Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
12 – 16 April 2021
19 – 23 April 2021
26 April 2021 – 28 April 2021
8 June 2021
16 – 17 August 2021

Virtual Hearing

Name of registrant:	Karen Foster
NMC PIN:	00I6995E
Part(s) of the register:	Registered Midwife 1 September 2003
Area of registered address:	Cheshire
Type of case:	Misconduct
Panel members:	John Vellacott (Chair, Lay member) Ian Dawes (Lay member) Pauline Esson (Registrant member)
Legal Assessor:	Nigel Ingram
Panel Secretary:	Max Buadi (12 -15, 19 – 23, 28 – 28 April 2021) Xenia Menzl (8 June, 16 – 17 August 2021)
Nursing and Midwifery Council:	Represented by Sophie Quinton-Carter, Case Presenter
Miss Foster:	Present via telephone and via video link in part and not represented
Facts admitted:	1(a), 1(b), 1(c), 1(d), 1(e), 2(f), 3(c), 3(e), 3(f), 3(g), 5(a), 6(a), 6(b) 6(c), 6(d), 6(e), 6(f), 6(g), 6(h), 9(a), 11(c), 11(d), 12(a), 12(b), 12(c), 12(d), 13(a)(i), 13(b)(i), 13(c)(i), 13(d)(i), 14(a), 14(f), 15(b)(i), 15(e)(ii), 15(f)(i), 16(c), and 17(c)(i)
No case to answer:	8(a), 8(b) and 10(c)

Facts proved:	2(a)(i), 2(e)(i), 3(a), 3(b), 3(d), 4(a), 4(b), 4(c), 7(a), 7(b), 7(d), 8(c), 8(d), 9(b), 9(c), 10(a), 10(b), 10(d), 10(e), 10(f), 11(a), 11(b), 13(a)(ii), 13(b)(ii), 13(c)(ii), 13(c)(iii), 13(d)(ii),14(b), 14(c), 14(d), 14(e), 15(a)(i), 15(a)(ii), 15(b)(ii), 15(b)(iii), 15(c)(i), 15(c)(ii), 15(d)(i),15(d)(ii), 15(d)(iii), 15(e)(i), 15(e)(iii), 15(f)(ii), 16(b),16(d), 16(e), 16(f), 17(a)(i), 17(a)(ii), 17(a)(iii), 17(b)(i), 17(b) (ii), 17(b) (iii), 17(c)(ii)
Facts not proved:	2(a)(ii), 2(b)(i), 2(c)(i), 2(d(i), 2(e)(i), 7(c), 16(a)
Fitness to practise:	**Impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim Suspension Order, 18 Months**

Details of charge

That you, a registered midwife:

1) At One to One Midwives submitted and/or pursued a travel expenses claim for:

    a) travel to Birmingham for GAP training on 6 October 2016 which was not undertaken
    b) £18 in relation to 25 February 2017 without adequate supporting documentation
    c) £18 in relation to 3 March 2017 without adequate supporting documentation
    d) £29.70 in relation to 20 March 2017 without adequate supporting documentation
    e) travel to Warrington Pregnancy Advice Clinic (PAC) on 31 March 2017 when you did not take the clinic

2) And your actions specified in charge 1 were dishonest and/or lacking integrity in that:

    a) In respect of charge 1a)
        (i) you knew that you had not travelled to Birmingham for training on 6 October 2016
        (ii) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken
    b) In respect of 1b)
        (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken
    c) In respect of charge 1c)
        (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken
    d) In respect of 1d)
        (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken
    e) In respect of charge 1e)

(i) you knew that you had not travelled to the Warrington PAC on 31 March 2017

(ii) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

f) You knew that it was wrong to submit expense claims without adequate explanation or supporting documentation

3) In respect of Patient A you:

a) Failed to ensure that the abnormal result from a Glucose Tolerance Test (GTT) of 8 March 2017 was recorded in the patient's notes

b) Failed to document/adequately document the treatment, care or action which was to follow the abnormal GTT result from 8 March 2017

c) Failed to arrange a repeat GTT test straight away or in a timely manner

d) On 19 April 2017 you informed Colleague M that you had contacted the relevant hospital and that the repeat GTT test was normal

e) Failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017

f) Failed to document within the patient's notes that you had attended a Multi-Agency Risk Assessment Conference ("MARAC") on 11 April 2017

g) Failed to document within the patient's notes a summary of the MARAC

4) And your action specified in charge 3 d) was dishonest in that:

a) You knew that the repeat GTT test had not been conducted

b) You knew that it was wrong to state that a GTT test had been repeated and was normal

c) You intended to mislead colleague M into thinking that you had followed up on the abnormal GTT result and that no further action was required

5) In respect of Patient B:

a) Inaccurately documented the patient's blood group as A-rhesus positive, following a blood test on around 21 February 2017

6) In respect of Patient C:

   a) Failed to send a safeguarding notification form in a timely manner following the booking appointment on 8 February 2017
   b) Failed to provide sufficient information regarding safeguarding concerns on the initial safeguarding notification form dated 20 April 2017
   c) Failed to complete an adequate risk assessment within the patient's notes on 8 February 2017
   d) Failed to complete an entry within the safeguarding section of the patient's notes following the booking appointment on 8 February 2017 and prior to 3 April 2017
   e) Failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017
   f) Failed to notify Social Services of the patient's pregnancy
   g) Failed to complete adequate documentation in relation to safeguarding concerns following a safeguarding supervision on 3 April 2017
   h) Failed to carry out and/or document any action taken following the plan made at the safeguarding supervision on 3 April 2017

7) In respect of Patient D:

   a) Failed to identify and/or document the Patient's learning disability at the booking appointment on 6 February 2017
   b) Failed to send a safeguarding notification form in a timely manner following the booking appointment on 6 February 2017
   c) Failed to action the request for a social care enquiry as requested by Ms 2 on 27 February 2017
   d) Failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017

8) In respect of Patient E:

   a) Failed to obtain and/or sufficiently detail the patient's obstetric history at the booking appointment on 7 March 2017

b) Failed to complete an adequate risk assessment at the booking appointment
c) Failed to offer and/or failed to document an offer, to the patient, of a referral to a consultant following the identification of significant risk factors
d) Failed to offer and/or failed to document an offer, to the patient, of a Glucose Tolerance Test ("GTT")

9) In respect of Patient F:

a) Failed to complete an adequate risk assessment at the booking appointment on 30 March 2017
b) Failed to offer and/or failed to document an offer, the patient, of a referral to a consultant following the identification of significant risk factors
c) Failed to offer the patient a GTT or failed to document that she had offered such

10) In respect of Patient G:

a) Failed to complete the safeguarding notification form at or around the time of the booking appointment on 4 April 2017
b) Failed to complete an adequately detailed risk assessment in the patient notes at or around the time of the booking appointment
c) Failed to discuss and/or document safeguarding concerns with the patient on 4 April 2017 or record why such a discussion did not take place
d) Failed to arrange an opportunity to discuss the safeguarding concerns with the patient subsequent to 4 April 2017
e) Failed to make an entry in the safeguarding section of the patient's notes at or around the time of the booking appointment and/or subsequently
f) Failed to carry out and/or document any action taken following the plan made at the safeguarding supervision on 3 April 2017

11) In respect of Patient H:

a) Failed to acknowledge in the patient's notes that you were aware of Social Services involvement in this case and/or monitoring such, prior to the safeguarding supervision on 3 April 2017
b) Failed to document in the patient's notes whether the safeguarding plan agreed by the previous midwife continued to be appropriate and/or was being followed
c) Failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017
d) Failed to officially verify whether the case was still open to Social Services and/or "Team around the family" (TAF) following your contact with the patient on 3 April 2017

