Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 17 August - Friday 19 August 2022
Monday 13 March – Thursday 16 March 2023
Monday 28 March – Thursday 31 March 2023
Monday 2 April – Thursday 6 April 2023
Monday 6 November- Thursday 16 November 2023
and
Wednesday 13 March 2024

Virtual Hearing

Name of registrant:	Sharon Annette Hughes
NMC PIN:	81J0513E
Part(s) of the register:	Registered Midwife – September 2001 Registered Nurse – Sub Part 1 General Nursing – Level 1 – April 1999 General Nursing – Level 2 – January 2001
Relevant Location:	Cornwall
Type of case:	Lack of competence
Panel members:	Christina McKenzie (Chair, Registrant member) Matthew Wratten (Lay member) Laura Wallbank (Registrant member)
Legal Assessor:	Nigel Mitchell (17 August 2022- 6 April 2023) John Bromley-Davenport KC (6 November – 16 November 2023 and 13 March 2024)
Hearings Coordinator:	Xenia Menzl (17 August – 19 August 2022) Teige Gardner (13 March – 16 March 2023, 28 March – 31 March and 3 April – 6 April 2023) Taymika Brandy (6 November – 16 November 2023) Monsur Ali (13 March 2024)
Nursing and Midwifery Council:	Represented by Callum Munday, Case Presenter (17 – 19 August 2022) Represented by Dominic Evans (13 March – 16 March 2023, 28 March – 31 March and 3

	April – 6 April 2023) and (6 November – 16 November 2023, and 13 March 2024)
Mrs Hughes:	Present and represented by Thomas Buxton instructed by Thompsons Solicitors
Facts proved:	Charge 1.d. and 1e. Schedule 1 charge 4., 5.c.,5.d., 7.b., 7.c.,
Facts proved by admission:	Charge 1.c.
Facts not proved:	Charge 1.a. and 1.b. Schedule 1 charge 2., 2.,5.ba., 5.b., 7.a.,
No case to answer:	Schedule 1 charge 1 and 6.
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (18 months)
Interim Order:	Interim conditions of practice order (18 months)

Decision and Reasons on Admissibility of Evidence

Mr Buxton, on your behalf, made an application to exclude certain parts of the exhibit bundle and parts of the witness statement bundle. He submitted that this evidence is inadmissible because it is hearsay and is not supported by either witness statements or direct evidence.

Mr Buxton referred panel to the cases of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*, *El Karout v NMC* [2019] EWHC 28 (Admin) and *R (Bonhoeffer) v GMC* [2012] IRLR 37.

Mr Buxton provided the panel with an email (Exhibit 1) which had been sent to the Nursing and Midwifery Council (NMC) on 12 August 2022 and set out a list of his objections.

Mr Buxton submitted that the allegations relate to incidents which occurred between October 2017 and August 2020 and relate to medication administration, cardiotocography (CTG) monitoring, record keeping, communication, escalation and delegation and patient care. He referred the panel to Schedule 1 which specifies seven different dates involving allegations of lack of competence between 1 October 2019 and 5 June 2020. There are a number of witnesses to be called, some of whom are able to give direct evidence. However, within these statements there are many examples of hearsay evidence some of which are the sole or decisive evidence in respect of a particular charge. The evidence before the panel contains statements and emails sent by patients, workers and midwives who themselves have not provided witness statements to the NMC and who are not to be called as witnesses. Mr Buxton submitted that it follows in such areas of evidence that you are deprived of an opportunity to challenge and put a definitive case to these witnesses. He submitted that this results in unfairness.

Mr Buxton invited the panel to find that the following parts of the evidence were inadmissible:

- Evidence of Witness 1, related to evidence concerning the complaint made by Patient F as contained within the statement of Witness 1 and the documents that she exhibits (Schedule 1, Charge 6).
  Mr Buxton submitted that the evidence of Witness 1 relates to a complaint made by Patient F. Patient F made the complaint to Witness 1 who then wrote it down. He submitted that this was hearsay evidence as Patient F is not to be called as a witness and has not made a witness statement. Witness 1's evidence is the sole or decisive evidence regarding this allegation. Mr Buxton submitted that the hearsay evidence cannot be challenged by you nor tested by the panel. He therefore submitted that it would be unfair to allow this hearsay into evidence.

- Local investigation statements by Person A, Person B and Person C (Ex SHH 14, 15 and 16 relating to Schedule 1, Charge 7)
  Mr Buxton submitted that neither Person A, Person B nor Person C are to be called by the NMC as a witness nor have they provided a witness statement. He therefore submitted that the hearsay evidence cannot be challenged by you nor tested by the panel. He therefore submitted that it would be unfair to allow this hearsay into evidence.

- Email from Person D (ZEN 21)
  Mr Buxton submitted that Person D is not to be called as a witness neither has she made a witness statement. He submitted that Person D's evidence is therefore hearsay evidence. He further submitted that the hearsay evidence cannot be challenged by you nor tested by the panel. He therefore submitted that it would be unfair to allow this hearsay into evidence.

- Email from Witness 1 to Witness 4 regarding Patient F (ZEN 22 relating to Schedule 1, Charge 6)

  Mr Buxton submitted that this is hearsay evidence, and it would be unfair to admit it.

- Letter from Person E to Patient F regarding their complaint (ZEN 23 relating to Schedule 1, Charge 6)

Mr Buxton submitted that neither Person E nor Patient F were to be called as witnesses and neither have made witness statements. He submitted that the letter from Person E is therefore hearsay evidence. He further submitted that the hearsay evidence cannot be challenged by you nor tested by the panel as neither Person E nor Patient F are attending the hearing. He therefore submitted that it would be unfair to allow this hearsay into evidence.

- Letter from Patient A (ZEN 27 relating to Schedule 1, Charge 1)
  Mr Buxton submitted that this letter was the sole and decisive evidence regarding this incident. Neither Patient A nor the other midwife involved in their care were to be called as witnesses. Mr Buxton submitted that the letter is therefore hearsay evidence. He further submitted that the hearsay evidence cannot be challenged by you nor tested by the panel as neither Patient A nor the other midwife involved are attending the hearing. He therefore submitted that it would be unfair to allow this hearsay into evidence.

Mr Buxton submitted that this is a balance of fairness exercise and that as a consequence the panel should refuse to admit the hearsay evidence. He noted the panel will have regard to the explanations for the absence of these witnesses at the hearing. The panel will need to consider whether the evidence forms the sole or decisive evidence in relation to the charges. Mr Buxton submitted that it would be unfair in such a case, where evidence cannot be tested, to allow such evidence into the hearing. He therefore invited the panel to determine that the evidence, as outlined above, was inadmissible.

Mr Munday, on behalf of the NMC, submitted that hearsay evidence is not automatically unfair. Whilst he acknowledged that in some of the above outlined evidence the original statement maker was not giving evidence, their account was given to another person, who will be attending the hearing. Mr Munday therefore submitted that in such a case the admissibility of evidence was not unfair or inadmissible per se. Mr Munday submitted that not all the hearsay evidence, the subject of Mr Buxton's submissions, was sole or decisive.

Mr Munday submitted that the local investigation recollections of Person A, Person B and Person C were part of Witness 4's local capability report in which conclusions were reached. He submitted that the local recollections were included for completeness. Witness 2 will be attending to give evidence as to these events.

Mr Munday submitted that ZEN 21, 22, 23 and 27 were all appendices attached to a capability report. Mr Munday also submitted that the report itself had not been objected to and argued it would be unfair to read her report without seeing the other documents that Witness 4 refers to.

Mr Munday therefore submitted that the evidence in question was not the sole and decisive evidence before the panel and invited it to find that that the evidence in question was admissible.

The panel heard and accepted the legal assessor's advice.

The panel has heard from both parties that the following is redacted by agreement:

- Witness 3's paragraphs 8 and 40
- Witness 4's paragraphs 13, 25, 27 and 28
- SHH 3
- ZEN 1
- ZEN 2
- ZEN 6
- ZEN 13
- ZEN 24
- ZEN 25

The panel also heard from both parties that the following is remaining by agreement.

- Witness 3's paragraphs 19 through 22 (inclusive)
- SHH 6
- ZEN 8

The panel went on to discuss the remaining disputed evidence:

1. The evidence of Witness 1 in respect of Schedule 1, Charge 6. (Witness Statement of Witness 1, paragraphs 4 through 11, AD1, ZEN 22 and ZEN 23) The panel noted that Witness 1 states that she '*did not directly witness what happened with Patient F but I was made aware about what happened by Patient F on the 20 January 2020*'. Witness 1 raised the complaint on 25 February 2020.

   The panel determined that the only material that supported Schedule 1, Charge 6, is the hearsay evidence of Witness 1 in her witness statement paragraphs 4 to 11, Patient F's complaint as described by Witness 1 (AD 1), the hearsay contained within the Trust's response to Patient F's complaint (ZEN 23) and the email from Witness 1 to Witness 4 (ZEN 22). Patient F has not made a witness statement. Patient F is not attending the hearing. The panel were informed that Patient F has told the NMC that she does not wish to '*engage*'. Neither Witness 1 nor Person E can give direct evidence on this charge. They can only say what Patient F or others told them. There is no supporting evidence for this charge and therefore it cannot be said to be evidence that is demonstrably reliable nor is it capable of being tested. In these circumstances, all the material set out above falls into the category sole or decisive and therefore the panel decided it would be unfair to admit it.

2. SHH 14, 15 and 16, as well as Witness 3's paragraphs 32 (b), (c) and (d). These are three documents entitled 'Recollection of Events'. They concern the allegations set out in Schedule 1, Charge 7. All three documents have different authors, none of whom are to be called to give evidence nor have they made witness statements. However, Witness 2 was on duty on the day in question, 5 June 2020, and has provided a signed witness statement, a signed recollection of events and a copy of Patient G's patient records. The panel determined that notwithstanding that document SSH 14, 15 and 16 are hearsay they are not necessarily the sole or decisive evidence. Witness 2 will be attending the hearing and can be questioned about the events of that day. Therefore, the panel determined that the material contained within these documents is relevant and that it would be fair to admit it in evidence.

3. ZEN 21

   The panel noted that the email does not refer to a specific date. The panel have taken into account that the author of the email has not made a witness statement nor is she to be called as a witness. Further, the panel have no details as to what request Witness 4 made of the author. However, the panel have determined that it should remain as part of the NMC bundle and it will be explored further with Witness 4. The panel was informed by Mr Munday that this document is relevant to Charge 1. The panel therefore determined that it would be fair to admit it and it can attach such weight to it as appropriate after hearing all the evidence.

