific, relevant standards of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) which he submitted were breached by Ms Tasker's actions. Mr Kewley submitted that the following provisions of the Code are material:

1 Treat people as individuals and uphold their dignity

> ***1.2*** *make sure you deliver the fundamentals of care effectively.*

2 Listen to people and respond to their preferences and concerns

> ***2.1*** *work in partnership with people to make sure you deliver care effectively.*
>
> ***2.3*** *encourage and empower people to share decisions about their treatment and care.*
>
> ***2.5*** *respect, support and document a person's right to accept or refuse care and treatment.*

4 Act in the best interests of people at all times

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

8 Work cooperatively

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

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

> ***13.2*** *make a timely referral to another practitioner when any action, care or treatment is required.*

Mr Kewley submitted that Ms Tasker had a responsibility to provide safe and effective care to Patient A. He further submitted that Ms Tasker was not able to properly recognise the risk factors and failed to escalate to the appropriate healthcare professionals, which is a fundamental aspect of patient safety.

Mr Kewley referred to the panel's findings of facts in that Ms Tasker failed to obtain informed consent from Patient A, which meant that Patient A was not fully aware of the risks to her and her unborn baby. He submitted that the panel may consider that these facts show a serious departure from the standards expected of a registered midwife.

Mr Kewley identified five categories of concern within the panel's findings of fact, and further identified the charges that fell within these categories. The categories were:

- Escalation and seek senior input;
- Consent and patient communication;
- Acting within scope of practice;
- Assessment of both patient and of risk; and
- Documentation/record keeping

Submissions on impairment

Mr Kewley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Kewley acknowledged Ms Tasker's written reflective piece provided to the Trust, which states that she was now able to recognise that by pressing the emergency bell she would have obtained support sooner. Additionally, in relation to the CTG, commencing it immediately after the APH could have led to identifying concerns sooner. Mr Kewley also acknowledged that Ms Tasker in her response bundle highlighted what she would change in her practice. Mr Kewley submitted that, although Ms Tasker engaged with some reflection with her employer after this incident, what the panel has found proved is a wide ranging set of failures, which touch on different aspects of Ms Tasker's practice.

Mr Kewley submitted that there is no comprehensive insight demonstrated in this case including for example, how Ms Tasker's conduct may have affected Patient A and her family and what the public perception of this case may be. He submitted that there is clearly some attempt to show insight but there is no full insight.

Additionally, Mr Kewley also submitted that there is no evidence of any up to date training or anything to show that Ms Tasker has addressed these concerns. He further submitted that although Ms Tasker did continue to work for some time after this incident there is no evidence to show that she has addressed these concerns to remove the risk of repetition. Therefore, Mr Kewley submitted that the lack of remediation gives rise to a risk of repetition which would place patients at risk of harm. On that basis, Mr Kewley submitted that a finding of impairment is necessary on public protection grounds.

In relation to public interest, Mr Kewley submitted that Patient A became higher risk on admission to the hospital and there were serious failings in the clinical management of Patient A, which is capable of damaging the reputation of the profession. Therefore, Mr Kewley submitted that a finding of impairment is required on the ground of public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Grant* [2011] EWHC 927 (Admin) and *General Medical Council v Meadow* [2006] EWCA *Civ 1390.*

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.

The panel was of the view that Ms Tasker's actions did fall significantly short of the standards expected of a registered midwife, and that Ms Tasker's actions amounted to breaches of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.2 *make sure you deliver the fundamentals of care effectively.*

1.4 *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

2 Listen to people and respond to their preferences and concerns

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

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

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

4 Act in the best interests of people at all times

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

7 Communicate clearly

7.1 *use terms that people in your care, colleagues and the public can understand.*

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

8 Work cooperatively

8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

8.2 *maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

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

8.6 *share information to identify and reduce risk*.

