Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Hearing

Tuesday 13 – Friday 16 October 2020
Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Monday 19 – Wednesday 21 October 2020
Virtual Hearing

Name of registrant:	Emma Killick
NMC PIN:	11G0037E
Part(s) of the register:	Registered Midwife – 17 September 2011
Area of registered address:	Northamptonshire
Type of case:	Misconduct
Panel members:	Andrew Galliford-Yates (Chair, registrant member) Laura Wallbank (Registrant member) Bernard Herdan (Lay member)
Legal Assessor:	Jeremy Barnett
Panel Secretary:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Robert Benzynie, Case Presenter
Miss Killick:	Not present and unrepresented in absence
Facts proved:	Charges 1, 2a, 2b, 2c, 3a, 3b, 3c, 3d, 4, 5, 6, 7, 8a, 8b, 9a, 9b, 9c, 9d, 10, 11, 12, 13c, 13e, 13f
Facts not proved:	Charges 13a, 13b, 13d, 14
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Killick was not in attendance and that the Notice of Hearing letter had been sent to Miss Killick's registered email address on 9 September 2020.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Miss Killick's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Killick has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Killick

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

Mr Benzynie referred the panel to the email correspondence from Miss Killick's dated 1 October 2020. In response to questions set out by the NMC she stated that she did not

wish to attend the hearing, she was happy for the hearing to proceed in her absence, she did not wish to participate in the hearing by video link or telephone and she did not have anything to present to the hearing panel.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Killick. In reaching this decision, the panel has considered the submissions of Mr Benzynie and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Killick;
- Miss Killick has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience witnesses scheduled to give live evidence, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case and indeed Miss Killick who stated she wished for this.

There is some disadvantage to Miss Killick in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Miss Killick, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Killick's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Killick. The panel will draw no adverse inference from Miss Killick's absence.

Details of charge (as amended)

That you, whilst employed as a registered Community Midwife by Northampton General Hospital NHS Trust:

1) *Failed to carry out a full risk assessment or adequate assessment of Patient A on one or more occasions on the dates or attendances as set out in schedule 1.*

2) *Failed to identify or demonstrate sufficient professional curiosity to risks relating to Patient A on one or more occasions on the dates set out in schedule 1 including:*

    a) *Child sexual exploitation*
    b) *Previous involvement with the Child and Adolescent Mental Health Services (CAMHS)*

c) *The background or age of Patient A's partner.*

3) *Failed to make a referral for Patient A relating to one or more of the following:*

a) *The Multi-Agency Safeguarding Hub (MASH)*
b) *Child and Adolescent Mental Health Services (CAMHS)*
c) *Regional Integrated Support for Education (RISE)*
d) *A specialist teenage pregnancy midwife*

4) *Failed to keep accurate records of Patient A's medical history.*

5) *Falsified records, namely by indicating at the Booking Assessment, on 25 October 2017, in patient A's medical notes by the use of a tick box that you had reviewed Patient A's primary care/GP records.*

6) *Your action in charge 5 was dishonest as you had not carried out a review of Patient A's primary care/GP records when the box was ticked.*

7) *Failed to carry out a full risk assessment or adequate assessment of Patient B on one or more occasions as set out in schedule 2.*

8) *Failed to identify or demonstrate sufficient professional curiosity to risks relating to Patient B on one or more occasions on the dates set out in schedule 1 including:*

a) *Patient B's mental health*
b) *Previous involvement with the Child and Adolescent Mental Health Services (CAMHS)*

9) *Failed to make a referral for Patient B relating to one or more of the following:*

a) *The Multi-Agency Safeguarding Hub (MASH)*

b) *Child and Adolescent Mental Health Services (CAMHS)*

c) *Regional Integrated Support for Education (RISE)*

d) *A specialist teenage pregnancy midwife*

10) *Failed to keep accurate records of Patient B's medical history.*

11) *Falsified records, namely by indicating at the Booking Assessment, on 20 September 2017, by indicating in patient B's medical notes by the use of a tick box that you had reviewed Patient B's primary care/GP records.*

12) *Your action in charge 11 was dishonest as you had not carried out a review of Patient B's primary care/GP records when the box was ticked.*

13) *Failed to provide safe patient care and/or ensure further action was taken on one or more occasions to:*

a) *Patient C, on an unknown date, by not detecting that patient C had diabetes.*

b) *Patient E, on an unknown date, by not making a referral to the safeguarding team regarding patient E's condition relating to hearing.*

c) *Patient 1, on an unknown date prior to 9 August 2016, by not making a referral to the safeguarding team in relation to Patient 1's learning difficulties and childhood history.*

d) *Patient 2, by not making a referral to the Multi-Agency Safeguarding Hub (MASH) or additional support relating to mental health concerns.*

e) *Patient 3 by not making any or any adequate enquiries regarding patient 3's financial and/or housing requirements.*

f) *Patient 4 by not making any or any adequate enquiries into her financial and/or housing arrangements.*

14) *Failed to treat patient D, on an unknown date, with kindness, respect and compassion during an appointment where one of Patient D's twins was found to be incompatible with life.*

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

Schedule 1
25.10.17
13.12.17
14.02.18
19.03.18
04.04.18 or at the 31/40 weeks stage.
25.04.18 or at the 34/40 weeks stage.

