Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 20 – Friday 21 October 2022
Monday 19 – Wednesday 21 December 2022
Tuesday 3 – Friday 6 January 2023
Thursday 12 – Friday 13 January 2023
Monday 10 - Wednesday 19 July 2023
Monday 8 – Wednesday 10 January 2024

Virtual Hearing

Name of registrant:	Krishinda Powers-Duff
NMC PIN:	10G0712E
Part(s) of the register:	RM: Midwife (10 September 2010)
Relevant Location:	Glasgow
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, Lay member) Rachel Jokhi (Registrant member) David Boyd (Lay member)
Legal Assessor:	James Holdsworth Gerrard Coll (10-17 July 2023) Graeme Henderson (18-19 July 2023) (8-10 January 2024)
Hearings Coordinator:	Anya Sharma (20–21 October 2022) Taymika Brandy (19–21 December 2022) Roshani Wanigasinghe (3–6 January 2023 Tyrena Agyemang (12-13 January 2023) Roshani Wanigasinghe (10-20 July 2023) Stanley Udealor (8-10 January 2024)
Nursing and Midwifery Council:	Represented by Leeann Mohamed, Case Presenter
Mrs Powers-Duff:	Not present, represented by Neomi Bennett of Equality 4 Black Nurses (Thursday 20 – Friday 21 October 2022 and Monday 19 December 2022)

	Present and represented by Neomi Bennett of Equality 4 Black Nurses (Tuesday 20-Wednesday 21 December 2022) Not present, represented by Neomi Bennett of Equality 4 Black Nurses (Tuesday 03 January 2023 – 5 January 2023) Not present and represented by Neomi Bennett of Equality 4 Black Nurses (Thursday 12 – Friday 13 January 2023) Not present, represented by Neomi Bennett of Equality 4 Black Nurses (Monday 10 July – Wednesday 19 July 2023) (8-9 January 2024) Not present and not represented at the hearing (10 January 2024)
Facts proved:	1b, 1c, 1d(i), 1d(ii), 1d(iv), 2c, 2e(ii), 2e(iii), 3a, 3c, 3d(iv), 3(v), 4, 5a, 5b, 5c, 6a, 6b, 6d, 6e, 7a, 7b and 7c.
Facts not proved:	1a, 1d(iii), 1d(v), 2a, 2b, 2d, 2e(i), 3b, 3d (i), 3d(ii), 3d(iii) and 6c.
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to adjourn the Hearing on Thursday 20 October 2022

On day one of the hearing, the panel heard an application from Ms Bennett to adjourn proceedings. Ms Bennett submitted that the initial referral in this case received by the Nursing and Midwifery Council (NMC) included reference to another registrant who was working with Mrs Powers-Duff at around the time of the majority of the allegations.

Ms Bennett submitted that the allegations that have been put against Mrs Powers-Duff involve both registrants equally. Ms Bennett explained to the panel that she is concerned that the other registrant has not been identified by the NMC and there is therefore a public protection and public interest risk. She told the panel that in the name of justice it is not fair for one registrant, namely Mrs Powers-Duff to be put through the Fitness to Practise process when the other registrant who is involved in ninety percent of the allegations has not been included.

Ms Bennett told the panel that she has been informed today that the NMC have not received a referral in regard to the other registrant. She submitted that the registrant is an accomplice who was involved and aware of what was going on and this registrant's contribution to placing patient safety at risk should be considered jointly with Mrs Powers-Duff.

Ms Bennett told the panel that she notes that this case has experienced delays due to the Covid-19 situation and the NMC backlog, but in order to speed up the process and in light of the public protection concerns, both registrants should be considered jointly today. She told the panel that she has prepared a referral for this registrant which is appropriate and proportionate in the circumstances and in the name of justice.

Ms Bennett submitted that she is requesting an adjournment in order for the NMC to consider both registrants jointly as it would be unfair for one registrant to be proceeded with when there is evidence of two registrants being involved throughout the information that is before the panel. Ms Bennett submitted that the adjournment would allow time for

the new information in regard to the registrant's referral to be obtained and considered by the NMC, which has not been obtained in the course of the NMC's investigation.

Ms Mohamed submitted that in considering this application for an adjournment, the NMC has live witnesses warned, and the panel should proceed with the hearing. Ms Mohamed submitted that she notes Ms Bennett's submissions in regard to any injustice in relation to the other registrant.

Ms Mohamed submitted that there would be no injustice to proceed with the hearing with Mrs Powers-Duff as a sole registrant at this stage. She submitted that it is a matter for Ms Bennett whether she wishes to make a referral or not in relation to the other registrant, which would then need to go through the NMC processes once received. Ms Mohamed submitted that this could take some time and that the charges relate to four individual patients which could be fairly determined without the other registrant. She submitted that the panel would be able to consider Mrs Powers-Duff fairly as a sole registrant because the evidence that is being relied on by the NMC could be fairly attributed to Mrs Powers-Duff.

Ms Mohamed submitted that it is the NMC's position that it is fair to proceed with this hearing. She submitted that there is a public interest in the expeditious disposal of this case and live witnesses have been warned to give evidence. She submitted that this case is in regard to events which took place in 2020 and if the hearing were to be delayed further, it is unclear as to when the next hearing will be.

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

The panel decided to refuse the application to adjourn.

The panel was of the view that the charges against Mrs Powers-Duff raise serious concerns about her practice and it is in the public interest for those to be dealt with expeditiously. Any allegations against the other registrant will be considered separately, should a referral be made.

There is therefore no unfairness to Mrs Powers-Duff in proceeding today.

The panel noted that there are a number of live witnesses who have been warned for today and for tomorrow and would be inconvenienced should the hearing be adjourned. The panel considered that these events are already some two years in the past and any further delay could have a detrimental effect on witnesses' memories and possibly prejudice a future hearing.

Decision and reasons on application to amend the charges on 20 December 2022

The panel heard an application made by Ms Mohamed to amend the wording of charges 1 and 3. The proposed amendment was to provide clarity and to remove any duplications in the charges. She submitted the proposed amendments would not result in prejudice or unfairness to you.

Ms Bennett did not object to the proposed amendment to charges 1 and 3.

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

The panel was of the view that such an amendment, as applied for, was relevant, fair and provided clarity. The panel also considered that it removes duplication in the charges. The panel noted that you did not object to this proposed amendment. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment as follows:

Original charges:

That you, a Registered Midwife:

1) On 24 July 2020, in relation to Patient A, failed to:

a) Identify/recognise the signs of hyponatremia;

b) adequately monitor and/or record the patients fluid balance;

c) Arrange for the patient to be transferred to hospital in a timely manner;

d) Maintain an adequate standard of record keeping in that you did not: record:

i) the patients fluid balance;

ii) a urine analysis

iii) maternal observations whilst the patient was in labour;

iv) a VTE risk assessment;

v) an assessment and/or plan of care

2) In relation to Patient B, failed to:

a) ensure that the patient had weekly appointments from 36 weeks as per the schedule of care;

b) diagnose/identify the baby was in the breech position during the latter stages of pregnancy;

c) diagnose/identify the baby was in the breech position when attending to the patient in the early stages of labour on 06 June 2020;

d) escalate that the baby was in the breech position;

e) maintain an adequate standard of record keeping in that you failed to:

i) record why the patient did not have weekly appointment from 36 weeks as per the schedule of care;

ii) properly complete the antenatal plan of care;

iii) sign and/or date the labour notes;

3) On 6 June 2020,in relation to Patient C, failed to:

a) adequately assess and/or record an assessment of the patient who had started to bleed;

b) record/say how much blood there was, despite recording a trickle of blood;

c) escalate a significant Postpartum Haemorrhage ('PPH') in a timely manner;

d) maintain an adequate standard of record keeping in that you did not record:

i) the patient's haemoglobin ('Hb') level before the birth;

ii) the patient had sustained a PPH;

iii) record / say how much blood there was, despite recording a trickle of blood?;

iv) what happened between the birth and the PPH, other than that the baby was being breastfed;

v) how the placenta was managed between the birth and the ambulance arriving;

vi) sign and/or date, one or more records;

4) On 1 August 2020, performed an episiotomy on Patient D;

5) The episiotomy referred to on 1 August 2020 was performed:

   a) at the wrong angle;

   b) in the wrong position;

   c) below an acceptable clinical standard;

6) On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above:

   a) without having in place appropriate indemnity insurance;

   b) having advised /been advised by your manager, that you would no longer be involved in Patient D care and/or Patient Ds intrapartum care had been cancelled;

   c) without having told Patient D that you had been instructed not to carry out any labour care;

   d) without making any and/or any adequate birth notes and/or records;

   e) without handing over to the paramedics that the baby had been resuscitated;

7) Your conduct at any and/or all of charge 6 above was dishonest in that you:

   a) knew that you should not be proving the care referred to;

   b) intended to conceal that you had provided the care referred to;

   c) intended to create a misleading impression of the care that you provided to Patient D

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

Proposed Amended Charges:

That you, a Registered Midwife:

1) On 24 July 2020, in relation to Patient A, failed to:

   a) Identify/recognise the signs of hyponatremia;

   b) **adequately monitor** ~~and/or record~~ **the patient's fluid balance;**

   c) Arrange for the patient to be transferred to hospital in a timely manner;

   d) Maintain an adequate standard of record keeping in that you did not: record:

      i) the patient's fluid balance;

      ii) a urine analysis

      iii) maternal observations whilst the patient was in labour;

      iv) a VTE risk assessment;

      v) an assessment and/or plan of care

2) In relation to Patient B, failed to:

   a) ensure that the patient had weekly appointments from 36 weeks as per the schedule of care;

b) diagnose/identify the baby was in the breech position during the latter stages of pregnancy;

c) diagnose/identify the baby was in the breech position when attending to the patient in the early stages of labour on 06 June 2020;

d) escalate that the baby was in the breech position;

e) maintain an adequate standard of record keeping in that you failed to:

i) record why the patient did not have weekly appointment from 36 weeks as per the schedule of care;

ii) properly complete the antenatal plan of care;

iii) sign and/or date the labour notes;

3) On 6 June 2020,in relation to Patient C, failed to:

a) adequately assess and/or record an assessment of the patient who had started to bleed;

b) record/say how much blood there was, despite recording a trickle of blood;

c) escalate a significant Postpartum Haemorrhage ('PPH') in a timely manner;

d) maintain an adequate standard of record keeping in that you did not record:

i) the patient's haemoglobin ('Hb') level before the birth;

ii) the patient had sustained a PPH;

~~iii) record / say how much blood there was, despite recording a trickle of blood?;~~

iv) what happened between the birth and the PPH, other than that the baby was being breastfed;

v) how the placenta was managed between the birth and the ambulance arriving;

vi) sign and/or date, one or more records;

4) On 1 August 2020, performed an episiotomy on Patient D;

5) The episiotomy referred to on 1 August 2020 was performed:

a) at the wrong angle;

b) in the wrong position;

c) below an acceptable clinical standard;

6) On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above:

a) without having in place appropriate indemnity insurance;

b) having advised /been advised by your manager, that you would no longer be involved in Patient D care and/or Patient Ds intrapartum care had been cancelled;

c) without having told Patient D that you had been instructed not to carry out any labour care;

d) without making any and/or any adequate birth notes and/or records;

e) without handing over to the paramedics that the baby had been resuscitated;

7) Your conduct at any and/or all of charge 6 above was dishonest in that you:

a) knew that you should not be proving the care referred to;

b) intended to conceal that you had provided the care referred to;

c) intended to create a misleading impression of the care that you provided to Patient D

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

Details of charge (as amended):

That you, a Registered Midwife:

1) On 24 July 2020, in relation to Patient A, failed to:

a) Identify/recognise the signs of hyponatremia;

b) Adequately monitor the patients fluid balance;

c) Arrange for the patient to be transferred to hospital in a timely manner;

d) Maintain an adequate standard of record keeping in that you did not: record:

i) the patients fluid balance;

ii) a urine analysis

iii) maternal observations whilst the patient was in labour;

iv) a VTE risk assessment;

v) an assessment and/or plan of care

2) In relation to Patient B, failed to:

a) ensure that the patient had weekly appointments from 36 weeks as per the schedule of care;

b) diagnose/identify the baby was in the breech position during the latter stages of pregnancy;

c) diagnose/identify the baby was in the breech position when attending to the patient in the early stages of labour on 06 June 2020;

d) escalate that the baby was in the breech position;

e) maintain an adequate standard of record keeping in that you failed to:

i) record why the patient did not have weekly appointment from 36 weeks as per the schedule of care;

ii) properly complete the antenatal plan of care;

iii) sign and/or date the labour notes;

3) On 6 June 2020,in relation to Patient C, failed to:

a) adequately assess and/or record an assessment of the patient who had started to bleed;

b) record/say how much blood there was, despite recording a trickle of blood;

c) escalate a significant Postpartum Haemorrhage ('PPH') in a timely manner;

d) maintain an adequate standard of record keeping in that you did not record:

i) the patient's haemoglobin ('Hb') level before the birth;

ii) the patient had sustained a PPH;

iii) what happened between the birth and the PPH, other than that the baby was being breastfed;

iv) how the placenta was managed between the birth and the ambulance arriving;

v) sign and/or date, one or more records;

4) On 1 August 2020, performed an episiotomy on Patient D;

5) The episiotomy referred to on 1 August 2020 was performed:

a) at the wrong angle;

b) in the wrong position;

c) below an acceptable clinical standard;

6) On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above:

a) without having in place appropriate indemnity insurance;

b) having advised /been advised by your manager, that you would no longer be involved in Patient D care and/or Patient Ds intrapartum care had been cancelled;

c) without having told Patient D that you had been instructed not to carry out any labour care;

d) without making any and/or any adequate birth notes and/or records;

e) without handing over to the paramedics that the baby had been resuscitated;

7) Your conduct at any and/or all of charge 6 above was dishonest in that you:

a) knew that you should not be proving the care referred to;

b) intended to conceal that you had provided the care referred to;

c) intended to create a misleading impression of the care that you provided to Patient D

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

Decision and reasons on application to admit written statement of Patient B

The panel heard an application made by Ms Mohamed, pursuant to Rule 31, to allow the written statement of Patient B into evidence. She submitted that Patient B was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, Patient B is no longer engaging with the NMC and does not wish to attend. Ms Mohamed told the panel that the last substantive communication between the NMC and Patient B was via the Case Coordinator on 18 October 2022. On this date, Patient B stated the following:

> *'[…] as mentioned before: no longer interested. Please stop bothering me with emails and phone calls. You are still welcome to use my written testimony. If you contact me again I WILL WITHDRAW MY CONSENT to that too.'*

Ms Mohamed submitted that, whilst it is clear that Patient B does not wish to engage with these proceedings the NMC did make further attempts to contact Patient B in November 2022 and secure the witnesses attendance, however to no avail.