10 Keep clear and accurate records relevant to your practice

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event.*

10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.*

13 Recognise and work within the limits of your competence

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.*

13.2 *make a timely referral to another practitioner when any action, care or treatment is required.*

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.*

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

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.*

20 Uphold the reputation of your profession at all times

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

The panel adopted the approach outlined by the NMC for the purpose of considering if the facts found proved amount to misconduct and grouped together the charges found proved in categorial form for ease of reference, namely:

1. Escalation and seeking senior input;
2. Consent and patient communication;
3. Acting outside of scope of practice;

4. Patient assessment and/or risk assessment; and
5. Documentation/record keeping

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Tasker's actions did amount to misconduct for the reasons stated below.

The panel reminded itself that throughout the evidence that was presented to it, that the time that Patient A was under the care of Ms Tasker it was agreed that Patient A should have been categorised as a high risk patient and therefore should have been under '*consultant led care'*. The panel considered misconduct in this context.

1. **Escalation and seeking senior input**

Charges 6a and b

At the time of discontinuing the CTG at 21.37 hrs, Patient A should have been categorised as high risk and the CTG should have been assessed by the OT or CDSC before it was discontinued, but it was not. The evidence of Witness 2 and 3 and the expert agreed that this fell well short of the required standard of a midwife that had the potential to put Patient A and her unborn baby of real risk of harm. The panel determined that this amounted to misconduct.

Charge 16

The absence of a fetal heartbeat was described by the witnesses as an obstetric emergency which required an immediate response. Ms Tasker waited 15 minutes before escalating the absence of a fetal heartbeat to the CDSC and the OT. All witnesses agreed that this matter should have been escalated immediately and, on the basis of the expert evidence, the panel determined that this was a serious departure from the required standard and therefore misconduct.

Charges 17a and b

The evidence of the witnesses was that the risks of fresh blood loss/APH and raised blood pressure should have been escalated to the OT and the CDSC, but they were not. The expert witness described this as a serious departure from the required standard and had the potential to put Patient A and her unborn baby at risk of harm. The panel considered this to amount to misconduct.

Charge 20

The panel noted that in charge 16, it was determined that not detecting the fetal heartbeat should have been escalated immediately and that not doing so was misconduct. The panel noted that the emergency buzzers were in each delivery room for the purposes of escalating obstetric emergencies, but this was not used by Ms Tasker. Therefore, the panel determined, based on the expert evidence, this fell seriously short of the required standards expected of a midwife namely not escalating an emergency situation appropriately. The panel therefore determined that this was misconduct.

Charge 21

The panel acknowledged that witnesses 2 and 3 stated that they would not have had an expectation in the circumstances of this charge that the buzzer would have been pressed following a small APH. The panel acknowledged that the APH should have been escalated to and discussed with the OT. However, the charge found proved, as worded, was not serious as there was a local expectation that the emergency buzzer would not be used in this situation. The panel therefore considered this not to be serious.

In conclusion, having considered each charge individually the panel took a holistic view of the failings that occurred in the care of Patient A that were considered in the context of ‘escalation and seeking senior input’. The panel determined that save in relation to charge 21, the actions/omissions of Ms Tasker were serious and therefore fell significantly short of the required standards of a midwife and amounted to misconduct in this category.

2. Consent and patient communication

The panel considered that patients have the right to be fully informed of any risks that are evolving in their care, any proposed changes to their care plan and what that involves. Further, the panel determined that this information is fundamental to enable patients to make fully informed decisions about their care.

Charge 1d

The panel considered the evidence of the expert who stated that they did not find this charge to be serious. The panel had regard to Ms Tasker's statement to the Trust where she explained that she was trying to keep Patient A calm. It was clear to the panel that there must have been some discussions about what the care plan was, as Patient A agreed to have a cannula inserted and blood tests taken. There was however, no evidence of a direct conversation with Patient A regarding the requirement for her to become '*consultant led care'.*

Having considered this charge solely as opposed to collectively, and on the basis of the expert's opinion, the panel determined that this charge is not serious enough to reach the threshold of misconduct.

Charge 10

The panel considered Patient A's evidence where she stated that she was never informed about the APH. The expert witness confirmed that an APH is serious and Patient A should have been informed. Therefore the panel determined, that on the basis of expert evidence, this failure is serious and fell short of the standards required of a midwife and amounted to misconduct.