Schedule 2
20.09.17
25.09.17
27.09.17
10.01.18
24.01.18
12.02.18

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Benzynie, on behalf of the NMC, to amend the second entry of Schedule 1 the wording of charge 12.

The proposed amendment to the second entry of Schedule 1 was to change the date **'13.12.18'** to **'13.12.17'**. It was submitted by Mr Benzynie that the proposed amendment would provide clarity and more accurately reflect the evidence.

The proposed amendment to charge 12 was to change ***'GP'*** *to* ***'GP records'***.

Original Charge 12

"Your action in charge 11 was dishonest as you had not carried out a review of Patient B's primary care/GP when the box was ticked".

Proposed Charge

"Your action in charge 11 was dishonest as you had not carried out a review of Patient B's primary care/GP ***records*** *when the box was ticked".*

It was submitted by Mr Benzynie that this was a typographical error and the proposed amendment would provide clarity and more accurately reflect the evidence.

The panel noted that Miss Killick had been notified by email on 8 October 2020 about the change to Schedule 1. She responded that she had no objection to the proposed amendment.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Killick and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

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

Mr Benzynie made a request that parts of this case be held in private on the basis that proper exploration of Miss Killick's case involves reference to her personal circumstances. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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.

Having heard that there will be reference to Miss Killick's personal circumstances, the panel determined to hold those parts of the hearing in private.

Decision and reasons on facts

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Cystic Fibrosis Specialist Nurse at the Trust;

- Witness 2: Interim Matron for community and outpatients services

- Witness 5: Community Midwife at the Trust

It also read witness statements from four witnesses.

Background

The charges arose whilst Miss Killick was employed as a Registered Community Midwife by Northampton General Hospital NHS Trust (the Trust).

The regulatory concerns are that Miss Killick failed to preserve patient safety in that she:

- failed to review patient records prior to appointments with the patients and failed to identify potential safeguarding concerns
- failed to demonstrate sufficient professional curiosity when informed of potential safeguarding concerns
- failed to keep accurate record keeping: in that she failed to keep accurate records
- Failed to provide safe patient care and lacked empathy

Witness 5 worked alongside Miss Killick at the same GP surgery, with separate case loads of pregnant women. Between 2014 and late 2017, Witness 5 raised concerns about the number of women who no longer wished to have Miss Killick as their community midwife and there were concerns about Miss Killicks failure to refer a number of women for safeguarding and/or social support.

Further, concerns, were raised later in 2018 and these were investigated by Witness 1. Miss Killick was transferred to Robert Watson Ward to be supervised in practice during the

Trust's investigation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, in particular the case of *Ivey v Genting Casinos [2017] UKSC 67* as per Lord Hughes concerning dishonesty which related to charges (6 and 12).

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> *When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individuals knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held.*
>
> *When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.*

The panel considered the witness and documentary evidence provided by the NMC.

The panel considered the evidence of the witnesses and made the following conclusions:

Witness 1: The panel considered Witness 1 to be a credible and consistent witness. She assisted the panel and accepted when she did not know the answer to any questions. Witness 1 was an independent witness who was not a midwife. She was clear and concise and focussed on explaining her role in undertaking the Trust's investigation.

Witness 5: The panel considered the Witness 5 to be a credible witness. She assisted the panel with background and contextual information. The panel found her to be balanced and fair in her explanation about the many different reasons why a patient may not want to be seen by a particular midwife.

Witness 2: The panel considered Witness 2 to be a credible witness. She answered the panel questions well and corroborated what was said by other witnesses. The panel found her to be less objective in her answers regarding the impact Miss Killick's actions may have had on patients.

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

The panel noted that, in correspondence between Miss Killick and the NMC Case Investigators, she had admitted all charges. However, the panel were concerned that she may have made these admissions to expedite the process and without full understanding of the fitness to practice procedures. The panel determined that it was important to test the evidence itself.

Context

The panel took into account the context of this case. This is a misconduct case where Miss Killick has not being charged with any clinical failings but the main concern is that Miss Killick did not not look more broadly into needs of women who came into her care namely in relation to their mental health, family, lifestyle and social history.

These omissions had the potential to increase risk both for the mother and baby. Through safeguarding and specialist support, such risks would normally be mitigated by referral to external agencies, which Miss Killick failed to do.