4. ZEN 27

   This document is Patient A's letter of complaint. Patient A has not made a witness statement neither has she been called as a witness. Further, the panel noted, that at the material time the patient records indicate that you were the midwife responsible for the care of Patient A until 1pm when another midwife took over her care. The panel would not be able to test Patient A on which midwife was responsible for her care which she has complained about. The panel determined that this evidence falls into the category sole or decisive and has therefore ruled that it would be unfair to admit it.

Application to adjourn the Hearing

On Thursday, 18 August 2022, the panel was informed around midday that Witness 2 only had availability until 2pm as she was leaving the country for an extended period.

Mr Buxton made an application to adjourn. He submitted that there was no certainty regarding Witness 2's availability for the resuming dates in September.

Mr Buxton further submitted that, in any event, you wish for Mr Buxton to represent you. Given the unforeseen circumstances the hearing might have to be listed for further dates, beyond September 2022, and Mr Buxton was not available until March 2023. He

submitted that in these circumstances it would be fair and appropriate to adjourn the hearing.

Mr Munday submitted that he did not oppose Mr Buxton's application.

The panel heard and accepted the legal assessor's advice.

The panel considered that it will not be able to hear from Witness 2 today, however, it was of the view that it should be possible for the NMC to organise for her to give evidence remotely from abroad during the resuming dates in September.

The panel had regard to the overall interests of justice and fairness to all parties. It noted that:

- Three witnesses were lined up to give evidence tomorrow and a further three in September. The panel was conscious that these witnesses had already taken time out of their diaries to attend the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;
- The hearing was unlikely to conclude in September, however Mr Buxton's availability will be taken into account when rescheduling addition dates for the event;
- The panel was of the view that with tomorrow and the three days in September the NMC will be able to complete its case;
- It is fair to you to have a quick resolution to the case; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed.

Charges

That you, a registered midwife:

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of:

    a. Medications administration; [THIS CHARGE IS FOUND NOT PROVED]
    b. CTG monitoring; [THIS CHARGE IS FOUND NOT PROVED]
    c. Record keeping; [THIS CHARGE IS FOUND PROVED BY WAY OF ADMISSION]
    d. Communication, escalation and delegation; [THIS CHARGE IS FOUND PROVED]
    e. Patient care; [THIS CHARGE IS FOUND PROVED]

    on one or more of (but not limited to) the occasions set out within Schedule 1;

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

Schedule 1:

1. Between 1 and 8 October 2019, when caring for Patient A, failed to commence induction of labour care with oxytocin; [NO CASE TO ANSWER]

2. On 13 November 2019, failed to administer IV antibiotics to Patient B despite requests from the patient, a doctor, and a fellow midwife; [THIS CHARGE IS FOUND NOT PROVED]

3. On 18 November 2019:

a. Inappropriately delegated a CTG, ECG and prophylactic fragmin to a junior colleague (Midwifery Support Worker A) when;
    i. The tasks at 3a were assigned to you by a doctor;
    ii. You had capacity to deal with the tasks at 3a;
    iii. You did not confirm with MSW A that they were capable of taking on the tasks at 3a;
    iv. The tasks at 3a were not appropriate to delegate to a MSW;

b. Failed to provide adequate care for the patients in your care, in that you;
    i. Took 4 hours to administer an IV antibiotic, Benzyl penicillin, to Patient C;
    ii. Failed to carry out any observations on a patient that required observations for 12 hours;

[THIS CHARGE IS FOUND NOT PROVED IN ITS ENTIRETY]

4. On 22 November 2019, failed to carry out any observations on Patient D when observations should have been carried out every 5 hours over a 12-hour period; [THIS CHARGE IS FOUND PROVED]

5. On 25 November 2019, failed to properly carry out a CTG in relation to Patient E, in that you;

a. Failed to regularly monitor the CTG, when this should have been done every 20 minutes; [THIS CHARGE IS FOUND NOT PROVED]
b. Failed to realise the CTG was monitoring the maternal heartbeat; [THIS CHARGE IS FOUND NOT PROVED]
c. Failed to record the CTG readings and changes; [THIS CHARGE IS FOUND PROVED]
d. Escalate the reading of 90bpm when it should have been between 110 and 160bpm; [THIS CHARGE IS FOUND PROVED]

6. On 17 January 2020, failed to provide adequate care for Patient F, in that you;

    a. Failed to fully communicate the reasons for Patient F's transfer to a different ward, omitting the need for meconium observations and catheter care;
    b. Acted in an unprofessional manner by telling Patient F, "you're never going to sleep again now that you're parents", or words to that effect, when Patient F stated they were exhausted and wanted to go home; [NO CASE TO ANSWER IN ITS ENTIRETY]

7. On 5 June 2020, failed to provide adequate care for Patient G, in that you;

    a. Failed to escalate significant APH blood loss, both at 450mls and at 1500mls; [THIS CHARGE IS FOUND NOT PROVED]
    b. Failed to provide information to colleagues on allergies, medication, blood type, initial blood results, previous birthing history, and Covid-19 testing at handover; [THIS CHARGE IS FOUND PROVED]
    c. Failed to act on, request assistance, or escalate when Patient G had become unresponsive following low blood pressure and blood loss. [THIS CHARGE IS FOUND PROVED]

Mr Buxton told the panel that you admitted Charge 1c) and contested all other charges.

Mr Munday opened the case to the panel with a view to hear the first witness on Friday 19 August 2022.

Joint application to adjourn the Hearing

After the panel's decision not to allow the application to adjourn the hearing the NMC received further information from Witness 2. Witness 2 informed the NMC that whilst

she was keen to engage with the hearing, she was travelling during the September dates with no access to the internet.

Mr Munday, on that basis, made an application to adjourn the hearing until a later date when Witness 2 was available to give evidence. He reminded the panel that one factor that led to its refusal to adjourn was that it believed that it could be arranged for Witness 2 to give evidence in September, however, it now transpired that this was no longer an option.

Mr Munday submitted that Witness 2 is a witness upon whose evidence the NMC relies in relation to the incident with Patient G. Witness 2's evidence is not accepted by you, and you therefore have the right to cross examine her.

Mr Munday submitted that both parties agree that Witness 2 needs to be heard and that her statement cannot simply be read into evidence. Mr Munday therefore submitted that he in effect joined Mr Buxton's previous application to adjourn the hearing.

Mr Munday reminded the panel that one of the reasons not to adjourn the hearing was that there was a possibility to conclude the NMC's case in the remaining allocated days. Whilst it was clear that the hearing would go part heard at that stage, the hearing could then resume afresh with starting your case. However, this was no longer possible due to Witness 2's unavailability. The prospect of adjourning in the midst of the NMC case is even less attractive.

In reply to a question by the panel Mr Munday clarified that this would not be an indefinite adjournment. Witness 2 made it clear that she is willing to give evidence, but that she is not available during the dates the hearing is listed.

Mr Munday therefore renewed the application to adjourn the hearing.

Mr Buxton supported the renewed application.

The panel heard and accepted the legal assessor's advice.

In light of the new information the panel determined that it would be fair and appropriate to adjourn the hearing to a later date. It was of the view that the unavailability of Witness 2 during the remaining listed dates changed the circumstances. The panel concluded that it would be highly undesirable for the NMC not to be able to finish their case by the end of the current listed dates. It was of the view that the hearing should adjourn until such a time at which that all witnesses are available to give evidence.

The panel suggested that the NMC relists this hearing after the 13 March 2023 to accommodate Mr Buxton's and the other witnesses' availability.

The hearing resumed on 13 March 2023.

Application for no case to answer in regard to Schedule 1 paragraphs 1 and 6(a) and 6(b).

At the outset of the hearing, the panel heard submissions from Mr Evans, on behalf of the NMC, regarding no case to answer in relation to Schedule 1, paragraphs 1 and 6(a) and 6(b).

Mr Evans submitted that, following the panel's decision on the admissibility of some of the evidence in this case as set out above, there is no longer any evidence that goes to paragraphs 1 and 6(a) and 6(b) of Schedule 1. He submitted that there is no realistic prospect that these charges will be found proved. He submitted that state of evidence has changed since the Case Examiners findings, and it is no longer in the public interest for these charges to remain.

Mr Buxton did not contest Mr Evans' submissions.

The panel accepted the advice of the legal assessor.

The panel considered the evidence before it and determined that there is no evidence that supports paragraphs 1 and 6(a) and 6(b) of Schedule 1. It determined that there is

no realistic prospect of it finding either paragraph proved. The panel, having considered Rule 24(7), found that there is no case to answer in relation to paragraphs 1 and 6(a) and 6(b).

Decision and reasons on application for hearing to be held in private

Mr Buxton made a request that parts of this case be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Evans indicated that he supported the application to the extent that any reference to [PRIVATE] should be heard in private.

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

The panel determined to go into private session in connection with any references to [PRIVATE] and when such issues are raised in order to protect your right to privacy.

Background

On 11 June 2020, the NMC received a self-referral from you, following your resignation as a Band 6 midwife at the Royal Cornwall Hospitals NHS Trust (the Trust). Your referral outlines that you resigned from the Trust prior to completing a Personal Development Action Plan ('PDAP'). It is alleged that you failed to demonstrate the requisite standards of knowledge, skill and judgement required to practise without supervision as a Band 6 midwife, during this time period.

On 24 June 2020, the NMC also received a referral from the Trust, the referral raised alleged concerns regarding you not completing your PDAP and that you were involved in multiple alleged incidents. The objectives in the PDAP were:

a. Patient Observations;
b. Communication of findings;
c. Responsibility;
d. Correct identification of fetal heart;
e. CTG interpretation;
f. Timely administration of medication; and
g. Working in line with the expectations of a Band 6 Midwife working with the acute setting

You began working at the Trust in October 2017. Initially, you were working in the community team. In November 2017, you moved to the Birth Centre at the Trust. In January 2018 following a period of annual leave you moved back to the community team. [PRIVATE]. From July 2018 onwards you rotated around various wards starting on the postnatal ward.

Following concerns raised regarding your clinical practice, a number of informal meetings took place under the Trust's capability procedure between 17 August 2018 and December 2018 and a PDAP was implemented. The objectives in the informal PDAP were:

a. Adult IV antibiotics;
b. Awareness of own responsibilities regarding taking over patient care at beginning of shift;
c. Effective communication and escalation of concerns;
d. Baby IV Antibiotics and TC feeds;
e. NIPE practical;
f. Midwives Mandatory training;
g. EPMA competency;
h. MEOWS competency in recognising the deterioration patient; and

i. Understanding of capability process and responsibilities of a Midwives journey through a capability review.

Your informal PDAP was signed off on 6 February 2019 as you had met all of your objectives.