Charges 11 and 12

The panel determined from evidence presented to it that the action of breaking a patient's waters can both increase pain and the potential for complications and the patient has the right to be fully informed to enable them to give consent. Therefore, the panel was of the view that, based on the expert evidence, not adequately explaining, obtaining consent and documenting that this had been done was serious and thereby amounted to misconduct.

Charge 13

The panel determined that, based on the evidence of the expert, this was serious as not having discussed the care plan with Patient A prevented her from making fully informed choices. This takes away Patient A's right to give informed consent and therefore amounted to misconduct.

Charge 14

The panel accepted the evidence of the expert who said in isolation not explaining that Patient A's baby was '*back to back'* in itself was not serious but poor clinical practice. The panel therefore determined that this did not amount to misconduct.

In conclusion, having considered each charge individually the panel then took a holistic view of the failings that occurred in the care of Patient A that were considered in the context of 'consent and patient communication'. The panel determined that, notwithstanding its findings in relation to charges 1d and 14 above, the omissions in communication by Ms Tasker, which prevented Patient A from making informed decisions and giving informed consent, when viewed collectively, were serious and therefore all fell significantly short of the required standards of a midwife and amounted to misconduct in this category.

3. **Acting outside of scope of practice**

Charges 9a and 9b

At the time of discontinuing the CTG at 21.37 hrs, Patient A should have been categorised as high risk and the discontinuation of the CTG should have been assessed by the OT or the CDSC. Ms Tasker made the decision that Patient A was low risk and discontinued the CTG without appropriate escalation and consultation on either matter. The panel heard evidence from the expert that it was not a midwife's role to re-categorise a high risk patient nor to stop the CTG without consultation, and that Ms Tasker working outside of her scope practice is serious. Therefore the panel concluded, based on the expert evidence, that this amounted to misconduct.

Charges 18 and 19

The panel heard evidence from the witnesses, including the expert, that performing an ARM is within the scope of practice of a midwife but in this clinical situation, where an APH has been observed, the decision to perform an ARM should have been made by the OT following a clinical review of Patient A.

The panel heard no evidence to suggest that Ms Tasker performed the ARM procedure incorrectly but determined that the decision by Ms Tasker to perform the ARM in this clinical situation, without an obstetric review, was incorrect and out of Ms Tasker's scope of practice. The evidence of the expert witness was that this was a serious departure from the standards expected of a midwife. The panel therefore concluded that, in performing an ARM in this clinical situation and without OT review, Ms Tasker acted outside of scope of her practice which is a serious breach of the Code and amounts to misconduct.

In conclusion, having considered each charge individually the panel then took a holistic view of the failings that occurred in the care of Patient A that were considered in the context of 'acting outside of scope of practice'. The panel determined that all of Ms Tasker's omissions were serious and therefore fell significantly short of the required standards of a midwife and amounted to misconduct in this category.

4. **Patient assessment and/or risk assessment**

Charge 4

The panel noted that Patient A was considered high risk. The panel determined, based on expert evidence, that not recording a risk assessment would indicate that the risks have not been considered. In addition, not recording a risk assessment would mean that it is not available for other professionals involved in the care of Patient A to review. The expert considered this to be serious in the context of Patient A. Therefore, the panel determined that this amounted to misconduct.

Charge 5a

The panel considered the evidence of the expert that the use of a pinnard or handheld dopplex to assess the fetal heartrate prior to commencing a CTG was very important to ensure that it was actually the fetal heart that was being recorded on the CTG. The failure to document that this was done was considered an '*extremely serious'* failing by the expert and breached both local and national guidelines. The panel determined that this amounted to misconduct.