12) In an application form dated 15 June 2017 submitted to Pulse Nursing Agency you indicated that:

a) You had never been, nor were not currently subject to an investigation
b) You had never been, nor were currently subject to disciplinary action
c) You had never been dismissed, nor suspended from a position
d) You were not currently being investigated for misconduct nor had received any negative feedback

13) And your actions specified in charge 12 were dishonest in that:

a) In respect of 12a)
    (i) you knew that you had been the subject of an investigation while working at One to One Midwives
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
b) In respect of 12b)
    (i) you knew that you had been subject to disciplinary action while working at One to One Midwives

(ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

c) In respect of 12c)

(i) you knew that you had been suspended from your position at One to One Midwives

(ii) you knew that you had been dismissed from your position at One to One Midwives

(iii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

d) In respect of 12d)

(i) you knew that you had received negative feedback while working at One to One Midwives

(ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

14) In a Pulse investigation meeting on 25 September 2018 you gave inaccurate information to the effect that:

a) You had never received a complaint in relation to your clinical practice from a family or patient

b) You did not receive any letter regarding a meeting in May 2017 led by someone called Colleague O

c) You were “terminated” at the meeting in May 2017

d) You did not receive any letter confirming your termination of contract

e) You heard nothing from the NMC concerning referral for a year after receiving a letter from the NMC in July 2017

f) You found out about the NMC referrals in July 2018

15) And your actions specified in charge 14, were dishonest in that:

a) In respect of 14a)

(i) you knew that you had received a complaint in relation to your clinical practice from a patient

(ii) you intended to mislead Pulse Nursing Agency as to the details of your clinical history

b) In respect of 14b)
    (i) you were made aware by letter of a meeting in May 2017 led by Colleague O
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
    (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
c) In respect of 14c),
    (i) you knew that no decision to dismiss you had been taken at the meeting led by Colleague O
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
d) In respect of 14d)
    (i) you were sent a letter dated 26 May 2017 from Colleague O that you had been dismissed with immediate effect
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
    (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
e) In respect of 14e)
    (i) you heard from the NMC when preliminary enquiries had been completed
    (ii) you heard from the NMC that your case was to be sent to a Case Examiners meeting
    (iii) you intended to mislead Pulse Nursing Agency as to your knowledge regarding NMC proceedings
f) In respect of 14f)
    (i) you had been made aware, by the NMC, of 2 referrals in June 2017
    (ii) you intended to mislead Pulse Nursing Agency as to your knowledge regarding NMC referrals

16) In a Pulse disciplinary hearing on 23 October 2018 you gave inaccurate information to the effect that:

a) One to One Midwives had put you on garden leave
b) You were not able to state when your employment with One to One Midwives ended
c) You were never formally suspended
d) You were never formally terminated
e) When you received the letter from the NMC telling you that you were being investigated, you told Colleague P (at Pulse) straight away
f) The dismissal letter from One to One Midwives did not refer to any of the issues and/or say that the dismissal was a result of any or all of the issues

17) And your actions specified in charge 16 were dishonest in that:

a) In respect of 16a) and 16c)
    (i) you knew that you had been suspended by One to One Midwives
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
    (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
b) In respect of 16b) and 16d)
    (i) you knew that you had been dismissed by One to One Midwives with immediate effect from 26 May 2017
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
    (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
c) In respect of 16e)
    (i) you knew that you were being investigated by the NMC and did not tell Colleague P (at Pulse)

(ii) you intended to mislead Pulse Nursing Agency as to your knowledge of NMC proceedings

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

Decision and reasons on for part of the hearing to be heard in private

At the outset of the hearing, Ms Quinton-Carter informed the panel that she was going to make an application to allow Colleague M to give their evidence over the phone. Ms Quinton-Carter made a request that the application be made in private as it would reference the underlying health conditions of Colleague M. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You did not oppose this application.

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 the health conditions of Colleague M during the Rule 31 application and her evidence the panel determined to hold the duration of that application in private.

Decision and reasons on application to admit the telephone evidence of Colleague M

The panel heard an application made by Ms Quinton-Carter under Rule 31 to allow Colleague M to give their evidence over the telephone. Ms Quinton-Carter informed the panel that Colleague M was not present at this hearing and explained she was unable to attend today due to the health of Colleague M. She submitted that a prolonged period of looking at a screen would exacerbate her medical condition.

Ms Quinton-Carter submitted that most of Colleague M's evidence covers charges to which you have already made admissions. Therefore, she submitted, there is only limited evidence from Colleague M that would be deemed to be sole and decisive.

You did not oppose this application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Colleague M serious consideration. The panel noted that Colleague M's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and was signed by her.

The panel took account of the health concerns of Colleague M which have prevented her from giving evidence via video link. It also noted that, in light of your admissions to some of the charges, Colleague M's evidence is not sole and decisive. Further, there are other witnesses and documentary evidence that appear to support the other charges.

The panel also bore in mind that you did not oppose this application.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Colleague M to give evidence remotely over the telephone, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application of no case to answer

The panel considered an application from you that there is no case to answer in respect of charges 3a) and 3b), 7a), 7b), 8a, 8b), 8c), 8d) and 10a), 10b), 10c), 10d), 10e), and 10f). This application was made under Rule 24(7) of the Rules. This rule states:

> 24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –

(i) either upon the application of the registrant …

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

With regards to charge 3a), you submitted that it was Ms 2 who had undertaken the Glucose Tolerance Test (GTT) in respect of Patient A. Therefore, you submitted that it was Ms 2's responsibility to ensure that the abnormal result arising from the GTT test was recorded in Patient A's notes.

In respect of charge 3b), you again submitted that Ms 2 had undertaken the GTT for Patient A so it would have been Ms 2's responsibility to document the treatment, care or action which was to follow the abnormal result arising from the GTT.

With regards to 7a) you accepted that the evidence showed that you conducted this booking appointment with Patient D, on 6 February 2017. However, you submitted that there was insufficient evidence arising from this appointment to determine that Patient D had learning difficulties.

With regards to 7b), you submitted that, it was not completely evident that, from the appointment on 6 February 2017, Patient D needed safeguarding. You submitted that this could have been more apparent upon over time. However the evidence did not show, at the time of the appointment, that a safeguarding notification was needed.

In respect of all the sub charges of charge 8, you submitted that the evidence did not show that you had undertaken the booking appointment for Patient E which occurred on 7 March 2017. Consequently, the evidence did not show your responsibility for the risks identified at this appointment.

In respect of the all the sub charges of charge 10, you submitted that the evidence did not show that you did not conduct the booking appointment for Patient G on 4

April 2017. Consequently, you submitted that it was not your responsibility to document the concerns arising from this booking.

With regards to charge 3a) Ms Quinton-Carter reminded the panel that Ms 2 stated in her evidence that there was a joint responsibility to obtain the results of the GTT. She submitted that Ms 2 stated that she did pass on the results of the GTT to you in an email which you subsequently acknowledged. Ms Quinton-Carter also submitted that you were the responsible midwife for Patient A and you do not dispute this. As a result, you were jointly responsible with Ms 2, for the patient and to document any results arising from the GTT.

Ms Quinton-Carter submitted that the charge is worded as “failed to ensure” rather than “failed to document”. She submitted that when you noticed that Ms 2 did not document the abnormal result, you should have documented this yourself or ensured that Ms 2 had. Ms Quinton-Carter submitted that you had overall responsibility for Patient A.

