Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 25 September 2023 – Wednesday 4 October 2023

Virtual Hearing

Name of Registrant:	**Joan Anne Barber**
NMC PIN	83G1515E
Part(s) of the register:	Adult Nursing – September 1986 Children's Nursing – October 1989 Registered Health Visitor – November 2014 Registered Nurse Prescriber – January 2015
Relevant Location:	Birmingham
Type of case:	Lack of competence
Panel members:	Nicola Dale (Chair, Lay member) Richard Curtin (Registrant member) Louise Guss (Lay member)
Legal Assessor:	Nigel Mitchell (25 – 27 September 2023) Cyrus Katrak (28 September 2023) Jayne Salt (29 September 2023 – 4 October 2023)
Hearings Coordinator:	Alice Byron
Nursing and Midwifery Council:	Represented by Unyime Davies, Case Presenter
Ms Barber:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17 (in full), 18 and 19
Facts not proved:	Charges 5 and 13
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 Barber was not in attendance and that the Notice of Hearing letter had been sent to Ms Barber's registered email address by secure email on 14 August 2023.

Ms Davies, 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 Barber's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

The panel next considered whether it should proceed in the absence of Ms Barber. It had regard to Rule 21 and heard the submissions of Ms Davies who invited the panel to continue in the absence of Ms Barber. She invited the panel to have regard to the evidence of the unsuccessful attempts made by the NMC case coordinator to contact Ms Barber to ascertain whether she would be attending this hearing. Ms Davies further invited

the panel to consider the email which Ms Barber sent to an NMC employee in relation to another matter, which sets out:

> *"With reference to your email, I do not wish to be contacted regarding the processes you mention , either by email or postal mail.*
>
> *As I stated in my letter over two years ago, I was withdrawing from the NMC processes [PRIVATE] . As of December 2020, I have been retired.*
>
> *I have no wish to return to any form of a caring role within health or social care."*

Ms Davies submitted that there has been no engagement by Ms Barber with the NMC in relation to these proceedings, that she has voluntarily absented herself and has expressed a desire not to be involved in any NMC processes. As a consequence, Ms Davies submitted that there was no reason to believe that an adjournment would secure Ms Barber's attendance on some future occasion and that it would be in the public interest in the expeditious disposal of hearings, when taking account that there are 11 witnesses waiting to give evidence in this matter, for the panel to proceed in Ms Barber's absence.

The panel has decided to proceed in the absence of Ms Barber. In reaching this decision, the panel has considered the submissions of Ms Davies and the email from Ms Barber from 13 March 2023 in which she expressed that she did not wish to engage with the NMC. The panel accepted the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Barber;
- Ms Barber has not engaged with the NMC since her email of March 2023, in which she stated that she does not wish to be contacted and was

withdrawing from the NMC processes. She has not responded to any of the correspondence sent to her about this hearing;

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 11 witnesses are scheduled to give live evidence within the first eight days of this hearing;
- 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 in 2017 and 2020 respectively;
- 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 Barber in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the charges as drafted by the NMC. The panel bore in mind that Ms Barber 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 Barber'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 Barber. The panel will draw no adverse inference from Ms Barber's absence in its findings of fact.

Details of charge

That you a registered nurse :

Between 2015 and 2020 failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 6 Health Visitor in that you

In 2017 in relation to Baby A

1. Did not include Baby A on your caseload. **[PROVED]**

2. Did not put an alert on Baby A's case notes. **[PROVED]**

3. Did not make antenatal contact with Baby A's mother. **[PROVED]**

4. Did not successfully complete a new birth visit in a timely manner. **[PROVED]**

5. Did not document any progress notes following the new birth visit on [PRIVATE]. **[NOT PROVED]**

6. Did not document Baby A's rash despite being aware of it. **[PROVED]**

7. Did not place Baby A on the premature pathway. **[PROVED]**

8. Did not keep adequate records and/or complete a care plan. **[PROVED]**

9. Assessed Baby A as universal which was incorrect. **[PROVED]**

10. Did not put an alert on Rio regarding Baby A. **[PROVED]**

With regards to record keeping

11. Did not complete records and/or assessments for one or more of your cases on your June 2017 caseload. **[PROVED]**

In 2020 in relation to Baby B

12. Did not follow the premature baby pathway. **[PROVED]**

13. Did not record the baby's weight. **[NOT PROVED]**

14. Did not record in the care plan any restrictions in place due to corona virus. **[PROVED]**

15. [PRIVATE]. **[PROVED]**

16. On being unable to conduct a 6-8 week review on Baby B did not raise this with your team leader and/or your supervisor. **[PROVED]**

17. On writing a care plan did not include sufficient detail in that you.

    17.1 Did not describe the restrictions imposed via lockdown. **[PROVED]**

    17.2 Did not describe that there was a compelling need to see Baby B. **[PROVED]**

18. Between 2 June – 29 June 2020 did not contact Baby B's mum. **[PROVED]**

19. Did not offer weekly weight appointments for the first six weeks. **[PROVED]**

And in light of the above your fitness to practise is impaired by reason of your lack of competence.

Background

Ms Barber qualified as a registered adult nurse in September 1986 and a registered children's nurse in October 1989. In November 2014, Ms Barber qualified as a registered health visitor.

The charges arose whilst Ms Barber was employed by Birmingham Community Healthcare and Trust (the Trust) as a health visitor. She was referred to the NMC on 24 November 2017.

Prior to the time in which these charges arose, Ms Barber had previously been subject to the Trust's performance and capability procedures between 5 November and 3 December 2015, during which time she completed an informal action plan.

Ms Barber was subject to a further formal action plan, from 4 November 2016, with the first review meeting taking place on 25 January 2017 where concerns about Ms Barber's general performance as a health visitor were raised, with specific issues raised in relation to record keeping, care planning and prioritising and escalating concerns.

Ms Barber was allocated as the health visitor for Mother A and Baby A, following Baby A's birth [PRIVATE] at 36 weeks gestation. [PRIVATE].

Baby A was taken by their mother to a drop off clinic on 17 April 2017. They were not registered with a GP and presented with eczema to the face and scalp, and a red inflamed nappy rash which was reported to have been present since birth. Baby A died from sepsis [PRIVATE], aged 8 weeks. The coroner concluded that Baby A died from natural causes.

Following the death of Baby A, Ms Barber was suspended from her role on 23 November 2017 whilst the Trust carried out an investigation into the concerns about the health

visiting support provided to Baby A and their family. It is alleged that Ms Barber failed to make timely or sufficient antenatal contact with Mother A and failed to recognise and appropriately act on risk factors including Baby A's prematurity [PRIVATE]. It is further alleged that Ms Barber failed to keep accurate records of observations and contact with Baby A, and also failed to follow up, escalate and communicate concerns to colleagues.

It is alleged that Ms Barber did not apply her knowledge relating to the [PRIVATE] history of Baby A and their extended family when assessing their needs as "universal", and failed to place them on the Trust's premature baby pathway, which meant that neither Baby A nor their family was identified as requiring additional support services and increased visits. It is also alleged that, neither a care plan, nor an alert, was made for Baby A when it was clinically appropriate to do so, and that Mrs Barber failed to document any progress notes following a new birth visit to Baby A on 21 March 2017, and that she failed to complete accurate records in relation to Baby A.

In June 2017, an audit was undertaken of 37 of Ms Barber's live cases, and a number of record keeping concerns were identified, including: dependency score alerts which were missing or reflected an inaccurate level or need, retrospective entries, incomplete care plans and families within her case load which required additional contacts, visits or assessments. Ms Barber said that these errors arose as a result of workload demands.

Ms Barber was suspended by the Trust on 23 November 2017.