Patient A (charges 1, 2, 3, 4, 5 and 6)

On 25 October 2017 Miss Killick booked Patient A for care. When Miss Killick completed

the booking assessment, she indicated on Patient A's medical records that she had reviewed her GP records. Patient A was 16 years old with significant risk factors:

- Child sexual Exploitation
- Previous involvement with Social Care following MASH referral
- CAMHS involvement with self-harm and anger difficulties
- 21 year old partner who had history of drugs, violence, weapons and sexual offence against a minor (due in court)

On 27 April 2018, Patient A was seen by health visitor, Witness 3, who reviewed Patient A's history and spoke to the mental health services to whom Patient A was known. Witness 3 spoke to Miss Killick about her concerns and then made an urgent safeguarding referral herself. Witness 3 also raised concerns about Miss Killick's failure to have made such a referral earlier in Patient A's pregnancy.

The allegation is that Miss Killick had failed to review the history of Patient A thoroughly enough by going back through her history at the booking appointment on 25 October 2017 and at subsequent appointments.

Witness 1's evidence is that she met with Miss Killick during the Trust's investigation to discuss the concerns about Patient A on 11 September 2018. Miss Killick said that she had established that social services were involved with Patient A as she had not been attending school but this was now resolved. Miss Killick is said to have accepted that she should have checked the system before she booked Patient A and was not able to explain why she had not, although she explained that this was around the time of the anniversary of her father's death, which adversely affected her.

Charge 1

That you, whilst employed as a registered Community Midwife by Northampton General Hospital NHS Trust:

1) *Failed to carry out a full risk assessment or adequate assessment of Patient A on one or more occasions on the dates or attendances as set out in schedule 1.*

This charge is found proved.

In reaching this decision, the panel took into account Miss Killick's admissions to the charges.

The panel accepted the evidence from all the live witness who consistently stated that there was a duty on Miss Killick to carry out a full or adequate risk assessment of Patient A. and what was expected of her in her role as a midwife. The witnesses all stated that Miss Killick's actions fell below the standards expected of a midwife and they gave examples of potential consequences. The dates of each of the occasions where Patient A was seen by Miss Killick is set out in Schedule 1.

The panel found the witnesses' evidence to be supported by Miss Killick's Job description and also the Trust's Antenatal Care Pathway which states the following

- *"Healthcare professionals should remain alert to risk factors, signs or symptoms that may affect the health of the mother and baby"*

- *"Midwives are autonomous practitioners in normal pregnancy and birth. They are responsible for taking a detailed history at the booking appointment and then referring the woman to be seen by the obstetrician if any risk factors are identified as part of this assessment".*

- *"Complete hand-held notes including taking a medical, anaesthetic, obstetric, mental health, family lifestyle and social history as part of the risk assessment. This will determine the type of antenatal care advised. Complete relevant referral forms."*

The panel therefore concluded that Miss Killick had a duty to carry out a full risk assessment or adequate assessment of Patient A and failed to do so on one or more occasions as set out in Schedule 1.

Charge 2

> *Failed to identify or demonstrate sufficient professional curiosity to risks relating to patient A on one or more occasions on the dates set out in schedule 1 including:*
>
> *a) Child sexual exploitation*
> *b) Previous involvement with the Child and Adolescent Mental Health Services (CAMHS)*
> *c) The background or age of Patient A's partner.*

This charge is found proved.

In reaching this decision, the panel took into account into account the witness statement of Witness 1 regarding Patient A, *"She was a 16 year old girl who had a long history of sexual exploitation. She had suffered from mental health issues and there were risk of self-harm. Patient A had anger issues and there were concern about the baby's father who was considerably older".* The panel found this to be supported by the witness statement of Witness 3.

The panel noted that all of the witness spoke about the importance of professional curiosity which could have a number of varied definitions. The panel heard the definition given by Witness 5 which was *'If something is out of the ordinary it requires professional curiosity and not taking everything at face value. An effective midwife would know to look for warning indicators and should not take things at face value, recognising that people may say what they want the midwives to hear*. *A midwife would be expected to ask*

questions about background, context and home life which might then trigger concerns and further action".

The panel accepted Witness 5's definition and was of the view that there was a duty on Miss Killick to enquire and obtain information regarding Patient A and act on that information and that duty amounts to professional curiosity. The panel concluded that she failed to do this and therefore found charge 2 proved in its entirety.

Charge 3

Failed to make a referral for Patient A relating to one or more of the following:

a) The Multi-Agency Safeguarding Hub (MASH)
b) Child and Adolescent Mental Health Services (CAMHS)
c) Regional Integrated Support for Education (RISE)
d) A specialist teenage pregnancy midwife

This charge is found proved.

In reaching this decision, the panel heard evidence from Witness 2 and Witness 1 regarding the referrals that should have been made by Miss Killick.