Charge 15

The panel noted that Patient A's baby's heartrate had been continuously monitored by the CTG until 21.37hrs. The panel heard evidence of the importance of intermittent auscultation to monitor fetal wellbeing in established labour and when continuous monitoring is not in use. The panel heard further evidence that local and national guidelines recommend intermittent auscultation every 15 minutes in the first stage of labour. Evidence from the expert was clear that delays in this monitoring increases the risk to the baby and therefore failure to undertake intermittent auscultation every 15 minutes was serious. Therefore, the panel concluded that this was serious and amounted to misconduct.

Charge 17c

The panel noted that national and Trust guidelines and the evidence of Witness 2, 3 and the expert all confirmed that the CTG should have commenced immediately following the APH to monitor fetal wellbeing. The expert witness stated that not re-commencing the CTG following recognition of the APH was serious and put the baby at risk of harm. The panel therefore determined that this amounted to misconduct.

Charge 17d

The panel noted the expert evidence that Ms Tasker should not have carried out a VE following the APH without having escalated the APH to the OT for assessment of fetal wellbeing and discussing the ongoing plan of care, including the need for a VE. The expert considered the fact that Ms Tasker carried out the VE without such an assessment as serious due to the associated risks. Therefore, the panel determined that this was misconduct.

Charge 17e

The panel noted that the local and national guidelines state that an abdominal palpation should be carried out before the VE. The panel noted the expert witness view that this was poor clinical practice and not serious misconduct when considered in isolation. The panel accepted this and therefore did not consider this failing, in isolation, as misconduct.

In conclusion, having considered each charge individually the panel took a holistic view of the failings that occurred in the care of Patient A that were considered in the context of 'patient and risk assessment'. The panel determined that, save in relation to charge 17e, the actions/omissions of Ms Tasker were serious and therefore fell significantly short of the required standards of a midwife and amounted to misconduct in this category.

5. **Documentation/record keeping**

Charge 1e

The panel accepted the evidence of the expert witness who stated that not recording that Patient A had been informed that she had been moved to consultant-led-care was not, in isolation, serious but poor practice and record keeping. The panel therefore determined that, in considering the failings in this charge in isolation, it was not misconduct.

Charge 2

The panel considered the evidence of the expert witness that assessing and recording risk was essential and not to do so was serious. The panel also noted that it was Trust policy to use the SBAR sticker. The panel considered that the risk assessment could have been done either using the SBAR sticker or in an alternative entry in the records that included all of the elements that are on the SBAR sticker. However, there was no evidence that any risk assessment had been completed. In that context, and based on the expert evidence, the panel determined that this failure is serious and amounts to misconduct.

Charge 3a

The evidence from the expert witness was that documenting a care plan was an important responsibility of the midwife. Not having a comprehensive record of that plan whether made by herself or the OT, and of any subsequent changes, was serious. Therefore, the panel determined that this failure amounted to misconduct.

Charge 3b

The panel noted that the Intrapartum Book 2, completed on admission, was signed and dated. The Intrapartum Risk Assessment Tool, which forms part of the Intrapartum Book 2, was not.

The panel noted that the expert considered that not having a date and time on the Intrapartum Risk Assessment Tool was serious, However, the panel considered that it would have been completed at the same time as the Intrapartum Book 2 as it was part of it. The panel therefore determined that, considering the failings in this charge in isolation, it was poor clinical practice but not serious enough to be considered misconduct.

Charge 8

The panel heard from the expert witness that it is local and national guidance to carry out and document a full systematic assessment of a CTG before it is discontinued, and failure to do so is serious. The panel accepted the opinion of the expert witness and determined that this failure was serious and amounted to misconduct.

In conclusion, having considered each charge individually the panel took a holistic view of the failings that occurred in the care of Patient A that were considered in the context of 'documentation/record keeping'. The panel determined that, save in relation to charge 1e and 3b, the actions/omissions of Ms Tasker were serious and therefore fell significantly short of the required standards of a midwife and amounted to misconduct in this category.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Tasker'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 and to maintain professional boundaries. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the 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*

The panel finds that Patient A and her baby were put at risk as a result of Ms Tasker's misconduct. The panel further found that Ms Tasker's misconduct had breached fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being remedied. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Tasker has taken steps to remedy and strengthen her practice. The panel took into account an undated reflective piece written by Ms Tasker at the request of her employer at

the time of the incidents, addressing her emotions and how she could have handled the situation differently. However the panel, in light of the factors set out below, determined that Ms Tasker had not in fact remedied her misconduct.