Following a disciplinary hearing on 12 and 13 March 2019, Ms Barber was issued with a final written warning, to remain live on her employment record for a period of 24 months. She was also subject to a stage 2 performance management plan and an action plan to target her training and support needs. The six-month performance management and action plans were extended until 10 January 2020 and it was confirmed that Ms Barber had completed the objectives required by the disciplinary panel and demonstrated a significant improvement in respect of decision making, record keeping and undertaking

clinical duties. Ms Barber successfully completed her stage 2 performance and capability plan on 10 January 2020.

In August 2020, a further disciplinary investigation was commenced in respect of Ms Barber following the death of another baby on her caseload, Baby B. It is alleged that Ms Barber received a new birth notification regarding Baby B [PRIVATE], in relation to twins born at 36 weeks gestation, with Baby B weighing 2.6 kilograms after concerns were raised about poor inter-uterine growth.

Baby B was born during the Covid-19 pandemic, at a time when a policy of lockdown and social isolation was mandated in England. As a result of this, the policy for visiting and conducting follow up assessments by health visitors employed by the Trust was that such visits should take place by telephone, with in-person visits to be arranged with appropriate personal protective equipment to be used where there was a "*compelling need*" to visit the child. It is alleged that the concerns relating to Baby B's prematurity and low birth weight amounted to a compelling need for an in-person visit. Baby B died [PRIVATE] aged 8 weeks. The coroner concluded that Baby B also died from natural causes.

Following the death of Baby B, similar concerns about Ms Barber's conduct were raised, including that she did not appropriately follow the Trust's premature baby pathway, and that she relied on information provided by Mother B to record Baby B's weight. It is further alleged that; Ms Barber made an initial new baby assessment by telephone [PRIVATE] and made unsuccessful attempts to conduct a six-week review with Baby B. It is reported that Ms Barber did not raise this lack of engagement by Mother B with her team leader or supervisor.

Further, it is alleged that Ms Barber did not include sufficient details with regard to the Covid-19 lockdowns in place at the time and the compelling need to visit Baby B in person within their care plans.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Barber.

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:

- Witness 1: Operational Manager for Health Visitors and Early Years at the Trust, responsible for the Trust investigation into health visitors in respect of the death of Baby A
- Witness 2: Health Visitor at the Trust and Ms Barber's Practice Teacher in respect of her Return to Practice process at the Trust in June 2019
- Witness 3: Named Nurse for Safeguarding Children at the Trust. Ms Barber's safeguarding supervisor in 2020

- Witness 4: Clinical Training Manager at the Trust who supported Ms Barber in 2018
- Witness 5: Management Specialist employed by the Trust, responsible for the Trust investigation into health visitors in respect of the death of Baby B
- Witness 6: Clinical Lead at the Trust responsible for the initial fact-finding investigation following the death of Baby A
- Witness 7: Operation Manager asked to support Ms Barber in 2015. Currently employed as the Head of Early Years Practice for Health Visitors at the Trust with a responsibility for policy
- Witness 8: District Clinical Manager employed by the Trust and Ms Barber's line manager between April and July 2020
- Witness 9: District Practice Lead employed by the Trust.
- Witness 10: Senior Practice Teacher employed by the Trust at the time of Baby A's death.

- Witness 11: District Practice Lead employed by the Trust.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC. It bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, but it has before it her responses to questions which were posed to her during the Trust's local investigations in 2018 and 2020 respectively.

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

Charge 1

In 2017 in relation to Baby A

1. Did not include Baby A on your caseload.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the evidence of Witness 1 and Witness 11, who spoke directly to the expectations of a health visitor in respect of the inclusion of babies on their caseloads. In her witness statement, dated 11 January 2020, Witness 1 set out:

> *"It was not picked up that Baby A was on the wrong pathway before the internal investigation as Joanie had failed to include the case on her caseload list"*

The panel found Witness 1's oral evidence to be consistent with her previous witness statement. Further, it noted that Witnesses 1, 9, 10 and 11 independently told the panel

that babies who were born and categorised as “universal” would not ordinarily need to be included within a practitioner’s caseload. The panel therefore interpreted “caseload” in this charge to mean those babies having needs above those which are universal, for which Ms Barber was the allocated health visitor.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC and did not directly address this allegation within her local level disciplinary interview on 1 February 2018.

The panel took account of the evidence before it, including the evidence of Witnesses 1 and 10 that Baby A was inappropriately assessed by Ms Barber as universal and should have been included within her caseload, which she seemingly accepted at the Trust disciplinary interview on 1 February 2019.

The panel had regard to the documentary evidence before it and noted that there is no evidence to suggest that Ms Barber had included Baby A in her caseload in 2017. Accordingly it found that, on the balance of probabilities, Ms Barber did not include Baby A on her caseload.

The panel therefore found this charge proved.

Charge 2

In 2017 in relation to Baby A

2. Did not put an alert on Baby A’s case notes.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the evidence of Witness 10 and Witness 11, who spoke directly to the expectations of a health visitor in respect of putting alerts on patient case notes. The panel noted that, in her witness statement, dated 18 August 2022, Witness 10 stated:

> *"It was clear to me that JB should have raised an alert for prematurity for Baby A [PRIVATE]".*

In her witness statement, dated 31 July 2022, Witness 11 set out:

> *"I was monitoring Joan's identified caseload at the time and had done some additional random dip sampling of a few of Joan's universal contacts before the review in April, but the primary focus was on the caseload management. Baby A had not been picked up during this additional random dip sampling and was not picked up on the caseload management as no alert had been added."*

The panel found that Witnesses 10 and 11's oral evidence was consistent with their previous statements. It took account of the fact that multiple witnesses in this matter gave evidence about the importance of using such alerts when working with babies whose needs were assessed as greater than universal. The panel also bore in mind that Witness 1 told the panel that the Trust had moved to RIO, an electronic patient record system between December 2015 and January 2016, which had therefore been in place for a minimum of 13 months when Baby A was born in February 2017.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked why there were no alerts or care plans for Baby A on RIO in the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

"JB stated also that she was not familiar with the alert system on RIO at the time, bit commented that working subsequently with [Witness 11] illustrated to JB what she had otherwise missed regards using this feature on RIO.

JB commented further that [Witness 11] worked with her also on her documentation issues & that JB was attentive to learning & listening to what [Witness 11] was teaching her. JB stated also she did not realise there were pieces of information about RIO she was unaware of".

The panel bore in mind that this amounted to a factual admission to the allegations which formed this charge, in that she accepted that no alert was made, but purported to put forward a defence in that she said that was unaware of how to use the RIO system. The panel concluded that this was unreasonable and insufficient to form a defence to this charge, given the period of around 13 months that RIO had been in place at the Trust by the time Baby A was born, as well as the high likelihood that she would have regularly used the RIO system within this time. Accordingly it found that, on the balance of probabilities, Ms Barber did not put an alert on Baby A's case notes.

The panel therefore found this charge proved.

Charge 3

In 2017 in relation to Baby A

3. Did not make antenatal contact with Baby A's mother.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which outlined the timeline in respect of the

communication attempts made with Mother A, as well as Ms Barber's response to this allegation.

The panel accepted the oral evidence of Witness 1 that an antenatal notification was received about Baby A in December 2016, at which point Ms Barber volunteered to take Baby A and their mother into her caseload. She told the panel that no antenatal contact was made by Ms Barber with Mother A before the baby's birth [PRIVATE]. The panel bore in mind that this account was supported the documentary evidence before it, including the timeline prepared for the Trust investigation, which outlined that an antenatal appointment was made to see Mother A on 26 January 2017, which was cancelled by Mother A's mother, who notified Ms Barber that Mother A had been admitted to hospital. This timeline further notes that there is nothing recorded in the progress notes to show that any subsequent contact took place.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked whether she had completed an antenatal visit for Mother A during the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

> *"JB informed that she was unable to complete the antenatal visit for Mother A. JB explained that she had made initial contact & sent a letter to Mother A for a morning appointment to take place.*
>
> *JB stated that on the original date she was to see Mother A JB received a call from Baby A's grandmother […] that Mother A had been admitted to hospital [PRIVATE] & would not be able to make the appointment.*
>
> *JB stated that the grandmother could not specify when Mother A would be out of hospital, but JB asked the grandmother to get Mother A to call JB as soon as she was out of hospital. JB informed that to the best of her recollection she did not receive a call back from Mother A".*

The panel considered that this amounted to an acceptance of the allegation at the Trust investigation meeting.