Further alleged concerns were raised from 13 November 2019 that form the subject of Charges 2- 6, as set out in Schedule 1. During December 2019, you were moved to a different ward whilst the Trust began investigating these concerns and you were informed that the Stage 3 Formal Capability process would be initiated. You were told that you would return back to the audit office pending the formal capability hearing. A formal Stage 3 Capability Hearing took place on 17 March 2020 and you were issued a final written warning. A new PDAP was implemented that commenced on 1 May 2020. The objectives were:

a. Patient Observations;
b. Communication of findings;
c. Responsibility;
d. Correct identification of fetal heart;
e. CTG interpretation
f. Timely administration of medication; and
g. Working in line with the expectations and Job description of a Band 6 midwife working with the Acute setting.

You returned to the Ward on 4 May 2020 and a further alleged incident occurred on 5 June 2020 (Charge 7 Schedule 1). You resigned from the Trust on 9 June 2020.

Decision and reasons on facts

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

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 2: Delivery Suite Coordinator at the Trust, at the time of the allegations;
- Witness 3: Midwifery Ward Manager at the Trust, at the time of the allegations;
- Witness 4: Local Maternity and Neonatal System ('LMNS') Midwife at the Trust, at the time of the allegations;
- Witness 5: Midwifery Sister/ Transitional Care Ward Manager at the Trust, at the time of the allegations;
- Witness 6: Suite Coordinator and Fetal Monitoring Lead Midwife at the Trust, at the time of the allegations;
- Witness 7: Core Midwife at the Trust, at the time of the allegations;

The panel also heard evidence from you under oath.

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 Mr Evans and Mr Buxton.

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

Charge 2 (schedule 1).

Schedule 1:

2. On 13 November 2019, failed to administer IV antibiotics to Patient B despite requests from the patient, a doctor, and a fellow midwife;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3, your reflective account entitled 'Understanding the importance of Neonatal Infection and the use of Antibiotics, prior to birth' (undated) and Patient B's Antenatal Notes.

The panel noted Witness 3's NMC statement that states:

> *'Patient B had arrived on the Ward in labour and saw Shan who had noted on her admission sticker that Patient B had GBS. Patient B [sic] waters broke at 21.40. Shan could have known the importance of arranging a prescription of antibiotics with the doctor immediately noting Patient B had GBS. […] Patient B arrived at the Ward at 22.10, she was seen by the doctor at 22:15. The doctor saw Patient B again at 0:44 and stated that labour will be induced and the antibiotics should be started straight away. Shan did not start the IV antibiotics at this point either'*

The panel accepted that you had not yet passed your assessment for patient cannulation, and as a result you were unable to cannulate Patient B to begin administering their IV antibiotics. When this was put to Witness 3 during panel questions, she explained that in these circumstances she would have expected you to escalate this to a doctor, the Delivery Suite Coordinator, Anaesthetist or a Midwife Support Worker.

The panel had regard to Patient B's Antenatal notes for 13 November 2019 and noted that there was no record of the prescription or administration of IV antibiotics in the records before the panel or on the patient's initial assessment record sticker. The panel considered that Witness 3's evidence in respect of this charge was hearsay as it had not been provided with any further contemporaneous documentation to evidence when the IV antibiotics had been prescribed and administered. The other members of staff allegedly present at the time had not provided any evidence in this case, as a result, the panel was not able to test Witness 3's account. Therefore, the panel attached little weight to Witness 3's evidence in respect of this charge.

The panel then noted your reflective account that states:

> '*On this occasion, the IV antibiotics (IAP) were delayed because I was not signed off to cannulate with this Trust (Competency at other Trust was not acceptable). I had been told that I could not cannulate until I had passed the assessment with this Hospital. So I could not complete this task myself and my colleagues were busy with their work. I asked the Doctor to attend the ward, to cannulate for me, but he informed me that the activity on Delivery Suite did not allow him to attend, at that point in time. He said he would attend as soon as possible. I explained this to the woman but I did not ask if anyone else on the ward could help and in hindsight I should have. I regret this missed opportunity to provide the necessary care.'*

The panel found your evidence to be consistent with the evidence of Witness 3, in that it is not contested that you did administer Patient B's antibiotics but that you had not done

so immediately. The panel was of the view that your evidence was detailed and credible and therefore, accepted your evidence in respect of this charge.

The panel concluded that you had administered IV antibiotics to Patient B, albeit with a delay. Accordingly, the panel determined that this charge is found not proved.

Charges 3a i.- iii. (schedule 1).

Schedule 1:

3. On 18 November 2019:

    a. Inappropriately delegated a CTG, ECG and prophylactic fragmin to a junior colleague (Midwifery Support Worker A) when;
        i. The tasks at 3a were assigned to you by a doctor;
        ii. You had capacity to deal with the tasks at 3a;
        iii. You did not confirm with MSW A that they were capable of taking on the tasks at 3a;
        iv. The tasks at 3a were not appropriate to delegate to a MSW;

These charges are found NOT proved.

The panel considered charges 3a i.- iii. together as they relate to the same alleged incident.

In reaching this decision, the panel took into account the evidence of Witness 7 and your reflective account entitled '*Schedule 1- Incident 3 (a) (i) (ii) (iii) (iv)'* (undated).

Your reflective account states:

'This patient was reviewed by the doctor and a plan of care was put in place with a number of investigations arranged for an chest X-ray, ECG, CTG, and prophylactic Fragmin (Blood thinner) used in the prevention of blood clots (deep vein thrombosis)

With a professional understanding that this was a potentially urgent situation, I decided that it would be beneficial for her to be cared for on a one-to-one basis on the Delivery Suite (DS) and I discussed this with the Core midwife [Witness 7] making my concerns known to her, This was however met with some resistance and she appeared to think I was being obstructive in getting the investigations completed. She stated that I should get on with the investigations myself on the antenatal ward and she appeared somewhat annoyed. I did not agree and was assertive in my actions by calling the Delivery Suite, where I explained my findings and aired my concerns for the wellbeing of my patient. The Co-ordinator agreed with my concerns and a midwife was sent, she was transferred her under her one-to-one care.

I did not agree with her and continued to act upon my professional judgment at that time. I would always want my patient to be well cared for, in a timely manner, in the correct setting and with the most appropriate and skilled healthcare professionals, to provide that care. […]

This was a difficult situation with a strong character and a Core member of staff. My defining points and focus were on my patient, who was in need of direct and immediate clinical input and for the best care, in the safest place.'

The panel noted Witness 7's NMC statement that states:

'[…] was suspected to have suffered a Pulmonary Embolism. Sharn was responsible for […] who had a new plan of care placed by the Doctors. The NMC asked me what the plan entailed but I do not remember the patient's name or the plan. In my email I've mentioned that Sharn had to complete a CTG, ECG and prophylactic fragmin. […] Sharn did not do anything with and sat at the ward desk. Sharn was getting MSW A to do her tasks. MSW A was visibly struggling and it was not tasks you'd ask a Midwifery Support Worker to do. Unfortunately, I do not remember much more about the patient and whether harm was caused or to comment on the potential of harm.'

During Witness 7's oral evidence she stated that she *'couldn't remember the shift'.* The panel was of the view that Witness 7's evidence lacked detail and was of the view that the inconsistencies between her written and oral evidence made her evidence unreliable in respect of this charge.

The panel also had regard to Witness 7's contemporaneous email dated 18 November 2019 to Witness 3, which outlined some of the alleged concerns Witness 7 had regarding your clinical practice during a shift on 18 November 2019. In her email Witness 7 states *'Shan did question whether the patient should be on DS'.* The panel noted that this was consistent with your evidence.

During your oral evidence you had explained this incident in detail. You maintained that you had escalated Patient B's care as you felt that they required 1-1 care on Delivery Suite and denied delegating any tasks to MSW A and stated that you would never do that. The panel noted that your oral evidence had been consistent with your written documentation, namely, your relevant reflection and your document that outlined a timeline of events at the Trust.

The panel was not provided with any evidence from MSW A or the doctor referred to at charge 3a. The panel bore in mind that the burden of proof rests upon the NMC and that no further evidence had been provided to support the assertion in the charge. In the absence of this information, the panel accepted your evidence, and it was unable to conclude that you had inappropriately delegated a CTG, ECG and prophylactic fragmin to MSW A. It therefore follows that the panel found charge 3a not proved in its entirety.

Charge 3b. i. (schedule 1).

Schedule 1:

3. On 18 November 2019:

b. Failed to provide adequate care for the patients in your care, in that you;

i. Took 4 hours to administer an IV antibiotic, Benzyl penicillin, to Patient C;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 7.

The panel noted Witness 7's NMC statement that states:

> '*Sharn had to administer an IV antibiotic to Patient C, Benzyl penicillin (referred to as ben pen in my email) but this took 4 hours for Sharn to do this on the shift. All IVs need to be second checked at the Trust and I was willing to check the Benzyl penicillin with her but when I would free myself Sharn would say she was busy and she would come and get me. I needed to free myself to carry out the second check and ensure it was safe.*
>
> *I would start another task and once I finish, I would ask Sharn again and she said I'm still doing something. At this point, I had to tell Sharn I'm very busy and keep having to clear out time to second check the antibiotics for her to administer. To administer Benzyl penicillin it would only take 5 minutes but another Midwife had to second check it. As a result of Sharn's delaying, the Benzyl penicillin was administered 4 hours late to Patient C. The task Sharn was busy with was not important at the time and could have been picked up after the Benzyl penicillin had been administered.*
>
> *Patient C had a Group B Streptococcus infection and needed the antibiotics. The delay in administering antibiotics meant would not be covered during the labour and had to stay longer on the Ward. In extreme circumstances, Patient C could have developed Sepsis and possible died along with her baby. Luckily for Sharn, there were safety nets in place and no harm was caused to Patient C.'*

During Witness 7's oral evidence she stated that she could not remember the shift or what patients had been present on the ward at the material time. The panel was not

provided with Patient C's maternal records and noted that Witness 3 had made no reference to the date in the charge in her written statement. Further, in her email dated 18 November 2019 to Witness 3 she states, *'she took nearly 4 hours to give ben pen on my night shift with her'*, however, again Witness 7 makes no reference or the patient or the date specified in the charge.

The panel considered that the NMC had not adduced any further evidence in respect of this charge, specifically relating to18 November 2019 and in the absence of such evidence, the panel determined that this charge is found not proved.

Charge 3b. ii. (schedule 1).

Schedule 1:

3. On 18 November 2019:

b. Failed to provide adequate care for the patients in your care, in that you;
   ii. Failed to carry out any observations on a patient that required observations for 12 hours;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 7.

The panel noted Witness 7's NMC statement that states:

> *'Shan had a patient who required observations for 12 hours but Shan did not carry these out.'*

The panel noted that this was not supported by any of the documentary evidence before it. Further, the panel had regard to Witness 7's email dated 18 November 2019, noting that no reference was made to this allegation. The panel bore in mind that during

Witness 7's oral evidence she stated that she could not remember the shift on 18 November 2019 or what patients had been present on the Ward at the material time.