Ms Mohamed explained that it is possible for the witness to be issued a summons to attend the hearing and give evidence, however given the difficulty in obtaining a summons at this stage due to jurisdiction, the NMC have not pursued this option. Ms Mohamed did however invite the panel to consider its power under Rule 22 (5) to, of its own motion, require a person to attend the hearing to give evidence.

Ms Mohamed invited the panel to consider the relevant principles as set out in the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), notably, the principles outlined in paragraph 56 of *Thorneycroft* when considering this application:

(i) whether the statements were the sole or decisive evidence in support of the charges;

(ii) the nature and extent of the challenge to the contents of the statements;

(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;

(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;

(v) whether there was a good reason for the non-attendance of the witnesses;

(vi) whether the Respondent had taken reasonable steps to secure their attendance; and

(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.

Ms Mohamed addressed the panel on each of factors in paragraph 56 of *Thorneycroft*.

She submitted that Patient B's evidence relates only to charge 2 and its sub charges. However, it is not the sole and decisive evidence, as much of the evidence relating to charge 2 is contained within the witness statement of Ms 1 and the clinical notes that she has exhibited.

Ms Mohamed submitted that your representative does not object to the admission of this hearsay evidence. Further, there is no suggestion that Patient B has any reason to fabricate the evidence in her witness statement.

Ms Mohamed submitted that every possible step has been taken to secure Patient B's attendance including a number of recent communication attempts. She submitted that you and Ms Bennett have known for some time that a hearsay application would be made in respect of this evidence, namely, at the opening of the NMC's case, in October 2022.

Ms Mohamed invited the panel to adduce the evidence of Patient B as hearsay for the reasons set out above.

Ms Bennett made no objection to this application.

The panel heard and accepted the advice of the legal assessor which included reference to the relevant cases of *Thorneycroft* and *Razzaq v Financial Conduct Authority (FCA)* [2014] EWCA Civ 770. This included that Rule 31 provides that, subject only to the requirements of relevance and fairness, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel took the factors as set out in *Thorneycroft* in turn. It did not consider Patient B's evidence to be sole and decisive. The panel concluded that there was no suggestion of fabrication of the evidence in this matter. The panel accepted that you

and Ms Bennett did have prior notice of this hearsay application and that you did not oppose this. The panel determined that the hearsay evidence should be admitted into evidence.

Application to adduce further evidence

Ms Bennett invited the panel to direct the NMC to obtain further evidence in the form of hospital notes in respect of Patient A, B, C and D and Baby D. She submitted that these hospital notes are independent of Private Midwives and will constitute reliable and independent evidence. She submitted that the lack of these documents puts Mrs Powers-Duff at a disadvantage and that it is unfair.

Further, Ms Bennett invited the panel to direct the NMC to call witness Colleague 1 to either give evidence to the panel or provide a witness statement. She submitted that doing so would ensure fairness to Mrs Powers-Duff's case.

Ms Mohamed submitted in relation to the hospital notes that they were not relevant to the issues in this case. She then submitted in relation to Colleague 1, that it was the NMC's position from the outset that Colleague 1 would not be called, nor would it adduce her witness statement. Ms Mohamed submitted that Mrs Powers-Duff was aware for many months that the NMC was not seeking to rely on Colleague 1's evidence and that Mrs Powers-Duff was told that if she wished, she could call Colleague 1 of her own volition.

The panel accepted the advice of the legal assessor.

Firstly, the panel considered the application in relation to the hospital notes for Patients A, B, C, D and Baby D. The panel concluded that the hospital notes only refer to events that occurred after the patients arrived at the hospital and after Mrs Powers-Duff had provided care, which are not pertinent to the charges. The panel also noted that trying to obtain the notes at this late stage will cause disruption to this hearing, resulting in it going part-heard. It was of the view that there will be more unfairness caused by such delays to the conclusion of this case.

The panel then considered the application in relation to Colleague 1's evidence. The panel concluded that, whilst it accepted that it might have been useful to hear Colleague 1's evidence, it bore in mind that it was made clear by the NMC at an early stage and at the very latest by October 2022, that the NMC did not seek to call Colleague 1. The panel considered that the NMC has the authority to decide which witnesses to call and that they had decided not to call Colleague 1. Further, the panel bore in mind that Ms Bennett has had ample opportunity to call Colleague 1 of her volition. The panel noted that no such efforts had been made to date.

The panel therefore rejected Ms Bennett's application to direct the NMC to obtain further evidence.

Application to adjourn the Hearing on Thursday 05 January 2023

Ms Mohamed invited the panel to adjourn this hearing in order for Ms Bennett to provide the NMC with a written report from her expert witness, Witness 5 prior to hearing his evidence. Ms Mohamed told the panel that Ms Bennett has also informed her that there is video evidence relating to Patient D that the NMC had not been made aware of previously. Ms Mohamed submitted that the NMC has dealt with its witnesses and closed its case on facts as it was unaware of the witnesses that Ms Bennett has subsequently called and intends to call. However, this expert witness will refer to matters that are key to the facts of this case and the NMC will need to consider the contents of the report and decide whether it would be necessary to recall witnesses who have already given evidence in light of the new evidence that Ms Bennett is intending to place before the panel which contains issues which were not put to these witnesses when they gave evidence.

Ms Bennett opposed the application. She submitted that the witness has a very busy schedule and is on standby to give evidence and therefore the panel should proceed to hear from him now.

The panel accepted the advice from the legal assessor.

The panel accepted the NMC's application. It accepted that the NMC should be provided with a report from the expert witness and should be able to see the video evidence before Ms Bennett's witness is called to give evidence, in order to properly assess its response. It bore in mind the effects this may have on this case and the possibility for witnesses to be re-called in order to fully explore matters related to the video and expert evidence.

The panel therefore directs that Ms Bennett provides a written report from her expert witness as soon as possible or at the very latest by 4pm on Monday 9 January 2023 in order that there is some chance to save two hearing days listed for next week. The panel also directs Ms Bennett to provide written consent from Patient D to the sharing of this video at this hearing due to the sensitive and personal nature of the evidence. The panel further directs that, should Ms Bennett be intending to call any further witnesses in this case, that she provide witness statements from those witnesses to the NMC by 4pm on Monday 9 January 2023.

Decision and reasons on whether to allow a No Case to Answer application

Ms Bennett on Thursday, 13 July 2023, during her closing arguments, indicated she wished to make a No Case to Answer Application (NCTA) under Rule 24 (7). She submitted that there is no evidence in support of any of the charges against Ms Power's Duff.

Ms Mohamed submitted that this is not the appropriate stage in which to make such an application. She submitted that the panel has heard further evidence from recalled witnesses and the NMC had closed its case and heard evidence from Mrs Powers-Duff. She submitted that it would be unfair for the panel to have heard all the evidence, and in essence be asked to put it out of their minds, in order to decide on a NCTA.

The panel heard advice from the Legal Assessor.

The panel determined that, given Ms Bennett is not legally qualified and given that the NMC had recalled its witnesses and had only just closed its case for the second time, it would be fair to allow Ms Bennett to make a NCTA at this stage.

Decision and reasons on an application of No Case to Answer

Ms Bennett made an application for NCTA on all charges. She submitted that the NMC had failed to provide sufficient documents in relation to the charges. she submitted that she makes this application on the grounds that there is a lack of sufficient evidence and lack of transparency and therefore invited the panel to dismiss this case. She submitted that this whole case is fundamentally flawed with contradictory, uncorroborated and inconstant witness testimony.

Ms Bennett submitted that the original referral, made on 13 August 2020, included within it a questioned posed to Witness 1: whether another midwife under similar circumstances would have acted in the same way, to which Witness 1 had marked/ticked ‘no’. Ms Bennett submitted that this indicates that there is information missing which has not been provided to this panel. She submitted that there should have been a witness statement provided by the ‘co-defendant’ (Colleague 1). Ms Bennett submitted that the evidence before the panel is incomplete and biased.

Ms Bennett further submitted that the evidence before the panel cannot truly point to Mrs Powers-Duff in relation to charges 1, 2, 3 as it cannot be determined which registrant (Mrs Powers-Duff or Colleague 1) is responsible for the alleged failings.

Ms Mohammed submitted that Ms Bennett’s application does not relate to specific charges but has been made generically. She submitted that there is ample evidence before the panel which is not tenuous or inconsistent in nature. She reminded the panel that Witness 1 gives evidence regarding Patient A, Patient B, Patient C and Patient D, through both oral evidence and witness testimony, which is supported and corroborated by notes and bundles. She also submitted that Witness 2 and Patient D provide evidence in relation to charges 4-7. She submitted that there is sufficient evidence before the panel for it to continue the case.

The panel heard advice from the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could potentially find the facts proved and whether Mrs Powers-Duff had a case to answer.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer.

It noted the NMC's acceptance that some of the charges relating to Patient B may not be made out. Nonetheless, it considered that this evidence should be weighed at the fact-finding stage. The panel therefore determined that it could not give effect to a NCTA submission.

The panel therefore rejected Ms Bennett's application of no case to answer.

Panel responses to allegations of abuse of process which occurred during submissions by Ms Bennett

The panel noted that Ms Bennett in her closing submissions made an abuse of process allegation that Colleague 1 should have been called as a witness, and that she had not provided a witness statement. The panel also bore in mind that Ms Bennett stated that certain documents had not been provided by the NMC, such as hospital notes, and furthermore, Ms Bennett further alleged that Witness 1 had substituted and/or omitted pages in the documents she had provided to the panel and that this had been done with a malicious intent motivated by racial prejudice.

The panel noted that the issue of Colleague 1 giving evidence had been dealt with at an earlier stage in the hearing, and in fact she was contacted by the NMC on behalf of Ms Bennett, to request her to give evidence. However, she had declined.

The panel further considered the issues of hospital notes for all patients. It bore in mind that, earlier on in the hearing, Ms Bennett had requested that the panel instruct the NMC to get these notes. The panel had heard submissions from both parties and had determined that, as the hospital notes only dealt with events after the patients arrived at the hospital and were no longer under the care of Mrs Powers-Duff, they were irrelevant to the charges to be considered by this panel. The panel had therefore rejected Ms Bennett's application.

The panel next considered the allegations in respect of Witness 1. The panel noted that Witness 1 had subsequently provided, in their entirety, all of the sequentially paginated booklets of patient notes which had been used by Mrs Powers-Duff in her midwifery practice. The panel considered that, on the face of it, there were no apparent '*orphan entries*', irregularities, incongruities or inconsistencies which pointed to records which were incomplete or had been manipulated.

Therefore, the panel was unable to find any evidence to support Ms Bennett's contentions. For this reason, the panel concluded that there was no evidence to demonstrate that pages and notes had been removed, tampered with or interfered with.

The panel took account of the NMC guidance DMA-4. The panel found no evidence of any abuse of process which would cause any prejudice or unfairness to Mrs Powers-Duff.

Background

The NMC received a referral from the Director of Midwifery, Quality & Safety at *'Private Midwives'*, (the Company) about Mrs Powers-Duff which raised a number of concerns. She was employed by the Company as a salaried, case loading midwife, providing antenatal, birth and postnatal care. The referral stated the following alleged concerns:

On 24 July 2020, Patient A was admitted to Hospital after 30 hours in labour. She was dehydrated with severe electrolyte imbalance and fitted upon arrival and was subsequently intubated. The Company had attempted to undertake an incident review, but the records had been of poor quality.