This evidence was supported by the Trust's Antenatal Care Pathway which states *"Complete hand-held notes including taking a medical, anaesthetic, obstetric, mental health, family lifestyle and social history as part of the risk assessment. This will determine the type of antenatal care advised. Complete relevant referral forms."*

Given Patients A's medical and social background, the panel found that a safeguarding referral would have been appropriate in this case. The panel accepts that Miss Killick did not feel there was a need to make a safeguarding referral but it is of the view that it would be for the specialist team to assess the need for enhanced services.

The panel was of the view that there was a duty on Miss Killick to make one or more a referrals to the various relevant agencies and had SystemOne (GP record system) been accessed or checked by Miss Killick affectively then the risk factors surrounding Patient A would have become apparent. The panel would expect a reasonable midwife to have made specialist referrals to the relevant external agencies set out in charge 3 a - d. This failure prevented other healthcare professionals identifying current and potential future risks. The panel therefore finds charge 3 proved in its entirety.

Charge 4

Failed to keep accurate records of patient A's medical history.

This charge is found proved.

In reaching this decision the panel took into account the witness statement of Witness 1 concerning Miss Killick's performance. "There was failure to take adequate-patient histories…*You always review the GP records and you confirm this is completed by ticking the box... [Miss Killick] ticks the box to confirm that she had reviewed the records. From the evidence I gathered she clearly had not reviewed the records".* The panel found Witness 1's evidence to be supported by Patient A's patient notes.

The panel also took into account the Trust's Antenatal Care Pathway.

The panel heard from Witness 7 that Miss Killick's paper work was 'fantastic' and the panel saw evidence of good record keeping in general. However, in failing to access records on the GP system and ticking the boxes to show that she had done so, the panel concluded that Miss Killick had created an incomplete record of Patients A's medical and social history and therefore failed in her duty to keep accurate records of Patient A's medical history.

Charge 5

Falsified records, namely by indicating at the Booking Assessment, on 25 October 2017, in patient A's medical notes by the use of a tick box that you had reviewed Patient A's primary care/GP records.

This charge is found proved.

In reaching this decision, the panel took into account Miss Killick's admission in the Trust's investigation interview notes. The panel also noted Patient A's patient notes with box that Miss Killick has ticked.

The panel took into account the witness statement of Witness 1 that Miss Killick did not review Patient A's GP records, *"[Miss Killick] did not review the GP records… [Miss Killick] ticks the box to confirm that she had reviewed the records. From the evidence I gathered she clearly had not reviewed the records.'* Witness 1 also states that *"Patient A required further involvement and it was [Miss Killick's] responsibility to refer everything to the teenage pregnancy midwife or the MASH. [Miss Killick] therefore failed to keep accurate records as she ticked to say that she had looked but she did not".* This was supported by the witness statement of Witness 2.

The panel therefore concluded that Miss Killick had falsified records, namely by indicating at the Booking Assessment, on 25 October 2017, in Patient A's medical notes by the use of a tick box that she had reviewed Patient A's primary care/GP records. This failure had the potential to cause more serious adverse consequences.

Charge 6

Your action in charge 5 was dishonest as you had not carried out a review of Patient A's primary care/GP records when the box was ticked.

This charge is found proved.

In reaching this decision the panel had regard to Miss Killick's admission in her investigation interview notes that *"I should be looking at the system beforehand but I don't know why I didn't".*

The panel concluded that Miss Killick had a duty to examine Patient A's record set out in Trust's Antenatal Care Pathway. By the standard of honesty of ordinary decent people, ticking the 'yes' box to indicate that she had looked at Patient A's GP records, knowing that she had not, was dishonest.

Patient B (charges 7, 8, 9, 10, 11 and 12)

Pending the investigation concerning Patient A, another incident was raised concerning Patient B who had had an initial appointment on 20 September 2017. Miss Killick had ticked to confirm that there were mental health factors and that Patient B had a raised body mass index and referred her to a consultant obstetrician.

The history of the patient suggested significant risk factors relating to her past mental health and current social situation, so Miss Killick referred to the consultant obstetrician but did not raise a safeguarding concern.

The allegations are that Miss Killick failed to adequately review Patient B's patient history and to identify that a safeguarding referral was required:

- Patient B is said to have a history of significant mental health problems, including around seven hospital admissions for suicide attempts.
- Patient B is said to have been sexually abused and gang raped prior to her pregnancy, her brother was drug dealing, her father had threatened to set fire to the house and someone threatened to shoot her.

On 11 May 2018 Patient B's baby, Baby B, was assessed in A&E with non-accidental injuries and was admitted to the children's ward with leg fractures. Miss Killick had provided antenatal care to Patient B.

In relation to Patient B, Witness 1's evidence is that at the meeting 11 September 2018, Miss Killick explained that Patient B had consulted her GP and requested a termination. Miss Killick did not expect Patient B to attend her booking appointment. Therefore, Miss Killick did not go back into the records to complete a thorough review of Patient B's previous history. Although Miss Killick says that she did not have time to view the Patient B's records at the booking appointment, she failed to review them at any other time during Patient B's pregnancy.