The panel considered that the NMC had not adduced any further contemporaneous evidence in respect of this charge specifically on 18 November 2019, and in the absence of such evidence, the panel determined that this charge is not found proved.

Charge 4 (Schedule 1)

Schedule 1:

4. On 22 November 2019, failed to carry out any observations on Patient D when observations should have been carried out every 5 hours over a 12-hour period;

This charge is found proved.

In reaching this decision, the panel took into account your evidence, Patient D's MEOWS chart and Antenatal notes and Person F's email dated 2 December 2019 and your undated response whilst on Wheal Rose (ZEN/15).

During the course of your oral evidence, you accepted failing to carry out any observations on Patient D on 22 November 2019. In your response document, exhibited by Witness 4 (ZEN/15), you state:

> '*The Datix incident form was completed and I fully take on board and understand why it was required. I understand that this was a 'near miss' and I accept the seriousness of what could have happened. I have looked at this carefully myself and take responsibility completely […]*
>
> *I really feel awful that a human factor caused this error of care. When I realised and completed the MEOWS, her blood pressure was normal and she was thankfully, well'.*

The panel noted that you had maintained this acceptance since the initial incident and this was consistent with Person F's email to the Clinical Skills Facilitator at the Trust that states:

> '*When leaving the staff room following her whole handover [you] stated "My bloods run cold, I've not taken the BP for the PET lady all day, I'll do it now" Furthermore she stated that she thought that the MSW would have done it throughout the day.'*

The panel had regard to Patient D's records, namely, the MEOWS chart and Antenatal Notes and noted that the only observation recorded is at 18:40. Taking into account your acceptance in failing to carry out Patient D's observations and the documentary evidence before it, the panel determined that this charge is found proved.

Charge 5.a. (schedule 1).

Schedule 1:

5. On 25 November 2019, failed to properly carry out a CTG in relation to Patient E, in that you;

    a. Failed to regularly monitor the CTG, when this should have been done every 20 minutes;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Trust's Antenatal Cardiotocography ('CTG') and Dawes Redman Analysis Clinical Guideline ('CTG guideline') dated January 2019 and your evidence.

The panel had regard to the Trust's CTG guideline and noted that it states:

> '***2.6 DURATION OF MONITORING***

[…]

2.6.3 The practitioner commencing the CTG MUST return within 10 minutes to ensure the quality and assess, visually, whether the monitoring is normal.'

The panel noted that a duty arises from these guidelines to monitor the CTG every 10 minutes, rather than 20 minutes as stated in the charge. Notwithstanding this, the panel went on to consider whether you had failed to monitor Patient E's CTG.

The panel noted your reflective account entitled 'Schedule 1 Incident - 5 Date 25.11.2019 CTG Monitoring – Induction of Labour'. You state:

'The CTG was prior to induction. The woman had been admitted from the community, following a raised blood pressure of 140/90mmHg at 39/40 and was classed as having the onset of Pre-eclampsia, as she also had a raised PCR level (Protein Creatinine Ratio) and this was the indication for induction.

I gained consent for the induction process and explained the CTG would be on for 30 minutes prior to the induction with Propess. I observed it for 10 minutes as per protocol'

And:

'[…] I could see the baby was becoming active and I explained this could lose the connection of the pick-up. She called me back as I was attending to another patient and I returned to her, to see the baby had moved and the CTG was picking up the maternal pulse of 90bpm. The fetal movements were very apparent and can be seen on the CTG graph.'

In addition, you told the panel that you had commenced the CTG at 12:20, monitored the CTG for 10 minutes and you checked it at 12:40. You explained that this is when the CTG started to lose contact, and between 12:40 and 12:50 the baby was moving a lot. You made a contemporaneous record on the CTG trace at 12:55, when you realised it

was picking up the maternal pulse, however you could still hear the fetal heartbeat in the background.

The panel had regard to Patient E's CTG trace, noting that your note of the maternal heartbeat was consistent with your oral evidence. The panel was of the view that your evidence in respect of this charge was detailed and remained consistent under cross examination. This enabled the panel to have a clear understanding of what you were doing at the material time. Further, the panel noted that Witness 3 was not present in the room at the time you were monitoring the CTG and therefore, did not observe any of the actions you described.

In all the circumstances, the panel accepted your evidence that you were in the room with Patient E at all times until you approached Witness 3 to obtain a new transducer.

Accordingly, the panel determined that on a balance of probabilities this charge is found not proved.

Charge 5.b. (schedule 1).

Schedule 1:

5. On 25 November 2019, failed to properly carry out a CTG in relation to Patient E, in that you;

    b. Failed to realise the CTG was monitoring the maternal heartbeat;

This charge is NOT proved.

In reaching this decision, the panel took into account your evidence and Patient E's CTG record.

During your oral evidence, you explained that you had realised that the CTG began picking up the maternal heartbeat. As a result, you began monitoring Patient E's radial pulse and moving the fetal heart transducer to try and relocate the fetal heartbeat.

The panel also had regard to Patient E's CTG record and noted that you had made a record at 12:55 on the CTG that states, '*Maternal 84bpm'*. The panel noted that this contemporaneous record was consistent with your evidence, and it accepted your evidence in this regard. The panel concluded that you had realised that the CTG was monitoring the maternal heartbeat.

Accordingly, the panel determined that this charge is found not proved.

Charge 5.c. (schedule 1).

Schedule 1:

5. On 25 November 2019, failed to properly carry out a CTG in relation to Patient E, in that you;

    c. Failed to record the CTG readings and changes;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3, Witness 6 and your evidence. It also took into account Patient E's Antenatal Notes.

The panel noted Witness 3's NMC statement:

> '*Based on the reading, the CTG is recording a baseline rate of 90bpm most likely maternal pulse due to the small episodes it goes back to a heart rate of 140bpm however you cannot rule out the baby could have been experiencing a hypoxic episode. Shan, based on the notes and lack of documentation, did not carry out any steps to rule this out. Patient E's notes mention a sticker at 14:21 which is*

the next entry from 12:00 but I cannot find this in the notes. Shan's notes aren't clear and lack information that I would expect such as, when she checked on Patient E, what action she took once she discovered a low CTG reading. The notes indicate no care between 12:00 and 14:21 as there is nothing noted.'

The panel acknowledged that you had been able to explain in detail during your oral evidence what actions you had taken at the material time and why they were appropriate in the circumstances. However, the panel found no record of these actions in Patient E's records, namely, the Antenatal notes and the CTG sticker included in these notes or on the CTG trace.

In all the circumstances, the panel concluded that you had failed to record the CTG readings and changes and accordingly, it determined that this charge is found proved.

Charge 5.d. (schedule 1).

Schedule 1:

5. On 25 November 2019, failed to properly carry out a CTG in relation to Patient E, in that you;

    d. Escalate the reading of 90bpm when it should have been between 110 and 160bpm;

This charge is found proved.

In reaching this decision, the panel took into account the Trust's CTG guidelines, Witness 3's evidence and your evidence.
The panel noted your reflective account entitled 'Schedule 1 Incident - 5 Date 25.11.2019 CTG Monitoring – Induction of Labour' states:

'the CTG was picking up the maternal pulse of 90bpm. The fetal movements were very apparent and can be seen on the CTG graph'.

The panel noted Witness 6's NMC statement:

'The issue here was that the CTG reading was showing the baby's heartrate was low for nearly 30 minutes but Shan took no action immediately. As the reading was showing a low heartrate, Shan or any midwife would be expected to eliminate the possibility of a hypoxic episode this should be clearly documented on the CTG or in the notes.

[…]

I would have expected Shan to document in her notes clearly when she checked on the CTG and what the reading was at the time, as based on what was documented, I cannot tell when Shan discovered the low reading and how quickly she escalated this to [Witness 3]. There is definitely a delay, as I would have expected Shan to check on at 12:40 and escalated immediately if she could not pick up the fetal heart rate correctly […]'

The panel noted Witness 3's NMC statement that states:

'[…] if the heartrate was low to escalate immediately using the emergency call bell and adjusting the mother's position. Instead Shan waited 20 minutes the approached me'.

The panel noted from the Trust's CTG guidelines that a CTG with a baseline less than 110bpm and greater than 160bpm is considered abnormal. In respect of abnormal CTG's the guidelines also state:

'2.7.1 If the CTG is suspected to be abnormal at any point, an immediate obstetric review MUST be sought using the appropriate SBARD escalation protocol.'

The panel acknowledged that you provided a clear and extensive explanation as to why you did not consider it necessary to escalate the reading of 90 bpm at the material time. This included that you were reassured by taking Patient E's radial pulse and that you could hear the fetal heartbeat in the background. You did not consider that this was an abnormal reading as you were of the view that the fetal heartbeat was fine.

However, the panel found that the Trust's CTG guidelines did establish a duty for you to escalate the reading of 90pbm. The panel further considered the evidence of Witness 6 and found that you had not escalated this reading in a timely manner.

Accordingly, the panel determined that this charge is found proved.

Charge 7a. (Schedule 1).

Schedule 1:

7. On 5 June 2020, failed to provide adequate care for Patient G, in that you;

    a. Failed to escalate significant APH blood loss, both at 450mls and at 1500mls;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2, your evidence, Patient G's MEOWS chart and maternal records.

The panel noted your undated statement entitled 'Obstetric Haemorrhage' that states:

> '*At approximately 17.00 hours [Patient G] buzzed to say that she could feel "something" I checked and there was a small clot, approximately the size of a 50p. I reassured her that this was only a small amount and expected with a miscarriage. Myself and the Student Midwife […] changed her pad and she was made comfortable. She was given the call bell and advised to call with any*

further concerns. At approximately 17.40 she called to say she was bleeding again and on examination the blood loss on the inco pad was fresh. When the pad was removed I estimated this as an abnormal loss for a miscarriage, so I decided to weigh the inco pad and then escalate using the weight to justify the escalation. I asked the student to stay and complete some observations, whilst I went to arrange transfer. The midwife in charge [Person B] was already on the phone to Delivery Suite (DS) so I took this opportunity to ask her to escalate this for me by trying to get her attention whilst she was on the phone. She did not seem to understand that this was urgent and I had to reiterate this with her in a louder voice. She did not take kindly to my forthright and proactive approach. I explained that I had a pad to weigh and that the student was with the woman, who was bleeding and I wanted to transfer her to be nearer to obstetric assistance, should it have been required.'

And

'I weighed the pad = 430g equating to 430mls because I knew that I would have resistance from the coordinator and I wanted to have justification for the transfer.'