On 6 June 2020, during a home birth, Patient C had experienced a 2-litre postpartum haemorrhage (PPH). The Company had investigated, and during this, found that the notes were sparse and difficult to read, and it appeared that the PPH Policy was not followed. The Company requested a statement from Mrs Powers-Duff in respect of this incident, but she resigned, stating she felt stressed and unsupported.

The Company had also been notified by a Glasgow Hospital that on 1 August 2020, Mrs Powers-Duff had attended a woman in labour at home (Patient D), performed an episiotomy and cared for her during the birth. Mrs Powers-Duff had resigned from the Company and therefore had no indemnity insurance for intrapartum care as she was not employed as a midwife.

Patient D had originally told the Hospital that she had free-birthed, and her partner performed the episiotomy. When told this would result in a safeguarding referral, she stated that Mrs Powers-Duff was present. Mrs Powers-Duff had therefore allegedly practiced without insurance and the Company believed she had coerced Patient D and her partner to lie to the Hospital about the circumstances of the birth.

The Company had also received a formal complaint from Patient B who had an undiagnosed breech birth leading to an emergency caesarean.

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 Mohamed on behalf of the NMC and by Ms Bennett on behalf of Mrs Powers-Duff.

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: Head of Midwifery and Director of Midwifery, Quality and Safety at UK Birth Centres;
- Witness 2: Charge Midwife based at Queen Elizabeth University Hospital, employed by NHS Greater Glasgow and Clyde Health Board;
- Patient D: Patient D

The panel heard live evidence from the following witnesses called on behalf of the Mrs Powers-Duff:

- Witness 3: Doula for Patient D;
- Witness 4: Consultant Midwife and Senior Research Fellow at Kings College London;
- Witness 5: Consultant in Obstetrics and Gynaecology.

The panel also heard evidence from Ms Powers Duff under affirmation.

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 both the NMC and Ms Bennett.

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

Charge 1a

1) *On 24 July 2020, in relation to Patient A, failed to:*

    a) *Identify/recognise the signs of hyponatremia;*

This charge is found NOT proved.

In reaching this decision, the panel took into account the Investigation report into the care of Patient A, Patient A's Birth notes, the written and oral evidence of Witness 1 and the evidence of Mrs Powers-Duff.

It is not in dispute that Patient A had an active labour of over 30 hours at home. It is recorded in the birth notes by Mrs Powers-Duff that it was some 11.5 hours after Patient A was assessed as being 8cm dilated before the decision was made to transfer her to hospital, due to her exhaustion. It is also not in dispute that on her admission, Patient A suffered several fits. She underwent a forceps delivery and was taken to theatre for repair of an episiotomy before being transferred to the Intensive Care Unit (ICU) where she was placed in an induced coma in order to stabilise her condition. The diagnosis of Hyponatremia was made following blood tests taken as part of her hospital care.

Witness 1, in her evidence stated that the signs and symptoms of Hyponatremia are confusion, exhaustion, nausea and vomiting. The panel noted that, whilst there was mention in the birth notes that Patient A had vomited on several occasions, this can occur during any labour. The panel considered that any woman would be exhausted after 30 hours of labour. Furthermore, there was no evidence in the birth notes of Patient A being confused.

The panel noted that in the birth records, Mrs Powers-Duff has signed to say that she is the lead professional and lead care giver in labour. The panel considered that, although Mrs Powers-Duff should have been aware of the risk factors involved in such a prolonged labour, there was no documentary evidence of any clinical observations that

would support deterioration and the development of hyponatremia during the time care was being provided by Mrs Powers-Duff.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to identify/recognise the signs of hyponatremia.

In light of this evidence, the panel found charge 1a not proved.

Charge 1b

1) *On 24 July 2020, in relation to Patient A, failed to:*

b) *Adequately monitor the patients fluid balance;*

This charge is found proved.

In reaching this decision, the panel took into account Patient A's birth notes, Witness 1's oral and written evidence and Mrs Powers-Duff's evidence.

The panel had sight of Patient A's birth notes in which Mrs Powers-Duff has signed to say that she is the Lead Professional and Lead Carer in labour. The panel therefore considered that it was Mrs Powers-Duff's responsibility to ensure that the records were adequately completed.

The panel noted that the boxes within Patient A's birth notes for 'fluids in and out' are not completed. Throughout her patient notes, Mrs Powers-Duff makes reference to Patient A drinking liquids, passing urine and vomiting. However, no specific details of volumes have been recorded or marked. The panel accepted Witness 1's evidence that it would be standard practice for such records to be made as set out in the pro forma.

The panel considered Mrs Powers-Duff's evidence, in which she told the panel that where she and Colleague 1 worked together, Mrs Powers-Duff would provide hands on care and Colleague 1 would do the scribing. Mrs Powers-Duff indicated that this was because she was unfamiliar with the hospital-based paper notes provided by the Company. Witness 1 told the panel these were nationally approved records from the Perinatal Institute. The panel noted that Mrs Powers-Duff qualified as a Midwife in in 2010 having trained in Bristol. She then worked for several years in Spain. On her return in 2020 she worked for the Princess Royal Maternity Hospital in Glasgow. The panel therefore was of the view that Mrs Powers-Duff should have been familiar with the standards of and requirements for record keeping within the NHS, as well as the standards expected by the NMC as her regulatory body. In particular, section 6.2 of the *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ('the Code')*, *"to maintain the knowledge and skills you need for safe and effective practice".*

The panel considered that, had Mrs Powers-Duff not been familiar with the processes, she should have escalated matters. The panel bore in mind Witness 1's evidence in which she told the panel that there was ample training material available to staff. Bearing this in mind, the panel was of the view that Mrs Powers-Duff had an obligation to her patients and the public to work to the required standard.

In these circumstances, the panel found that it had sufficient evidence before it to find that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to adequately monitor the patient's fluid balance.

The panel therefore found charge 1b, on balance of probabilities, proved.

Charge 1c

1) On 24 July 2020, in relation to Patient A, failed to:

c) Arrange for the patient to be transferred to hospital in a timely manner;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Mrs Powers-Duff.

The panel noted that Patient A had a prolonged active stage of labour. The panel accepted Witness 1's evidence that a full assessment should be carried out every four hours and a plan should be in place for such instances. The panel noted that her witness statement dated 22 January 2021 stated:

> *"When in labour there should be ongoing assessments every 4 hours and a plan of care is made, including when to transfer the patient to hospital and what we would do if there are issues. Krishinda did not recognise that there was a need for escalation. This was Patient A's first pregnancy and there was no plan of care or assessment carried out by Krishinda."*

The panel bore in mind that in her oral evidence, Mrs Powers-Duff discussed having spoken to the patient about hospital transfers. However, the panel did not have any documentation of any such discussion between 22:00 on 23 July 2020 and 11:00 the following day.

The panel did not have adequate information before it of any assessment of how the labour was progressing. Whilst the panel acknowledged Mrs Powers-Duff's evidence that Patient A did not wished to be transferred to hospital, it considered that it would have been correct procedure for Ms Power-Duff as the lead midwife, to have escalated matters to her line manager and to the hospital. Mrs Powers-Duff should have made a plan of care including when to transfer the patient to hospital, given that there appeared to have been arrested progress in labour.

In these circumstances, the panel found that it had sufficient evidence before it to find that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to arrange for the patient to be transferred to hospital in a timely manner.

The panel therefore found charge 1c, on balance of probabilities, proved.

Charge 1d

1) On 24 July 2020, in relation to Patient A, failed to:

d) Maintain an adequate standard of record keeping in that you did not: record:

i) the patients fluid balance;

ii) a urine analysis

iii) maternal observations whilst the patient was in labour;

iv) a VTE risk assessment;

v) an assessment and/or plan of care

Charges 1d (i), (ii) and (iv) are found proved.
Charges 1d (iii) and (v) are found NOT proved

In reaching this decision, the panel took into account Patient A's pregnancy and birth notes, the evidence of Witness 1 and Mrs Powers-Duff's evidence.

The panel had sight of Patient A's birth notes in which Mrs Powers-Duff has recorded that she is the lead professional and the lead carer in labour. The panel therefore determined that Mrs Powers-Duff was responsible to ensure that the records were adequately completed.

The panel had sight of the fluid balance chart contained within the birth notes and noted that the *'fluids in and fluid out'* boxes had not been completed. Witness 1, in her oral evidence explained to the panel the importance of completing and recording these observations. The panel therefore determined that it had sufficient evidence to establish

that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record the patient's fluid balance.

Therefore, the panel found charge 1d(i) proved.

The panel noted that in respect of Patient A's urine analysis, there is no recording or documentation. In the birth notes, on page three, under *'initial assessment-general examination'* the box relating to urine is crossed through. Furthermore, where there is reference to Patient A passing urine in the handwritten birth notes, there is no record of any analysis of the urine. The panel therefore determined that it had sufficient evidence to establish that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record a urine analysis

Therefore, the panel found charge 1d(ii) proved.

In relation to maternal observations whilst the patient was in labour, the panel noted that whilst much of the initial assessment page in the birth notes had not been completed, there was evidence throughout the hand-written notes that maternal observations had been taken, recorded, and documented by Colleague 1.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record maternal observations whilst the patient was in labour.

In light of this evidence, the panel found charge 1d(iii) not proved.

In relation to the VTE risk assessment, the panel noted Patient A's pregnancy notes where the VTE assessment appears on page thirteen. However, the entire page has been crossed out without a signature. The panel further noted that within the pregnancy

notes, there is a checklist for the booking assessment where the VTE assessment is included within one of the boxes. However, this box has been ticked as *'no'* and signed by Mrs Powers-Duff on 17 June 2020.

The panel noted, within the birth notes *'risk factors for venous thromboembolism'* that the VTE assessment box is ticked as '*yes'* but the page is not signed nor dated.

The panel bore in mind Mrs Powers-Duff's oral evidence in which she told the panel that the assessment had been conducted by Colleague 1 and put into the file on a separate sheet of paper. However, the panel did not have any evidence of any such recordings. The panel could find no reason for completing an assessment on a separate sheet when there was a pre-printed assessment contained within the booklet.

Given the above evidence, the panel determined that it had sufficient evidence to establish that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record a VTE risk assessment.

Therefore, the panel found charge 1d(iv) proved.

In respect of whether an assessment and/or plan of care had been recorded, the panel had regard to Witness 1's witness statement dated 22 January 2021 in which she wrote:

> *"When in labour there should be ongoing assessments every 4 hours and a plan of care is made, including when to transfer the patient to hospital and what we would do if there are issues. Krishinda did not recognise that there was a need for escalation. This was Patient A's first pregnancy and there was no plan of care or assessment carried out by Krishinda"*

The panel has already found that the labour was allowed to progress for a long time without escalation. There is no evidence of ongoing assessment as suggested by Witness 1. Nonetheless, the panel found that there are records throughout the pregnancy and birth notes of assessment of the mother and discussions of birth plans.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that on 24 July 2020, in relation to Patient A, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record an assessment and/or plan of care.

In light of this evidence, the panel found charge 1d(v) not proved.

Therefore, in relation to charge 1d, the panel found charges 1d (i), (ii) and (iv) proved and charges 1d (iii) and (v) not proved.

Charge 2a

2) *In relation to Patient B, failed to:*

a) *ensure that the patient had weekly appointments from 36 weeks as per the schedule of care*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Patient B and Mrs Powers-Duff.

The panel had sight of Patient B's pregnancy notes in which Mrs Powers-Duff has recorded on 5 October 2020, that she is the lead professional.

Patient B, in her witness statant dated 19 February 2021:

> *"I had a phone conversation with Krishinda on 31 March 2020 and I confirmed with Private Midwives, I was happy to go with her… I instructed Private Midwives to provide me with Birth and post-natal care in parallel to the NHS providing ante-natal care. On 2 April 2020, I received the contract to sign from Private Midwives."*

Witness 1, in her written statement stated that:

> *"Patient B should have had weekly appointments from 36 weeks as this is our schedule of care."*

Witness 1, in her oral evidence said that the Company do not offer birth only packages and that any packages must include antenatal and postnatal care. She reiterated that if a client does not want to accept these together, then the Company would decline to support the patient and they would be referred to the NHS.

Mrs Powers-Duff in her oral evidence confirmed to the panel that she was aware that Patient B should have had weekly antenatal assessments. She told the panel that she had undertaken three visits and Colleague 1 had undertaken two.

The panel also noted Mrs Powers-Duff's evidence in which she told the panel that the patient did not want to be seen weekly, and only wanted to see her NHS midwife. However, the panel did not have any notes to corroborate this, either from Mrs Powers-Duff or any record of liaison or discussions with the NHS midwife.

The panel had sight of the booking contract dated 2 April 2020 from the Company in which it stated:

> *"After this booking appointment, your antenatal care will be discussed with you and visits will be arranged to suit your individual needs and wishes. Typically, weekly after 36 weeks of pregnancy."*

The panel had sight of Patient B's pregnancy notes where at page seven, there is a pregnancy planner showing appointments at 34, 36 and 38 weeks with an appointment at 40 weeks for women having their first baby. The panel noted that Mrs Powers-Duff saw Patient B on 10 May 2020 and 28 May 2020 which would correspond to the 36 and 38 weeks. Patient B went into labour at 39 weeks.