Charge 7

> *Failed to carry out a full risk assessment or adequate assessment of patient B on one or more occasions as set out in schedule 2.*

This charge is found proved.

In reaching this decision the panel accepted that there was a duty on Miss Killick to carry out a full risk assessment or adequate assessment of Patient B. This was supported by Miss Killick's job description and the Antenatal Care Pathway. The panel also took into account the live evidence from three witnesses at this substantive hearing regarding what was expected of Miss Killick in her role as a midwife.

Having earlier defined the duty that Miss Killick was under in respect of carrying out risk assessments for Patient A in charge 1, the panel found that in relation to Patient B this duty had not been fulfilled.

Charge 8

Failed to identify or demonstrate sufficient professional curiosity to risks relating to patient B on one or more occasions on the dates set out in schedule 2 including:

a) *Patient B's mental health*
b) *Previous involvement with the Child and Adolescent Mental Health Services (CAMHS)*

This charge is found proved.

In reaching this decision the panel took into account the evidence of Witness 1. Witness 1 says in her witness statement that *"Patient B was known to CAMHS even though she was now older this previous CAMHS referral should have raised the concerns. If you see historic problems you would refer to safeguarding". This was supported by the witness statement of* Witness 2*.*

The panel also heard evidence from the live witnesses regarding the importance and significance of conducting a full risk assessment at the initial booking appointment and all subsequent antenatal appointments. The panel noted that each of the occasions set out in schedule 2 were appointments where Patient B was seen by Miss Killick.

The panel had earlier accepted the definition given by Witness 5 regarding professional curiosity which was *'If something is out of the ordinary it requires professional curiosity and not taking everything at face value. An effective midwife would know to look for warning indicators and should not take things at face value, recognising that people may say what they want the midwives to hear*. *A midwife would be expected to ask questions about background, context and home life which might then trigger concerns and further action".*

The panel concluded that there was a duty on Miss Killick to enquire and obtain information regarding Patient B and act on that information and that duty amounts to professional curiosity. The panel therefore finds charge 8 proved in its entirety.

Charge 9

Failed to make a referral for Patient B relating to one or more of the following:

a) The Multi-Agency Safeguarding Hub (MASH)
b) Child and Adolescent Mental Health Services (CAMHS)
c) Regional Integrated Support for Education (RISE)
d) A specialist teenage pregnancy midwife

This charge is found proved.

In reaching this decision the panel took into account the witness statement of Witness 1 where she says *"[Miss Killick] did not look at the notes, if she had, she would have seen and referred Patient B to the MASH team and it may have been a level four single assessment and a social worker may have become involved".*

It also took into account the evidence of Witness 2 who says *"[Miss Killick] should have asked Patient B to come back after booking an initial appointment. If not, she could have waited until the 12 week scan, but should have made a referral to safeguarding by 16 weeks at the latest. This was simply never done".*

The panel found this evidence to be supported by the Trust's Antenatal Care Pathway.

The panel was of the view that there was a duty on Miss Killick to make one or more referrals to the various relevant agencies .The panel would expect a reasonable midwife to have made referrals to the relevant external agencies, set out in charge 9 a – d, to allow

specialist assessment of potential risk factors. The panel therefore finds charge 9 proved in its entirety.

Charge 10

Failed to keep accurate records of Patient B's medical history.

This charge is found proved.

In reaching this decision the panel accepted the evidence of Witness 2. It noted in her witness statement she says that "*Throughout Patient B's pregnancy there would have been around 8 appointments, at no point was her history reviewed or questioned. There was no evidence of any discussion having taken place. At 28 weeks you are expected to carry out a mental health and domestic violence review. There is no evidence of [Miss Killick] doing this. When booking an appointment, you need to indicate whether the patient has had any social service input, [Miss Killick] ticked 'no' at the first and 28 week appointments. [Miss Killick] therefore failed to keep accurate records".*

The panel also took into account the Trust's Antenatal Care Pathway.

The panel concluded that Miss Killick had created an incomplete record of Patients B's medical history and therefore failed in her duty to keep accurate records of Patient B's medical history.

Charge 11

Falsified records, namely by indicating at the Booking Assessment, on 20 September 2017, by indicating in patient B's medical notes by the use of a tick box that you had reviewed Patient B's primary care/GP records.

This charge is found proved.

In reaching this decision, the panel took into account Miss Killick's admissions in the Trust's investigation interview notes. Ms Killick states that *"There's not time to look at notes once they are there. We can at the end of the clinic of if there is a missed appointment. As nothing was highlighted at the time I didn't look."* The panel also noted the risk assessment form the hand-held notes.