The panel is of the view that there is a risk of repetition as the nature of the charges are wide ranging and there is no evidence before it of strengthened practice after this incident. The panel acknowledged that Ms Tasker had worked from October 2017 until leaving in 2019 and had completed training on CTG interpretation whilst still employed by the Trust. However, the panel has no evidence of Ms Tasker's work since leaving the Trust, nor testimonials or references relating to her current skills, as she has not engaged with the NMC. There is also no evidence as to whether Ms Tasker's knowledge has been kept up to date or whether she undertook any further relevant training to support strengthened practice.

Regarding insight, the panel considered that Ms Tasker had recognised some of her failings, had some understanding of how her actions put Patient A and her unborn baby at a risk of harm, and had demonstrated some understanding of what she did wrong and what she would do differently. However, the panel determined that this was limited and did not cover all aspects of the charges found proved. In addition, the panel was of the view that Ms Tasker only reflected on her own practice, but not on the impact on Patient A and her family, the public and the wider profession. The panel is also of the view that there is no evidence before it of remorse.

Therefore, the panel determined that the risk of repetition is high and decided that a finding of current 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 determined that a finding of current impairment on public interest grounds is required because any fully informed member of the public or the profession who knew of the circumstances of this case would be concerned if Ms Tasker was allowed to practise unrestricted as a midwife given the charges found proved.

Having found misconduct across a wide ranging set of charges, the panel determined that not to make a finding of current impairment would significantly undermine trust and confidence in the midwifery profession.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of one year. The effect of this order is that the NMC register will show that Ms Tasker's registration has been suspended.

Submissions on sanction

Mr Kewley submitted that a suspension order would be the most appropriate order and that it is a matter for the panel to determine the period of suspension. Mr Kewley submitted that the NMC suggests a suspension order for a period of between 6-12 months with a review in order to address the public protection and public interest grounds, but confirmed it is a matter for the panel.

Mr Kewley outlined the aggravating factors as follows:

- Ms Tasker's lack of full insight;
- No evidence of remorse; and

- Ms Tasker's conduct put Patient A and her unborn baby at an increased risk of harm.

Mr Kewley then outlined the mitigating factors:

- The incidents occurred on a single shift in an otherwise long career as a midwife with no previous NMC findings.

Mr Kewley submitted that no action or a caution order would not restrict Ms Tasker's practice and would fail to address the risk of repetition. Therefore, the public would not be protected from the risk of harm.

Mr Kewley submitted that a conditions of practice order would not be appropriate, in this case because there are wide ranging nature of concerns, there is an absence of meaningful insight, and a lack of engagement with the NMC. He submitted that there is no evidence that Ms Tasker would be willing to engage with any conditions. Therefore, Mr Kewley submitted that a conditions of practice order would not be sufficient to protect the public.

Mr Kewley submitted that a suspension order with a review would be appropriate because it would deal with the public protection concern, including addressing the risk of repetition. He further submitted that it would clearly mark the seriousness of the facts found proved and the increased risk of harm to which Patient A and her unborn baby were subject. Mr Kewley submitted that a suspension order would acknowledge that the misconduct related to a single shift, that the panel's findings are that the misconduct is remediable in this case, and that there is no suggestion of any deep seated attitudinal issues or dishonesty.

Mr Kewley submitted that if the panel imposes a suspension order with a review, this will give Ms Tasker a further opportunity to engage with the detailed findings both at the facts and the impairment stage of this determination.

Mr Kewley submitted that if the panel is minded to impose a suspension order with a review, it must be made very clear to Ms Tasker that the onus is on her to reflect on these matters and decide how she wishes to proceed in the future. Any reviewing panel will have a full range of sanctions available to them, including strike off. If there was to be a period of suspension, Ms Tasker would need to engage with the NMC and with the points raised by the panel. Mr Kewley therefore submitted that a suspension order with a period of 6-12 months is appropriate.

