Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

19 November 2019

Nursing and Midwifery Council 2 Stratford Place, Montfichet Road, London,

E20 1EJ

Name of registrant:	Christine Garvey
NMC PIN:	81E0520E
Part(s) of the register:	Sub part 1—RN1: Adult nurse (24 July 1984) Midwives—RM: Midwife (3 November 1986)
Area of registered address:	Northamptonshire
Type of case:	Misconduct
Panel members:	Barbara Stuart (Chair, lay member) Anne Grauberg (Registrant member) Jade Rankine (Registrant member)
Legal Assessor:	Fiona Barnett
Panel Secretary:	Anita Abell
Nursing and Midwifery Council:	Represented by Richard Webb, Case Presenter
Ms Garvey:	Not present and not represented
Consensual Panel Determination:	Accepted
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim Suspension order, 18 Months

Decision on Service of Notice of hearing

Ms Garvey was not in attendance at the hearing. Mr Webb, on behalf of the NMC, informed the panel that written notice of this hearing had been sent to her registered address by recorded delivery and by first class post on 17 October 2019. The notice contained details of the hearing including time and place. At the time notice was sent it was anticipated that there would be a substantive hearing lasting a week, from 18-22 November 2019. In an additional email to Ms Garvey on 8 November 2019, the NMC confirmed that the hearing was now listed for one day on Tuesday 19 November 2019.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Garvey has been served with notice of this hearing in accordance with the requirements of Rules 5 and 34 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 ("the Rules").

Decision on proceeding in the absence of the registrant

The panel then considered continuing in the absence of Ms Garvey.

Mr Webb submitted that the panel should proceed in the absence of Ms Garvey. He placed an email dated 8 November 2019 before the panel. In that email Ms Garvey states "I will not be attending the hearing". Mr Webb informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Ms Garvey.

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

The panel concluded that Ms Garvey was aware of the hearing and had chosen not to attend. She has not requested an adjournment and the panel concluded she would be unlikely to attend on a future occasion if the hearing were to adjourn. In the light of the email and the signed CPD agreement the panel has decided to proceed in the absence of Ms Garvey.

Consensual panel determination

The panel has considered the provisional CPD agreement reached by the parties:

Consensual panel determination: provisional agreement

Christine Garvey, PIN 81E0520E, ('the Registrant') is aware of the CPD hearing. The Registrant does not intend to attend the hearing and is content for it to proceed in her and her representative's absence. The Registrant or her represntative will endeavour to be available by telephone should any clarification on any point be required.

The Nursing and Midwifery Council ('the NMC') and the Registrant ('the Parties') agree as follows:

The Charges

1. The Registrant admits the following charges:

That you, a registered midwife, in relation to Patient A:

1) On the night shift of 11/12 April 2018;

a) At around 05:00 did not request a "fresh eyes" review of the cardiotocograph ("CTG").

b) *At around 05:47 did not escalate a non-reassuring CTG to the coordinating midwife and/or obstetrician.*
c) *At around 06:18 left Patient A unattended in the delivery room prior to delivery of the placenta and membranes.*

2) *On the night shift of 12/13 April 2018*
   a) *Made entries in Patient A's notes without indicating that the entries had been made retrospectively.*
   b) *Completed a CTG sticker for 05:00 on 12 April 2018 without indicating that the sticker had been completed retrospectively.*
   c) *Completed a CTG sticker to indicate that Colleague C had conducted a "fresh eyes" review at 05:00 on 12 April 2018 when she had not.*

3) *Your conduct in Charge 2(c), above, was dishonest in that you intended to create the impression that Colleague C had conducted the "fresh eyes" review when she had not.*

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

Agreed Facts

2. The Registrant appears on the register of nurses and midwives maintained by the NMC as a Registered Midwife. She registered as a midwife in 1981. The Registrant also appears on the register as a Registered Nurse – Adult. However, her nursing registration lapsed in 2002.

3. The NMC received a referral regarding the Registrant on 14 June 2018 from Kettering General Hospital NHS Foundation Trust ("the Referrer") regarding the Registrant's fitness to practise. The Registrant was employed as a bank only midwife by the Referrer from 07 August 2017 until 20 April 2018.

4. The regulatory concerns identified in this case are as follows:

    - Did not provide adequate care/adequately record the provision of care to Patient A.
    - Falsified patient records, and associated dishonesty.

5. On 11/12 April 2018, the Registrant was caring for Patient A, who was in labour. Patient A had an epidural for pain relief and continuous Cardiotocograph ('CTG') monitoring of her baby's heartbeat was being undertaken.