The panel took into account the witness statement of Witness 1 that Miss Killick had ticked to say she had reviewed the GP notes. Witness 1 says in her witness statement that *"[Miss Killick] did not look at the notes, if she had, she would have seen and referred Patient B to the MASH team."*

This was supported by the witness statement of Witness 2 who says *"You are obviously falsifying records if you tick that you have reviewed a patient's history when you have not done so".*

The panel therefore concluded that Miss Killick had falsified records, namely by indicating at the Booking Assessment, on 20 September 2017, in Patient B's medical notes by the use of a tick box that she had reviewed Patient B's primary care/GP records.

Charge 12

> *Your action in charge 11 was dishonest as you had not carried out a review of Patient B's primary care/GP records when the box was ticked.*

This charge is found proved.

In reaching this decision the panel had regard to Miss Killick's admission in her investigation interview notes.

The panel concluded that Miss Killick had a duty to examine Patient B's record as set out in Trust's Antenatal Care Pathway. By ticking the 'yes' box to indicate that she had looked at Patient B's GP records when she knew that she had not, the panel concluded that she was clearly dishonest.

Patient C (charge 13a)

Charge 13a

Failed to provide safe patient care and/or ensure further action was taken on one or more occasions to:

a) Patient C, on an unknown date, by not detecting that patient C had diabetes.

This charge is found not proved

In reaching this decision, the panel was of the view that there was insufficient evidence to identify Patient C. Witness 2 was unable to satisfy the panel in relation to this charge when questioned in her oral evidence. The panel therefore finds charge 13a not proved.

Patient E (charge 13b)

It is also alleged that, on an unknown date in 2017, Miss Killick failed to raise a safeguarding concern in relation to Patient E who was deaf and had concerns that she would not be able to hear her baby cry. The concerns were addressed by Witness 7, who was at that time Miss Killick's line manager. The concerns regarding Miss Killick's practise appeared to be ongoing, despite Witness 7's involvement and the letter of expectation to Miss Killick set out in the letter dated 28 August 2016. Therefore, Miss Killick was sent another letter of expectation dated 15 January 2018 by Witness 2.

Charge 13b

b) *Patient E, on an unknown date, by not making a referral to the safeguarding team regarding patient E's condition relating to hearing.*

This charge is found not proved

In reaching this decision, the panel noted that the only information relating to this charge was in the witness statement of Witness 6. The panel was of the view that there was insufficient evidence in the witness statement of Witness 6 to be sure that this evidence related to Patient E. The panel therefore finds charge 13b not proved.

Patient 1 (charge 13c)

Witness 5 reported that in August 2016, she saw Patient 1 at an antenatal clinic when Miss Killick was on annual leave. Witness 5 felt that, due to her learning difficulties, Patient 1 required additional support. Witness 5 established that EK had not referred her to social services and that she had been on a normal care pathway. Therefore, Witness 5 made an urgent safeguarding referral.

Charge 13c

c) *Patient 1, on an unknown date prior to 9 August 2016, by not making a referral to the safeguarding team in relation to Patient 1's learning difficulties and childhood history.*

This charge is found proved

In reaching this decision the panel took into account the evidence of Witness 5. In her witness statement she says that *"I felt that [Patient 1] had mild learning difficulties so I urgently referred her to the safeguarding midwife and to social services. Patient 1 had been on a normal low risk pathway, however upon review it was seen that she had*

experienced quite a significant level of abuse in childhood. No harm came to the baby, but Patient 1 did need to have additional support and [Miss Killick] had not picked up on this".

The panel noted that the only information about Patient 1 comes from Witness 5 and having found her to be credible and reliable witness it accepted her evidence and was satisfied with the detailed information to find this charge proved.

Patient 2 (charge 13d)

Charge 13d

d) *Patient 2, by not making a referral to the Multi-Agency Safeguarding Hub (MASH) or additional support relating to mental health concerns.*

This charge is found not proved

The panel was of the view that there was insufficient information to find this charge proved. The panel therefore finds charge 13d not proved.

Patient 3 (charge 13e)

Witness 5 visited Patient 3 at her home on 6 February 2017. Patient 3 was 17 years old and lived with her three siblings and her parents. Witness 5 considered the home was unclean, overcrowded and housed two large dogs which made it unsuitable for a new-born baby. She considered that Miss Killick had failed to identify the problems faced by Patient 3 and failed to provide the appropriate support with her housing needs.

Charge 13e

e) *Patient 3 by not making any or any adequate enquiries regarding patient 3's financial and/or housing requirements.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5*. It noted in her witness statement that she had direct evidence about Patient 3's living environment. "When I visited Patient 3 at home I was concerned about her home conditions… It concerned me that there was a baby going to be brought up in a very dirty house like this…* It was also an opportunity for us to talk about her own housing situation and support her to get her own house and to be aware of what money and financial support she has. *It was not the right environment to bring up a child. The bedroom was not clean and the bathroom was the worst bathroom I had ever seen covered with dirt yet. [Miss Killick] had not addressed any of these concerns*.

The panel accepted the evidence of Witness 5 and concluded that Miss Killick failed to provide safe care and or ensure further action was taken by not making any or any adequate enquiries regarding Patient 3's financial and/or housing requirements.