On charge 3b), Ms Quinton-Carter submitted that you were the responsible midwife. She reminded the panel that you acknowledged, in an email to Ms 2, the action that needed to be taken namely to undertake another GTT. She submitted that you would have been responsible to document any follow up treatment, care or action to follow the abnormal GTT result was documented. Ms Quinton-Carter also reminded the panel that Ms 2 in her evidence stated that she telephoned you, to which there was no response, and then had to email you. She stated that it would be the case loading midwife’s responsibility to document the subsequent treatment and action required.

In respect of charge 7a), Ms Quinton-Carter submitted that Colleague O and Ms 2 stated that you were an experienced senior midwife. As a result, she submitted that they would have expected you to be able to identify Patient D’s learning difficulty at the booking appointment.

Ms Quinton-Carter acknowledged that you stated that Patient D’s learning difficulties would not have been apparent to you. She drew the panel’s attention to Patient D’s safeguarding notes. She submitted that as soon Patient D was taken over by another

midwife, Patient D's learning difficulties were apparent to that midwife and action was taken immediately. Ms 2 also stated in her evidence that she met Patient D and noted that the learning difficulties were apparent to her and it would be unusual for an experienced midwife not to be aware.

With regards to charge 7b), Ms Quinton-Carter drew the panel's attention to your own entry in Patient D's safeguarding notes on 6 February 2017. At 14:52, you recorded "Referral made to safeguarding…" Ms Quinton-Carter therefore submitted that you were aware of evident safeguarding issues at the time of the booking appointment.

Ms Quinton-Carter also submitted that the safeguarding notification form was sent three weeks later. She reminded the panel that it had heard evidence that these forms should have been sent 24 to 48 hours after the safeguarding issues were identified.

Ms Quinton-Carter made no positive submissions in respect of charges 8a) and 8b). She provided some explanatory comments to assist the panel.

With regards to 8c) and 8d), Ms Quinton-Carter submitted that while you may not have been responsible for booking the appointment for Patient E, on 7 March 2017, she submitted that you accept that you were the responsible midwife for Patient E. She submitted that you had undertaken a risk assessment for Patient E later that same day and drew the panel's attention to your entry in this regard. In respect of charge 8c) Ms Quinton-Carter reminded the panel that Ms 2 stated that there would need to have been a consultant referral made as a result.

Ms Quinton-Carter submitted that, notwithstanding that you may not have booked Patient E, as the responsible midwife for Patient E and the proximity in time you had undertaken a risk assessment, there is a case to answer in respect of charge 8c) and 8d).

With regards to charge 10a), Ms Quinton-Carter reminded the panel of how the charge was worded – "At or around". She submitted that the panel are not

constrained by the question as to whether you were responsible for the booking appointment of Patient G.

Ms Quinton-Carter reminded the panel of the evidence of Ms 2 who stated, regarding the safeguarding notification form, that it would have only been Colleague P's responsibility if there had been no prior awareness of the issues. Ms Quinton-Carter reminded the panel that there was safeguarding supervision between you and Ms 2 the day before Patient G's booking appointment. She drew the panel's attention to the safeguarding notes of Ms 2 which stated that you were aware of the information shared in advance by the police in respect of Patient G. Ms Quinton-Carter reminded the panel that Ms 2 stated, therefore, that it would have been your responsibility to see the safeguarding notification through in conjunction with Colleague P. Ms 2 also stated that, in her view as the safeguarding officer, it would have been your responsibility irrespective of whether you had booked Patient G.

With regards to 10b) Ms Quinton-Carter, once again, reminded the panel that the charge is worded "at or around…". Ms Quinton-Carter submitted that Ms 2 stated that, as the case midwife, you were responsible. She drew the panel's attention to the risk assessment and submitted that you would have been responsible to ensure that the risk assessment was followed up as soon as possible and ensure it was completed.

Ms Quinton-Carter made no positive submissions in respect of charge 10c). She provided some explanatory comments to assist the panel.

With regards to 10d), 10e) and 10f), Ms Quinton-Carter submitted that you were the responsible midwife for Patient G. She drew the panel's attention to the patient notes for Patient G and submitted that Colleague P did not take over responsibility for Patient G until early May 2017. She submitted that just because you did not book Patient G, does not exempt you from any responsibility thereafter. She submitted that Ms 2 stated that she would have expected to have seen a further entry in the safeguarding notes between 3 April 2017, when you were made aware of the concerns of Patient G, and 5 May 2017 when Colleague P had taken over.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor. He reminded the panel of the principles set out in *R-v-Galbraith*, 73 Cr. App. R 124 CA. The panel took into account the case of *Galbraith* in which Lord Lane C.J. laid down a two limbed approach to the evidence:

> *'If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. [Limb 1].*
>
> *The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. [Limb 2].*
>
> *Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, is his duty, upon a submission being made, to stop the case.'*

The panel also reminded itself that if a charge alleges a failure the NMC must prove a duty on the registrant to carry out the actions alleged as a failure. It applied the test in *Galbraith* to each charge and each part of each charge separately.

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

With regard to charge 3a) the panel considered that the evidence of Ms 2 was quite clear in that there was a joint responsibility to obtain the results of the GTT in respect of Patient A. It noted that Ms 2 accepted that there was a failure on her part, but she also stated that she emailed you in this regard. The panel noted that you acknowledged this and it appears you did not follow up on this. The panel bore in mind that Ms Quinton-Carter submitted that there was a responsibility for you to ensure or to make certain something was done. Therefore, there remains a case for you to answer in respect of charge 3a).

In respect of charge 3b), the panel noted that Ms 2 stated she tried to contact you. When she could not reach you by telephone, she sent you an email which the panel have seen. The panel noted that you acknowledged the email and, as the responsible midwife, stated you would follow up on this and deal with it. It appears that you did not follow up on this as you said you would and the panel has yet to hear your evidence in this regard so as it stands there remains a case for you to answer in respect of charge 3b).

With regards to 7a), the panel noted that you have been described as an experienced senior midwife by the witnesses. It also noted that you had documented in records that Patient D informed you that she had dyslexia. The panel was of the view that it needs to hear your evidence as to why you did not or should not have identified the learning difficulties of Patient D. Therefore, there remains a case for you to answer in respect of charge 7a).

In respect of 7b), it appears that you did not have a discussion in regards to safeguarding. Therefore, there remains a case for you to answer in respect of charge 7b).

The panel noted that the NMC made no positive submissions in respect of charge 8a) and 8b). Having conducted a comprehensive review of the evidence available to it at this stage, the panel determined that there was no, or no sufficient, evidence before it for charge 8a) and 8b) to be properly capable of being found proved. The panel also looked at the specific wording of these charges which state “at the booking appointment” and noted that the booking was done by Colleague P. It was therefore of the view that you had not participated in the booking of Patient E. The panel therefore found there to be no case for you to answer in respect of these charges.

With regards to charge 8c and 8d), the panel took account of the specific wording of these charges which state “failed to offer and/or failed to document an offer”. The panel was of the view that this can be interpreted as having occurred at the time of the booking appointment on 7 March 2017 or sometime after. It also bore in mind that you were the responsible midwife of Patient E at that time and had undertaken a

risk assessment later that day. Therefore, there remains a case for you to answer in respect of charge 8c) and 8d).

In respect of charge 10a) and 10b), the panel took account of the specific wording of this charge which stated “at or around the time of the booking appointment…” It also bore in mind that Colleague P booked this appointment however, it noted that you had been briefed by Ms 2 in supervision the day before the booking in appointment. Therefore, as the responsible midwife, the panel is of the view that there is a prima facie case that you had a responsibility to complete the safeguarding notification and complete a risk assessment. Therefore, there remains a case for you to answer in respect of these charges.