The panel also had regard to Witness 1's evidence, which was supported by other health visiting practitioners, including Witnesses 7 and 10, that antenatal contact at the relevant time in 2017 was to be interpreted as a visit to assess the home environment before the child is born. It took into account that this interpretation is also supported by the policies in place at the time, which Ms Barber confirmed she was aware of during her Trust interview on 1 February 2018. Accordingly, the panel found that, although some contact and communication was made by Ms Barber to Mother A in arranging a prenatal appointment, this contact did not fulfil the purpose of prenatal contact as outlined in the Trust policy.

The panel therefore found this charge proved.

Charge 4

In 2017 in relation to Baby A

4. Did not successfully complete a new birth visit in a timely manner.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which outlined the timeline in respect of the communication attempts made with Mother A, as well the evidence of Witness 1 who spoke directly to the expectations of a health visitor in respect of new birth visits. In her witness statement, dated 11 January 2020, Witness 1 set out:

"Joanie received the allocation to complete the New Birth Visit for Baby A [PRIVATE] when Baby A was six days old and although she completed two unsuccessful visits the first of them was when Baby A was 15 days old. Sometimes Health Visitors do have unsuccessful visits but usually they aim to visit between 10-14 days. If a health visitor cannot make a successful visit it would be expected for them to chase it up with the GP to check for any changes of address, contact the midwife as they are likely to have visited the family and may know more. If there were concerns they would do checks with safeguarding. If after these checks they may go down the course of "is this a missing baby".

The first visit was done at 15 days; the KPI [Key Performance Index] is 10-14 days. When you know a baby is premature, if they are still in hospital Health Visitors still try and make contact with mother in that time. It was not Joanie's fault she didn't get a response on the first visit, she did the first visit on [PRIVATE], and then she didn't do another visit until [PRIVATE], a week later. Typically for a full time Health Visitor, I would expect more inquiries and for Joanie to go back in the next couple of days. There is no formal guidance to say that but if the visit is already late, a week is a considerable length of time to wait to then visit again."

The panel found this evidence to be consistent with both the documentary records relating to the timeline of these events and the policies which set out the KPI for the first visit to be 10 – 14 days. This KPI was also confirmed by other witnesses who practised as health visitors, including Witness 11, who also confirmed that if an unsuccessful visit had taken place towards the end of, or just outside of, the period in which it was expected by the KPI, a health visitor should not wait a further week to conduct another visit.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked when she had completed a new birth visit for Baby A during the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

"JB explained that she received the allocation of the case on [PRIVATE] & that baby was 6 days old as of this date.

JB stated she could not explain why the delay had occurred and it is normal practice to make contact with families after allocation, or by no later than the following morning after allocation.

JB explained further that she made an initial appointment to make a home visit on the [PRIVATE], after making phone contact with Mother A. JB stated Baby A was 15 days old as of this date.

JB stated that when she went on this date to Mother A's residence, there was no answer. JB commented that there was no facility to have left a message card stating she had attempted to visit […]

JB next stated that she went back to the property again on the [PRIVATE] but there was no answer.

[…]

JB explained that delays also occurred on then arranging another date for the visit due to other diary commitments JB had at the time, & that upcoming weekend meant a new visit could not happen until the following week. JB also stated she wished to best accommodate Mother A for arranging a suitable new date to visit.

JB commented that on the [PRIVATE], she went to the local GP practice nearest to Mother A's residence to investigate if Mother A was registered at the practice, & if the practice could provide JB with either a contact for a relative JB could otherwise contact.

JB explained further that the GP practice provided her with a contact number for the grandmother of the A family, to which JB rang & spoke to the grandmother.

[…]

JB stated that yes the grandmother's residence was close by, but it did not occur to her at the time to attempt a visit for Mother A whilst she was at the grandmother's residence because of issues around privacy & confidentiality for Mother A.

[…]

JB stated then that she made a new appointment to see Baby A and Mother A [PRIVATE]."

The panel accepted the evidence of Witnesses 1 and 11 in relation to the KPI of 10 to 14 days after birth being a timely manner in which to complete a new birth visit. It noted that it is accepted that the new birth visit did not take place until [PRIVATE], when Baby A was 34 days old. It bore in mind that Ms Barber had made some attempts to carry out this appointment sooner, however these were unsuccessful. The panel accepted the evidence of multiple witnesses that, following an unsuccessful new birth visit outside of the timings established by the KPI, a health visitor should not wait a further week to conduct this visit. Accordingly, the panel found that, on the balance of probabilities, Ms Barber did not successfully complete a new birth visit in a timely manner.

The panel therefore found this charge proved.

Charge 5

In 2017 in relation to Baby A

5. Did not document any progress notes following the new birth visit on [PRIVATE].

This charge is found NOT proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence, including the progress notes for Baby A, recorded on [PRIVATE]. The panel noted that these progress notes recorded limited details and set out:

"[PRIVATE]"

The panel considered that these progress notes were inadequate when considering the purpose of this appointment as they did not contain details about the new birth, Baby A's assessment as universal or record the nappy rash which Ms Barber later recalled having been present at this appointment. However, the panel bore in mind the wording of this charge. Having found that Ms Barber did document some, albeit inadequate, progress notes following the new birth visit on [PRIVATE], the panel did not find this charge proved.

The panel therefore found this charge not proved.

Charge 6

In 2017 in relation to Baby A

6. Did not document Baby A's rash despite being aware of it.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence, including the progress notes for Baby A. The panel noted that there was no reference to a nappy rash being contained within any of Baby A's clinical notes. It further noted that that under the box where minor ailments were to be recorded, "*no concerns*" was typed in.

The panel took account of the evidence of Witness 1, who confirmed that there would have been a requirement to document such a rash within Baby A's progress notes. The panel found this evidence to be credible and consistent with the understanding which other witnesses had of the need to record such concerns.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked about this issue during the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

> *"JB commented that Baby A's skin was generally good, but when the baby was undressed JB noticed that her vulval area was a little red.*
>
> *After observing this, JB queried this with Mother A to which Mother A stated that this condition had been present on Baby A since birth.*
>
> *[…]*
>
> *Witness 1 queried with JB – what was the extent of the rash, was it a large area?*
>
> *JB replied that the red area was contained between her legs and her vulval area."*

The panel concluded that in her responses, Ms Barber acknowledges that a rash was present at the new birth visit and a discussion took place with Mother A of how to manage it, but did not offer any explanation of why it was not documented. Accordingly, the panel found that, on the balance of probabilities, Ms Barber did not document Baby A's rash despite being aware of it.

The panel therefore found this charge proved.

Charge 7

In 2017 in relation to Baby A

7. Did not place Baby A on the premature pathway.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which outlined the policies to be followed in respect of premature babies, as well the evidence of Witness 1 who spoke directly to the expectations of a health visitor in respect of following this policy. In her witness statement, dated 11 January 2020, Witness 1 set out:

> *"Baby A was born premature and within the Trust there is a premature baby pathway for all pre-term babies to be placed on this pathway as it gives direction and guidance about additional support and frequency of contact for premature babies. For dependency level, core service offer is a universal offer and spans to universal partnership plus. Because Joanie did not put Baby A on the right care pathway and put Baby A on universal level which was not correct. Universal is the core pathway, it does not take account of*

prematurity and [PRIVATE]. For a premature baby visits are needed every week or every two weeks.