Patient 4 (charge 13f)

Witness 5 also reported that Miss Killick had failed to recognise that Patient 4 was in need of additional support. Patient 4 was pregnant with her fifth baby, lived in a two bedroom flat, without enough beds for her children and had a low income. Witness 5 considered Miss Killick had failed to make adequate enquiries into her financial and housing arrangements.

Charge 13f

f) Patient 4 by not making any or any adequate enquiries into her financial and/or housing arrangements.

This charge is found proved.

In reaching this decision the panel took into account Witness 5's oral evidence. Witness 5 was of the view that having read Patient 4's social history and being aware that she was expecting her fifth child with significant financial deprivation and being aware that the family were residing in a two bedroom house with insufficient beds for each of children, any reasonable midwife would have made a referral.

Witness 5 gave the panel examples of what interventions could have been put in place including early health assessment, asking for rehousing from the council, ensuring that the family have applied for all benefits that they may be entitled to. Witness 5 says in her witness statement that *"Patient 4 lived in a two bedroom house and was expecting her fifth baby. There was nowhere for the baby to sleep and she did not have a lot of money. This was someone who needed extra support. [Miss Killick] was her midwife but she had not picked up that there were any concerns".*

The panel accepted the evidence of Witness 5 and concluded that Miss Killick failed to provide safe care and or ensure further action was taken to Patient 4 by not making any or any adequate enquiries into her financial and/or housing arrangements.

Patient D (charge 14)

Charge 14

> *Failed to treat patient D, on an unknown date, with kindness, respect and compassion during an appointment where one of Patient D's twins was found to be incompatible with life.*

This charge is found not proved.

In reaching this decision the panel noted that the only information relating to this charge is within the disciplinary hearing which the panel considered to be hearsay evidence. The panel was of the view that there was insufficient information to find this charge proved. The panel therefore finds charge 14 not proved.

Fitness to practise

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

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

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

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Benzynie invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Benzynie identified the specific, relevant standards where Miss Killick's actions amounted to misconduct. He submitted that the facts found proved including the finding of dishonesty are serious and fall significantly short of the conduct and standards expected of a registered midwife. Miss Killick's conduct undoubtedly had an effect on her colleagues.

Mr Benzynie asked the panel to consider whether the admissions in the Case Management Form indicates that Miss Killick accepts that the facts, individually and collectively, amount to misconduct.

Submissions on impairment

Mr Benzynie moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Benzynie submitted that Miss Killick's fitness to practice is impaired by reason of her misconduct on public protection and public interest grounds. It is further submitted that there is a need to declare and maintain proper standards and public confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: Fatnani & Raschid v General Medical Council [2007] EWCA Civ 46, Meadow v General Medical Council 2006 EWCA civ 1390 and CHRE v Grant [2011] EWHC 927 (Admin) in respect of the need to maintain public confidence in the profession.

Decision and reasons on misconduct

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

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

"1.2 make sure you deliver the fundamentals of care effectively

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.

4 Act in the best interests of people at all times

8.6 share information to identify and reduce risk,

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

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

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

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

20 Uphold the reputation of your profession at all times 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 misconduct.

Miss Killick's omissions had the potential to put patients at risk of significant harm and prevented patients receiving the appropriate care. The panel also found that Miss Killick's actions when she ticked in the records of two patients, indicating that she had reviewed their notes on SystemOne when she knew that she had not, was dishonest. This was behaviour that colleague practitioners and the wider public would find fell far below the standard expected of a registered midwife.

The panel was of the view that, although some of the incidents were not at the most serious end of the spectrum, taken collectively they amounted to misconduct. Despite Miss Killick being offered support and retraining on two occasions, the panel was of the view that these significant failings were repeated and occurred over a period of time and clearly amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Killick's fitness to practise is currently impaired.

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

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

The panel found that all four limbs of the test in Grant were engaged in Miss Killick's case. As a result of Miss Killick's misconduct, the panel found that patients were put at risk which had the potential to cause physical harm and psychological and social distress.

Furthermore, her failure to make referrals on safeguarding or mental health grounds created unnecessary risks to mothers and their unborn children.

Miss Killick's misconduct had breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute.

The panel accepted that Miss Killick had made partial admissions to the charges in her first case management form dated 11 February 2019 and full admissions in her second case management form completed on 4 February 2020 and accordingly it gave her full credit for those admissions. The panel accepted that she had chosen not to participate in this hearing because she had made an application for voluntary removal and therefore did not hold her absence from these proceedings against her. Regarding insight, the panel have not received any evidence of reflection or remorse from Miss Killick about her actions. It noted that any correspondence from Miss Killick to the NMC demonstrated that she appeared to only be concerned with the impact the proceedings had had on her and her reputation rather than how her failings had affected patients, colleagues and the wider midwifery profession.