The panel noted that the NMC made no positive submissions in respect of charge 10c). Having conducted a comprehensive review of the evidence available to it at this stage, the panel determined that there was no, or no sufficient, evidence before it for charge 10c) to be properly capable of being found proved.

In respect of charges 10d), 10e) and 10f), the panel bore in mind that it heard evidence that you were the responsible midwife, and that you were aware of the concerns raised in regards to Patient G in supervision with Ms 2 and it appears that you had not followed up on this. It also noted that it appears that you were late in submitting the safeguarding notification. It did note on 19 April 2017, you had updated the risk assessment but it does not appear to be sufficient in light of the risk factors identified for Patient G after the initial booking appointment. Therefore, there remains a case for you to answer in respect of this charge.

Decision and reasons on application to amend the charge

During its deliberation on the facts, the panel, on its own volition decided to amend the date in charge 14(b) and 14(c). It was clear from the statements and exhibits in the case that you had a meeting with One to One Midwives, led by Colleague O, in May 2017 and not June 2017 as the charge suggests.

The panel was of the view that the proposed amendment would provide clarity and more accurately reflect the evidence.

14) In a Pulse investigation meeting on 25 September 2018 you gave inaccurate information to the effect that:

b) You did not receive any letter regarding a meeting in ~~June~~ May 2017 led by someone called Colleague O
c) You were “terminated” at the meeting in ~~June~~ May 2017

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 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 you and no injustice would be caused to the NMC by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

This case is made up of three NMC referrals that have been joined.

On 10 June 2017, the NMC received the first referral from the Head of Clinical Services on behalf of One to One Midwives. At the time of the concerns, you had been working as a midwife.

You joined One to One Midwives in 2014 as a caseload midwife then progressed to being a team leader before being promoted to Head of Clinical Services in July 2016. Concerns were raised regarding your performance which led to your suspension and then subsequent demotion back to a caseload midwife in January 2017.

Further concerns then arose into both your expense claims and basic midwifery practice. It is alleged that a number of inaccurate expense claims for travel were made.

Regarding your midwifery practice, it is alleged that there are concerns relating to eight patients. These include failings in respect of safeguarding, care and documentation. It is further alleged that there were numerous record keeping errors that were identified following an audit of your caseload. This was conducted following initial concerns that had been raised in respect of Patient A.

Ms 2 and Ms 3 were tasked with reviewing the safeguarding and clinical concerns respectively which they documented and sent to Colleague M. Colleague M and Colleague O reviewed the relevant finding and concurred therein.

You were suspended on 21 April 2017 and dismissed on 26 May 2017, by way of a formal letter, in connection with the fraudulent/inaccurate expense claims. One to One Midwives, did not therefore, complete their internal disciplinary process regarding their concerns in relation to your clinical practice.

The second referral was made by the NMC itself on 16 May 2018.

You worked your first shift for Pulse Nursing Agency on 8 August 2017. The allegations concern numerous elements of dishonesty arising out of false information latterly discovered to have been provided by you on your application form, during an investigation meeting and a disciplinary hearing with Pulse Nursing Agency through 2017 and 2018.

Decision and reasons on the facts

At the outset of the hearing, you made full admissions to charges 1(a), 1(b), 1(c), 1(d), 1(e), 2(f), 3(c), 3(e), 3(f), 3(g), 5(a), 6(a), 6(b) 6(c), 6(d), 6(e), 6(f), 6(g), 6(h), 9(a), 11(c), 11(d), 12(a), 12(b), 12(c), 12(d), 13(a)(i), 13(b)(i), 13(c)(i), 13)(d)(i), 14(a), 14(f), 15(b)(i), 15(e)(ii), 15(f)(i), 16(c), and 17(c)(i).

The panel therefore finds charges 1(a), 1(b), 1(c), 1(d), 1(e), 2(f), 3(c), 3(e), 3(f), 3(g), 5(a), 6(a), 6(b) 6(c), 6(d), 6(e), 6(f), 6(g), 6(h), 9(a), 11(c), 11(d), 12(a), 12(b), 12(c), 12(d), 13(a)(i), 13(b)(i), 13(c)(i), 13)(d)(i), 14(a), 14(f), 15(b)(i), 15(e)(ii), 15(f)(i), 16(c), and 17(c)(i) proved in their entirety, by way of your admissions.

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

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:

- Colleague O: At the concerning time, the Head of safeguarding at One-to-One Midwives;

- Colleague M: At the concerning time, a Clinical Lead Coach at One-to-One Midwives;
- Ms 1: At the concerning time, a Clinical Governance Manager at One-to-One Midwives;
- Ms 2: At the concerning time, a Safeguarding Practitioner at One-to-One Midwives;
- Ms 3: At the concerning time, a Senior Midwife at One-to-One Midwives;
- Ms 4: At the concerning time, a Clinical Nurse adviser at Pulse Nursing Agency;
- Mr 5: At the concerning time, a National Clinical Lead at Pulse Nursing Agency;
- Ms 6: At the concerning time, an Employee Relations Officer in the Human Resources department of the Independent Clinical Services;
- Colleague P: At the concerning time, a Recruitment Consultant at Pulse Nursing Agency;

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

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

The panel considered the evidence of Colleague O to be credible. The panel found her to be fair, reliable, professional and assisted the panel as much as she could considering the concerns occurred a few years ago. She admitted when she could not remember and relied on her witness statement to assist her. The panel was of the view that she was clear and articulate with her answers.

The panel considered the evidence of Colleague M to be credible. It found her to be professional, considered, careful and relied heavily on the documentary evidence. The panel was of the view that the passage of time has impacted on her memory. As a result, she found it difficult to expand on any questions outside of the documentary evidence she had. It noted that she conceded if she could not recall certain details and the panel considered her to be helpful by recalling as best as she could in response to questions asked. Overall, the panel noted that she was fair, balanced and reliable.

The panel considered the evidence of Ms 1 to be credible. It noted that she was professional and assisted the panel as best as she could in light of the fact that her role was limited to supporting the investigating officer and taking notes. As a result, she could not expand on anything else as she was not actively involved in the investigation. The panel did however note that at times that Ms 1 overstepped her role in supporting the investigating officer. However, this did not undermine her reliability or detract from her evidence overall. The panel noted that she was fair and balanced.

The panel considered the evidence of Ms 2 to be credible. It noted that she was professional and had considerable knowledge of safeguarding. As a result, she was able to assist the panel with the process and understanding policies. The panel also noted that, despite the passage of time, she was more able to recall events than other witnesses, discussions and action taken using the documentary evidence. She did acknowledge the responsibilities of Ms 7 within her evidence and was fair, balanced and reliable.

The panel considered the evidence of Ms 3 to be credible. The panel noted she had a good recollection of the concerns. Further, she was knowledgeable in her duty as a midwife in that she was able to provide the panel with more information in addition to the documentary evidence it had before it. The panel also noted that she accepted her own responsibilities in relation to Patient A. Overall, the panel considered her to be reliable, consistent, fair and balanced.

The panel considered the evidence of Ms 4 to be less helpful. The panel noted that the passage of time appeared to have an impact on her recollection of events. The panel also noted that although she sought to be helpful, she could not provide it with clear answers even when taken to documentary evidence particularly in regards to her own interview notes. Ms 4 could not elaborate on what she put in her witness statement nor was she able to explain it very well.

The panel considered the evidence of Mr 5 to be credible. It noted that he gave clear evidence to the best of his understanding. It noted that despite the passage of time, he did his best to assist the panel. Overall, the panel considered him to be fair, reliable and balanced.