[…]

As Baby A was not placed on the premature pathway, there was no care plan which is a plan tailored to meet specific needs of that baby. As part of the pathway, some of the areas that would be focused on for a premature baby are baby's nutrition, weight and development. Joanie's rationale for the lack of care plan was that she had assessed Baby A as universal so she did not put Baby A on a care plan."

The panel found Witness 1's oral evidence to be consistent with her witness statement. It found that it was further supported by the oral evidence of Witnesses 10 and 11, who also explained to the panel that the Trust policy was that babies born under 37 weeks gestation should be automatically placed on the premature pathway. The panel had sight of this policy, which confirmed the witnesses understanding to be correct.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked about this issue during the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

"JB informed that she could not explain why she did not use the premature pathway to support & plan the care of Baby A, stating she knew that the baby was born at 36 weeks close to the 37 week cut off, but that looking back she saw a well & healthy child gaining weight"

The panel accepted that there is no dispute that Baby A was premature. It had accepted the evidence of Witnesses 1, 10 and 11, which was supported by the Trust's policy documentation, that the policy in place at the Trust in 2017 clearly stated that a baby born before 37 weeks gestation should have been placed on the premature pathway. It noted

that this would have resulted in an alert being placed on RIO and further support being made available to Mother and Baby A.

The panel therefore found this charge proved.

Charge 8

In 2017 in relation to Baby A

8. Did not keep adequate records and/or complete a care plan.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence, including the progress notes for Baby A, and the Trust policy for babies on the premature pathway, which stated that babies on the premature pathway should have a care plan in place.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked whether she had completed a care plan during the Trust disciplinary meeting on 1 February 2018, the following response was recorded:

> *"JB explained that, having allocated Baby A as for only universal care, she did not proceed to create a care plan correctly"*

The panel therefore found that it was factually accepted that a care plan was not completed for Baby A.

In respect of the adequacy of records, the panel had regard to its findings in relation to charge 5. It took account that the records which Ms Barber made in respect of Baby A did not contain details of any antenatal concerns which may have been raised, did not record the outcome of the new birth visit, failed to allocate Baby A to the premature pathway and did not detail Baby A's weight or the presence of Baby A's rash, as outlined in charge 7, above. In relation to Mother A, the progress notes [PRIVATE] did not record in sufficient detail any matters relating to the general health and wellbeing of Mother A and her new baby. The panel expected that such details would be properly recorded, [PRIVATE]. Accordingly, the panel found that, on the balance of probabilities, Ms Barber did not keep adequate records for Baby A, and did not complete a care plan at all.

The panel therefore found this charge proved.

Charge 9

In 2017 in relation to Baby A

9. Assessed Baby A as universal which was incorrect.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence, including the Trust policy for babies on the premature pathway, as well the evidence of Witnesses 1 and 10, who outlined when a baby should be placed on the premature pathway, and why this would result in a baby being assessed as having greater needs than that of a full-term baby who would be assessed as "universal".

The panel also had regard to the policy guidance, which outlined that, alongside a child's prematurity, other health and social care factors should be considered when assessing

whether a baby is universal, universal plus (where a parent or child has an identified level or need that might affect the child's development), or partnership plus (where significant concerns regarding a child's wellbeing have been identified, [PRIVATE]).

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, when asked whether she had completed a care plan during the Trust disciplinary meeting on 6 March 2018, the following response was recorded:

> *"JB stated that on reflection, her first thought now would have been that all 3 members [Mother A, Baby A and Sibling A] of Mother A's family should have received partnership plus level of care."*
>
> *[…]*
>
> *Witness 1 queried with JB – why did you not assess as partnership plus level of caret the time?*
>
> *JB responded that she could not explain why this wasn't done at the time during allocation"*

The panel considered that this amounted to an acceptance of the allegation at the Trust investigation meeting.

The panel also bore in mind that there is evidence before it that, alongside her knowledge of Baby A's prematurity, [PRIVATE]. Furthermore, the panel bore in mind that there was evidence of concerns about Mother A's non-attendance of planned appointments with health visitors, including the initial new birth visit scheduled for Baby A. In the light of this, the panel concluded that Ms Barber was aware of the risks associated with Baby A's prematurity and health [PRIVATE] concerns, yet failed to appropriately assess them. Accordingly, the panel concluded that, on the balance of probabilities, Ms Barber assessment of Baby A as universal was incorrect.

The panel therefore found this charge proved.

Charge 10

In 2017 in relation to Baby A

10. Did not put an alert on Rio regarding Baby A.

This charge is found proved.

The panel found this charge to be duplicitous with the concerns alleged at charge 2, above.

The panel therefore found this charge proved for the same reasons as outlined in charge 2.

Charge 11

With regards to record keeping

11. Did not complete records and/or assessments for one or more of your cases on your June 2017 caseload.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which included the audit which outlined the concerns found in respect of the incomplete records and assessments for the cases on Ms

Barber's caseload. Witness 1 addressed these concerns in her witness statement, dated 11 January 2020:

> *"In June 2017, more issues were identified on an audit on Joanie's caseload, there were several gaps in her record keeping practice, there were incomplete assessments, there were children where Joanie had closed the case, or put the dependency down from a high level of need to universal, Joanie had assessed those as universal when there were cases that still identified needs and needed to be kept open."*

The panel found this account to be consistent with the witness statement of Witness 11, dated 31 July 2022, who set out:

> *"I went back in to look at Joan's work, I did a dip sample of her caseload. What I found was that most of what Joan said had been completed, hadn't been completed.*
>
> *[…]*
>
> *Joan had reassured them [sic] us in May that all the caseload notes were all up-to-date, but there was a lot of work which hadn't been completed. […]. The NMC asked about the content she inputted and whether that was sufficient; Joan had acted on some advice, had re-opened records which I had identified to have been prematurely closed, there was lots of work outstanding […] there were still quite a few areas in record keeping which hadn't been done when I did the dip sample."*

The panel found that both Witness 1 and Witness 11 gave clear and credible oral evidence which was consistent with their respective witness statements in respect of this charge.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, indicated during her Trust investigation interviews that she had difficulties with completing records as a result of workload pressures.

The panel had regard to the findings of the audit, which it noted to include evidence of Ms Barber's failure to check and properly monitor her caseload. It found the audit to note multiple errors, mistakes and omissions on Ms Barber's part. Accordingly, the panel concluded that evidence in support of this charge was sufficient, on the balance of probabilities, to substantiate a finding that Ms Barber did not complete records and/or assessments for one or more of her cases on her June 2017 caseload.

The panel therefore found this charge proved.

Charge 12

In 2017 in relation to Baby B

12. Did not follow the premature baby pathway.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which outlined the policies to be followed in respect of premature babies, it noted that babies born under 37 weeks gestation were to be placed under the premature pathway at the Trust.

The panel noted that further policies were in place at the time of Baby B's birth as a result of the Covid-19 pandemic, including "The Healthy Child Programme provision by the Health Visiting Service during Covid 19 pandemic Operational Guidance", which came into

place on 21 April 2020, and was emailed to health visiting staff at the Trust, including Ms Barber. The panel noted that this guidance set out that health visitor appointments during this time were to take place by telephone, except where a compelling reason to offer a face-to-face visit was identified, with such visits taking place at an isolation clinic or at the parents' home, with the health visitor wearing full PPE. This guidance states that:

> *"An Isolated clinic contact may take place in order to weight and assess the baby, assess maternal mental health, address a domestic abuse risk or any other professional concern or compelling need as identified through professional assessment. A Home visit may be required if there are compelling concerns identified relating to issues of neglect."*

The panel took into account Baby B's clinical notes, which outline that Ms Barber received the new birth notification in respect of Baby B on [PRIVATE]. Baby B's care plan outlined that Ms Barber placed them on the premature pathway, and the following notes were recorded:

> *"Health visitor to review and record weekly weights for Baby B at family home until Baby B reaches 4.5kg, when she may then be brought to Well baby Clinic for review at an agreed time schedule with her mother.*
>
> *[…]*
>
> *Health Visitor to use the Premature Pathway to coordinate contacts and reviews of Baby B's growth"*

The panel bore in mind that there is no evidence before it that this care plan was followed, in that there is evidence that 3 weeks of visits in respect of 9, 16 and 21 June 2020 are not recorded within Baby B's clinical notes, and Baby B's weight is not recorded for these dates.