The panel also noted Witness 2's NMC statement that states:

'I don't recall whether it was Sharn or another Midwife that handed over the amount of blood lost Patient G. Patient G had lost approximately 450mls Antepartum Haemorrhage ("APH"). APH is the amount of blood loss and flags up concerns that maternity health may be compromised or the patient may be suffering a miscarriage. During a miscarriage 300-400mls is considered a significant APH. Postpartum Haemorrhage ("PPH") is the amount of blood lost after the baby delivered. Anything over 500mls is considered a significant PPH. The uterus is easier to manage when it is empty which is why we try to remove the [sic] any products of conception before dealing with the bleed, the amount of blood lost is something we would need to know to aid recovery of the mother and arrange blood to be given to her'.

The panel noted that Witness 2 had not been a direct witness to this incident and that she confirmed in her oral evidence that she could not recall who had escalated Patient G's blood loss.

The panel had regard to Patient G's records and noted that the entries that state:

> *'1600 call to room and small clot on pad. Using Entonox'*
> *1740 Call to room large loss on inco – weighed 430g'*
> *'1800 called again more loss on inco requested reg to be bleeped to RM [Person B]'*

The panel also had regard to Patient G's MEOWS chart, noting that the scores recorded evidence a clear deterioration in Patient G's condition, in that a score of 0 is recorded at 15:00 and a score of 11 is recorded at 18:10. The panel was provided with Person B's local investigation statement. However, Person B had not been adduced by the NMC and therefore, the panel was not able to test her hearsay evidence and it attached little weight to this evidence. The other practitioners directly involved in the care of Patient G at the material time were also not adduced by the NMC.

The panel did not have any documentary evidence before it in respect of Patient G's blood loss of 1500mls. The panel noted that is referred to in Witness 2's local investigation statement, but there is no reference to a 1500mls blood loss in Patient G's maternal records or any other evidence put before the panel. The panel concluded there is insufficient evidence before it regarding a blood loss of 1500mls. Therefore, the panel only considered the escalation of 450mls blood loss.

The panel had regard to the wording of the charge, noting that the mischief of it is a failure to escalate. The panel concluded from the evidence before it that you did escalate Patient G's 450mls blood loss to Person B, albeit the panel determined it was not done in a timely manner.

Accordingly, the panel determined that this charge is found not proved.

Charge 7b. (schedule 1).

Schedule 1:

7. On 5 June 2020, failed to provide adequate care for Patient G, in that you;

b. Failed to provide information to colleagues on allergies, medication, blood type, initial blood results, previous birthing history, and Covid-19 testing at handover;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Patient G's maternal records and your evidence.

The panel noted Witness 2's NMC statement:

'Sharn was only able to give most basic information but not a meaningful handover not even the name Patient G liked to be addressed as'.

And:

'Sharn's handover was Patient G was experiencing a miscarriage and Sharn told me she had not been responsible for Patient G for long. […] Sharn did not handover of the following for Patient G that I expected her to tell me:
a. Allergies;
b. Current medication;
c. Blood type;
d. Initial blood results;
e. Any other relevant medical information,
f. Previous birthing history (i.e. has she given birth before, is she Rhesus Negative)
g. If Patient G had been swabbed for Covid-19 Testing'

Witness 2's local Trust investigation statement also states:

> *'On Delivery Suite Shan failed to give us any meaningful handover - she kept repeating that she hadn't looked after this patient for very long (she took over the care at 15:30 - the transfer took place at 18:10). She did not know how to address the woman (named but liked to be called). She wasn't aware of her previous history, exact gestation, what tests had been done (if she was swabbed for Covid). She failed to hand over her blood group and whether there was a valid G+S. She failed to inform us of any other significant information regarding this patient (such as latex allergy significant during the catheterisation to manage severe APH/PPH during which the patient was hardly responsive).'*

The panel heard oral evidence from Witness 2 and, as a result the panel was able to test Witness 2's evidence. The panel noted that Witness 2's NMC statement was consistent with her local statement that she was the midwife you had provided the handover to.

However, under cross examination Witness 2 qualified her response in her NMC statement in regard to the handover provided by you:

> *'I don't think what I meant was that Shan didn't mention any of those things, but the (a), (b), (c), (d) in point 11, all of those points are examples of information that would be required when you're escalating the care of someone who is bleeding heavily in this instance. I wouldn't confidently say what Shan did or did not say, I just remember feeling that the handover wasn't very detailed. But I can't say that Shan told me about (b) and (c) but she hasn't told me about (a) and (f), for example, I can't say that. (a), (b), (c), (d), (e), (f), (g), these are the examples of information that normally would be relevant to the care of the patient. In the case of this handover, I don't know what exactly she -- I don't remember exactly what she said, I just know that I felt there was not much information in terms of --'*

The panel noted your reflection entitled 'Schedule 1 Incident 7 (b) (ii) 5.6.2020 - Record Keeping and Patient Care (Allergies)' that states:

> *'I did not receive a handover from either the midwife that went home or the EGU nurse. However I should have taken it upon myself to find and read the notes and I have learnt from this. I was unaware that she was Rh Negative blood group or that she had allergies to Latex and Pethidine. This was partly due to having not seen the notes myself and that I had not received a comprehensive handover from midwife JP or the EGU nurse. When I found the notes there were no alerts on the front (Sticker) and the woman was not wearing a Red wrist band that, I would normally expect to see if there were allergies. It would be an obvious alert and is useful as a swift aide memoir in such an incident; when dealing with an emergency situation. It is extremely regretful that I did not read her notes thoroughly and have time to do this before the emergency began. It only came to light when the patient was asked in theatre if she had any allergies. When the notes were fully checked some days later, it was found that she did have a latex allergy but this was written in her booking information, in a very small and detailed print off, therefore very difficult to pick out.*
>
> *[…]*
>
> *I am very sorry that I missed this and I have changed my practice since this incident. It is one of the first things I look for when I take over the care and I pose those specific questions to the midwife that is handing over to me. I also ask the woman herself to confirm this and if it is not written on the front of the woman's notes (as an alert) I write it there myself, in large, bold print, so it will not be missed. I learnt a huge lesson from this incident'*

The panel accepted that you had not received a sufficient handover from the previous midwife or the emergency gynaecology nurse. The panel acknowledged your acceptance of not checking Patient G's notes prior to providing a handover to Witness 2. The panel had regard to Patient G's records, noting that you had not documented a handover to Witness 2. In all the circumstances, notwithstanding the qualification made

by Witness 2 in oral evidence, the panel concluded that on a balance on probabilities you failed to provide information to colleagues on allergies, medication, blood type, initial blood results, previous birthing history, and Covid-19 testing at handover.

Accordingly, the panel determined that this charge is found proved.

Charge 7 c. (Schedule 1)

Schedule 1:

7. On 5 June 2020, failed to provide adequate care for Patient G, in that you;

c. Failed to act on, request assistance, or escalate when Patient G had become unresponsive following low blood pressure and blood loss.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, your evidence and Patient G's records.

The panel noted your undated statement entitled 'Obstetric Haemorrhage' that states:

'A short while later (time unknown) I noted she suddenly felt unwell and as her Blood Pressure dropped to 76/32mmHg she went into vasovagal episode. I recorded this (2) and immediately alerted the Band 7(MK) who was dealing with something on the other side of the room and had her back to the monitor. She looked across but did not understand what I was alerting her to, so I tapped the screen of the monitor. She used the call bell and the Doctors attended immediately.'

Patient G's antenatal notes state:

'1855 RM [Witness 2] in room and alerted to blood pressure as attending to 1900 More help required to the room'

During your oral evidence, you stated that Witness 2 had been in the room the whole time. During your cross examination you were asked whether you had recorded both who was in the room at the material time and who had left in Patient G's notes. You explained that you would only record in the patients notes who was in the room at the time you wrote in the notes. It was not a contemporaneous record of anyone entering or leaving the room, and that Witness 2 had been in and out of the room, restocking medical equipment and was not continuously present. The panel noted that your evidence in this regard was inconsistent. Further, it was unclear from Patient G's maternity records who had been present at time of the incident.

The panel noted that the other health professionals directly involved in the care of Patient G at the material time were not adduced by the NMC and therefore, it could not test their evidence produced from the Trust local investigation.

The panel noted Witness 2's NMC statement that states:

> *'[…] I had to leave the room to deal with something else being one of the coordinators on shift.*
>
> *When I returned to the room Patient G was grey and unresponsive and nothing was done about it by Sharn. I asked Sharn what happened and she pointed at the vitals screen saying – she pointed out the blood pressure had dropped. Shaen did not actively call for any help. I just happened to return to the room at the time, which was a concern for me as anything could have happened. Patient G was bleeding, her blood pressure was low and Sharn told me the figure 70/30*
>
> *[…]*
>
> *I escalated the care of Patient G and a Consultant and Anaesthetist were in the room'.*

Witness 2's local investigation statement says:

[You were] not actively calling for help (I happened to walk back into the room and saw the patient looking very unwell at which point Shan stated the last BP was 73/34)'.

During the course of her oral evidence, Witness 2 maintained that she was not in the room continuously and it was upon entering the room that she found Patient G had deteriorated. You subsequently brought the patients' blood pressure to her attention. The panel accepted Witness 2's consistent evidence.

In all the circumstances, the panel concluded that Witness 2 had escalated Patient G's low blood pressure and you had failed to act on, request assistance, or escalate when Patient G had become unresponsive following low blood pressure and blood loss.

Accordingly, the panel determined that on a balance of probabilities this charge is found proved.

The panel noted that there were various contextual factors apparent and that there were a number of relevant issues that are not disputed. Therefore, the panel determined that it would consider these before making its findings in respect of charges 1a-e. These are as follows:

Context of the working environment

The panel noted that you felt the Trust was a difficult environment to work in. You felt that the witnesses in this case were excessively critical of you, and that you felt constantly under scrutiny. You felt pressured as you were under the spotlight and constantly watched.

The panel noted that there appeared to be a close knit clique amongst some of the long standing staff on the Wards and that there was some evidence that a broader group of staff were aware of you being subject to a PDAP. The panel also noted that you [PRIVATE] which placed restrictions on you working on Delivery Suite. This was substantiated by [PRIVATE] correspondence with your manager.

Capability process

The panel noted that you had successfully completed your informal and first formal PDAP. After completing the initial PDAP you worked for a period of seven months, where no further concerns were raised. You were agreeable to the objectives set out in the PDAP and accepted that there were some errors of your clinical practice you needed to work on. You accept that you resigned before completing stage three of the Trusts Capability process and did not complete the PDAP started on 1 May 2020.

Working history

You worked at the Trust for a period of three years before concerns were raised and prior to working at the Trust you had worked as a midwife for a period of approximately 16 years during which no regulatory concerns were raised. You are an experienced community midwife, and you accept that you have not worked in an acute setting for many years, and the panel considered that you would have required a period of orientation and support to develop your skills to work in the acute setting.