The panel was satisfied that the majority of the misconduct in this case is capable of remediation, but recognised that dishonesty is particularly hard to remediate. The panel noted that Miss Killick has not practised as a midwife since September 2018 and there is evidence to suggest that she has not worked in a clinical setting since this time. In her application for voluntary removal dated 4 February 2020, Miss Killick states *"I do not intend to pursue a career in midwifery… I am currently working in retail…"* The panel is of the view that there is a risk of repetition of Miss Killick's misconduct based on her lack of insight and remediation and there remained a risk of her repeating the shortcomings in her practice and acting dishonestly in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold

and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that a finding of impairment on public interest grounds is also required. The panel concluded, in particular, that confidence in the midwifery profession would be undermined if charges relating to dishonesty were not to lead to a finding of impairment.

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

Sanction

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

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

Submissions on sanction

Mr Benzynie submitted that a suspension order for 12 months (with a review) could be considered appropriate and proportionate to address the issues which led to this referral. However, there is the further consideration that Miss Killick has not practiced for some time and states she does not want to pursue a career in midwifery.

Mr Benzynie submitted that this is a case where the charges found proved are capable of falling into the highest level of sanction that is a striking off order. Such an order would be proportionate and appropriate in regard to the charges found proved. The attitudinal issue

relating to not making the appropriate referrals to safeguarding may not be compatible with Miss Killick maintaining her registration.

Ms Benzynie submitted that Miss Killick was employed to be in the front line and is the first person to ensure any further investigations or referrals were made. That required Miss Killick to be fully appraised of history of the patient and a medical curiosity to consider all the strands of information relating to the patient. Failing to do so has a knock on effect to the care and medical treatment that is provided to patients. Miss Killick held a key role of responsibility and she fell far short of what was required.

Mr Benzynie invited the panel to consider a striking-off order in this case notwithstanding the admissions that have been made, and the possible mitigation in this case.

The panel accepted the advice of the legal assessor. He advised the panel that it should act proportionately and drew its attention to the case of *Parkinson v NMC 2010 EWHC 1898 admin,* where it was said that a nurse who has acted dishonestly who does not attend the panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct was dishonest and undertaking that there will be no repetition, will face an uphill task in persuading the panel to take a lenient course.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Miss Killick's failures were repeated and occurred over a prolonged period of time.
- Miss Killick's dishonest conduct created a real risk of harm to women and their babies.
- Miss Killick's failure to make appropriate referrals would have had adverse effects on vulnerable women and their babies had they not been detected by other health professionals.
- Miss Killick's poor multidisciplinary communication.
- The absence of any evidence of Miss Killick's insight, remorse or remediation.
- Miss Killick's failure to appreciate the seriousness of safeguarding issues.

The panel also took into account the following mitigating features:

- Miss Killick has had no previous regulatory concerns.
- Miss Killick made admissions to all the charges.
- Miss Killick was experiencing [PRIVATE].
- Miss Killick's dishonesty was not for personal gain.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

The panel next considered whether placing conditions of practice on Miss Killick's registration would be a sufficient and appropriate response. The panel is of the view that there are practical or workable conditions that could be formulated, for the majority of the charges but took into account that Miss Killick has said that she does not wish to return to midwifery. Furthermore, the dishonest misconduct identified in this case was not something that can be easily addressed through retraining. The panel had no evidence that Miss Killick would be willing to remediate her practice through conditions of practice. Looked at in the round, the panel concluded that it would not be possible to formulate conditions that satisfied all the appropriate tests in this case and would not adequately address the public protection or public interest in relation to the dishonesty.

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

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

The conduct, as highlighted by the facts found proved, involved more than one incident over a period of time. Miss Killick has not practised as a midwife since December 2018 and has indicated that she does not wish to return to midwifery. As Miss Killick has not provided evidence of any insight, the panel cannot be satisfied that she does not pose a significant risk of repeating her misconduct.

Miss Killick's conduct was a significant departure from the standards expected of a registered midwife. The panel noted that there had been a serious breach of the

fundamental tenets of the profession evidenced by Miss Killick's actions. Although there was no evidence of harmful deep-seated personality or attitudinal problems, a significant amount of remediation would be required before Miss Killick could safely return to practise.

In this particular case, the panel was of the view that to prolong these proceedings with a period of suspension when Miss Killick has indicated that she does not wish to return to midwifery would not be in the public interest. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Miss Killick's actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with her remaining on the register. Moreover, she has failed to demonstrate insight, to show any remorse or to engage in remediation. The panel was of the view that the findings in this particular case demonstrate that Miss Killick's actions were seriously deficient and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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

This decision will be confirmed to Miss Killick in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Killick's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Benzynie. He submitted that having seen the decision of the panel, the imposition of an interim suspension order for a period of 18 months is necessary on the grounds of public protection and the public interest.

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 facts found proved and

the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.