The panel noted that, although Ms Barber has not provided a formal response to the charges as drafted by the NMC, in her Trust investigation interview, dated 6 October 2020, Ms Barber said that it was not possible for her to visit Baby B as a result of the Covid-19 restrictions, as well as concerns over her high workload.

The panel also had regard to the evidence of Witnesses 5 and 7, who outlined for the panel there were known concerns about Baby B's prematurity, low birth weight [PRIVATE]. The panel found these witnesses to be clear and consistent that such concerns would amount to a compelling need to visit Baby B in person, in line with the Covid-19 guidance. These witnesses also indicated that some of Ms Barber's tasks, including following up on Baby B's care plan, could have been delegated to an assistant in the team, and that Ms Barber would have known this.

The panel therefore concluded that, on the basis of the evidence that, having placed Baby B on the premature pathway, Ms Barber failed to follow the care plan that she had set, and further failed to recognise a compelling need to conduct weekly in person visits with Baby B, despite her knowledge of the risks present [PRIVATE]. The panel concluded that this amounted to Ms Barber's failure to follow the premature baby pathway.

The panel therefore found this charge proved.

Charge 13

In 2017 in relation to Baby B

13. Did not record the baby's weight.

This charge is found NOT proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to Baby B's clinical notes.

The panel noted that, within their progress notes, a record has been made for Baby B's weight in respect of 2 June 2020. The panel noted that it seems to be accepted by all parties that this weight was not taken by Ms Barber herself, but was instead input from a text message received from Mother B, who told Ms Barber the weight which the midwife had recorded for Baby B. The panel bore in mind that Baby B's weight is recorded in a similar way within Baby B's new assessment document.

The panel took into account the evidence of Witnesses 5 and 7, who outlined that this was not the proper process for recording a baby's weight, which ought to be recorded by a health visitor having weighed the baby on consistent and accurate scales. However, the panel bore in mind the wording of this charge, which alleges that Ms Barber did not record Baby B's weight, not that it was inaccurately or improperly recorded. The panel found that, as there is evidence before it that Ms Barber had recorded Baby B's recorded weight, this charge could not be found proved.

The panel therefore found this charge not proved.

Charge 14

In 2017 in relation to Baby B

14. Did not record in the care plan any restrictions in place due to corona virus.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence which outlined the policies to be followed in respect of the Covid-19 pandemic, including "The Healthy Child Programme provision by the Health Visiting Service during Covid 19 pandemic Operational Guidance", which came into place on 21 April 2020, and was emailed to health visiting staff at the Trust, including Ms Barber. The panel noted that this guidance set out:

> *"Follow up the EPR assessments and record on the progress notes 'Due to COVID 19 no home visit undertaken/ baby not seen'*
>
> *[…]*
>
> *As standard practice, in all professional assessments at any time, all contacts with parent /carers are a holistic assessment of family needs. This is an important principle of practice to apply in this unprecedent time of Covid19. Accurate, contemporaneous record keeping is always required which clearly reflects professional judgment. Any actions or decisions not to support further must be documented on Rio."*

Accordingly, the panel was satisfied that Ms Barber had a duty to record restrictions put in place due to Covid-19 within Baby B's care plan.

The panel took account of Baby B's care plan and took into account that there was no reference to Covid-19, or the restrictions in place at the time, which Ms Barber relied upon to justify her decision not to visit Baby B in person.

Accordingly, the panel found this charge proved.

Charge 15

In 2017 in relation to Baby B

15. [PRIVATE]

This charge is found proved.

[PRIVATE].

Charge 16

In 2017 in relation to Baby B

16. On being unable to conduct a 6-8 week review on Baby B did not raise this with your team leader and/or your supervisor.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the witness statement of Witness 5, dated 7 March 2023, which set out:

> *"Joanie received the new birth notification for Baby B and her twin on [PRIVATE]. Joanie conducted the initial new baby assessment by telephone [PRIVATE]. Joanie made telephone attempts and unannounced visits to the home to book 6-8 week review with no success, She also approached the GP and put a note on he file for them to ask the mother to call her. This was correct however at no point she raised this lack of engagement with the Team Leader or Supervisor.*

Joanie had safeguarding supervision but again did not raise this in these sessions.

Joanie failed to follow the Was Not Brought policy […] it details the action to be taken following the first defaulted appointment. In the interview with Joanie she stated that she had not checked this policy as she was "so overwhelmed with trying to keep on top of everything else".

Had she followed the policy a more experienced Health Visitor or Safeguarding Supervisor could have advised on other ways to contact and further escalated concerns. Joanie did not meet Baby B once in her short lifetime."

The panel bore in mind that the Was Not Brought Policy in place at the time does not explicitly state that a team leader or supervisor should be notified in these circumstances, however, multiple witnesses, including Witnesses 5 and 7, gave consistent evidence that it would be expected practice for a health visitor to escalate not being able to conduct a 6-8 week review with their team leader, particularly when no previous contact with the baby had been achieved.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however during her Trust investigation interview, on 6 October 2020, Ms Barber gave the following response:

"I tried to make contact with mum, I rang 3 times. Normally she would respond within a day or 2, she was good at responding.

[…]

I would normally escalate but I didn't think there was an issue. After 3 times of not hearing from them I did a home visit."

When asked who she would normally escalate to, Ms Barber said *"the team leader to discuss with them".* She accepted that she did not escalate her concerns in relation to this visit.

The panel found this charge proved on the basis of all of the evidence before it, including the lack of dispute that the common procedure was be for a health visitor to escalate concerns about being able to conduct a visit with a family to their supervisor or team leader. The panel bore in mind Ms Barber's similar learning and experience from the performance plan put in place following similar concerns in relation to the lack of contact with Baby A's family. The panel determined that Ms Barber ought to have known to properly escalate this as an issue to an appropriate safeguarding lead, team leader or supervisor.

Accordingly, the panel found this charge proved.

Charge 17.1

In 2017 in relation to Baby B

17. On writing a care plan did not include sufficient detail in that you.

    17.1 Did not describe the restrictions imposed via lockdown.

This charge is found proved.

The panel found this charge to be duplicitous with the concerns alleged at charge 14, above.

The panel therefore found this charge proved for the same reasons as outlined in charge 14.

Charge 17.2

In 2017 in relation to Baby B

17. On writing a care plan did not include sufficient detail in that you.

17.2 Did not describe that there was a compelling need to see Baby B.

This charge is found proved.

The panel found this charge to be duplicitous with the concerns alleged at charge 12, above. The panel noted that Ms Barber did not assess, or record, that there was a compelling need to see Baby B.

The panel therefore found this charge proved as a result of the lack of documentation in respect of the compelling need to see Baby B, and for the same reasons as outlined in charge 12.

Charge 18

In 2017 in relation to Baby B

18. Between 2 June – 29 June 2020 did not contact Baby B's mum.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence in relation to this charge.

The panel took into account Baby B's clinical notes, which outline that Ms Barber received the new birth notification in respect of Baby B [PRIVATE]. Baby B's care plan outlined that Ms Barber placed them on the premature pathway, and the following notes were recorded:

> *"Health visitor to review and record weekly weights for Baby B at family home until Baby B reaches 4.5kg, when she may then be brought to Well baby Clinic for review at an agreed time schedule with her mother.*
>
> *[…]*
>
> *Health Visitor to use the Premature Pathway to coordinate contacts and reviews of Baby B growth"*

The panel bore in mind that there is no evidence before it that this care plan was followed, in that there is evidence that 3 weeks of contact and visits in respect of 9, 16 and 21 June 2020 were not made as records for these dates are not recorded within Baby B's clinical notes, and Baby B's weight is not recorded for these dates.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, and that she was not asked specifically about the lack of contact with Mother B between 2 June and 29 June 2020. However, it noted that Ms Barber did not deny a break in contact in this period, or allege that any contact was made.