The panel considered that it did not have compelling evidence of a Schedule of Care which required weekly appointments, despite the evidence of Witness 1. The pregnancy planner is contained within the pregnancy notes provided by the Company. Patient B did not wish to have weekly appointments and the contract offered appointments to be arranged to suit her needs and wishes.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, in relation to Patient B, Mrs Powers-Duff failed to ensure that the patient had weekly appointments from 36 weeks as per the schedule of care.

In light of this evidence, the panel found charge 2a not proved

Charge 2b

2) In relation to Patient B, failed to:

b) diagnose/identify the baby was in the breech position during the latter stages of pregnancy

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it in relation to Patient B including the evidence of Witness 4.

There is no dispute that Baby B was presenting in the breech position and had been for some time prior to Patient B's hospital admission. On being admitted to hospital, Patient B was given a scan which confirmed Baby B’s breech presentation which resulted in it being necessary for Baby B to be delivered by caesarean section. There was evidence to show that Baby B had been in the breech position for some time and almost certainly in the late stages of pregnancy.

The panel accepted that it might have been possible for Mrs Powers-Duff to have diagnosed and or identified that fact during the latter stages of Patient B's pregnancy. However, the panel heard evidence from Witness 4 who explained that the diagnosis of a breech presentation is one that is easily missed by midwives acting with ordinary skill and care. The panel appreciated the clinical challenges of recognising a breech presentation at this stage of pregnancy. Mrs Powers-Duff did not diagnose or recognise Baby B's breech presentation. However, the panel was not satisfied that this could be attributed to a failure on Mrs Powers-Duff's part. Furthermore, Patient B was examined by several midwives during the late stages of her pregnancy and labour, none of whom diagnosed the breech.

The panel therefore found that the NMC has not discharged its burden of proof and this charge is found not proved since there was no failure by Mrs Powers-Duff.

Therefore, in coming to this conclusion, the panel did not have sufficient evidence to find that, in relation to Patient B, Mrs Powers-Duff failed to diagnose/identify the baby was in the breech position during the latter stages of pregnancy.

In light of this evidence, the panel found charge 2b not proved.

Charge 2c

2) In relation to Patient B, failed to:

c) *diagnose/identify the baby was in the breech position when attending to the patient in the early stages of labour on 06 June 2020*

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it in relation to Patient B.

In respect of charge 2c, the panel considered that a different conclusion had to be arrived at on balance of probabilities. The evidence supported that a routine and necessary examination that any midwife acting with ordinary skill and care would have carried out on a mother in the early stages of labour was an abdominal palpitation followed by a vaginal examination. These examinations taken in sequence would have a very high degree of likelihood of disclosing that a baby was presenting in the breech position. This is a routine preliminary examination expected of any midwife with care of a mother in the early stages of her labour. There is no evidence, including from Mrs Powers-Duff, that she carried out this sequence of examination on Patient B while she was in the early stages of her labour. If conducted with reasonable skill and care the examinations sequence is, the panel concluded, likely to lead a midwife to a correct identification of a breech presentation. The panel was satisfied that Mrs Powers-Duff did not identify or diagnose Baby B's breech presentation as a direct result. The panel was satisfied that no midwife acting with ordinary skill and care would have neglected to do so.

Accordingly, in these circumstances, Mrs Powers-Duff failed in her duty.

It therefore determined that it had sufficient evidence to establish that in relation to Patient B, Mrs Powers-Duff failed to diagnose/identify the baby was in the breech position when attending to the patient in the early stages of labour on 06 June 2020.

Therefore, the panel found charge 2c proved.

Charge 2d

2) In relation to Patient B, failed to:

d) escalate that the baby was in the breech position;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence in relation to Patient B and its decision at charge 2b above.

The panel decided that given Mrs Powers-Duff had not diagnosed that the baby was in breech, she could not have escalated any concerns. The breech was only diagnosed when Patient B had an ultrasound scan, after continuing her labour in hospital for several hours.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, in relation to Patient B, Mrs Powers-Duff failed to escalate that the baby was in the breech position.

In light of this evidence, the panel found charge 2d not proved

Charge 2e (i)

2) In relation to Patient B, failed to:

e) maintain an adequate standard of record keeping in that you failed to:

i) record why the patient did not have weekly appointment from 36 weeks as per the schedule of care;

This charge is found NOT proved.

In reaching this decision, the panel took into account its decision on charge 2a where it had already determined that it did not have compelling evidence that there was a schedule of care requiring weekly visits.

The panel also noted the entry in the management plan of Patient B's pregnancy notes where Mrs Powers-Duff has written:

"Would prefer only this visit – she would like to concentrate on her method and have us present at birth."

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, in relation to Patient B, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she failed to record why the patient did not have weekly appointment from 36 weeks as per the schedule of care.

In light of this evidence, the panel found charge 2e (i) not proved

Charge 2e (ii)

2) In relation to Patient B, failed to:

e) maintain an adequate standard of record keeping in that you failed to:

ii) properly complete the antenatal plan of care

This charge is found proved.

In reaching this decision, the panel took into account Patient B's pregnancy notes and the evidence of Witness 1 and Mrs Powers-Duff.

The panel had sight of Patient B's pregnancy notes which were partially completed and signed by Mrs Powers-Duff, in which she was named as the lead professional. However, the panel noted that many sections were not completed or were crossed through. In particular, the management plan at page fifteen has no record of any discussion of care options and risk assessments between this 35-week appointment and birth.

Given the evidence before it, the panel determined that in relation to Patient B, Mrs

Powers-Duff failed to maintain an adequate standard of record keeping in that she failed to properly complete the antenatal plan of care.

Therefore, the panel found charge 2e (ii) proved.

Charge 2e (iii)

2) In relation to Patient B, failed to:

iii) sign and/or date the labour notes;

This charge is found proved.

In reaching this decision, the panel took into account the birth notes for Patient B and Mrs Powers-Duff's evidence.

The panel noted from Patient B's notes that Colleague 1 had been recording observations and the progress of labour from 18:07 until 20:50 on 6 June 2020. However, from 21.30 onwards, the notes are recorded as having been written in retrospect and are in a different handwriting without a signature. The panel also noted that there was no indication as to the date and time when this retrospective entry was actually written.

Mrs Powers-Duff accepted in her oral evidence that the labour notes were hers, were not signed and were written in retrospect.

Given the evidence above, the panel determined that in relation to Patient B, Mrs Powers-Duff failed to sign and/or date the labour notes.

Therefore, the panel found charge 2e (iii) proved.

Charge 3a

3) *On 6 June 2020,in relation to Patient C, failed to:*

a) *adequately assess and/or record an assessment of the patient who had started to bleed;*

This charge is found proved.

In reaching this decision, the panel took into account Patient C's birth notes.

The panel noted that within Patient C's birth notes, Mrs Powers-Duff has recorded that she is the lead carer in labour.

The panel noted that Patient C's observations were taken at 15:24 and then again at 15:35. The panel was of the view that within that short time, there had been a noticeable drop in blood pressure and an increase in pulse rate. The panel accepted that Patient C had requested a physiological third stage of labour and that this had been followed up to this point. However, the records show that Syntometrine IM was administered at 15:28 and Ergometrine IM was administered at 15:32 following what was thought to be a separation bleed, indicating a change in the patient's condition which required a change in management. The panel noted that an ambulance had been called at 15:30. However, there is no record of any assessment of blood loss, any palpation of the uterus or any attempts to deliver the placenta using Controlled Cord Traction (CCT).

The panel also had sight of an email exchange between Witness 1 and Mrs Powers-Duff dated 10 June 2020. Witness 1 asked if Mrs Powers-Duff had attempted CCT after the Syntometrine. Mrs Powers-Duff replied:

> *"Nooo, the bleeding did not really stop hence the ergometrine and ambulance. I learnd the meaning oh 'hoseing' blood."* [sic]

Given the above, the panel determined it had sufficient evidence before it to find that Mrs Powers-Duff, on 6 June 2020, in relation to Patient C, failed to adequately assess and/or record an assessment of the patient who had started to bleed.

Therefore, the panel found charge 3a proved.

Charge 3b

3) *On 6 June 2020,in relation to Patient C, failed to:*

b) *record/say how much blood there was, despite recording a trickle of blood;*

This charge is found NOT proved.

In reaching this decision, the panel took into account the Patient C's birth records.

The panel noted at that at 15.24, there is a record made by Colleague 1 of a *"trickle of lochia and cramping. Heavier lochia ?separation bleed".* The panel accepted that up until this point, Colleague 1 has been recording observations and the progress of labour.

The panel accepted that although there is no note of the amount of blood loss written by Mrs Powers-Duff at around the time the ambulance was called, there is a retrospective note timed at 16:30 which mentions a loss of just under 2 litres.

The panel also has sight of the Intrapartum Transfer Form, dated 6 June 2020, which also records 2 litres of blood loss, as measured by weighing the "puppy pads". This form was signed and dated by Mrs Powers-Duff.

Given the evidence above, the panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to record/say how much blood there was, despite recording a trickle of blood.

Therefore, the panel found charge 3b not proved.

Charge 3c

3) On 6 June 2020, in relation to Patient C, failed to:

c) escalate a significant Postpartum Haemorrhage ('PPH') in a timely manner

This charge is found proved.

In reaching this decision, the panel took into account the Flow chart for the Management of PPH at home contained within the Company's guidelines (No 22) which is based on national guidance from NICE 2007 and 2014, and the RCOG green top guideline No 52 2016. The panel also considered the evidence of Witness 1 and Mrs Powers-Duff.

The panel considered the Flow chart which sets out how to manage PPH at home. The panel noted that there is a clear instruction to call the on-call manager in such an event and provides a phone number.

In Witness 1's oral evidence, she told the panel that she was the on-call manager on the date in question and that she did not receive a call from either Mrs Powers-Duff or Colleague 1.

Mrs Powers-Duff's evidence was that Colleague 1 had phoned the manager, however, there is no documentary evidence to support this.

The panel accepted Witness 1's evidence.

Given the evidence above, the panel determined that on 6 June 2020, in relation to Patient C, Mr Powers-Duff failed to escalate a significant Postpartum Haemorrhage ('PPH') in a timely manner.

Therefore, the panel found charge 3c proved.

Charge 3d (i)

3) On 6 June 2020,in relation to Patient C, failed to:

d) maintain an adequate standard of record keeping in that you did not record:

i) the patient's haemoglobin ('Hb') level before the birth;

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient C's birth notes.

The panel noted that within the birth notes, Mrs Powers-Duff had recorded that she was the lead carer in labour.

The panel also noted that at page eleven within Patient C's birth notes, there is a blood group and a Hb level recorded.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record the patient's haemoglobin ('Hb') level before the birth.

In light of this evidence, the panel found charge 3d (i) not proved

Charge 3d (ii)

3) On 6 June 2020, in relation to Patient C, failed to:

d) maintain an adequate standard of record keeping in that you did not record

ii) the patient had sustained a PPH;

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient C's birth notes.

The panel noted that within the birth notes, Mrs Powers-Duff had recorded that she was the lead carer in labour.

Whilst the panel noted that there is no record of a post-partum haemorrhage on the handwritten labour notes for Patient C, it had sight of the post-natal transfer form (SBAR) which was used to transfer care of Patient C to the hospital midwife where it is recorded *"PPH-15:24 first heavy loss ?2000ml".* The form is signed by Mrs Powers-Duff and dated 06 June 2020.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record the patient had sustained a PPH.

In light of this evidence, the panel found charge 3d (ii) not proved

Charge 3d (iii)

3) On 6 June 2020,in relation to Patient C, failed to:

d) maintain an adequate standard of record keeping in that you did not record

iii) what happened between the birth and the PPH, other than that the baby was being breastfed

This charge is found NOT proved.

In reaching this decision, the panel took into account the Patient C's birth notes.

The panel noted that within the birth notes, Mrs Powers-Duff had recorded that she was the lead carer in labour.

The panel noted that between the birth at 13:06 and 15:28 when the IM Syntometrine was administered, Colleague 1 was scribing the notes. Within the records there are notes of patient observations and Patient C's wishes for the management of the third stage of labour. There are also entries pertaining to vaginal loss and bladder management.

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record what happened between the birth and the PPH, other than that the baby was being breastfed.

In light of this evidence, the panel found charge 3d (iii) not proved

Charge 3d (iv)

3) On 6 June 2020,in relation to Patient C, failed to:

d) maintain an adequate standard of record keeping in that you did not record

iv) how the placenta was managed between the birth and the ambulance arriving;

This charge is found proved.

In reaching this decision, the panel took into account Patient C's birth notes.

The panel noted that within the birth notes, Mrs Powers-Duff had recorded that she was the lead carer in labour.

The panel also considered the Guidelines issued by the Company on the management of the third stage of labour.

The panel noted that Patient C had requested a physiological third stage and that this approach had initially been adopted following the birth at 13:06. The panel noted the guidelines states that a placenta should be delivered within sixty minutes if the third stage is physiological. Anything longer than this is considered a retained placenta. There is no documentation of any discussion with Patient C regarding the risk of retained placenta at this point or the recommendation to move to active management after sixty minutes as per the guidelines. However, it was apparent from the notes that at 15:28, IM drugs were administered which indicated a move to active management of the third stage, although no explanation for doing so was recorded, other than "*heavier lochia ? separation bleed*" [sic]. The panel noted that there was no record of any attempts to deliver the placenta by Controlled Code traction (CCT) following the administration of the drugs as per the guideline.