6. The CTG showed an abnormal fetal heart whilst Patient A was in the latter stages of her labour. The Registrant did not inform the midwife in charge at the time or escalate this to a doctor. Baby A was born in poor condition and needed to be resuscitated. The Registrant pulled the emergency bell and took Baby A to another room where the resuscitaire was located; this left Patient A on her own with the placenta in situ, which was not appropriate care.

7. On the night shift of 12/13 April 2018, the Registrant made entries in Patient A's written clinical notes regarding the previous incidents which were not marked as retrospective entries.

8. A CTG sticker is used for interpreting the CTG, which according to the local guideline titled 'Guideline for Antenatal and Intrapartum Fetal Monitoring' should be filled in and interpreted every hour. There is also a requirement to have the CTG seen by a suitably qualified practitioner in order for a 'fresh eyes' assessment to be carried out.

9. At the same time that the Registrant made the amendments in the clinical records, and without indicating this was done retrospectively, the Registrant also completed a CTG sticker indicating that Colleague C had reviewed the CTG using a 'fresh eyes'

review at 05:00 on 12 April 2018. When asked, Colleague C said that the Registrant had not asked her to undertake a ‘fresh eyes review’.

10. The Registrant had falsified the clinical records in order to create the impression that Colleague C had conducted a ‘fresh eyes’ review and make it appear as though the CTG guidance had been followed, when it had not.

11. The Registrant subsequently resigned from the bank and has now retired form midwifery practice.

12. As part of its own investigation the NMC has received and assessed all of the relevant evidence obtained during the local investigations.

13. Witness statements have been obtained from:

- Ms 1, Midwife present on the 11/12 April 2018 nightshift who witnessed Patient A being left alone in the delivery room with the placenta still in situ and the Registrant making additional notes in Patient A’s records.
- Colleague C, Midwife and Coordinator in charge on the 11/12 April 2018 nightshift.
- Ms 2, Line-manager for bank only nurses and midwives who conducted the Referrer’s investigation.
- Ms 3, Midwife and Labour Ward Manager. Ms 3 saw Patient A’s records before the retrospective entries were made and confirms that the entries made by the Registrant were retrospective.

14. All facts as detailed in the charges are admitted by the Registrant.

Misconduct

15. In the case of *Roylance v General Medical Council (No.2)* [2000] 1 AC 311, Lord Clyde stated that:

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

16. The Registrant admits that her conduct fell seriously short of the standards of behaviour expected of Registered Midwives. Moreover, the Registrant accepts that her actions breached the following paragraphs of the 2015 NMC Code of Conduct:

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

7 Communicate clearly

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

1.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times

17. The failings in care provided by the Registrant had the potential to put patients at significant risk of harm. There is also evidence to suggest that Baby A suffered actual harm as a result of those failings. The tests conducted on the cord blood indicated that, had Baby A been delivered earlier, Baby A may not have required resuscitation.

18. The Registrant did not act on a deteriorating CTG or write adequate records in relation to what occurred and these failings placed those in her care at risk of significant harm. Further, by documenting that someone else had undertaken a review when they had not was a dishonest act, bringing the Registrant's trustworthiness into question. In relation to the Registrant's dishonest behaviour, a nurse acting dishonestly in a professional capacity clearly has the potential to impact on those in their care.

19. The Registrant accepts that the facts, individually and collectively, amount to misconduct.

Current Impairment

20. The Parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of *CHRE v Grant & NMC* [2011] EWHC 927 (Admin) (‘*Grant*’) by Cox J. They are 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. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.

21. The Parties agree that the admitted facts do amount to the Registrant putting patients at unwarranted risk of harm. The Registrant accepts that she has brought the reputation of the nursing profession into disrepute. The Parties also agree that the Registrant has breached fundamental tenets of the profession and has acted dishonestly.

22. In considering the question of whether the Registrant’s fitness to practise is currently impaired, the Parties have considered *Cohen v GMC* [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being ‘highly relevant’ to the determination of the question of current impairment:

> 1. Whether the conduct that led to the charge(s) is easily remediable
> 2. Whether it has been remedied
> 3. Whether it is highly unlikely to be repeated

23. The Parties agree that the clinical errors in this case are capable of being remedied, namely; escalating concerns, patient care or record keeping. However, the failings in this case also involve dishonest behaviour and attitudinal issues on the part of the Registrant and the Parties agree that such conduct could not be described as easily remediable.