The panel considered the evidence of Ms 6 to be professional and concise. Despite the passage of time, she did her best to assist the panel. The evidence she did provide was limited due to its discreet nature. However, overall, it found her to be credible.

The panel was little helped by the evidence of Colleague P. While her evidence was limited due to its discreet nature, she was not very clear in her answers. It noted that

the passage of time had significantly impacted her recollection of events. The panel noted she tried her best to assist the panel but struggled in this regard.

When considering your credibility as a witness the panel bore in mind that you were unrepresented, unfamiliar with the hearing process and struggled to recall events which had taken place a significant time ago. Additionally, you were a person of good character with the consequences to both your credibility and propensity. It also took account of the references you supplied to the panel. Whilst you appear to have sought to assist the panel by giving evidence and tender yourself for cross examination to the best of your ability, it found your evidence often inconsistent and contradictory. When cross examined by the case presenter and taken to various documents you made significant concessions which resulted in your admitting to additional charges. In respect of various areas of contested evidence the panel have been unable to accept your account, particularly where it was contradicted by witnesses called on behalf of the NMC and consequently have rejected your account.

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

Charge 2

2) And your actions specified in charge 1 were dishonest and/or lacking integrity in that:

Sub-charge

a) In respect of charge 1a)

(i) you knew that you had not travelled to Birmingham for training on 6 October 2016

This sub-charge is found proved.

The panel noted that during the course of your evidence, you accepted this charge. You knew that you had not travelled to Birmingham for training on 6 October 2016.

The panel therefore found this sub charge proved.

Charge 2

2) And your actions specified in charge 1 were dishonest and/or lacking integrity in that:

a) In respect of charge 1a)
   (ii) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

b) In respect of 1b)
   (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

c) In respect of charge 1c)
   (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

d) In respect of 1d)
   (i) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

These sub-charges are found not proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. It had to now determine what your actual state of mind was as to the facts and decide whether your conduct with that state of mind would be considered dishonest by the standards of ordinary honest and decent people.

The panel noted that you had accepted you claimed expenses for travel you had not undertaken. It now had to consider whether this was due to a genuine lack of understanding of the expenses system or if it there was a deliberate intention to mislead One to One Midwives. In order to find the dishonesty proved it would have to be satisfied that the latter was your state of mind.

The panel bore in mind that in your oral evidence that you stated that you had pre-populated the expense form the night before you were to travel to Birmingham for GAP. However, your evidence was that you were informed by email, which you picked up that morning, that you were no longer required to travel to Birmingham and you were to attend another meeting instead at the local Trust. You then stated that you submitted the expense form without making the necessary amendments and that it was an error in documentation and record keeping. You only realised your error when it was brought to your attention.

The panel also noted that you made numerous subsequent expense claims without supporting evidence which you accepted was wrong. Based on your oral evidence, it appeared to the panel that your system or lack thereof, for dealing with expense claims was cavalier and chaotic. You also admitted that you “did not know what you were doing” when you were completing these expense forms.

The panel also bore in mind that the NMC witnesses accepted that there were shortcomings in the expenses and accounts system which lacked checks and balances. However, the panel noted that you appeared to have a very cavalier attitude towards this inefficient accounting system. With regards to the other expense forms, you stated that you had done the same for more mileage than you had actually claimed at times. However, it was not necessarily to the locations set out in your expense claims forms.

The panel heard evidence that you made notes on pieces of paper and kept them in your diary. These notes were never produced in evidence, your diary entries did not match your expense claims on occasions and records could not be verified on the company computer system at times. You also stated that you thought it “swings and roundabouts” in that you thought the amount claimed to travel was the same. It was

of the view that you were careless when submitting expense forms and did not give the forms the scrutiny they deserved.

The panel found that you did not give your expense claims the priority that it required, combined with the submissions process which was not robust. The panel were unable to conclude to the requisite standard that your conduct was either dishonest or lacked integrity.

Therefore, the panel found these sub-charges not proved.

Charge 2

2) And your actions specified in charge 1 were dishonest and/or lacking integrity in that:

Sub-charge

e) In respect of charge 1e)

(i) you knew that you had not travelled to the Warrington PAC on 31 March 2017

This sub-charge is found proved.

The panel noted that during the course of your evidence, you accepted this charge. You knew that you had not travelled to Warrington PAC on 31 March 2017.

The panel therefore found this sub charge proved.

Charge 2

2) And your actions specified in charge 1 were dishonest and/or lacking integrity in that:

Sub-charge

e) In respect of charge 1a)

(ii) you intended to mislead One to One Midwives as to this and thereby obtain expenses for travel you had not undertaken

This sub-charge is found not proved

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 as set out above.

As with charges 2(a)(ii), 2(b)(i), 2(c)(i) and 2(d)(i) above, the panel concluded that your actions fell somewhere short of amounting to a lack of integrity when completing expense forms in advance. You should have ensured that they were accurate before submitting them.

Therefore this sub-charge is found not proved.

Charge 3

3) In respect of Patient A you:

Sub Charge

a) Failed to ensure that the abnormal result from a Glucose Tolerance Test (GTT) of 8 March 2017 was recorded in the patient's notes
b) Failed to document/adequately document the treatment, care or action which was to follow the abnormal GTT result from 8 March 2017

These sub-charges are found proved.

During the course of your evidence, you accepted both of these sub-charges. The panel therefore finds both of these sub-charges proved.

Charge 3

3) In respect of Patient A you:

Sub Charge

d) On 19 April 2017 you informed Colleague M that you had contacted the relevant hospital and that the repeat GTT test was normal

This sub-charge is found proved.

In considering this charge, the panel took account of the evidence of Colleague O, Colleague M, Ms 3 and you.

The panel noted that there were conflicting accounts regarding this charge.

The panel took account of the witness statement of Colleague O, where she stated:

> *"…[Ms 3] (the midwife who originally took the bloods from Patient A), had been informed by Royal Liverpool Blood Laboratory that the GTT was abnormal on 9th March 2017… [Ms 3] took the appropriate action in notifying [Ms Foster] of the abnormal result…As shown in the interview transcript, between [Colleague M] and [Ms Foster], [Colleague M] had contacted the registrant on 19th April, to enquire who she had spoken to at the hospital regarding Patient A's bloods. This conversation was witnessed by [Ms 9]…The registrant reported during this conversation that the GTT had been taken and was normal and therefore no further action was required, despite what she acknowledged from [Ms 3]…"*

The panel also took account of a statement by Ms 9 who had witnessed the telephone conversation on speaker phone.

"…Statement from [Ms 9] as requested by . On the evening of 19/4/17 I was at St James (head office). asked myself if I would sit in on a conversation between [Ms Foster] and herself as she felt [Ms Foster] was stating conflicting information. During this call [Ms Foster] was asked about a gtt for lady . [Ms Foster] stated that the GTT had been taken at the LAT and was normal, and there was no further action required…" [sic]

The panel noted that Colleague O reiterated her witness statement in her oral evidence. This was also reaffirmed by Ms 3 in her oral evidence. They stated that you told them you had contacted the hospital regarding Patient A and the hospital confirmed to you that the repeat GTT was fine.

The panel noted that in your oral evidence, you stated that you attempted to contact the hospital but had difficulties in attaining the information from the hospital due to confidentiality concerns they had. You also stated that you had spoken to Patient A who informed you that the test result was normal. However, your evidence in relation to the timings was confusing and you often changed its sequencing.

The panel noted that it found your evidence to be inconsistent and noted that your response to the charge changed. It also noted that, during cross examination, you never asked Colleague M or Ms 3 about the confidentiality concerns the hospital had. Additionally, it appears that they were not made aware of this.