The panel therefore found that it had sufficient evidence before it to establish that on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not record how the placenta was managed between the birth and the ambulance arriving.

The panel therefore found charge 3d(iv) proved.

Charge 3d (v)

3) On 6 June 2020,in relation to Patient C, failed to:

d) maintain an adequate standard of record keeping in that you did not record

v) sign and/or date, one or more records

This charge is found proved.

In reaching this decision, the panel took into account Patient C's birth notes.

The panel noted that within the birth notes, Mrs Powers-Duff had recorded that she was the lead carer in labour.

The panel noted that within Patient C's birth notes, there are entries at 16:30, 16:45 and 16:55, none of which are signed. It however noted that the entry at 17:00 is signed by Mrs Powers-Duff. Furthermore, these notes are recorded as being written in retrospect but there is no clear indication as to the actual time and date when they were written.

The panel considered that it is best practice for each entry in the record to be signed at the time of completion. The panel found that there has been a lack of adequate recording by Mrs Powers-Duff's failure to ensure all entries are signed and dated.

Given the above evidence, the panel found that it had sufficient evidence before it to establish that on 6 June 2020, in relation to Patient C, Mrs Powers-Duff failed to maintain an adequate standard of record keeping in that she did not sign and/or date, one or more records.

The panel therefore found charge 3d(v) proved.

Charge 4

4) On 1 August 2020, performed an episiotomy on Patient D

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient D and Mrs Powers-Duff and the video evidence provided by Witness 3.

Mrs Powers-Duff accepted during her oral evidence that she performed an episiotomy with Patient D's consent. This was further confirmed during evidence by Patient D. The panel also saw video evidence that an episiotomy had taken place.

In these circumstances, the panel found that it had sufficient evidence before it to find that on 1 August 2020, Mrs Powers-Duff performed an episiotomy on Patient D.

The panel therefore found charge 4 proved.

Charge 5

5) *The episiotomy referred to on 1 August 2020 was performed:*

   a) *at the wrong angle;*

   b) *in the wrong position;*

   c) *below an acceptable clinical standard;*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 5 and Mrs Powers-Duff and the video evidence provided by Witness 3.

It is not in dispute that an episiotomy was carried out on Patient D on 1 August 2020 during her birth at home. After delivery, Patient D was transferred to hospital in order for the episiotomy to be repaired. The paramedics and the staff at the hospital were informed by Patient D that the episiotomy had been carried out by her partner using a pair of kitchen scissors. There was no mention of Mrs Powers-Duff having been present or having carried out the episiotomy. Witness 2 who examined Patient D on arrival and

carried out the repair, explained that she had treated Patient D on the basis of the information provided. In her written and oral evidence, she described there being a posterior vaginal wall tear and a superficial lateral labial cut. Witness 2 explained that she did not originally describe this labial cut as an episiotomy because *"the cut was not what I would have expected from a trained midwife but by someone who has never carried out an episiotomy."*

Witness 2 was shown the video and told the panel that this did not alter her opinions and she stood by her original statements. Witness 2 told the panel that the correct procedure was not followed by Mrs Powers-Duff. Witness 2 explained that the correct procedure would be to insert 2 fingers between the vaginal wall and foetal head and slide the blade of the scissors between the fingers up to the hilt and perform one incision with one closure of the blade to facilitate one smooth cut. She confirmed to the panel that this was not done.

The panel noted that Witness 2 is an experienced midwife with 30 years' experience in carrying out and repairing episiotomies. The panel was of the view that Witness 2 was well placed to provide evidence in respect of this charge as she had assessed and treated the trauma at the time. She was also able to draw on the Datix which was completed on the same day.

The panel heard evidence from Witness 5, a consultant in obstetrics and gynaecology. He also was able to view the video and provided the panel with a report as to his observations of what could be seen at each stage. This included an initial minimal right lateral episiotomy which did not suffice, followed by an injection of local anaesthetic with a "*full"* episiotomy followed by delivery of the baby's head. He described the episiotomy as a "*lateral/transverse*". He told the panel that, in his opinion, this particular incision is an acceptable one although it is not commonly performed in the NHS due to risk of damage to underlying structures in the vagina. He told the panel that he had no criticism of the way the episiotomy was carried out.

It is accepted that midwives in the UK are taught to carry out medio-lateral episiotomies. Given that Mrs Powers-Duff qualified in the UK in 2010, the panel noted that this would

have been the technique which she was taught, as supported by the NMC's standards for pre-registration midwifery education (2009). Whilst the panel accepted Witness 5's evidence that a transverse episiotomy is an accepted procedure, this is not a technique that midwives are trained to carry out in the UK.

The panel reviewed the video comparing the incision made to the types of episiotomies shown on the diagram provided by Witness 5. In the panel's opinion, the incision made does not reflect the position of either a medio-lateral or transverse episiotomy as indicated on the diagram.

The panel also noted that, rather than the single clean cut described by Witness 2, Mrs Powers-Duff made several attempts.

The panel also noted that Mrs Powers-Duff did not administer local anaesthetic before her first attempt at the episiotomy. Having viewed the video evidence, it was obvious to the panel from Patient D's reaction that this caused her pain.

In these circumstances, the panel found that it had sufficient evidence before it to find that on 1 August 2020, Mrs Powers-Duff performed an episiotomy on Patient D at the wrong angle, in the wrong position and below an acceptable clinical standard.

The panel therefore found charge 5 proved.

Charge 6 (stem)

> *6) On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above:*

This charge is found proved

Before considering charge 6, the panel noted that there was no dispute that Mrs Powers-Duff was present at the birth.

Patient D had always wanted a home birth and that had been arranged through the NHS. However, that arrangement was withdrawn due to the COVID-19 Pandemic when all NHS home birth support was suspended. Patient D then contacted the Company and arranged for them to provide a package of home birth support. Mrs Powers-Duff was allocated as her named midwife. However, before Patient D's due date, Mrs Powers-Duff was suspended by the Company due to concerns about her practice and subsequently resigned. She was told by the Company, both verbally and by email that she was no longer to provide care to Patient D. There were no other midwives available so the Company had told Patient D on 29 July 2020 that they would no longer be able to provide her with a package of home birth support. Patient D contacted NHS Glasgow midwifery services but was told that they were unable to support her with a home birth and offered her to deliver in a midwife led unit. Patient D subsequently expressed her intention to free birth.

Patient D, in her oral evidence confirmed to the panel that she had been intending to free birth and that she had contacted Mrs Powers-Duff as a friend when the supporters who she had arranged to be present at the birth were unavailable. Patient D in her witness statement to the NMC:

> *"I wanted some extra support but I still couldn't get through to… so I tried Krishinda…I asked Krishinda to come over as a friend to give me support. Krishinda agreed to come over"*

Mrs Powers-Duff has maintained throughout that she was not there to support Patient D in her capacity as a midwife. However, the panel noted from Patient D and Witness 3's statements and from the video evidence that Mrs Powers-Duff had access to local anaesthetic, her surgical equipment, uterotonic drugs and resuscitation equipment which she used on Baby D.

The panel was of the view that, had Mrs Powers-Duff attended Patient D's birth solely in her capacity as a friend, there would have been no reason for her to have brought the medical equipment with her, particularly, when she had told the Company that she was unwell and unfit for work.

Having reviewed the video, the panel considered that there was ample time for Mrs Powers-Duff to have called for additional support, rather than undertaking midwifery care herself.

Furthermore, it was clear to the panel that the birth was not straightforward, and that Mrs Powers-Duff should not have carried any of the midwifery duties as seen on the video evidence presented to it. The panel determined that Mrs Powers-Duff should have alerted emergency services as she was not practicing as a midwife.

The panel also has sight of a blog posted by Mrs Powers-Duff entitled: *"Fear of a birthing mutha: Laying it on the line*" dated 31 August 2020, where it states:

> *"She actually went into labour just 2 days before they started home birth again and near the end of her labour, she felt she needed more support so she contacted me. She contacted me because she trusted me. I understood that I had a duty of care and I went to support her. This was not a planned attendance, I actually had a friend staying that night. I was in no way thinking of attending anyone's birth but I also knew if this brave woman was asking for support that I had to give it. I was not insured to attend her but in my mind, I only thought of my duty of care. I knew I was not only breaking the rules but possible the law but in those moments I was only thinking of this woman's physical and emotional safety."*

Charge 6a

6) *On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above:*

   a) *without having in place appropriate indemnity insurance*

This charge is found proved.

In reaching this decision, the panel took into account an email dated 4 August 2020 from Mrs Powers-Duff to the Company relating to Patient D, Mrs Powers-Duff's blog posted on 21 April 2021, her oral evidence and the Royal College of Midwives (RCM) website.

The panel had sight of Mrs Powers-Duff's email to the Company sent on 4 August 2020 in which it stated:

> *"…i made it clear that I acted as an independent and uninsured midwife as I had previously made it clear to [Witness 1] that I was no longer working for Private Midwives or myself as a homebirth midwife.* [sic]*"*

The panel also noted that in her blog posted on 31 August 2020, Mrs Powers-Duff stated:

> *"With this said I know that I absolutely broke the rules by attending that birth uninsured and that I would have take responsibility for my actions.* [sic]*"*

The panel then considered Ms Bennett's submissions on Mrs Powers-Duff's behalf that she was covered by the RCM insurance in relation to this. However, the panel noted the following from RCM's website:

> *"For more than 90% of RCM members Medical Malpractice Insurance (MMI) is very straightforward and you are covered for all of the midwifery, nursing or maternity support work you provide as a midwife, student midwife, nurse or maternity support worker under* ***contract to the National Health Service*** *(NHS) and other national or local authorities in the United Kingdom, the Isle of Man and the Channel Islands. This includes midwives and nurses employed to undertake nursing and midwifery duties in local government or in arms length bodies such as Public Health England. This is because these governmental bodies assume the 'vicarious liability' for the care services you provide*

Insurance cover for all full members who are providing midwifery and nursing care (dependent on your qualification and registration) within the NHS and other local or national authorities;

Who is covered under the Policy?

- *Full members of the RCM who are **directly employed in the NHS** or a local or national authority are covered for all of the midwifery and nursing practice undertaken as part of their employment*

*All members are also covered for Good Samaritan Acts worldwide. Good Samaritan Acts are defined "as medical, nursing, midwifery and therapeutic care performed at the scene of a medical emergency, accident or disaster where you are **present by chance** or in response to any general emergency call"*

Examples for illustrative purposes only:

Beatrice is an independent midwife contracting directly with women to provide antenatal and postnatal care. She is not covered and should make alternative arrangements to purchase appropriate and adequate insurance."

Upon closely considering the RCM Guidance and examples, the panel did not consider this to have represented indemnity insurance as suggested by Ms Bennett.

The panel noted the submissions which indicated that the care provided by Mrs Powers-Duff should be classed as a Good Samaritan Act. The panel considered that the definition from the RCM website indicates that such an act would only fall under this exception in an absolute emergency. However, the panel does not consider that Mrs Powers-Duff was present '*by chance'* having been asked to attend by Patient D. Furthermore, the panel has already determined that in this circumstance, Mrs Powers-Duff had the time and opportunity to call for extra support.

In these circumstances, the panel found that it had sufficient evidence before it to find that on 1 August 2020, Mrs Powers-Duff provided intrapartum / home birth care to

Patient D, including that referred to charges 4 and 5 above without having in place appropriate indemnity insurance.

The panel therefore found charge 6a proved.

Charge 6b

6) *On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above;*

b) *having advised /been advised by your manager, that you would no longer be involved in Patient D care and/or Patient Ds intrapartum care had been cancelled*

This charge is found proved.

In reaching this decision, the panel took into account an email dated 4 August 2020 from Mrs Powers-Duff to the Company regarding Patient D's care, Mrs Powers-Duff's evidence and Patient D's evidence.

The panel had sight of Mrs Powers-Duff's email to the Company sent on 4 August 2020 in which it stated:

> *"…i made it clear that I acted as an independent and uninsured midwife as I had previously made it clear to [Witness 1] that I was no longer working for Private Midwives or myself as a homebirth midwife…there was no agreement…I stepped forward and allowed it to be known that I was present at the birth and that had done the episiotomy to expiate the birth of the baby as it was in distress...My actions were taken off my own back independently and Private Midwives was not involved.* [sic]*"*

The panel also had sight of Patient D's witness statement dated 4 April 2021 in which it stated:

"Cancellation by Private Midwives

On Wednesday 29 July 2020, I received an email (no phone call, only communicated through email) from…, Business Manager for Private Midwives informing me that they will no longer be providing me with midwifery services..."

Given the above evidence, the panel was satisfied that it has sufficient evidence before it to establish that Mrs Powers-Duff had been advised that Patient D was not being provided with care by the Company.

Therefore, the panel found that on 1 August 2020, Mrs Powers-Duff provided intrapartum/home birth care to Patient D, including that referred to charges 4 and 5 above having advised /been advised by her manager, that she would no longer be involved in Patient D care and/or Patient Ds intrapartum care had been cancelled.