The panel found that the documentary evidence before it is clear and consistent to support a finding that, between 2 June and 29 June 2020, Ms Barber did not contact Baby B's mother.

The panel therefore finds this charge proved.

Charge 19

In 2017 in relation to Baby B

19. Did not offer weekly weight appointments for the first six weeks.

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it. It had particular regard to the documentary evidence in relation to this charge.

The panel took into account Baby B's clinical notes, which outline that Ms Barber received the new birth notification in respect of Baby B on [PRIVATE]. Baby B's care plan outlined that Ms Barber placed them on the premature pathway, and the following notes were recorded:

> *"Health visitor to review and record weekly weights for Baby B at family home until Baby B reaches 4.5kg, when she may then be brought to Well baby Clinic for review at an agreed time schedule with her mother.*
>
> *[…]*
>
> *Health Visitor to use the Premature Pathway to coordinate contacts and reviews of Baby B growth"*

The panel bore in mind that there is no evidence before it that this care plan was followed, in that the only entry made in relation to Baby B since their birth was in relation to their weight was a retrospective note added for 2 June 2020, on 26 June 2020, which outlined Baby B's weight, as reported in a text message from Mother B on 1 June 2020. The panel

noted that there was no evidence of any weight appointments being made or offered by Ms Barber, despite her identifying that this should be carried out on a weekly basis within Baby B's care plan.

The panel bore in mind that Ms Barber has not responded to the charges as drafted by the NMC, however, in her Trust disciplinary interview, she seemingly accepted that she overlooked this concern as she was overwhelmed by her *"workload and the expectations".* Ms Barber further added: *"it got missed, I'm appalled about that, I really am. I felt so bad. I had other priorities expected of me."*

The panel found that the documentary evidence before it is clear and consistent to support a finding that, in respect of Baby B, Ms Barber did not offer weekly weight appointments for the first six weeks.

The panel therefore finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Ms Barber'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 must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Ms Barber's fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Davies invited the panel to take the view that the facts found proved amount to a lack of competence. She invited the panel to have regard to the terms of "The Code: Professional standards of practice and behaviour for nurses and midwives (2015)" (the Code) in making its decision, and identified the specific, relevant standards of the Code where Ms Barber's actions amounted to a lack of competence.

Ms Davies submitted that lack of competence needs to be assessed using a three-stage process:

- Is there evidence that Ms Barber was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

Ms Davies submitted that the facts found proved show that Ms Barber's competence at the time was below the standard expected of a band 6 registered nurse and health visitor

which amounted to an unacceptably low standard of professional performance and included failings which should form the basic essential standard of a health visitor.

Ms Davies submitted that the panel is able to make a finding of lack of competence based on a fair sample of Ms Barber's work, having found charges proved in relation to two separate incidents in 2017, and further concerns over an extended period of time again in 2020. She further submitted that the charge found proved in relation to the audit of Ms Barber's work undertaken in June 2017 showed an unacceptably low standard of professional performance which raised a risk of harm to vulnerable patients, namely newborn and premature babies.

Ms Davies invited the panel to have regard to the NMC guidance on lack of competence, which states that a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate. However, she indicated that it is submitted by the NMC that the facts found proved do not relate to a single incident. Ms Davies outlined that the guidance states that, as issues have been raised about Ms Barber's general competence, the panel should seek to understand the circumstances at the time, including Ms Barber's practising history beyond the period of time when the facts found proved arose, to consider whether the concerns about her practice are limited or more general in nature.

Ms Davies reminded the panel of the evidence before it that Ms Barber was previously placed on an informal action plan following concerns about her record keeping in 2015. She said that the panel may also wish to take into account that, during the Trust's investigation meetings, Ms Barber raised her concerns about a difficult working environment caused by a colleague. She said that some support of this issue was raised by Witness 4 in her oral evidence, who said that this colleague made the working environment difficult for some individuals, including Ms Barber and another colleague of similar limited experience.

Ms Davies also submitted that, when considering contextual factors, the panel may also wish to take into account the appropriateness of the allocation of Baby A to Ms Barber given the matters raised in respect of her workload. However, she submitted that this should also be balanced against the fact that concerns about Ms Barber's level of competence had previously been raised in 2015 and that she was given sufficient training and support within her workplace yet, despite this, the failings were repeated over a period of time and featured poor and inaccurate record keeping. She also invited the panel to take account of the evidence of Witness 1 who said that Ms Barber herself did not assist in the reduction of her own caseload when she was instructed to hand over cases to her colleagues.

Submissions on impairment

Ms Davies 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Davies submitted that limbs a), b) and c) of the *Grant* "test" are engaged. This 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *[…]*

In respect of limb a), Ms Davies submitted that the panel should take the evidence of multiple witnesses in this case, who said that vulnerable patients were put at an unwarranted risk of harm as a result of Ms Barber's acts and omissions. Ms Davies highlighted that these patients were vulnerable because they were premature and newborn babies who required professional care and input from a health visitor. She submitted that the panel has also heard from multiple witnesses about the risks which were caused by Ms Barber's poor record keeping and failure to make an accurate initial assessment or birth assessment, particularly in respect of the impact which these failings had in relation to Baby A and Baby B's future care.

In relation to limb b) of the test, Ms Davies submitted that Ms Barber's actions have brought the nursing profession into disrepute. She said that the panel has heard first-hand from witnesses about the impact that Ms Barber's acts and omissions had on colleagues at the Trust.

Ms Davies submitted that limb c) is engaged as Ms Barber's actions have breached the fundamental tenets of the nursing profession.

Ms Davies submitted that, when considering current impairment, the panel should bear in mind that it is a forward-looking test, as established in *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), namely:

- Is the misconduct easily remediable?
- Has it been remedied?
- Is it highly unlikely to be repeated?

In respect of the first question, Ms Davies submitted that the conduct which led to the charges effectively amounts to poor recordkeeping and a failure to follow policy which should be capable of being addressed through evidence of insight, reflection, further training and current good practice. Ms Davies invited the panel to consider whether Ms Barber has shown any insight. She highlighted that Ms Barber has not provided any direct evidence to this panel to indicate her level of insight, but the panel may make an assessment of this on the basis of her responses in the Trust investigations in 2018 and 2020. She submitted that the panel has received evidence from multiple witnesses about Ms Barber's attitude towards the concerns about her practice which could be described as a lack of insight. Accordingly, Ms Davies submitted that Ms Barber has shown very limited insight into the seriousness of the alleged conduct, which is compounded by the repetition of errors in respect of Baby B.

In respect of the second question of the *Cohen* test, Ms Davies said that, following the death of Baby A, Ms Barber successfully completed a comprehensive action plan, so it appears that, at that stage, she had taken steps to strengthen her practice. However, she submitted that this does not appear to have embedded within her practice as similar concerns were raised about Ms Barber's practice following the death of Baby B. Further, she submitted that the panel has heard evidence that Ms Barber has not worked clinically as a nurse since the death of Baby B, therefore she has not demonstrated any evidence of strengthened practice since this time. Accordingly, she said that the panel may feel that, because of the recurrence of these concerns and the absence of any strengthened practice, Ms Barber has not remedied the concerns which have been raised.

Finally, in relation to whether the concerns are highly likely to be repeated, Ms Davies submitted that the panel has heard evidence that there is a high risk of repetition of the

concerns alleged, which means there is a risk to public safety. Accordingly, she invited the panel to find that Ms Barber is currently impaired on the ground of public protection.