Schedule 1 charges

The panel noted that the evidence presented in respect of the alleged incidents in Schedule 1 was limited and that there were some inconsistencies in your behaviour, particularly relating to your ability escalate patient care.

The panel found that the remaining charges in Schedule 1 relate to a narrow period of time from 22 November 2019 to 25 November 2019 and a further incident on 5 June 2020. The panel found two of four sub charges proved in relation to charge 5 (5.c. and 5.d.) and two of four sub charges proved in relation to charge 7 (7.b. and 7.c.). No case to answer was found in respect of charge 1 and 6 due to the reasons outlined above. And you made admissions to charge 4 schedule 1 during the course the course of your evidence and charge 1.c. at the outset of the hearing.

The panel then considered charges 1.a. - 1. e. and made the following findings.

Charge 1.a.

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of:

    a. Medications administration;

on one or more of (but not limited to) the occasions set out within Schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel bore in mind its findings at charge 2 of Schedule 1 and 3.b. i. The panel did not find theses charge proved and the panel noted the lack of documentary evidence adduced by the NMC in respect of charge 3.b.i. The panel accepted that there was a delay in administering Patient B's IV antibiotics in respect of charge 2. The panel noted that this is the only incident relating to medication administration during your period of employment at the Trust before it. Further, the panel accepted that you were not able to cannulate patients at the material time as you were required to be signed off by the Trust, despite you being trained previously with a different employer. The panel was of the view that you could have escalated your inability to cannulate to other practitioners on the Ward after you were made aware that there would be some delay in the junior doctor assisting. The panel determined that this delay in administering medication on one occasion is not sufficient to prove that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife.

Accordingly, the panel determined that this charge is found not proved.

Charge 1.b.

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of:

    b. CTG monitoring;

on one or more of (but not limited to) the occasions set out within Schedule 1;

This charge is found NOT proved.

In reaching its decision, the panel took into account its findings in respect of charge 5 Schedule 1. The panel bore in mind that only sub charges 5.c. and 5.d. proved that relate to failing to record the CTG readings and changes and to escalate the reading of 90bpm. The panel did not find that you had failed to monitor the CTG in accordance with the Trust's CTG guidelines. The panel noted that this is the only incident relating to CTG monitoring during your period of employment at the Trust before it and it took into account your written and oral evidence provided in respect of this incident. The panel found your evidence compelling and detailed. The panel noted that CTG interpretation had been included in your PDAP prior to you resigning, but you continued to carry out CTG's during your period at the Trust without supervision. The panel was of the view that there is insufficient evidence before it to prove that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in relation to CTG monitoring, on the basis of one incident.

Accordingly, the panel determined that this charge is found not proved.

Charge 1.c.

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of:

c. Record keeping;

on one or more of (but not limited to) the occasions set out within Schedule 1;

This charge is found proved.

In reaching its decision, the panel took into account its findings in respect of charge 4, charge 5.c. and charge 7.

The panel noted that you had also formally admitted this charge at the outset of the hearing and accepted your record keeping was poor during your oral evidence. In relation to charge 4, you accepted failing to carry out any observations on Patient D on 22 November 2019 during your oral evidence and the panel was provided with Patient D's records noting that only one observation had been recorded whilst Patient D was in your care during a 12-hour shift. In relation to charge 5.c., the panel noted that you had failed to record any CTG readings and changes on 25 November 2019. In relation to charge 7.c, the panel found that your record keeping was inconsistent in respect of Patient G on 5 June 2020 in that it you had only recorded some information contemporaneously and that there was a lack of detail provided to properly reflect the care provided to the patient. The panel noted that concerns regarding your record keeping had occurred on various occasions as set out above in this paragraph. The panel considered that this evidences an ongoing inability to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in relation to record keeping.

Accordingly, the panel determined that this charge is found proved.

Charge 1.d.

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and

judgement required to practise without supervision as a registered midwife in respect of:

d. Communication, escalation and delegation;

on one or more of (but not limited to) the occasions set out within Schedule 1;

This charge is found proved.

In reaching its decision, the panel took into account its findings in respect of charge 2, charge 5.b., 5.d. and charge 7 of Schedule 1.

In relation to charge 2, the panel bore in mind that it found this charge not proved, as you had administered Patient B's antibiotics. However, the panel was of the view that you although you escalated that you could not cannulate to the House Officer on the Delivery Suite, when it became apparent they were delayed, you should have escalated this further to other staff who may have been able to help you. Witness 3 had explained that in these circumstances she would have expected you to escalate this to a doctor, the Delivery Suite Coordinator, Anaesthetist or a Midwife Support Worker.

In relation to charge 7.a., the panel noted that you were the midwife responsible for Patient G's care and that you had left the patient for a period of 20 minutes after recording a significant blood loss of 430mls at 17:40. Although the panel has found that you did escalate Patient G's blood loss and deteriorating condition, the panel was of the view that as soon as you became aware about the heavy blood loss you should have sought help immediately by pulling the emergency bell.

You stated that you escalated this to Person B while she was on the phone to the Witness 2 and she did not listen to you, however you did not take further steps to communicate and escalate this to someone else. The panel considered at that stage, a blood loss of 430mls is serious and you should have in the circumstances taken further steps to transfer Patient G to the Delivery Suite immediately. This may have reduced the risk of harm to Patient G.

The panel found that this error in judgment was in stark contrast to the approach you had taken in respect of charge 3.a., whereby you had communicated and escalated your concerns promptly by calling the Delivery Suite yourself to ensure the patient received urgent one-to-one care in the appropriate setting.

In relation to charge 7.c., the panel found that you had not acted on the clinical symptoms of the patient and failed to escalate Patient G's low blood pressure of 73/34. Witness 2 was not present at this time, and she had only discovered the patient's condition upon returning to the room. The panel was of the view that this deterioration should have been communicated and escalated immediately by use of the emergency call bell and you failed to do so.

The panel concluded that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of communication and escalation, not in relation to delegation (charge 3.a.).

Accordingly, the panel determined that this charge is found proved in relation to communication and escalation only.

Charge 1.e.

1. Whilst working at Royal Cornwall Hospitals NHS Trust, between October 2017 and August 2020, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of:

    e. Patient care;

This charge is found proved.

on one or more of (but not limited to) the occasions set out within Schedule 1;

In reaching this decision, the panel took into account its findings in respect of charge 2, 4, 5.d., and 7 of Schedule 1.

In relation to charge 2, the panel considered that your delay in administering Patient B's IV antibiotics demonstrated a lack of patient care. In these circumstances, safe patient care would have been evidenced by being proactive in finding another practitioner to administer antibiotics in a timely manner. The panel noted that in this case there was no harm caused to the baby by the delayed administration of IV antibiotics.

The panel found that your failure to carry out observations on Patient D at charge 4 demonstrated a lack of patient care as Patient D was undergoing an induction of labour for Pre-Eclampsia. The failure to monitor Patient D's blood pressure on a regular basis put her and her baby at increased risk of any deterioration in her condition being missed.

In relation to charge 5.d., the panel found that the Trust's CTG guidelines did establish a duty for you to escalate the reading of 90pbm. Your actions in failing to escalate the reading of 90bpm on Patient E's CTG could have put her baby at risk because if this was fetal heartrate there could have been evolving fetal hypoxia.

In relation to charge 7., you did not provide adequate care for Patient G in that you did not escalate the blood loss of 430mls in a timely manner and that increased the risk to her. You did not provide adequate care for Patient G in that you did not provide a sufficient handover of her clinical background. This meant that your colleagues did not have all the information needed to provide safe care to Patient G. This resulted in the use of a latex catheter when Patient G was allergic to latex. Moreover, your failure to escalate when Patient G had become unresponsive following a blood pressure recording of 74/34 put her at increased risk of morbidity because the appropriate health professionals could not provide the necessary emergency care to her promptly.

The panel concluded that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife in respect of patient care.

Accordingly, the panel determined that this charge is found proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence and impairment

Mr Evans submitted that the facts found proved amount to a lack of competence. He referred to the relevant cases of *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) and *Ogundele v NMC* [2013] EWHC 2748 (Admin) and *Holton v General Medical Council* [2006] EWHC 2960 (Admin).

Mr Evans referred to *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). He then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, your actions amounted to a breach of those standards.

Mr Evans submitted that the areas of concern involved record keeping, escalation and communication and patient care. He outlined the background in which the concerns around your competence arose and submitted that there is a demonstrative pattern of short comings throughout November 2019. Despite support, supervision and the implementation of PDAPs, he submitted that an incident had taken place in June 2020, prior to you resigning on 9 June 2020. Mr Evans accepted however, that you had successfully completed your informal and first formal PDAPs.

Mr Evans submitted that your failures relate to fundamental areas of safe midwifery practice, namely, communication with patients and colleagues, escalation, patient care and recognising change and deterioration in patients. He submitted that your failure to escalate patient care is particularly demonstrated at charge 7.c. He submitted that your failure to take observations and the delay in administering antibiotics fall under the remit of patient care. He submitted that there is evidence before the panel that relates to your inability to communicate with patients and colleagues, your demeanour and your inability to take on board constructive feedback.

Mr Evans submitted that there are numerous examples of incidents that occurred during your employment at the Trust, these were not isolated incidents. He submitted that these errors continued despite you being offered support and an opportunity to demonstrate improvement in your practice. He submitted that these errors did not occur due to a lack of support, but due to a lack of competence.

Mr Evans submitted that your actions fell significantly short of the standards expected of a registered midwife and invited the panel to find that these failings amount to a lack of competence.

Mr Evans then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Evans referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery*

Council (2) Grant [2011] EWHC 927 (Admin). He submitted that limbs a, b and c of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged by your past actions.

In inviting the panel to assess whether you were likely to put patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future, Mr Evans referred the panel to the documentation you have provided. He acknowledged that you had worked at Frimley Health NHS Foundation Trust for a period of 12 months as a Band 6 midwife and invited the panel to consider whether this period of practice was sufficient to remediate the concerns and that whether you are capable of safe and effective practice as you are not currently working as a midwife.

Mr Evans referred to your developmental plan and daily reflection logs which included feedback from Practice Development midwives at Frimley Health NHS Foundation Trust. He acknowledged that there are some examples of improvement in your record keeping and that there are examples of shifts when no concerns were raised and this log does contain positive aspects.

However, he submitted that there is evidence in the report that areas of your practice relating to the charges found proved still require improvement, namely, communication, escalation and patient care. He submitted that themes are evident and persistent even throughout the year at Frimley Health NHS Foundation Trust.