In light of the conflicting accounts, the panel preferred the evidence of Colleague M and Ms 3. It noted that both Colleague M and Ms 3 were clear in what you relayed to them during the telephone conversation.

On the balance of probabilities, the panel concluded that it was more likely than not that on 19 April 2017 you informed Colleague M that you had contacted the relevant hospital and that the repeat GTT test was normal.

The panel therefore found this sub-charge proved.

Charge 4

4) And your action specified in charge 3 d) was dishonest in that:

Sub Charge

a) You knew that the repeat GTT test had not been conducted
b) You knew that it was wrong to state that a GTT test had been repeated and was normal
c) You intended to mislead colleague M into thinking that you had followed up on the abnormal GTT result and that no further action was required

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague M, Ms 3 and your evidence. It bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 as set out above.

Ms 3 stated that she would have expected you to follow up on the abnormal GTT result especially after you acknowledged it and confirmed you would take action namely in response to the email she had sent you on 9 March 2017, requesting a repeat GTT in March 2017. The panel had already concluded that you informed Colleague M and Ms 3 that you had contacted the relevant hospital and stated that the repeat GTT test was normal. It also bore in mind that this was after Ms 3 had noted on 20 April 2017 that the repeat GTT results had not been recorded. Further, on 19 April 2017 Colleague M had brought the fact that you had not done the repeat GTT nor followed this up to your attention. The panel noted that at this moment you could have admitted this and dealt with it accordingly. Instead, you went on to state that the GTT had in fact been done by the hospital despite there being no documentary evidence to support this.

The panel also noted that you stated you spoke to Patient A regarding her results and just accepted what she said. The panel noted that your account conflicts with Ms 3 who stated that she spoke to Patient A on 22 April 2017 and Patient A stated that she had not been made aware that her GTT results were abnormal.

Despite this, Colleague M and Ms 3 both state that as an experienced midwife, you should have known not to just accept the word of one of your patients, particularly, regarding something that Ms 3 described as something quite serious.

Your recollection of who you spoke to and when was confused and changed as you gave your evidence.

You told the panel that the results for Patient A were not in keeping with how she presented and you felt the test had provided a false result. Nevertheless, it was not disputed that the potential serious consequences of such a result required a repeat test to be undertaken.

Therefore, the panel, in reviewing your evidence set against that of the witnesses from the NMC, are of the clear view that you were dishonest. The panel were of the view that you were dishonest in that you knew that the repeat GTT test had not been conducted and inaccurately informed Colleague M to prevent this omission being identified.

Applying the standards of ordinary decent people, the panel considered that, your actions in charge 3(d) were done despite knowing the GTT had not been conducted. Further, you knew this was wrong and in knowing this, intentionally tried to mislead Colleague M. The panel concluded that on the balance of probabilities your actions in relation to charge 4(a), 4(b) and 4(c), based on the test in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] UKSC 67, were both subjectively and objectively dishonest.

Therefore, these sub-charges are found proved.

Charge 7

7) In respect of Patient D:

Sub Charge

a) Failed to identify and/or document the Patient's learning disability at the booking appointment on 6 February 2017

This sub-charge is found proved

In reaching its decision, the panel took account of the evidence of Colleague O, Ms 3 and your evidence.

The panel noted that Colleague O, in her witness statement stated, regarding your safeguard notification for Patient D:

> *"…The notification form outlined very low-level safeguarding concerns, and a result Patient D was not open to the safeguarding team. These concerns were reported by the registrant as low-level, however, they were later found not to be low-level…it was noted by another midwife during her visit to Patient D there were some concerns regarding parenting of another child for this patient. This new midwife…noted these concerns…and made appropriate enquires with the Health Visiting team regarding her concerns. It was then identified that the patient actually had significant input social services and was registered disabled and classified as a vulnerable adult.*
>
> *As Head of Safeguarding, I would have expected that the registrant would have identified this at booking due to the patient's presentation, and due to the questions asked about the patient's history in the booking appointment…"*

The panel noted that Colleague O reaffirmed this in her oral evidence. She and Ms 3 both described you as an experienced midwife who would have been expected to be

able to identify Patient D's learning difficulty at the booking appointment on 6 February 2017.

The panel also noted that in your oral evidence, you stated that during the booking appointment with Patient D you said you had what you described as an "inkling" in regards to Patient D's learning difficulties. The panel also bore in mind that in Patient D's records you have noted, in an entry dated 6 February 2017, that Patient D has dyslexia.

However, despite this, it appears to the panel that you did not follow up on this. When you were asked about this, you stated that you did not want to be judgemental and "saw people as they are". In your evidence you told the panel that Patient D and her child were clean and well dressed.

The panel was not persuaded by this. It was of the view that, as an experienced midwife, you would have known that you had a duty to explore safeguarding needs and you did not do this. It considered that being judgemental is irrelevant as the most important thing is to ensure people are safeguarded and get people the support they need.

It also took account of the subsequent entries made by the midwives who saw Patient D after you. It appears that Patient D's learning difficulties were quite significant. Despite this "inkling" you had, which you documented on the safeguarding section of Patient D's records, it appears to the panel that you have not explored this sufficiently with any of your colleagues or the safeguarding supervisor. Further, you did not document it thoroughly as others had done.

The panel found it difficult to accept that you found nothing to alert you to Patient D's learning difficulties, when Colleague O and Ms 3 both stated that it was quite apparent to anybody trained in this area.

The panel determined that there was a duty for you to explore any safeguarding needs identified and you were not professionally inquisitive in this regard. As a result, the panel determined that on 6 February 2017, you failed to identify and/or

document the patient's learning disability at the booking appointment on 6 February 2017.

This sub-charge is therefore found proved.

Charge 7

7) In respect of Patient D:

Sub Charge

b) Failed to send a safeguarding notification form in a timely manner following the booking appointment on 6 February 2017

This sub-charge is found proved

In reaching its decision, the panel took account of the evidence of Colleague O and your evidence.

The panel noted that Colleague O, in her witness statement stated, regarding your safeguard notification for Patient D:

"…The safeguarding notification form was again late, 3 week [sic] after the booking appointment…"

The panel bore in mind that the booking appointment was on 6 February 2017, however the date underneath your signature on the Safeguarding Notification Form was 23 February 2017. The panel heard evidence from Ms 2 who stated that these forms should have been sent 24 to 48 hours after the safeguarding issues were identified. In light of this, the panel noted that you did not send the Safeguarding Notification Form in a timely manner.

The panel noted that Ms 2, in her witness statement stated:

> "…*As discussed previously, on 20 February I sent an email to the registrant to request an appointment for a supervision session. Due to no response, I sent a second request on the 27 February and a further request on the 14 March. Following this third request, we agreed to have a supervision session on the 28 March 2017, the registrant emailed to cancel the scheduled session for that day. It was then rebooked and the supervision was held on 3 April 2017. This is a significant delay in organising and attending supervision which, as discussed previously, in my opinion could cause delay in completing the risk assessment and potentially put patients at the risk of harm*…"

The panel bore in mind that you had returned to the role in February 2017 as a case loading midwife. It noted that, in your oral evidence, you stated that you thought that you had done the right thing by completing the safeguarding notification tab, you stated that you were not trained and did not understand the safeguarding notification process in terms of the forms. In light of Ms 2's witness statement, it would appear to the panel that your first supervision session could have been on 3 April 2017.