The panel found charge 6b proved.

Charge 6c

6) *On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above;*

c) *without having told Patient D that you had been instructed not to carry out any labour care;*

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient D's witness statement and her oral evidence and Mrs Powers-Duff's blog posted 21 April 2021.

The panel considered Patient D's oral and written evidence. It was clear that Patient D had been informed by the Company that Mrs Powers-Duff would no longer be providing

home birth care on their behalf. However, there is no reference to Patient D being informed directly by Mrs Powers-Duff herself.

However, the panel noted that in her blog, Mrs Powers-Duff wrote:

> *"I made the decision to end my association with this company and had to tell my two remaining home birth patients that we could not attend them…"*

The panel therefore determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel did not have sufficient evidence to find that, on 1 August 2020, Mrs Powers-Duff provided intrapartum/home birth care to Patient D, including that referred to charges 4 and 5 above; without having told Patient D that she had been instructed not to carry out any labour care.

The panel therefore found charge 6c not proved.

Charge 6d

6) *On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above;*

d) without making any and/or any adequate birth notes and/or records;

This charge is found proved.

In reaching this decision, the panel took into account Mrs Powers-Duff's oral evidence.

The panel reminded itself of the question asked of Mrs Powers-Duff during her cross examination and her response:

"Question: ... So is it then fair to say that because you didn't let the paramedics know that you were involved in that birth at that stage, that there were no notes? You didn't make any notes in relation to that birth. Is that a fair assumption?

Answer: No, I don't think your assumption is fair. It's true that there were no notes because I was not working for this woman. I was not intending to support her in birth. I was not taking notes. I literally -- well, you can refer to my statement. It wasn't a pre-meditated experience and no, there were no notes taken. It's not normal that you take notes in an emergency situation."

The panel therefore had sufficient evidence in respect of this charge, by way of Mrs Powers-Duff's acceptance.

The panel therefore found that on 1 August 2020, Mrs Powers-Duff provided intrapartum/home birth care to Patient D, including that referred to charges 4 and 5 above without making any and/or any adequate birth notes and/or records.

The panel therefore found charge 6d proved.

Charge 6e

6) On 1 August 2020, provided intrapartum / home birth care to Patient D, including that referred to charges 4 and 5 above;

e) without handing over to the paramedics that the baby had been resuscitated;

This charge is found proved.

In reaching this decision, the panel took into account Patient D's witness statement, the evidence of Witness 2 and Witness 3 and Mrs Powers-Duff's evidence.

The panel also considered Patient D's witness statement dated 4 April 2021 in which she wrote:

> *"…We knew something was wrong, we were gently stimulating the baby but it was obvious she was not breathing. The baby needed resuscitation, Krishinda used a bag she had to resuscitate the baby. The baby began breathing fine."*

The panel also reminded itself of Witness 3's evidence in which she had confirmed that the baby had required resuscitating and that despite this, Mrs Powers-Duff had not informed the paramedics that the baby had been resuscitated.

Mrs Powers-Duff in her oral evidence accepted that the baby had needed resuscitation but she had not handed this information over to the paramedics.

Given the above evidence, the panel determined that it had sufficient evidence to find that on 1 August 2020, Mrs Powers-Duff provided intrapartum/home birth care to Patient D, including that referred to charges 4 and 5 above without handing over to the paramedics that the baby had been resuscitated.

The panel therefore found charge 6e proved.

Charge 7

7) *Your conduct at any and/or all of charge 6 above was dishonest in that you:*

   a) *knew that you should not be proving the care referred to;*

   b) *intended to conceal that you had provided the care referred to;*

   c) *intended to create a misleading impression of the care that you provided to Patient D*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account its decision at charge 6 above, an email dated 4 August 2020 from Mrs Powers-Duff to the Company, Mrs Powers-Duff's oral evidence, Witness 3's evidence and Patient D's evidence.

The panel bore in mind that Mrs Powers-Duff accepted during her oral evidence that she knew she should not have been providing midwifery care to Patient D. She also accepted that she had not informed the paramedics of her involvement in Baby D's birth, including administration of local anaesthetic, performing an episiotomy and the subsequent resuscitation of Baby D.

The panel then had sight of Mrs Powers-Duff's email to the Company sent on 4 August 2020 in which it states:

> *"I was wrong to do this. I was also wrong not to be upfront and honest about it…how I reacted after the fact was inexcusable…I allowed the paramedics and hospital staff to believe that Patient D had fully free birthed and was assisted solely by her husband and Doula… it was only when the community midwife threatened to report Patient D's husband to the police … that I stepped forward and allowed it to be known that I was present at the birth and that had done the episiotomy to expiate the birth of the baby as it was in distress…*[sic]*"*

The panel considered that it was essential that the paramedics should be informed of all of the circumstances around Baby D's birth, including the resuscitation, in order that the appropriate care pathways could be initiated for both Patient D and Baby D. The panel could find no reason why Mrs Powers-Duff did not provide this information to ambulance staff, other than to conceal that fact that she had provided intrapartum/home birth care to Patient D when she was not allowed to do so.

The panel therefore found that Mrs Powers-Duff created a misleading impression as she allowed the paramedics and the hospital to believe that the baby was free-birthed.

The panel considered what Mrs Powers-Duff's state of mind was at the time of her actions. She was well aware that she should not have been providing care without Indemnity Insurance or even the permission of her employers. Her decision not to tell the paramedics was not in the interest of either Patient D or her baby. She deliberately concealed her involvement. She would have been well aware that her actions were dishonest and, in light of her state of mind, dishonest according to the standards of ordinary decent people.

The panel therefore found charge 7 in its entirety proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Powers-Duff'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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Powers-Duff's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Mohamed referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving*

some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'

Ms Mohamed submitted that Mrs Powers-Duff's conduct fell well short of the acceptable standards expected from a registered nurse and breached the Code. She submitted that Mrs Powers-Duff had breached the following sections of the Code: 1.2, 3.3, 8.1, 8.2, 8.3, 8.5, 8.6, 10.1, 12.1, 13.1, 13.2, 15.2, 20.1 and 20.2.

Ms Mohamed highlighted that misconduct must be serious to amount to professional misconduct. She submitted that Mrs Powers-Duff's actions are serious as they involved several clinical failings which impacted on four patients. They also involved dishonesty which by its nature, is very serious. Ms Mohamed therefore invited the panel to find that the charges found proved amount to serious misconduct.

Ms Mohammed then moved on to the issue of impairment. She referred the panel to the *NMC Guidance on Impairment (*DMA-1). She stated that in considering the question whether Mrs Powers-Duff's fitness to practise is currently impaired, it is a matter for the panel's professional judgement.

Ms Mohamed referred the panel to the test formulated By Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) which provides:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Mohamed submitted that all limbs of the *Grant* test are engaged in this case.

With regards to limb a of the *Grant* test, Ms Mohamed submitted the charges found proved placed four patients at risk of harm. With respect to Patient A, she submitted that a failure to maintain accurate record-keeping does not allow future medical professionals to either correctly assess the patient or provide that patient with the correct medical treatment. She submitted that Mrs Powers-Duff's conduct therefore placed Patient A at risk of harm. This was in addition to her conduct in not arranging for Patient A to be transferred to the hospital in a timely manner which also placed Patient A at risk of harm as there was a risk that appropriate treatment would not have been given in a timely manner.

Ms Mohamed submitted that, with respect to Patient B, Mrs Powers-Duff's failure in not diagnosing that the baby was in a breech position, placed Patient B at the risk of not getting appropriate treatment at the required time. There were also concerns with record-keeping which would not have allowed future medical professionals to correctly assess the position and apply the appropriate medical treatment, which placed Patient B at risk of harm.

Ms Mohamed submitted that, with respect to Patient C, the charges found proved exposed that particular patient to risk of harm. She referred the panel to her earlier submissions in relation to Patients A and B.

Ms Mohamed submitted that, in relation to Patient D, Mrs Powers-Duff's conduct in concealing the intrapartum care she provided to Patient D from paramedics, placed Patient D at risk of harm as future medical professionals would not have been able to adequately assess Patient D and provide the appropriate medical care to her. Mrs Powers-Duff did not also reveal that Patient D's baby had been resuscitated, which placed the baby at risk of harm.

In relation to limb b of the *Grant* test, Ms Mohamed submitted that Mrs Powers-Duff's actions have brought the midwifery profession into disrepute. She submitted that the concerns relate to basic midwifery skills and competencies which the public would expect Mrs Powers-Duff to be able to exhibit.

With regards to limb c of the *Grant* test, Ms Mohamed submitted that Mrs Powers-Duff's actions breached fundamental tenets of the midwifery profession. She referred the panel to the sections of the Code which she had earlier highlighted in her submissions on misconduct.

With respect to limb d of the *Grant* test, Ms Mohamed submitted that Mrs Powers-Duff had acted dishonestly in relation to the incident with Patient D. It is particularly serious as the panel has found that she sought to conceal the treatment that she provided to Patient D and her baby.

Ms Mohamed highlighted that it is a matter for the panel in considering the evidence provided by Mrs Powers-Duff in the course of these proceedings, to evaluate whether there is a risk of repetition in this case. She submitted that Mrs Powers-Duff has shown limited insight on the impact of her actions on patients under her care and the reputation of the profession.

Ms Mohamed therefore submitted there is a risk of repetition and a finding of current impairment on both public protection grounds and public interest grounds is required in this case.

Ms Bennett's Reply

In replying to Ms Mohamed's submissions, Ms Bennett criticised the panel's findings in fact and developed a submission that the panel should recuse itself.

Ms Bennett submitted that Mrs Powers-Duff is a dedicated midwife whose professional conduct is under scrutiny by the NMC. She asserted that Mrs Powers-Duff's defence rests on the fact that the entire NMC process is fundamentally flawed, and it exhibits clear racial bias, adversely impacting on the fair treatment of Mrs Powers-Duff. She highlighted that her submissions would focus on the concerns and challenges faced during this process.

Ms Bennett submitted that there was racial bias by Witness 1 in the disciplinary process at the Company and which has now been supported by the NMC. She asserted that the entire process has been tainted by racial bias as evidenced by the failure of the panel to recognise or acknowledge racial elements within the case and the involvement of a white midwife who was involved in all the incidents but who has faced no repercussions or serious allegations. This raises serious concerns about the fairness and impartiality of this NMC process.

Ms Bennett submitted that Witness 1, the complainant, harboured a personal vendetta against the black registrant, leading to a biased and prejudice interpretation of events. She asserted that the fact that Witness 1's husband is affiliated with the NMC, raises concerns about the potential conflicts of interest and abuse of the NMC process to target the black registrant unfairly.

Ms Bennett highlighted that a reputable witness had clarified that the episiotomy performed by Mrs Powers-Duff was different but was not wrong. Also countering the allegations against Mrs Powers-Duff, Patient D testified that Mrs Powers-Duff played a crucial role in saving her baby's life, a testament that contradicts the charges brought forward by the NMC. Ms Bennett stated that Mrs Powers-Duff also contests that the NMC has failed to provide evidence from the hospital or from any independent witnesses to substantiate the allegations against her. She submitted that the lies and

deception displayed by several of the NMC witnesses has been disregarded by the panel, showcasing a one-sided and unfair evaluation of the case.

Ms Bennett submitted that the case has been presented in a manner that significantly favours white individuals and whitewashing. It discredited the accounts of black witnesses, including Patient D, who is married to a black man. She submitted that the panel's failure to consider the weight and testimonies of black witnesses, is indicative of a discriminatory approach that compromises the integrity of the entire NMC process as Colleague 1, a white midwife involved in most of the concerns, has been completely excluded from an investigation and did not submit any statements. This suggests a bias in her favour.

Ms Bennett submitted that evidence of Mrs Powers-Duff's trade union insurance cover was also presented but was disregarded. The fact that Mrs Powers-Duff was covered by trade union insurance should have been a significant factor in assessing the severity and implications of the allegations, but this crucial aspect was not taken into account by the panel and the charge was found to be proven.

Ms Bennett asserted that something needs to be fixed within the NMC because no patient came to any harm and the panel has relied heavily on Witness 1's assumptions. She submitted that despite Mrs Powers-Duff's best efforts to present a comprehensive case with substantial evidence, none of her defence evidence was given due consideration. Therefore, the outcome of these proceedings seemingly favours Witness 1, Colleague 1 and the NMC, suggesting a concerning bias against Mrs Powers-Duff. Witness 5, an obstetrician, who is black, also provided a professional opinion that the episiotomy provided by Mrs Powers-Duff was not wrong, but this valuable input was not believed or acknowledged by the panel. The apparent scepticism towards the opinion of a black obstetrician raises serious concerns about racial bias within the decision-making process.

Ms Bennett submitted that it is noted that there is lack of diversity on the panel, with no representation of black individuals, the absence of black voices on the NMC panel may

have contributed to an environment where biases could thrive, potentially influencing the case outcome.

Ms Bennett submitted that, given the concerns raised, the panel is invited to re-evaluate the case, consider the evidence presented, the insurance cover and the potential bias that may have influenced the proceedings as a fair and impartial examination of the facts will reveal the flaws of the current decision and contribute to a more just resolution.