Mr Evans submitted that there is a risk of repetition of the conduct found proved and that these concerns were repeated despite a good level of support from both Trusts during your periods of employment. He submitted that there is insufficient information before the panel for it to conclude that there is no longer a risk of repetition. Mr Evans invited the panel to find that your fitness to practise in currently impaired on both public protection and public interest grounds.

Mr Buxton invited the panel to take into account the context in which the concerns arose. He submitted that you had successfully completed your informal and first formal PDAP and that you had worked for seven months without any concerns being raised.

He submitted that the matters that need to be considered relate to three distinct areas: record keeping, communication and escalation and patient care.

Mr Buxton accepted that whilst the panel do not have evidence of your current record keeping, he submitted that in relation to your record keeping, these accepted errors occurred over a very limited period of time and that your record keeping has since improved. In respect of patient care, communication and escalation, he submitted that it should be considered whether the matters adduced in relation to these matters represent a fair sample of your work.

Mr Buxton submitted that in relation to charge 4, you explained during your oral evidence that you had thought another member of staff had been undertaking the observations and that this was a single incident. In relation to patient care, he accepted that your errors do demonstrate a departure from the acceptable standards of patient care, however, he invited the panel to take into account the context and the circumstances at the time of these incidents. He submitted that you have an exemplary record as a registered midwife with substantive practice being in a community setting, and not in an acute setting. He submitted that in relation to charge 7, this is the first time you have had to deal with an APH patient.

Mr Buxton invited the panel to take into account your clear insight and accountability where failures have occurred in assessing your competence. He submitted that your alleged demeanour or defensiveness should not play a part in the panel's assessment.

Mr Buxton then moved on to the issue of current impairment. He invited the panel to consider all the documentation you have provided, which include your reflections and evidence of your most recent practice at Frimley Health NHS Foundation Trust. He submitted that your developmental plan daily reflection log presents a fair picture of your practice, and he referred the panel to examples in this log where, he submitted, you have evidenced safe and effective practice. He explained that this log was devised to assist you in strengthening and improving your practice and maintain the expected standards of a registered midwife and that you have provided a selection of these. He

submitted that instances where feedback has been provided do not point to deficiencies in your practice or amount to your practice being unsafe.

Mr Buxton submitted that your practice does not pose a risk to the health, safety and wellbeing of the public. He submitted that the log demonstrates an improvement in your practice overtime, and you have evidenced good practice regarding escalation of difficult clinical matters, patient care and communication. He submitted that you have learnt from your errors and that you have demonstrated insight and strengthened practice through your reflections. Mr Buxton stated that you have engaged with these proceedings throughout.

The panel accepted the advice of the legal assessor which included reference to the relevant cases of *Calhaem* and *Holton.*

Application to admit further evidence

Before the panel made its decision in respect of lack of competence and impairment, the panel made enquiries as to whether it was possible to obtain a report, as required by condition 3 of your conditions of practice order from your line manager at Frimley Health NHS Foundation Trust. The panel was of the view that this information would assist in understanding your most recent period of clinical practice.

The panel was made aware that the NMC had received a report dated 10 August 2022, relating to your practice at Frimley Health NHS Foundation Trust. The panel invited both parties to make submissions before deciding whether to admit this evidence at the impairment stage.

After seeking instructions, Mr Evans submitted, it is the NMC's view that this report its highly relevant to the impairment stage and made an application pursuant to Rule 31 to adduce this evidence. He submitted that the report provides a broader picture of your practice at Frimley Health NHS Foundation Trust and that it includes feedback from those supervising you.

Mr Evans submitted that this report would assist the panel in assessing future risk and if you remain likely to repeat the matters found proved. He submitted that whilst this document has been acquired at this late stage, you have had sight of this document and it also was not new to the NMC. He explained that it is not clear whether this document had been before any interim order panel and if this documentation had previously been considered. Notwithstanding this, the NMC are of the view that this document should be adduced in fairness to the NMC and in consideration of the wider public interest.

Mr Evans submitted that you are able to provide a response to this evidence by giving oral evidence under oath at this stage and this would prevent any unfairness to you. Further, it would not be necessary to call any further witnesses in light of this evidence. He submitted that the panel could take this information into account alongside your reflection log. For these reasons, Mr Evans invited the panel to admit this document into evidence.

Mr Buxton submitted that he opposed this application. He submitted that there has been no application previously made to adduce evidence relevant to the question of impairment. Neither counsel had seen this document before and that it is unclear whether any previous Investigating Committee had considered this.

Mr Buxton submitted that the report contains opinion evidence from individuals the panel have not heard from and therefore, have not been able to test the credibility of the evidence. He submitted that the panel have sufficient information before it to reach a conclusion in respect of lack of competence and impairment. He submitted that admitting this evidence at this late stage would cause undue delay and that it would likely result in inherent unfairness to you.

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

The panel was initially of the view that this information would assist it in making the decision on whether your fitness to practise is currently impaired. However, in light of the concerns raised by Mr Buxton, the panel carefully considered whether it had sufficient evidence before it to reach its decision on the next stage without adducing this

further document. The panel considered that Mr Buxton had opposed this application as it would lead to unfairness to you. It bore in mind that Mr Evans had submitted that this report was highly relevant. Balancing all of these factors, the panel was of the view that it had sufficient information before it to reach its decision. The panel was of the view that it was not in the public interest or in your interest to admit this evidence at such a late stage and would likely cause an undue delay in the conclusion of these proceedings, having adjourned on two occasions previously. The panel concluded that it would not be fair to admit this document.

Accordingly, the panel determined not to admit this document.

Decision on lack of competence

When determining whether the facts found proved amount to a lack of competence the panel had regard to the terms of the Code.

The panel, in reaching its decision, has had regard to the protection of the public, the wider public interest and accepted that there is no burden or standard of proof at this stage and exercised its own professional judgement.

The NMC has defined a lack of competence as:

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

The panel determined that the following sections of the Code were engaged by your actions:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *[…]*

1.2 make sure you deliver the fundamentals of care effectively

[…]

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

[…]

8 Work co-operatively
To achieve this, you must:

[…]

8.2 maintain effective communication with colleagues

[…]

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

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

8.6 share information to identify and reduce risk
[…]

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

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

[…]

[…]

13 Recognise and work within the limits of your competence
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

[…]

[…]

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'

The panel appreciated that breaches of the Code do not automatically result in a finding of lack of competence. In considering whether your actions amounted to lack of competence, the panel considered each charge individually.

The panel noted that your actions in the charges found proved took place from 22 November 2019 to 5 June 2020. The panel was of the view that the various incidents in these charges and the information provided, reflected a fair sample of your practice at the Trust. The panel also took into account the contextual factors at the time of these incidents, which included that you had felt unsupported and pressurised during your period at the Trust, working in an acute setting as opposed to a community setting for the first time in many years. It also took into account your completion of your first informal and first formal PDAP and that you had worked for a period of seven months at the Trust where no concerns had been raised.

Charge 4 (Schedule 1)

In relation to Charge 4 (Schedule 1), the panel considered that you had accepted the error in respect of this charge from the outset of the hearing. The panel was of the view that carrying out observations is important, notwithstanding this, the panel accepted that you had thought another member of staff was carrying out these observations and that you had not noted your error until you were asked about these observations. The panel concluded that this single instance of not taking patient observations on its own, would not amount to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. Accordingly, the panel determined that this did not amount to a lack of competence.

Charge 5.c. and 5.d. (Schedule 1)

In relation to charge 5.c., the panel considered that you had not recorded any CTG readings and changes on one occasion. The panel noted that during your oral evidence, you gave cogent evidence in respect of you monitoring the CTG and what you were doing at the time. The panel was of the view that this single incident was not sufficiently serious on its own to amount to a lack of competence.

In relation to charge 5.d., the panel was of the view that that this was serious. The panel found that your actions were contrary to the Trust's guidelines and that your failure to escalate put the baby at a potential risk of harm. The panel acknowledged that no actual

harm was caused to the baby and in your evidence, you had explained why you did not find it necessary to escalate the reading of 90bpm. Nevertheless, the panel considered that this demonstrated a serious lack of judgment. In light of this, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife. As a result, the panel determined that your performance at this charge demonstrated a lack of competence.

Charge 7.b. and charge 7.c. (Schedule 1)

In relation to charge 7.b., the panel bore in mind that this was an emergency situation, and it was of the view that in such circumstances adequate handovers are particularly important. The panel considered that you had not informed the other health professionals directly involved in the care of Patient G about her latex allergy and that consequently a latex catheter had been used in the care of patient G. Whilst the panel acknowledged that you had not been provided with a handover from the previous midwife, it was of the view that your actions were sufficiently serious in that you were responsible for Patient G's care for 2.5 hours prior to her transfer to the Delivery Suite. The panel was of the view that you should have checked Patient G's records yourself. Not doing this meant you increased the risk for Patient G and your resulting lack of clear communication to your colleagues during the subsequent emergency was serious. In all the circumstances, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife. Accordingly, the panel determined that this did amount to a lack of competence.

In relation to charge 7.c., the panel considered that you failed to act on, request assistance, or escalate a visibly deteriorating patient and this could have resulted in a serious risk of harm to Patient G. The panel was of the view that this incident was a serious emergency situation and that you did not respond appropriately. Other health professionals should have been alerted immediately by use of the emergency bell. In all the circumstances, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as

a registered midwife. Accordingly, the panel determined that this did amount to a lack of competence.

Charge 1.c.

In relation to charge 1.c., the panel took into account its earlier findings in respect of charges 4, 5.c and 7.c. of schedule 1. Whilst the panel accepted that these were demonstrative of poor record keeping, it was of the view that these errors on their own were not sufficiently serious to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife. Accordingly, the panel determined that this did not amount to a lack of competence.

Charge 1.d.

In relation to charge 1.d., the panel took into account its earlier findings in respect of charges 5.d and 7 of Schedule 1. The panel considered that you had failed to escalate signs of a deteriorating patient in a serious emergency situation (charge 7.c.) and that you had failed to escalate an abnormal CTG. The panel did accept that you had demonstrated your ability to escalate patient care appropriately and in a timely manner in respect of charge 3a. However, the panel was of the view that the incidents in charges 7.c. and 5.d. involved fundamental failures to recognise risk and escalate your concerns in a manner appropriate to the emergency situation. In all the circumstances, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife. Accordingly, the panel determined that this did amount to a lack of competence.

Charge 1.e.

In relation to charge 1.e., the panel took into account its earlier findings in respect of charges 4, 5.d.,7. b. and 7.c. of Schedule 1. The panel considered that safe and effective patient care is a fundamental requirement expected of a registered midwife and that you had failed to meet this requirement. The panel did accept that in the circumstances of charge 7.b., you were also caring for another bereaved family, and

you were not aware that Patient G had returned to the ward until notified by another member of staff at approximately 15:30. Further, you had not received a handover for this patient, and it was of the view there was not a robust approach in place at the Trust to signal allergies.