Remediation and insight

24. The Registrant has responded to the allegations as follows (**Appendix 1**):

"*I am fully aware of the seriousness of the accusations against me me and I know this is not acceptable practice. I am deeply sorry that my practice has fallen short of what I know I was capable of. I was removed from the bank employment at KGH and was therefore unable to participate in any remedial training/ supervised safe practice. I have done lots of reflection myself and realise the errors I have made and how my actions have affected others*."

25. The Registrant has stated that she does not intend to return to midwifery practise and she has not practised since leaving the Referrer. Accordingly there is no evidence that the Registrant has attempted to remediate her practice by undertaking further training in relation to escalating concerns, patient care or record keeping.

26. The Registrant has demonstrated very limited insight and remorse into her clinical failings. She does not address what went wrong with her care to Patient A and does not say what she would do differently in the future.

27. Further, there is no evidence demonstrating the Registrant's understanding of the seriousness of her dishonest behaviour, particularly in relation to it occurring in the context of her long career. Nor has the Registrant demonstrated any insight into the wider impact dishonesty has on the reputation of the profession.

Impairment - public protection

28. It is noted that the Registrant has not been referred to the NMC aside from the matters arising in this case. However, the Registrant's failings should also be considered in the context of her many years of experience during which she had previously worked as a Supervisor of Midwives.

29. The Parties agree that the Registrant has not provided evidence of her understanding into the seriousness of her failings and does not therefore show insight into these failings.

30. Accordingly, the Parties agree that there is a risk of repetition of the misconduct. Therefore, a finding of current impairment is required on public protection grounds.

Impairment – public interest

31. The full seriousness of the regulatory concerns has been identified and is accepted by the Parties. The clinical allegations are, of themselves, serious in nature which is increased by the Registrant's dishonest behaviour.

32. Accordingly the Parties agree that this is a case where a finding of current impairment is also required to declare and uphold proper professional standards and protect the reputation of the nursing profession. This is in accordance with the comments of Cox J in *Grant* at paragraph 101:

> 'The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.'

Sanction

33. The appropriate sanction in this case is a striking-off order.

34. The Referrer's comments on the above sanction have been sought. The Referrer has agreed with the provisional agreement between the parties of a striking-off order.

35. The Parties considered the NMC Sanctions Guidance, bearing in mind that it provides guidance not firm rules.

36. The aggravating feature of this case is that, prior to the incident occurring, the Registrant had worked as a supervisor of midwives. With such experience, the Registrant would have been fully aware of the risks associated with her practice, and that retrospective and dishonest entries are wholly unacceptable.

37. No mitigating features are identified in this case.

38. In considering what sanction would be appropriate the Parties began by considering whether this is a case in which it would be appropriate to take no further action. The Parties agree that this would leave the public exposed to an unwarranted risk of harm, given the risk of repetition of the misconduct. The Parties also agree that such a sanction would not be sufficient to maintain public confidence.

39. The Parties next considered whether a caution order would be appropriate. A caution order would not restrict the Registrant's practice and would therefore be insufficient to protect the public given the risk of repetition of the misconduct. The Parties also agree that such a sanction would not be sufficient to maintain public confidence.

40. The Parties considered the imposition of a conditions of practice order. The Parties agree that there are serious failings, including dishonesty, in this case. The Registrant has stated that she does not intend to return to practise. The Parties agree that it could not formulate workable conditions of practice and further that conditions would not provide sufficient protection to the public. In addition, the Parties agree that the wider public interest would not be satisfied by the imposition of a conditions of practice order due to the very serious nature of the attitudinal and dishonesty concerns.

41. The accepted failings demonstrate issues with the Registrant's practice as well as dishonest behaviour. The Registrant has not demonstrated remediation for her clinical failings through training and/or supervised safe practise nor has she shown any significant remorse and/or reflection regarding her misconduct. In the context of the Registered stated intentions with regard to her practise and that her insight into her dishonesty has not been demonstrated, and does not seem likely to be provided at a later stage, the Parties agree that a suspension order is neither sufficient nor appropriate in this case. Further, the Parties agree that a suspension order is not sufficient to address the wider public interest.

42. In relation to a striking-off order, the Parties agree that the Registrant's conduct is fundamentally incompatible with continued registration. The Registrant acted dishonestly to protect her own interests and in an attempt to prevent her omissions in care being identified. Taking into account the Registrant's current intentions regarding her midwifery and the likelihood she will address the identified concerns, a striking-off order is the necessary and appropriate sanction in this case.

Interim order

43. Finally, the Parties agree that an interim order is required in this case. The order is necessary for the protection of the public and is otherwise in the public interest (for the reasons given above). The order should be for a period of 18 months to guard against the risk to the public in the event that the Registrant seeks to appeal against

the substantive order. The interim order should take the form of an interim suspension order.