Further, Ms Davies said that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions, and upholding proper standards. She therefore submitted that public confidence in the nursing profession would be gravely undermined if a finding of impairment was not made on public interest grounds in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Grant, Cohen, Cheatle v General Medical Council* [2009] EWHC 645 (Admin) and *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin).

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

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

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

8 Work co-operatively

To achieve this, you must:

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.

8.4 work with colleagues to evaluate the quality of your work and that of the team.

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

8.6 share information to identify and reduce risk.

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance.

10.1 complete 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 used to deal with them, so that colleagues who use the records have all the information they need.

10.5 take all steps to make sure that records are kept securely.

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 form a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information.

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

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

The panel bore in mind, when reaching its decision, that Ms Barber should be judged by the standards expected of the average band 6 registered nurse in a health visitor role, and not by any higher or more demanding standard. The panel reminded itself of the issues to consider in relation to lack of competence, namely:

- Is there evidence that Ms Barber was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

In relation to the first question, the panel considered that there was considerable evidence before it to suggest that Ms Barber was made aware of the issues around her competence. It determined that the evidence presented was judged on a fair sample of Ms Barber's work, including dip samples taken in January 2017, June 2017 and June 2020. The panel had regard to evidence that issues were identified around Ms Barber's competence, specifically in relation to her record keeping and decision making, which was fed back to Ms Barber during action plan reviews, formal disciplinary investigation meetings, and informal support discussions with her colleagues and practice teachers.

In respect of whether Ms Barber was given the opportunity to improve and whether further assessment was made, the panel bore in mind that there is evidence before it that Ms Barber worked under a preceptorship for a year and on two occasions was placed on a stage 1 performance plan. The panel also took account of the fact that Ms Barber was placed on a stage 2 performance plan following the death of Baby A, which required close monitoring and support, including the implementation of action plans. It took into account

that Ms Barber successfully completed this stage 2 performance plan on 10 January 2020, but still remained on an informal action plan for support after this time.

The panel noted that concerns about deficiencies in Ms Barber's practice were first identified in 2015, and she has been subject to an action plan for the majority of her career as health visitor. The panel accepted the evidence of the witnesses in this case that Ms Barber received regular support and input from colleagues and practice teachers, and was particularly supported with concerns about her record keeping. Accordingly, the panel was satisfied that Ms Barber was very well supported whilst working at the Trust, given multiple opportunities and resources to improve her practice, and was regularly assessed whilst working under performance and action plans, working with different cases, supervisors and mentors over a prolonged period of time.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Ms Barber's practice was below the standard that one would expect of the average registered nurse acting in Ms Barber's role.

In all the circumstances, the panel determined that Ms Barber's performance demonstrated a sustained lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Ms Barber's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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.'*

The panel noted that this case makes reference to misconduct, however subsequent case law recognises that the principles established in *Grant* equally apply to lack of competence cases.

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/their fitness to practise is impaired in the sense that S/He/They:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) […]

The panel found that patients were put at risk of harm as a result of Ms Barber's lack of competence. The panel noted that, although it is not suggested that Ms Barber's actions directly contributed to the death of Baby A or Baby B, it has received evidence from witnesses that other health visitors would have acted differently had they been aware of Baby A's full clinical history and that Baby A would have received more support through being placed on the correct premature pathway. The panel also determined that Baby B was not given the support that they required during their short life through Ms Barber's lack of competence. Accordingly, the panel found that vulnerable patients were potentially caused harm by Ms Barber's failure to update records and follow Trust pathways and guidance.

The panel found that Ms Barber's repeated failures and lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel took account of the contextual factors which were raised by Ms Barber within her Trust disciplinary meetings, namely the challenging work environment including feeling overwhelmed by her workload and a challenging working relationship with a colleague. In respect of Ms Barber's workload, although the panel recognises that health visiting is a challenging area of practice, which was described as being "*chaotic at times*" by some witnesses, the panel also took into account the evidence of Witness 11, who said that Ms Barber *"blamed work pressures for her failings".* The panel took into account that multiple witnesses were asked about the average caseload for a health visitor, and told the panel that Ms Barber's caseload was not excessive compared to her colleagues. It also had regard to the evidence of Witnesses 1 and 11, who told the panel that Ms Barber was given a direct instruction to reduce her caseload on 25 January 2017 and had failed to do so by 7 March 2017. Witness 11 said that Ms Barber repeatedly ignored instructions to hand over cases over several months, and said that she "*needed to sort them out*".

Furthermore, Witness 1 said that Ms Barber actively sought to take Baby A onto her caseload during this period, despite repeated instructions to reduce it and to not take new active cases. Accordingly, in these circumstances, the panel concluded that it was unable to attribute any mitigation to Ms Barber's actions in relation to her caseload, especially when she was working within a supportive environment.

Similarly, the panel concluded that it could attribute limited mitigation to Ms Barber's concerns about her challenging working relationship with her colleague. The panel noted that it has not received any evidence as to how it is suggested that this may have directly affected Ms Barber's competence, and bore in mind that registered nurses have a duty to work in a professional manner in a way which does not affect their patients and clinical practice. It concluded that, any such issues ought to have been escalated through Ms Barber's manager.

Regarding insight, the panel noted that Ms Barber has not provided any evidence to this panel, however it has the benefit of Ms Barber's responses to the concerns when raised at the four Trust investigation meetings in 2018 and 2020 respectively. The panel noted that, in these meetings, Ms Barber demonstrated a limited ability to reflect on her failings and verbalise her remorse for some of her failings. However, the panel concluded that throughout these interviews, Ms Barber ultimately rested on a position of blaming others and the Trust as an organisation, especially in relation to the deaths of Baby A and Baby B.

In its consideration of whether Ms Barber has taken steps to strengthen her practice, the panel took into account all of the evidence before it and noted that there is evidence of initial strengthened practice from Ms Barber's successful completion of her stage 2 performance plan, following the Trust investigation into the death of Baby A. However, the panel concluded that this learning had not been embedded into Ms Barber's practice, given the repetition of the strikingly similar concerns surrounding the death of Baby B. The panel would expect that, having been involved in an incident as serious as the death of Baby A, a practitioner would become very reflective and hypervigilant in order to avoid the

recurrence of such a serious incident again, yet Ms Barber did not act as such. Further, the panel took into account that Ms Barber has not been in clinical practice since her retirement from nursing in December 2020, therefore has not had any opportunity to prove that she can practice safely and effectively since this date. Accordingly, the panel found that there is no evidence of strengthened practice before it today.

The panel considered that the lack of competence found has the potential to be remedied, but there is no evidence of any remediation having taken place, therefore the panel is of the view that there is a risk of repetition.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 impairment on public interest grounds is required as a result of Ms Barber's lack insight, reflection or strengthened practice. The panel took account of its findings that vulnerable patients were not safely managed and not properly cared for as a result of Ms Barber's recordkeeping, assessment and escalation errors. It concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds Ms Barber's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Barber'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 12 months. The effect of this order is that the NMC register will show that Ms Barber's registration has been suspended.

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

Submissions on sanction

Ms Davies invited the panel to have regard to the NMC guidance on sanction, apply the principle of proportionality when considering sanction, and impose the sanction with the least impact to achieve public protection and uphold the public interest.

Ms Davies highlighted the panel's findings on impairment, including that the panel was satisfied that Ms Barber was well supported whilst working at the Trust, that she was given multiple opportunities and resources to improve her practice, was regularly assessed over a prolonged period of time and continued to demonstrate a lack of competence, which repeatedly put patients at a risk of harm.

Ms Davies addressed the panel on the aggravating features in this matter, which she identified as:

- Ms Barber's failures were linked to multiple babies, including Baby A and Baby B who subsequently died;
- Ms Barber's failures continued over a sustained period of time;
- Ms Barber has demonstrated a lack of insight into the impact of the clinical concerns on patients and colleagues;

- Ms Barber failed to improve her practice despite significant support from her employer;
- The potential for harm of vulnerable patients, significantly Baby A and Baby B; and
- Evidence of repeated errors which were similar in nature.