However, the panel bore in mind that it heard evidence from Ms 2 who stated that you had cancelled supervision in the previous weeks. Ms 2 informed the panel that you did not have a lot of safeguarding cases. The panel also noted that witnesses stated that you are an experienced midwife. It was of the view that as an experienced midwife you would have come across safeguarding in your previous roles outside of community case loading work. It noted that at 14:52 on 6 February 2017 in the safeguarding tab, you recorded "Referral made to safeguarding…" Since the booking was undertaken by you the panel noted that you were the responsible midwife and were aware of the safeguarding concerns. It also noted that you could have sought advice from another colleague or a supervisor but you did not take the steps to have this discussion and subsequently did not submit the safeguarding notification form in a timely manner.

In light of this, the panel concluded that you failed to send a safeguarding notification form in a timely manner following the booking appointment on 6 February 2017.

Therefore, this sub-charge is found proved.

Charge 7

7) In respect of Patient D:

Sub Charge

c) Failed to action the request for a social care enquiry as requested by Colleague N on 27 February 2017

This sub-charge is found not proved

In reaching its decision, the panel took account of the evidence of Ms 2 and your evidence.

The panel noted that Ms 2, in her witness statement, stated:

> "…*The registrant recorded these concerns in the safeguarding record following the booking appointment on 6 February, however, the safeguarding team were not notified of the concerns until the 23 February following receipt of the safeguarding notification report. There was no explanation…given for the delay in notifying the safeguarding team. However, following receipt of the notification, [Colleague N], Named Midwife, on 27 February in my absence requested that the registrant complete an information enquiry with social care as part of the risk assessment*…"

The panel was mindful that the account of Colleague N was hearsay. She had not attended to give evidence at this hearing and had not provided a formal witness statement. There was no way to test what she said and no corroborating evidence.

In light of this, the panel was of the view that the NMC had not provided sufficient evidence to persuade it that you failed to action the request for a social care enquiry as requested by Colleague N on 27 February 2017.

Therefore, the panel found this sub-charge not proved.

Charge 7

7) In respect of Patient D:

Sub Charge

d) Failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017

This sub-charge is found proved

In reaching its decision, the panel took account of the evidence of Colleague O, Ms 2 and your evidence.

The panel noted that Colleague O, in her witness statement, stated:

"…*Patient D was addressed in supervision on 3rd April, which subsequently the registrant had failed to follow up on the safeguarding actions as directed in supervision*…"

Ms 2 also confirmed in her witness statement and her oral evidence that she had met with you on 3 April 2017. The panel took account of the safeguarding section of Patient D's records. An entry made by Ms 2, dated 3 April 2017 at 22:36:35, stated:

"*Safeguarding supervision with [Ms Foster], named midwife on 3rd April 2017*…"

The panel also noted that there was an action documented in the plan for Patient D:

"…[Ms Foster] to liaise with the Health Visitor to identify if there are any concerns related to this family..."

However, the panel noted that it appears this action was not undertaken by you. The next entry was made by Ms 2 on 10 June 2017.

The panel noted that, in your oral evidence, you were unsure as to why this action had not been completed.

In light of this, the panel concluded that you failed to carry out and/or document, any action taken following the plan made at the safeguarding supervision on 3 April 2017

Therefore, the panel found this sub-charge proved.

Charge 8

8) In respect of Patient E:

Sub Charge

c) Failed to offer and/or failed to document an offer, to the patient, of a referral to a consultant following the identification of significant risk factors
d) Failed to offer and/or failed to document an offer, to the patient, of a Glucose Tolerance Test ("GTT")

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching its decision, the panel took account of the evidence of Colleague O and your evidence.

The panel noted that Colleague O in her witness statement stated:

> "…*This patient was allocated to the registrant and booked by her on 7th March 2017. During the booking appointment Patient E disclosed to the registrant*

that she had had a third degree tear and a post-partum haemorrhage (PPH) in 2005, as documented by the registrant…

…The registrant has documented in the obstetric history of the booking notes, that Patient E had a 33 week baby born in 2010, followed by postnatal depression. Both of these are significant risk factors… there is minimal documentation regarding the patient's obstetric history to provide an adequate summery [sic] of the previous concerns and subsequent outcomes which would affect the care provided by the registrant or any other clinician involved. I would expect her to complete this and obtain the relevant information, so that this is reflected correctly within the records…"

The panel noted that Colleague O confirmed this in her oral evidence.

The panel took account of Patient E's records and noted, in the risk assessment section, you have made an entry on 7 March 2017. Next to "Risk Identified Comments", you have entered "Depression". However, the panel noted that in the "Care Plan" section you have made no entry. Despite identifying the risk, the panel have noted you did not make any such offer in the form of a referral.

The panel noted that you stated, in your oral evidence, that Patient E was very early in her pregnancy. It also noted that you stated that if you identify a risk, you would create a plan. You also conceded that a plan would include a timeline.

The panel also noted that subsequent midwives noted other significant risk factors when they saw Patent E.

The panel was of the view that as an experienced midwife you should have known to create a care plan when you have identified a risk. However, you did not do this. In light of this, it concluded that you failed to offer and/or failed to document an offer, to the patient, of a referral to a consultant following the identification of significant risk factors.

The panel also noted that Colleague O in her witness statement said:

"…*Also for Patient E, it is noted that at booking the BMI was calculated…but no appropriate risk assessment was completed or an offer of a glucose tolerance test to screen for gestational diabetes*…"

The panel took account of Patient E's records and noted that no offer for a GTT was made.

The panel noted that in your oral evidence you stated that you would not offer a GTT to Patient E due to the early stage of her pregnancy. However, the panel was of the view that if you are going to identify a risk then this needs to be done thoroughly. It would have expected an experienced midwife to document the early stage of the pregnancy and note that a GTT should be offered at a later stage of Patient E's pregnancy. The panel noted that you did not do this. In light of this, it concluded that you failed to offer and/or failed to document an offer, to the patient, of a GTT.

Therefore, the panel found both these sub-charges proved.

Charge 9

9) In respect of Patient F:

Sub Charge

b) Failed to offer and/or failed to document an offer, to the patient, of a referral to a consultant following the identification of significant risk factors
c) Failed to offer the patient a GTT or failed to document that she had offered such

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching its decision, the panel took account of the evidence of Colleague O and your evidence.

The panel noted that Colleague O in her witness statement stated:

> "…*Patient F was booked by the registrant on the 30th March 2017. It was noted at booking that she had a [sic] obstetric history of previous caesarean section, a raised BMI (31.9) and that Patient F had a cleft lip and cleft palate at birth – all of which, in my clinical experience, would be noted as concerns by any qualified midwife which would require further review and referral… it would be expected that the registrant would be vigilant when it came to screening offered via ultrasound scan… I am concerned about the registrant's lack of accurate documentation during the booking appointment… the registrant has completed one risk assessment in which it is noted 'Previous Caesarean section – failure to progress in 1st stage of labour'. However, in …there is no documentation of risks, discussion with patient about referral or plan documented by the registrant*…"

The panel took account of Patient F's records and noted, in the risk assessment section, you have made an entry on 30 March 2017. Next to "Risk Identified Comments", you have entered "previous Caesarean". However, the panel noted that in the "Care Plan" section you have made no entry. Despite identifying the risk, the panel have noted you did not make any such offer in the form of a referral, as an example.

The panel also noted that subsequent midwives noted other significant risk factors when they saw Patent F.

The panel was of the view that as an experienced midwife you should have known to create a care plan when you have identified a risk. However, you did not do this. In light of this, it concluded that you failed to offer and/or failed to document an offer, to the patient, of a referral to a consultant following the identification of significant risk factors.