The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges set out at section 1 above, and the agreed statement of facts set out at section 2 above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Signed Christine Rose Garvey Dated 6 November 2019

Signed Richard Webb Dated 19 November 2019

Decision and reasons on the CPD

The panel decided to accept the CPD in its entirety.

The panel heard and accepted the legal assessor's advice. The panel took into consideration the submissions made by Mr Webb, and the 'NMC Sanctions Guidance' (SG).

The panel noted that Ms Garvey admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of her admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on misconduct and impairment

The panel then went on to consider whether Ms Garvey's fitness to practise is currently impaired. Whilst acknowledging that Ms Garvey admits that her fitness to practise is currently impaired, the panel has exercised its own independent judgement in reaching its decision on impairment.

Misconduct

In respect of the alleged misconduct, the panel determined that the facts found proved relate to fundamental midwifery skills, put a patient at a risk of potential harm and include dishonesty in relation to patient record-keeping. Furthermore, the dishonesty appears to have been premeditated. The panel concluded that these are all serious matters and that Ms Garvey's conduct fell seriously short of the standards expected of midwife.

The panel therefore endorsed paragraphs 15 to 19 of the provisional CPD agreement in respect of misconduct.

Impairment

The panel then considered whether Ms Garvey's fitness to practise is currently impaired by reason of her misconduct.

Taking into account the factors outlined in paragraph 20, the panel concurred with the contents of paragraph 21 that Ms Garvey put her patient at unwarranted risk of harm, that by so doing she had brought the reputation of the midwifery profession into

disrepute, that she has breached fundamental tenets of the profession and has acted dishonestly.

The panel noted that Ms Garvey is not working as a midwife and does not intend to do so again. Accordingly she has not had an opportunity to demonstrate remediation. The panel determined given the absence of remediation, the risk of repetition, should Ms Garvey return to practise, remains high. Further, there is an admission of dishonesty and it is difficult to demonstrate remediation of dishonesty.

The panel considered whether Ms Garvey had demonstrated insight. It took into account that there was an expression of remorse from her. Although she has stated "*I have done lots of reflection myself and realise the errors I have made and how my actions have affected others"* she has not provided any supporting material to the panel.

Taking into account the high risk of repetition, the lack of remediation and evidence of insight, and the dishonesty charge, the panel concluded that Ms Garvey's fitness to practise is currently impaired both on the grounds of public protection and the wider public interest.

In this respect the panel endorsed paragraphs 28 to 32 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Ms Garvey's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive, in may have punitive 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:

- the Registrant was a very experienced midwife, having previously worked as a supervisor of midwives and she would have been fully aware of the risks associated with her practice, and that retrospective and dishonest entries are wholly unacceptable.

The panel noted that no mitigating features have been identified.

The panel first considered whether to take no action but concluded that this would be inappropriate as the failings relate not only to fundamental midwifery skills, but also to honesty and integrity. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that due to the concerns regarding fundamental midwifery skills, and honesty and integrity, an order that does not restrict Ms Garvey's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise'* Given the seriousness of the issues identified, including premeditated work related dishonesty, the panel does not consider this case to be at the lower end of the spectrum.

The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Garvey's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel is

of the view that there could be practical conditions formulated to address the clinical concerns but it would not be possible to address the dishonesty through conditions of practice. The panel is therefore of the view that there are no practical or workable conditions that could be formulated, given the dishonesty charge in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into account that Ms Garvey has not addressed the question of her honesty and integrity. Further, she has not remediated the clinical concerns and has no intention of doing so. She has demonstrated very limited insight. Balancing all of these factors the panel determined that a suspension order would not be a sufficient sanction to address the public protection and public interest concerns in this case.

The panel therefore considered a striking off order. Mr Garvey acted dishonestly to protect her own interests and in an attempt to prevent her omissions in care being identified. Taking into account her stated intention not to return to midwifery practice and the likelihood she will not address the identified clinical concerns, the panel concluded that Ms Garvey's misconduct, in particular the dishonesty, is fundamentally incompatible with continued registration. It concluded that a striking off order is appropriate and proportionate in this case.

The panel considered that this order is necessary to both protect the public and maintain confidence in the nursing profession.

Determination on Interim Order

The panel took into account paragraph 43 in the CPD agreement in which it is agreed that an interim suspension order should be imposed on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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 proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel considered that to do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking off order 28 days after Ms Garvey has been sent the decision of this hearing in writing.

That concludes this determination.