However, it considered that as the midwife responsible for Patient G, you had a professional responsibility to ensure that you were aware of the full clinical picture and associated risks for Patient G. The panel was of the view that your failure to provide a sufficient handover of Patient G's clinical background in an emergency situation put Patient G at risk of unwarranted harm. Further, your failure to act on, request assistance, or escalate when Patient G had become unresponsive following a low blood pressure reading of 74/34 could have resulted in a serious risk of harm to Patient G. The panel was of the view that this incident was a serious emergency situation and that you did not respond appropriately.

The panel concluded that you demonstrated poor patient care in relation to these incidents and accordingly, the panel concluded that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered midwife. Accordingly, the panel determined that this did amount to a lack of competence.

The panel noted that, viewed individually, a number of the incidents referred to in charges 4, 5.c. and 5.d. of Schedule 1 did not amount to a lack of competence. However, viewed collectively, they demonstrated a number of different failings and a pattern of poor practice involving a range of basic midwifery skills. Viewed collectively the panel therefore concluded that these charges demonstrated a serious lack of knowledge, skill and judgment which amounted to a lack of competence. The panel determined that your practice was significantly below the standard expected of a Band 6 registered midwife at the Trust.

Decision and reasons on impairment

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that, midwives must ensure that their practice is safe and effective, and their knowledge is kept up to date. They must make sure that their practice at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

d) ....'

The panel considered that limbs a, b and c of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged in this case. The panel finds that your failures in respect of Patient G and Patient E, namely, failure to recognise and escalate concerns of deterioration and failure to escalate an abnormal CTG reading, placed Patient G and Patient E's baby, at an unwarranted risk of harm. The panel has determined that your lack of competence breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute by your past actions.

The panel are aware that this is a forward-looking exercise, and accordingly it went on to consider whether your lack of competence was remediable and whether it had been remediated. Having regard to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), the panel determined that your lack of competence relates to clinical concerns and as such can be remediated through sufficient demonstration of the required standards of knowledge, skill, and judgement of a registered midwife. Further the panel took into account that during your time at the Trust, you had successfully completed both your informal and first formal PDAP and that you had worked for a period of seven months where no concerns were raised. [PRIVATE].

The panel went on to consider whether you were likely to put patients at risk of harm, to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. In doing so, the panel considered your level of remorse and whether there was any evidence of insight and remediation.

Regarding insight, the panel noted that you had made a self-referral to the NMC prior to the Trust's referral and that you have made admission to charge 1c at the outset of the hearing. During the course of evidence, you had accepted your failings in respect of charge 4. The panel then took into account your reflections provided at the facts stage and the later documentation provided in respect of these stages. The panel acknowledged the extensive reflection you had undertaken, and the information you provided. It recognised that you had demonstrated remorse and that you had apologised for your actions. The panel was of the view, however, that you had not reflected on the impact of your actions on the patients, your colleagues, the wider profession and the public. The panel considered that overall, you have demonstrated developing insight into your actions, what went wrong and why and that you also explained what you would do differently.

The panel then considered what steps you have taken to strengthen her practice and to remediate your lack of competence. The panel had regard to the range of training records and whilst the panel acknowledged that you had completed these courses, it noted that these did not relate specifically to the areas of concern found proved.

The panel noted that you had worked for a period of 12 months at Frimley Health NHS Foundation Trust, under the support of the Practice Development team and it had regard to your reflection log provided. The panel was of the view that your logs dated from 19 July to 13 September 2022 evidenced improvement in your practice relating to the charges found proved, namely, communication and escalation and patient care. Notably, there were little concerns regarding your record keeping.

The panel determined that, although you have taken significant steps toward remediating your practice, and you have undertaken a wealth of reflection, however, it noted that 10 out of the 18 practice logs provided identified areas needing improvement that were of a similar nature to matters found proved, namely, communication, prompt escalation and patient care. The panel noted that despite extensive support, there are still concerns relating to communication, including your ability to receive constructive feedback and criticism and communicate appropriately with patients.

The panel concluded that there remained a risk of repetition, and you were therefore liable to put patients at unwarranted risk of harm, to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. The panel therefore determined that a finding of impairment was necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the midwifery profession and upholding the proper professional standards for members of the profession. The panel balanced this with the fact that you have engaged with your regulator and these proceedings and that there is a public interest in supporting the return of midwives to safe practice. However, the panel also considered that members of the public would expect a registered midwife to have the basic levels of competence and skills to carry out their duties to ensure patient safety. The panel considered that confidence in the profession would be undermined if a finding of impairment was not made in this case.

The panel therefore determined that a finding of impairment was also necessary on public interest grounds, in order to maintain confidence in the midwifery profession, and in order to declare and uphold proper standards of conduct and performance.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. Should you fulfil the requirements of the conditions of practice order before 18 months you can apply for an early review. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Mr Evans informed the panel that in the Notice of Hearing, the NMC had advised you it would seek the imposition of a suspension order with review if it found your fitness to practise currently impaired. Mr Evans submitted that at this stage that remains the suitable and appropriate sanction.

Mr Evans said that, given the nature of the behaviour found proved by the panel, to impose no order or a caution order in this matter would not be appropriate. Similarly, he submitted that a conditions of practice order would not be appropriate and sufficient as the NMC has concerns about your willingness to respond positively to any requirement to retrain. Mr Evans stated that it is not that you resist being taught but it is about your potential and willingness to respond positively to retraining. He further stated that you have difficulty in receiving and accepting constructive feedback. Therefore, there are real concerns that you may not be receptive to being retrained and strengthening your practice.

Mr Evans submitted that a suspension order is appropriate given the panel's findings on impairment. He submitted that a member of the public would be surprised were you to be permitted to practise as a midwife unrestricted or at all given the serious concerns which the panel have found proved. Mr Evans therefore invited the panel to impose a suspension order for a period of three months.

Mr Buxton submitted that you deeply regret these matters and have expressed genuine remorse and apologies for them. Prior to your employment at the Trust, you had an excellent career. [PRIVATE]. [PRIVATE].

Mr Buxton submitted that the panel described your insight as developing, however, you have demonstrated almost full insight. While initially, you may not have fully considered the broader public interest issues in your reflections, you have since taken these into account and shown an understanding of how patients would be impacted by such shortcomings, since the panel's decision on the facts of this case.

Mr Buxton submitted that it is argued that your failings are remediable, as evidenced by your willingness to undergo retraining and improve your practice. He argued that your apparent resistance to feedback was attributable to frustration and realization of your shortcomings, rather than a lack of willingness to respond positively to retraining.

Mr Buxton submitted that despite not having worked as a midwife for some time, you miss it dearly and aspire to resume your career. It is suggested that you should be given the opportunity to demonstrate your capability to strengthen your practice.

Mr Buxton stated that you acknowledge the need for support and are prepared to receive it, with the aim of demonstrating to the NMC that you are capable of strengthening your practice. He therefore invited the panel to impose a conditions of practice order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your 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:

- Conduct that put patients at risk of harm
- A pattern of concerns relating to communication, ability to receive constructive feedback and communicating appropriately with patients

The panel also took into account the following mitigating features:

- Evidence of remorse and developing insight
- [PRIVATE]
- Early admission to some of the concerns
- Change of work environment from community setting to acute [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate as it has already found that your insight is still developing and that there is a risk of repetition and therefore there is a potential risk of harm to patients. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your 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 your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *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 determined that it would be possible to formulate appropriate, practical and measurable conditions which would address the failings highlighted in this case. The panel had regard to the fact that other than these incidents, you have had an unblemished career of many years as a midwife. The panel noted that you are keen to return to midwifery and determined that it was in the public interest that you should be able to return to practise as a midwife provided appropriate safeguards in the form of conditions of practice were put in place.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel determined that to impose a suspension order would be punitive and disproportionate, leading to an unnecessary delay in you being able to demonstrate that you have satisfactorily strengthened your practice. Moreover, the panel determined that it would not be a reasonable response in the circumstances of your case because the concerns could be sufficiently addressed with a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will address public protection concerns in that your practice will be appropriately restricted until you can demonstrate competence and that you have strengthened your practice. It will also mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered midwife.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a midwifery role. Also, 'course of study' and 'course' mean any course of educational study connected to midwifery.

1. You must limit your midwifery practice to one substantive employer. This must not be an agency.

2. Until such time as you are deemed competent in identification, escalation, and management of obstetric emergencies either in a simulated or clinical setting you must be directly supervised by a registered midwife when you are working in a clinical setting.

   Following achievement of competence as described above, supervision of your midwifery practice can be indirect by a registered midwife working on the same shift as you.

3. When working as a midwife you must meet with your line manager, mentor or supervisor at least every month to discuss your general performance until deemed competent with particular attention to:
   a) Identification escalation, and management of obstetric emergencies
   b) Communication with patients and colleagues

4. When working as a midwife you must obtain and submit to the NMC a report from your line manager, mentor or supervisor prior to your next review hearing. The report must contain details of your:
   a) General performance,

b) Identification escalation, and management of obstetric emergencies

c) Communication with patients and colleagues

You must send your case officer this report prior to your next review hearing.

5. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment,

b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:

a) Telling your case officer within seven days of accepting any course of study

b) Giving your case officer the name and contact details of the organisation offering that course of study

7. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any educational establishment,

b) Any other person(s) involved in your retraining and/or supervision required by these conditions.

8. You must immediately give a copy of these conditions to:

a) Any substantive employer you work for,

b) Any employers you apply to for work (at the time of application),

c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study,

d) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

9. You must tell your case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in,

b) Any investigation started against you,

c) Any disciplinary proceedings taken against you.

The period of this order is for 18 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Should you fulfil the requirements of the conditions of practice order before 18 months you can apply for an early review.

Any future panel reviewing this case would be assisted by:

- Evidence of your professional development, including documentary evidence of completion of any courses, as well as testimonials from a line manager or supervisor that detail your current work practices.
- An up to date reflective piece using a recognised reflective tool such as *Gibbs* that demonstrates your insight into the impact of your conduct on patients, colleagues and on public confidence in the midwifery profession.

This decision will be confirmed to you in writing.

Interim order

As the conditions of practice 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 your own interests until the conditions of practice 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 Mr Evans. He submitted that, in view of its previous findings on impairment and sanction, an order was necessary for the protection of the public and is also otherwise in the public interest. He invited the panel to impose an interim order for a period 18 months.

Mr Buxton did not object to the application for an interim order.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months due to the panel having already identified the need for such conditions as necessary to protect the public and uphold public confidence in the profession, and to cover an appeal period should one be made.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.