Decision and reasons on sanction

Having found Ms Tasker's fitness to practise is 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 NMC's Sanctions Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel identified the following aggravating features:

- Lack of full insight into failings or of any remediation/strengthening of practice;
- Conduct which put Patient A and her unborn baby at an increased risk of harm; and
- Absence of remorse

The panel also identified the following mitigating features:

- The incidents occurred on a single shift in an otherwise long career as a midwife with no previous NMC findings.

The panel considered whether the Trust being under special measures at the time was a mitigating factor. It determined that the charges found proved were in relation to Ms

Tasker's own clinical practice while providing one to one care to Patient A. This would not have been directly impacted by the Trust being in special measures.

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 Ms Tasker'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 Ms Tasker's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Ms Tasker'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 took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*

The panel determined that the misconduct all related to Ms Tasker's clinical practice and, although it is wide ranging, it would be possible to formulate conditions appropriately to restrict Ms Tasker's practice and protect the public. However, the panel noted that there is no evidence before it regarding Ms Tasker's employment history since 2019, limited evidence of insight and no recent evidence of strengthening practice. The panel acknowledged that although there is no evidence of any deep seated personality or attitudinal problems, Ms Tasker has not engaged at any time with the NMC relating to this case. The panel therefore determined that, while it would be possible to create appropriate conditions, they would not be workable as there is no indication that Ms Tasker would engage with the conditions.

Furthermore, the panel concluded that the placing of conditions on Ms Tasker's registration would not adequately address the seriousness of this case from a public interest perspective.

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 panel was satisfied that in this case, the misconduct was not fundamentally incompatible with Ms Tasker remaining on the register. It determined that the misconduct, whilst wide ranging, had occurred on one shift and there was no evidence of deep-seated personality or attitudinal problems. The panel also noted that it had no evidence before it of any repetition during the time Ms Tasker continued to work for the Trust until 2019.

The panel therefore determined that a suspension order would both protect the public and mark the seriousness of the facts found proved on public interest grounds. The panel determined that the suspension order should be for a period of one year. This will provide Ms Tasker with sufficient time to demonstrate the steps she has taken to develop her insight and strengthen her practice to a reviewing panel.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Tasker's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order for a period of one year, with a review, would be the proportionate sanction and was appropriate in this case to protect the public and mark the seriousness of the misconduct.

The panel noted the hardship such an order will inevitably cause Ms Tasker. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order, including a strike-off order.

The panel noted Mr Kewley's submission that, should a suspension order be imposed, the onus would be on Ms Tasker to reflect on these findings and decide on her future career in midwifery. Any future panel reviewing this case would be greatly assisted by information provided by Ms Tasker regarding her future intentions. If she would like to continue to practise as a midwife in the future, the reviewing panel would be assisted by:

- Ms Tasker's attendance at the review hearing;
- A reflective piece from Ms Tasker that addresses all of the categories of failings in her practice, together with the effect that her failings had on Patient A and her family, colleagues, and the wider profession;
- Evidence of up to date training;
- Recent testimonials or references from any employer including either voluntary or paid employment; and
- Anything else that Ms Tasker feels that the panel would be assisted by.

If Ms Tasker no longer wishes to practise as a midwife, she should contact the NMC regarding her options for the future.

This will be confirmed to Ms Tasker in writing.

Interim order

As the suspension 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 Ms Tasker's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kewley. He submitted that an interim order for 18 months is necessary for public protection and is also required on the grounds of public interest.

Mr Kewley submitted that the substantive sanction will not come into effect until after the 28 day appeal period and notice is served on Ms Tasker. If Ms Tasker were to exercise her right of appeal, the sanction will not take effect until that appeal is dealt with. He submitted that an interim order application is made to cover the appeal period.

The panel accepted the advice from the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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 due to the risk of repetition of misconduct and the risk of harm to the public. It determined that an interim order is necessary to cover the appeal period and to mark the public interest grounds.

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

That concludes this determination.