Ms Bennett stated that, given the apparent racial bias in the NMC process, Mrs Powers-Duff has decided that this case will definitely go to the High Court to seek a fair and unbiased judgement because she does not believe that she could obtain such in these proceedings. She asserted that the outcome of these proceedings will not favour the black registrant. She intends to publicise the video which has been shared with the panel through various media channels to bring attention to the potential discrimination and lack of fairness within the NMC process as the reputation and career of Mrs Powers-Duff are at stake due to this flawed process. Mrs Powers-Duff trusts that the NMC will uphold its commitment to fairness, impartiality and anti-racism.

The panel asked Ms Bennett if she had any submissions to make with respect to the issues of misconduct and impairment as well as the issues raised by Ms Mohamed. Ms Bennett stated that she would not make any submissions on misconduct and impairment until the issues she had raised about the charges found proven, were addressed.

The panel, accordingly, heard an application from Ms Bennett for the panel to recuse itself. Ms Bennett invited the panel to recuse itself on the basis that the panel had exhibited unconscious bias in its decisions and the non-diversity of the panel composition. She submitted that the panel did not take into consideration the racial elements that had been highlighted in the course of the proceedings. She asserted that if such issues had been considered, the panel's findings on facts would have been different. She highlighted that due to the non-diversity of the panel composition, it could not understand the experiences faced by black people.

Ms Bennett submitted that if the panel recused itself, there would be no need to crowd-fund an appeal because a new hearing with a different panel would be arranged and she believed that such panel would make a different finding on facts.

Ms Mohamed submitted that in considering whether the panel should recuse itself, the test provided in the case of *Porter v Magill* [2001] UKHL 67, is relevant. The test is:

> *'A panel must first ascertain all circumstances which have a bearing on the suggestion that a panel is biased. It must then ask whether those circumstances would lead a fair minded and informed observer to conclude that there was a real possibility that the tribunal was biased.'*

Ms Mohamed highlighted that the panel had made its findings on facts and the hearing is currently in another stage which is whether Mrs Powers-Duff's fitness to practise is currently impaired. She highlighted that some charges were found not proved whilst others have been found proved. During the facts stage, Ms Bennett and Mrs Powers-Duff were provided with the opportunity to present their best evidence and this was utilised by them. There was also an allowance for Mrs Powers-Duff to present late evidence towards the end of the evidence stage as an expert witness was allowed to give evidence even though not originally scheduled.

Ms Mohamed submitted that these facts indicate that all parties have been provided with a fair platform to present their case. She submitted that in applying the test in *Porter v Magill*, a fair minded and informed observer would conclude that there has been no bias in this case.

Ms Mohamed submitted that, with regards to the ground of non-diversity in the composition of the panel, it should be noted that the background or ethnic group of potential panel members does not play a role in the appointment of panel members as they are appointed based on merits. It is expected that the panel is independent from the NMC and perform its role in an impartial manner. Ms Mohamed submitted that unless Ms Bennett could highlight any specific concern with the panel composition, such ground was unfounded and a generic comment.

Ms Mohamed therefore invited the panel to refuse the application to recuse itself.

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

The panel took into account the submissions made by Ms Bennett and the submissions of Ms Mohamed. The panel bore in mind that it is important for the public to have confidence in the administration of justice, and that tribunals must not be biased and should exercise impartial, independent and objective judgement.

The panel took into account the test as to bias in *Porter v Magill*. The test is:

> *'A panel must first ascertain all circumstances which have a bearing on the suggestion that a panel is biased. It must then ask whether those circumstances would lead a fair minded and informed observer to conclude that there was a real possibility that the tribunal was biased.'*

With regards to the ground of unconscious bias, the panel took into account that Mrs Powers-Duff was provided with the opportunity to present her case without any hindrance. Ms Bennett, acting on behalf of Mrs Powers-Duff, was provided with the opportunity to cross-examine the NMC witnesses, which she utilised. Ms Bennett also provided the panel with a defence bundle consisting of eleven attachments and presented three witnesses who gave evidence on behalf of Mrs Powers-Duff. The panel noted that Ms Bennett did not raise any concern throughout the course of the facts stage, about any bias exhibited by the panel or in the hearing process. It noted that the charges relate to incidents that occurred in 2020 and this hearing commenced in October 2022.

The panel was of the view that its findings were reached based on careful consideration of all the evidence provided by Ms Bennett and Ms Mohamed, with detailed reasons provided for each finding it made on the charges. It was satisfied that the findings reached by the panel, would have been the same regardless of the ethnic background of any registrant against whom such concerns were raised. The panel considered that

there is a strong public interest in the expeditious disposal of the case. In applying the test in *Porter v Magill*, it was satisfied that a fair minded and informed observer, fully aware of the circumstances of this case, would not conclude that that there was a real possibility that the tribunal was biased.

With regards to the ground of non-diversity of the panel, the panel noted that ethnic background/racial group does not qualify as one of the criteria for the selection of members of the panel. Panel members are selected based on merits and they are expected to act impartially and independently from the NMC. Furthermore, Ms Bennett had been aware of the ethnic balance of the panel from day one of this hearing when, due to technical problems, she joined by phone only and asked for panel members to identify their racial and ethnic backgrounds.

Having considered all these factors, the panel decided to refuse the application for recusal as it was satisfied that the hearing process has been transparent and above all fair to all parties.

Decision and reasons on misconduct

Having refused the application to recuse itself, the panel then went on to consider issues of misconduct and impairment. In doing so, it accepted the advice of the legal assessor.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Powers-Duff's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Powers-Duff's actions amounted to a breach of the Code. Specifically:

> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.2** make sure you deliver the fundamentals of care effectively*

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

To achieve this, you must:

3.3 *act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

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*

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

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 *make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
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*

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.2 *arrange, wherever possible, for emergency care to be accessed and provided promptly*

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, …..'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel took into account that Mrs Powers-Duff qualified as a Midwife in in 2010 having trained in Bristol. She then worked for several years in Spain. On her return in 2018, Mrs Powers-Duff worked for the Princess Royal Maternity Hospital in Glasgow before she commenced her employment at the Company in February 2020. The panel noted that Witness 1 stated in her Witness Statement dated 22 January 2021 that:

'When Krishinda joined Private Midwives, she informed us she was fully up to date with her training as she had just left the NHS.'

'On induction day we supply new starters with a booklet and DVD to enable selfdirected study. These are based on skill drills (scenario).'

'As part of the induction process, a three month interim review meeting was carried out with (…), Krishinda's Line Manager on 22 June 2020. There were no issues raised. Krishinda stated that she was quite happy and had no areas which she needed support in. Krishinda was also working with Midwife (Colleague 1) as her mentor as (Colleague 1) had only been qualified for 2 years.'

The panel considered that despite Mrs Powers-Duff's level of experience and training as a midwife, she failed to deliver the fundamentals of care to Patients A, B, C and D. These failures were in fundamental aspects of midwifery practice including basic midwifery skills which Mrs Powers-Duff, as an experienced midwife would be expected to show competence in. The panel further considered that it was also Mrs Powers-Duff's professional duty as a registered midwife to maintain up-to-date knowledge and skills necessary for safe and effective practice as a midwife in accordance with section 6.2 of the Code.

The panel was of the view that Mrs Powers-Duff's failures to deliver the fundamentals of care effectively, to arrange for emergency care when necessary and to make timely referrals to relevant medical practitioner when required, placed Patients A, B, C, D and Baby D at risk of harm. In some cases, actual harm was caused to them . The panel noted that Witness 1 stated in her Witness Statement dated 22 January 2021 that:

'During the labour, Patient A developed Hyponatraemia (low sodium) due to a prolonged labour with no fluid balance. This can be fatal….Patient A should have been transferred to hospital much sooner …… The harm caused was Patient A had a convulsion due to low sodium and luckily she was at the hospital when this occurred. The potential of harm was Patient A and her baby could have died.'

'…I would have expected Krishinda to transfer Patient C to hospital in a timely manner once she realised the blood loss was not stopping and the placenta could not be delivered….There was significant blood loss and Patient C should

have been transferred to hospital much sooner, so that emergency treatment could be commenced...'

'…I am informed by the hospital that Krishinda carried out the episiotomy incorrectly (…on Patient D…) I have been told by the Head of Midwifery at Glasgow, that the Midwife at Glasgow Hospital raised concerns and initially reported a labial tear, not a perineal incision. This was due to the incorrect episiotomy procedure. The potential of harm was something could have gone wrong with irreversible harm being caused….The potential harm of performing the episiotomy incorrectly is, haemorrhage, infection, incontinence, sexual dysfunction, pain and disfigurement.'

The panel was of the view that Mrs Powers-Duff's actions fell short of the standard of midwifery care expected from a registered midwife and amounted to a breach of fundamental duty of care to Patients A , B, C and D. However, the panel accepted the evidence heard during the hearing that diagnosis of a breech position is difficult and therefore considered that charge 2c could not be considered to amount to misconduct.

Accordingly, the panel determined that Mrs Powers-Duff's actions in charges 1b, 1c, 3c, 4, 5a, 5b, and 5c amount to misconduct.

The panel took into account that Mrs Powers-Duff, at various instances, failed to complete and maintain accurate records of Patients A, B, C and D, when required. She also failed to maintain effective communication with her colleagues in the course of delivering care to Patients A, B, C and D. The panel considered accurate record-keeping and effective communication as some of the fundamental tenets of the midwifery profession. It was of the view that Mrs Powers-Duff's failure to complete and maintain accurate records, posed a significant risk of harm to Patients A, B, C and D. There was evidence to the effect that if such records had been accurately completed and maintained by Mrs Powers-Duff when required, it could have mitigated some of the actual harm caused to Patients A, B, C and D. The panel noted that Mrs Powers-Duff's conduct deprived her colleagues and the appropriate health professionals from being

availed with the relevant information pertaining to the health and care of Patients A, B, C and D and to ensure the continuity of care provided.

The panel considered Mrs Powers-Duff's conduct to be a breach of her fundamental duty of care to Patients A, B, C and D and also constitutes a breach of the duty of candour to them, their families and her colleagues. Accordingly, the panel determined that Mrs Powers-Duff's conduct in charges 1d (i), 1d (ii), 1d (iv), 2e (ii), 2e (iii), 3a, 3d (iv), 3d (v), 6d and 6e amount to misconduct.

The panel took into account that, despite been advised by her manager, that Mrs Powers-Duff would no longer be involved in Patient D's care and that Patient D's intrapartum care had been cancelled, Mrs Powers-Duff provided intrapartum care to Patient D without having appropriate indemnity insurance. The panel noted that Mrs Powers-Duff had stated that she performed the procedure as an emergency service to Patient D. However, the panel was of the view that, given that Mrs Powers-Duff had been advised by her manager that she would no longer be involved in Patient D's care and her indemnity insurance was cancelled, she should have contacted the appropriate health professionals to assist Patient D if there was any emergency as Mrs Powers-Duff already had a prior professional relationship with Patient D.

The panel was of the view that Mrs Powers-Duff's conduct placed Patient D at significant risk of harm given that she was acting illegally as a midwife and without any indemnity insurance which would have covered any risks associated with the intrapartum care. The panel therefore found Mrs Powers-Duff's actions to be extremely serious and unprofessional. It considered Mrs Powers-Duff's conduct to constitute a serious breach of fundamental standards of professional conduct and behaviour that a registered midwife is expected to maintain.

The panel also noted that Mrs Powers-Duff had previously accepted that she acted without indemnity both in her email to her Manager dated 4 August 2020 and in her public blog dated 31 August 2020. She stated in her email that:

"…i made it clear that I acted as an independent and uninsured midwife as I had previously made it clear to [Witness 1] that I was no longer working for Private Midwives or myself as a homebirth midwife. [sic]*"*

In her public blog, Mrs Powers-Duff stated that:

"The truth is that I attended a free birth and performed an emergency procedure with no insurance…."

"With this said I know that I absolutely broke the rules by attending that birth uninsured and that I would have take responsibility for my actions. [sic]*"*

The panel noted Ms Bennett's continued assertions that Mrs Powers-Duff's RCM membership provided indemnity cover. However, the panel had already determined this issue at the facts stage.

Accordingly, the panel determined that Mrs Powers-Duff's actions in charges 6a and 6b amount to misconduct.

The panel then considered charges 7a, 7b and 7c. It was of the view that Mrs Powers-Duff deliberately attempted to conceal her actions in charges 6a, 6b, 6d and 6e, thereby failing to discharge the duty of candour as expected from a registered midwife. The panel considered honesty, integrity and trustworthiness to be the bedrock of the midwifery profession and, in being dishonest, it found Mrs Powers-Duff to have breached a fundamental tenet of the midwifery profession. It noted that Mrs Powers-Duff's dishonest conduct posed a risk of harm to Patient D and Baby D and brought the reputation of the midwifery profession into disrepute. The panel considered that to characterise Mrs Powers-Duff's actions as anything other than misconduct would send the wrong message about the midwifery profession. Therefore, the panel was in no doubt that Mrs Powers-Duff's actions in being dishonest amounted to misconduct.