Ms Davies acknowledged that the panel has placed limited weight on the mitigation which Ms Barber raised during the Trust investigation, however she said that it is open to the panel to consider the following factors as mitigating features:

- Ms Barber was working within a challenging situation, including concerns about working with a colleague; and
- Whether it was appropriate for Baby A to have been allocated to Ms Barber's case load.

Ms Davies submitted that taking no further action or imposing a caution order would be inappropriate in this matter as the facts found proved are too serious to be dealt with by such orders. Further, she submitted that such sanctions would be inadequate to deal with the concerns identified.

Ms Davies submitted that a conditions of practice order would be inappropriate. She reminded the panel of its findings in relation to impairment, and significantly the extensive support which Ms Barber received during the time that her practice was being monitored by the Trust, as well as the lack of insight which the panel identified. Ms Davies invited the panel to have regard to the NMC guidance on conditions of practice orders, which sets out that a key consideration for the panel is whether conditions can be put in place to sufficiently protect patients and, if necessary, address any concerns about public confidence or proper professional standards and conduct. She invited the panel to consider the non-exhaustive list of circumstances in which a conditions of practice order may be appropriate, which reads:

- *no evidence of harmful deep-seated personality or attitudinal problems*

- *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed.*

Ms Davies submitted that there are several of these factors which are not relevant when taking into account the facts of this case. She acknowledged that there are identifiable areas of Ms Barber's practice which are in need of assessment and/or retraining but submitted that, as these areas are somewhat widespread, the panel may consider that these amounted to evidence of Ms Barber's general incompetence when working as a health visitor.

In respect of potential and willingness to respond positively to retraining, Ms Davies invited the panel to consider Ms Barber's last email to the NMC in March 2023, in which she stated that she is retired. In light of this, Ms Davies submitted that this correspondence does not indicate a willingness to respond positively to retraining. Further, she queried that, in light of the significant training and support which Ms Barber received at the Trust, whether Ms Barber would have a willingness to respond positively to retraining.

Ms Davies said that there is no suggestion or any concern of health conditions in this matter. However, she submitted that there is evidence that patients could be put in danger, either directly or indirectly, as a result of the imposition of any conditions of practice due to the panel's identified risk of repetition of the concerns. She said that any conditions which the panel may seek to put in place may well be similar to the restrictions,

supervision and support that Ms Barber received when working at the Trust. Further, she submitted that, bearing in mind the facts of this case, a conditions of practice order will not appropriately protect vulnerable patients during the period that they are in force.

Ms Davies invited the panel to impose a suspension order for a period of 12 months, with a review. She submitted that the concerns found proved and the findings the panel have made in relation to public protection and public interest, as well as the serious and sustained regulatory concerns in this case, warrant Ms Barber's temporary removal from the nursing register in this case. Ms Davies submitted that there is a risk to patient safety if Ms Barber was allowed to continue to practice, even with conditions in place.

Ms Davies said that, as this matter is charged as lack of competence, a striking off order is not open to this panel or any reviewing panel until a finding of impairment and either a suspension order or a conditions of practice order has been imposed for a continuous period of two years.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Ms Barber's failures were linked to multiple patients over a significant period of time;
- Evidence of a lack of insight by Ms Barber into her failings, including by her seeking to take Baby A onto her caseload at a time when she was instructed to actively reduce her caseload;
- Potential harm to patients, including known risks to Baby A, Baby B and unknown risks other children on her caseload as a result of Ms Barber's sustained poor clinical conduct and recordkeeping found in the dip samples of her caseload;
- Significant repetition of errors of the same nature despite Ms Barber being provided with a high level of support and the expectation that Ms Barber should have been hypervigilant of these same concerns following the death of Baby A; and
- Ms Barber's lack of insight into her own competence and the effect that this had on her colleagues, including the actual impact of her failings which resulted in investigations being undertaken in relation to Ms Barber's colleagues and the wider team. [PRIVATE].

The panel also took account of the information before it in respect of mitigation. It took account of its finding in relation to impairment and concluded that the weight which could be attributed to Ms Barber's mitigation in relation to her working relationships and workload was so limited that they could not be properly considered as mitigating features in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the sustained nature of the lack of competence identified by the panel. 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 and public interest issues identified by the panel in its finding of impairment, an order that does not restrict Ms Barber'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 Barber's sustained lack of competence and repetition of strikingly similar concerns when caring for premature babies who both subsequently died on two separate occasions 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 Barber'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, which sets out that conditions of practice may be appropriate where the following features are present:

- *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;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *[…];*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated in this matter. The panel did not have before it any evidence of deep-seated personality issues, however it considered that there is evidence of attitudinal concerns as a result of Ms Barber's lack of insight, in that she did not follow instructions to reduce and handover her caseload and also took on new cases, contrary to the clear instructions of

her manager. The panel found that, although it cannot be said that there is evidence of general incompetence as a health visitor, there is strong evidence of incompetence around record keeping, assessment and managing her caseload which are fundamental skills of a health visitor's practice.

The panel was not confident that Ms Barber has the potential or willingness to respond positively to retraining. The panel had regard to the significant period of support across a range of methodology offered to Ms Barber, as outlined in the panel's decision in impairment, including the fact that Ms Barber was under an action plan which was supported by the Trust for the majority of her career as a health visitor. Despite this, the panel found that such extensive support did not assist Ms Barber in consistently improving her practice to a safe level and concerns of the same nature were repeated even after an action plan had been completed which targeted these issues. The panel therefore concluded that it could not be confident that any conditions of practice which it may impose would effectively assist Ms Barber beyond the support which she has already received.

The panel concluded that, especially as a result of the evidence of repetition of the same concerns after a sustained period of support, there is a high risk that patients would be put in danger either directly or indirectly as a result of the imposition of conditions and therefore there are no practical or workable conditions of practice which could be monitored and assessed which would protect patients during the period they are in force. Further, it bore in mind that Ms Barber has not engaged with the NMC, therefore the panel could not be satisfied that she would effectively comply with any conditions of practice.

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

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:

- *[…]*
- *No evidence of harmful deep-seated personality […] problems;*
- *[…]*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

For the reasons already outlined, the panel determined that there remains a significant risk to patient safety were Ms Barber permitted to practise as a nurse or health visitor even with conditions of practice in place.

The panel bore in mind that, in cases relating to lack of competence, it is not open to a panel to consider a striking-off order at a substantive hearing.

Balancing all of these factors the panel has concluded that a suspension order would be the only appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Ms Barber. 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 nurse.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of this case and the public interest concerns identified.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, it may confirm the order, it may replace the order with another order, or it may allow the order to lapse with a finding of impairment.

Any future panel reviewing this case would be assisted by:

- Should Ms Barber wish to return to nursing practice, evidence of engagement with the NMC and an extensive up-to-date reflective piece which addresses her insight, remorse and the impact which her lack of competence had on the patients in her care, their families, her colleagues and the reputation of the nursing profession.
- Should Ms Barber wish to be removed from the NMC register, evidence of her clear settled intentions that she no longer wishes to return to practice as a registered nurse, including a declaration that she would not seek readmission to the NMC register for a period of at least five years after her name has been removed.

This will be confirmed to Ms Barber 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 Barber's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Davies. She submitted that the suspension order cannot take effect until 28 days after the decision letter is sent to Ms Barber. She submitted that an interim suspension order is appropriate and necessary for the same reasons that the panel has imposed the substantive suspension order. She invited the panel to impose this order for a period of 18 months to cover any potential appeal of this order.

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 in order to cover the period that it may take to conclude any potential appeal of this decision, should one be made.

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

That concludes this determination.