Consequently, having considered the proven charges individually and as a whole, the panel determined that Mrs Powers-Duff's actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision and reasons on impairment

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

The panel considered the test of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

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

The panel found that all limbs of the Grant test are engaged in this case. At the time of the incidents, Mrs Powers-Duff's misconduct placed patients under her care at

unwarranted risk of harm, brought the midwifery profession into disrepute, breached fundamental tenets of the midwifery profession, relating to adequate patient care and she had acted dishonesty.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether Mrs Powers-Duff's misconduct is remediable and whether she had strengthened her midwifery practice.

Regarding insight, the panel was of the view that Mrs Powers-Duff has failed to show insight into her conduct. It noted that Mrs Powers-Duff has failed to demonstrate insight on the impact of her failings on Patients A, B, C and D, her colleagues and the midwifery profession. The panel was concerned that Mrs Powers-Duff did not demonstrate sufficient understanding of the seriousness of her failings. Although Mrs Powers-Duff made some admissions with respect to the provision of intrapartum care without indemnity insurance and her dishonesty in her email to the Company dated 4 August 2020, she subsequently sought to provide justifications for her actions in her social media blog post dated 31 August 2020 and also sought to minimise the severity of her actions. The panel further noted that Mrs Powers-Duff did not provide any information about any detailed steps she would take if similar scenarios should occur in future or to prevent such incidents from re-occurring. The panel was invited by Ms Mohamed to consider whether there was any material in the Registrant's Bundle which disclosed insight, reflection or remorse. The panel was unable to find any such material.

The panel had regard to the case of *Cohen v GMC,* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

The panel was of the view that Mrs Powers-Duff's misconduct was generally capable of remediation with respect to her clinical failings. However, it considered that Mrs Powers-Duff's lack of accountability for her failings, lack of professionalism and her dishonest conduct are suggestive of attitudinal concerns which are difficult to remediate. The panel noted that there was no evidence before it to indicate that Mrs Powers-Duff had strengthened her midwifery practice in the areas of concern and addressed her failings. Mrs Powers-Duff has not provided any evidence of training nor testimonials to demonstrate any positive steps she had taken to remediate her failings and strengthen her midwifery practice.

In light of this, this panel determined that there is a high risk of repetition of Mrs Powers-Duff's failings and a consequent risk of harm to the public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel had regard to the serious nature of Mrs Powers-Duff's failings and determined that public confidence in the profession, particularly as it involved dishonesty in clinical care, would be undermined if a finding of impairment were not made in this case. It was of the view that a fully informed member of the public, aware of the proven charges in this case and Mrs Powers-Duff's failure to strengthen her midwifery practice, would be very concerned if Mrs Powers-Duff were permitted to practise as a registered midwife without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the

importance of maintaining public confidence in the midwifery profession, and to uphold the proper professional standards for members of the midwifery profession.

Having regard to all of the above, the panel was satisfied that Mrs Powers-Duff's fitness to practise is currently impaired on both public protection and public interest grounds.

Decision and reasons on proceeding in the absence of Mrs Powers-Duff on day 22 of the proceedings

At the resumption of the hearing on day 22 of the proceedings, the panel noted that neither Mrs Powers-Duff nor her representative Ms Bennett were in attendance at the virtual hearing. The panel heard submissions from Ms Mohamed who invited the panel to continue in the absence of Mrs Powers-Duff and her representative Ms Bennett.

Ms Mohamed highlighted that the hearing was scheduled to resume today at 9:30 for submissions on sanction from both parties. Although Mrs Powers-Duff has not been attending some parts of this hearing, she has been fully represented by Ms Bennett throughout the course of the proceedings till today. Ms Mohamed informed the panel that at 9:47 today, Ms Bennett sent an email to her, the Hearings Coordinator and Mrs Powers-Duff, dated 10 January 2024, stating that they would no longer be participating in these proceedings based on the earlier concerns she had raised about the NMC, the panel and the hearing process.

Ms Mohamed submitted that it was evident from Ms Bennett's email dated 10 January 2024 that Ms Bennett and Mrs Powers-Duff would no longer attend this hearing and therefore, there was no reason to believe that an adjournment would secure their attendance on a future date. Ms Mohamed submitted that there is a strong public interest in the expeditious disposal of the case as these proceedings has been ongoing since it commenced in October 2022. She submitted that it was fair for the hearing to proceed in the absence of Mrs Powers-Duff and Ms Bennett.

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

The panel has decided to proceed in the absence of Mrs Powers-Duff and Ms Bennett. In reaching this decision, the panel has considered the submissions of Ms Mohamed, the email from Ms Bennett dated 10 January 2024 and the advice of the legal assessor. It has had particular regard to the *NMC Guidance on Proceeding with hearings when the nurse, midwife or nursing associate is absent* (CMT-8), the provisions of Rule 32(4) and the overall interests of justice and fairness to all parties. It noted that:

- Mrs Powers-Duff has not been in attendance for the majority of this hearing but she has been fully represented by Ms Bennett throughout the course of the proceedings till today;
- Ms Bennett has indicated in her email dated 10 January 2024 that she and Mrs Powers-Duff would no longer participate in these proceedings;
- No application for an adjournment has been made by Mrs Powers-Duff and Ms Bennett;
- There is no reason to suppose that adjourning would secure their attendance at some future date;
- Ms Bennett's email makes it clear that any future participation would be during the appeal process;
- The charges relate to events that occurred in 2020 and further delay may pose a risk of harm to the public given that the panel had earlier determined that Mrs Powers-Duff's fitness to practise is impaired and there is a risk of repetition; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Powers-Duff and Ms Bennett.

Sanction

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

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

Submissions on sanction

Ms Mohamed submitted that it is the NMC's position that a striking off order should be imposed given the findings of fact and the subsequent conclusion of the panel that Mrs Powers-Duff's fitness to practise is impaired.

Ms Mohamed submitted that the aggravating factors in this case are as follows:

- Dishonesty in relation to clinical care.
- Lack of insight, reflection or remorse
- A high risk of repetition.

Ms Mohamed submitted that in respect of mitigating factors, there is evidence, as highlighted by the panel, that there were some admissions by Mrs Powers-Duff with respect to the provision of intrapartum care without indemnity insurance and dishonesty, in her email to the Company dated 4th of August 2020.

Ms Mohamed referred the panel to the *NMC Guidance on Available sanction orders* (SAN-3) and submitted that the proper approach is to consider the full range of sanctions, starting with the least severe.

Ms Mohamed submitted that given the panel's findings that there is a high risk of repetition, taking no action would neither be proportionate nor appropriate in the circumstances of this case as it would not address the public protection concerns or satisfy the wider public interest.

Ms Mohamed submitted that, in relation to a caution order, given the panel's findings that there is a high risk of repetition in this case, a caution order would not restrict Mrs

Powers-Duff’s midwifery practice in any shape or form, but would merely mark the register. Therefore, this sanction is not proportionate or appropriate and it would not satisfy the public interest concerns or protect the public.

Ms Mohamed submitted that a conditions of practise order would not be appropriate or proportionate in this case. She highlighted that the panel had determined that Ms Powers Duff's lack of accountability for her failings, lack of professionalism, and her dishonest conduct are suggestive of attitudinal concerns, which are difficult to remediate. She further highlighted that the SG provides that a conditions of practise order may be appropriate when there is no evidence of harmful or deep-seated personality or attitudinal problems.

Ms Mohamed therefore submitted that, given that there are not only clinical concerns in this case and the panel’s findings, a conditions of practise order would neither be proportionate nor appropriate in this particular case.

With regards to a suspension order, Ms Mohamed highlighted that the misconduct in this case is not a single instance of misconduct as it involved four patients. The panel had also found that there are attitudinal concerns and there is a significant risk of repetition in this case. Ms Mohamed submitted that the circumstances of this case and the findings of the panel did not meet the criteria in the SG for when a suspension order is appropriate and proportionate. She therefore submitted that a suspension order is not appropriate or proportionate in this regard.

Ms Mohamed submitted that the only proportionate and appropriate sanction in this particular case is a striking-off order. She referred the panel to the *NMC Guidance on Considering sanctions for serious cases*, in particular, *Cases involving dishonesty* and the *NMC Guidance on Striking-off order.* She highlighted that the *NMC Guidance on Considering sanctions for serious cases*, in particular, *Cases involving dishonesty* provides:

'…Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*

Ms Mohamed submitted that this falls squarely with the facts found proved in this case. She highlighted that Mrs Powers-Duff deliberately sought to conceal the intrapartum care that she had provided to Patient D and Baby D.

Ms Mohamed submitted that there was no evidence before the panel that Mrs Powers-Duff has demonstrated insight or remorse. Mrs Powers-Duff has also not provided any evidence of training or testimonials to demonstrate any positive steps that she has taken to remediate her failings and strengthen her midwifery practise.

In conclusion, Ms Mohamed invited the panel to impose a striking-off order. She submitted that Mrs Powers-Duff's misconduct is fundamentally incompatible with her remaining on the register. She submitted that a striking-off order is the most proportionate sanction to maintain public confidence in the midwifery profession and to protect the public.

Decision and reasons on sanction

Having found Mrs Powers-Duff'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:

- Failures demonstrated across fundamental areas of midwifery practice.
- A pattern of misconduct over a period of time.
- Mrs Powers-Duff's lack of insight on the impact of her actions on Patients A, B, C, D and Baby D.
- Mrs Powers-Duff's misconduct placed Patients A, B, C, D and Baby D, at risk of harm.
- Serious dishonesty.
- No evidence to demonstrate remediation or strengthened practice.

The panel also took into account the following mitigating feature:

- Evidence of limited insight and admissions with respect to the provision of intrapartum care without indemnity insurance and dishonesty in Mrs Powers-Duff email to the Company dated 4 August 2020. However, there had been no formal admissions within this hearing and no evidence provided to this panel of reflection, remorse or strengthened practise.

The panel also had regard to the *NMC Guidance on Considering sanctions for serious cases*, in particular, *Cases involving dishonesty*. The panel took into account that Mrs Powers-Duff deliberately concealed that she had provided intrapartum care to Patient D without indemnity insurance from the paramedics and other appropriate health professionals. She also concealed that she had resuscitated Baby D and she failed to provide relevant information or complete any records with regards to provision of intrapartum care to Patient D. This placed Patient D and Baby D at significant risk of harm. The panel therefore found the dishonesty in this case to be serious and at the high end of the spectrum of dishonesty.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that Mrs Powers-Duff posed a risk of harm, had breached fundamental tenets of the midwifery profession and her misconduct would undermine the public's confidence in the midwifery profession if she were allowed to practise without restrictions. The panel therefore determined that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Powers-Duff's midwifery practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Powers-Duff's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Powers-Duff's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
> - *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 was of the view that some of the clinical concerns could potentially be addressed through retraining, however, it had found that Mrs Powers-Duff's dishonest conduct and lack of professionalism are suggestive of attitudinal concerns which are difficult to remediate.

The panel determined that given the seriousness of the concerns, Mrs Powers-Duff's attitudinal concerns and her lack of insight into the severity and impact of her failings on patients and the public, there are no practical or workable conditions that could be formulated. The panel had no evidence before it to suggest that Mrs Powers-Duff would comply with any conditions of practice order, given that she has not provided this panel with any evidence of positive steps taken to strengthen her midwifery practice. Accordingly, a conditions of practice order would not address the risk of repetition and therefore the risk of harm to the public. Consequently, the panel decided that a conditions of practice order would not protect the public nor be in the public interest.

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

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

The panel considered that Mrs Powers-Duff's failings were in fundamental aspects of midwifery practice and that they posed a significant risk of harm to Patients A, B, C, D and Baby D. It noted that Mrs Powers-Duff has failed to demonstrate insight into the

severity and the impact of her failings on Patients A, B, C, D, her colleagues and the midwifery profession. It considered that this was not a single instance of misconduct but rather a sustained pattern of behaviour towards several patients under care. It noted there was no evidence to show that Mrs Powers-Duff has taken any positive steps to strengthen her midwifery practice or to remediate her failings. She has also showed a lack of understanding of the importance of these proceedings and the duty of the NMC to protect the public and maintain public confidence in the midwifery profession. The panel was of the view that her lack of insight on the impact of her failings, her failure to strengthen her midwifery practice and her serious dishonest conduct, indicates deep-seated attitudinal problems which heightens the significant risk of repetition.

Consequently, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction and would not protect the public nor satisfy the public interest consideration in this case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

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

In the panel's judgement, all of the criteria as set out above, are met in this case.

The panel determined that Mrs Powers-Duff's misconduct, as highlighted by the facts found proved, constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered midwife is expected to maintain. The panel found that Mrs Powers-Duff's failings were significant departures from the standards expected of a registered midwife.

The panel concluded that the serious breach of fundamental tenets of the profession, evidenced by Mrs Powers-Duff's failings and dishonest conduct, is fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case raises serious and significant questions about Mrs Powers-Duff's professionalism and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Powers-Duff's actions in bringing the midwifery profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards of behaviour expected and required of a registered midwife.

This will be confirmed to Mrs Powers-Duff in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Powers-Duff's own interests until the striking-off 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 Mohamed. She submitted that, given that the panel has determined that a striking-off order is appropriate and proportionate, an interim suspension order for a period of 18 months is necessary in order to protect the public and also in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

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 protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.