The panel also noted that you did not offer a GTT to Patient F. In light of this, it concluded that you failed to offer and/or failed to document an offer, to the patient, of a GTT.

Therefore, the panel found both these sub-charges proved.

Charge 10

10) In respect of Patient G:

Sub Charge

a) Failed to complete the safeguarding notification form at or around the time of the booking appointment on 4 April 2017
b) Failed to complete an adequately detailed risk assessment in the patient notes at or around the time of the booking appointment
d) Failed to arrange an opportunity to discuss the safeguarding concerns with the patient subsequent to 4 April 2017
e) Failed to make an entry in the safeguarding section of the patient's notes at or around the time of the booking appointment and/or subsequently
f) Failed to carry out and/or document any action taken following the plan made at the safeguarding supervision on 3 April 2017

These sub-charges are found proved

The panel noted that during the course of your evidence, you accepted these sub-charges.

Therefore, the panel found these sub-charges proved.

Charge 11

11) In respect of Patient H:

Sub Charge

a) Failed to acknowledge in the patient's notes that you were aware of Social Services involvement in this case and/or monitoring such, prior to the safeguarding supervision on 3 April 2017
b) Failed to document in the patient's notes whether the safeguarding plan agreed by the previous midwife continued to be appropriate and/or was being followed

These sub-charges are found proved

The panel noted that during the course of your evidence, you accepted these sub-charges.

Therefore, the panel found these sub-charges proved.

Charge 13

13) And your actions specified in charge 12 were dishonest in that:

Sub Charge

a) In respect of 12a)
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
b) In respect of 12b)
    (ii) you intended to mislead Pulse Nursing Agency as to the detail of your employment history
c) In respect of 12c)
    (ii) you knew that you had been dismissed from your position at One to One Midwives
    (iii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

d) In respect of 12d)

(ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague O, Colleague M, Ms 3, Ms 4 and your evidence. It bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 as set out above.

The panel noted that you had accepted a number of charges in relation to your application form, dated 15 June 2017, submitted to Pulse Nursing Agency. In order to find the dishonesty proved it would have to be satisfied that at the time you completed your application form, you knew you had been subject to an investigation while working at One to One midwives.

To assist the panel in establishing what your state of mind was in the lead up to this charge, the panel documented a timeline of all the circumstances that had taken place at One to One Midwives prior to you applying to Pulse Nursing Agency.

The panel's chronology of events are as follows:

- You were suspended from One to One (OTO) midwives, from 22 December 2016 to 21 January 2017, pending an investigation into concerns raised;
- On 4 January 2017 you were informed that there was going to be a 360-degree appraisal of you which was sent to 10 members of staff who had worked with you the most – eight responded;
- On 9 January 2017, you were sent a letter regarding a disciplinary meeting with the themes summarised;
- On 13 January 2017, you had a disciplinary meeting;
- The panel noted a letter sent to you, dated 17 January 2017, which

summarised the themes addressed in the disciplinary meeting;

- These themes were “Divert of Phone”, “Additional annual leave taken”, “Lack of understanding and awareness of clinical and operational roles within OTO”, “Non-adherence to the OTO communication policy” and “Safety Concerns”;
- In January 2017, you were demoted;
- On 21 April 2017, you were suspended again;
- On 26 April 2017, you were interviewed by Colleague M in regards to concerns about the care to women on your caseload;
- On 27 April 2017, your caseload was re-allocated;
- On 4 May 2017, you had another meeting with Colleague M and Ms 3 and notes were taken;
- On 9 May 2017, you were sent a letter referencing this meeting;
- On 22 May 2017, you attended a disciplinary meeting;
- On 26 May 2017 you were sent a dismissal letter.

The panel bore in mind the chronology of events when it took account of the application form you submitted to Pulse Nursing Agency on 15 June 2017. There is a section which asks the following:

> “*Have you been, or are you currently subject to an investigation?*”
> “*Have you ever been, or are you currently subject to disciplinary action?*”
> “*Have you ever been dismissed or suspended from a position?*”
> “*Are you currently being investigated for misconduct or received any negative feedback?*”

In response to all these questions, you have checked the “No” box.

The panel also took account of the letter dated 22 December 2016 from One to One Midwives which stated:

> “…*I am writing to inform you that it is necessary to conduct an investigation in relation to a number of concerns which have been brought to my attention*…”

The panel also took account of another letter sent by One to One Midwives dated 17 January 2017 which stated:

> "...*You were suspended from work with effect from 22nd December 2016 pending an investigation into concerns raised, which require further scrutiny to identify if any further action was required*…"

The panel was of the view that the letters were quite clear and informed you that you were subject to an investigation. However, as stated above, you ticked the "No" box.

The panel also took account of the letter you received, dated 9 May 2017, inviting you to a disciplinary hearing to be held on 22 May 2017. The panel also took account of the transcripts of the disciplinary hearing that took place on 22 May 2017. It was of the view that your participation in these disciplinary meetings would have made it apparent that you were subject of an investigation.

The panel also took account of a letter dated 26 May 2017 addressed to you by Colleague O. This letter explains details of the concerns One to One Midwives had, the investigation against you, and the responses you had provided during the course of your investigation. It also provided an outcome to the investigation where it stated:

> "*Having carefully reviewed all the facts and circumstances I have decided that summary dismissal is the appropriate sanction.*
>
> *You are therefore dismissed with immediate effect; you are not entitled to notice or payment in lieu of notice*…"

The panel was of the view that this letter made it quite clear that you were subject to an investigation, and that you were dismissed as a result. Despite this, it bore in mind that you ticked the "No" box when asked if you were subject to an investigation or if you had been dismissed from a position.

The panel noted that in your oral evidence, you stated that you had always been honest with Pulse Nursing Agency. It also noted, however, that you did not provide the panel with a satisfactory response as to why you did not provide Pulse Nursing

Agency with the appropriate information. You stated that you thought the actions of One to One Midwives were all preliminary but when it became more significant you informed Pulse Nursing Agency. You also stated that you "Buried you head in the sand" and just "wanted it to go away."

The panel bore in mind the statement of Colleague O:

> "…*In my view, there can be no doubt in [Ms Foster]'s mind that she was under investigation for gross misconduct, that she was suspended from duty and that she underwent a disciplinary hearing, and was then dismissed by letter*…"

The panel was of the view that the questions on the application form are straightforward and clear. It considered that the honest thing to have done would, in light of the chronology of events and the information you would have received from One to One Midwives, have been to tick "Yes" and provide the correct information to Pulse Nursing Agency.

The panel bore in mind that you are an experienced midwife and this would not have been the first time you would have applied for a midwifery role. The panel was of the view that you chose not to answer the questions fully in the application form. Therefore, you chose to mislead the extent of your employment history during your application for the position at Pulse Nursing Agency. It appears to the panel that by omitting this information, you have tried to hide what you had been through in order to mislead them. If you were confused about the circumstances of what happened during your time with One to One Midwives, the application form had provided you with space to explain.

The panel also took account of the NMC referral you would have received which detailed the concerns raised during your employment at One to One Midwives. This referral was dated 10 June 2017 – which would have been five days before you submitted your application to Pulse Nursing Agency. The panel was of the view that this would demonstrate that you would have known of the concerns about your practice prior to submitting your application form to Pulse Nursing Agency. This

referral also stated that you had been suspended from your role as Head of Clinical Services due to capability concerns in December 2016.

The panel was of the view that by withholding this information from Pulse Nursing Agency, your intention was to mislead them.

The panel also noted that the application form states:

> "*I declare that the information given herein is true and complete and is not presented in a way to intend to mislead*…."

By signing and dating this declaration, you are stating that the information you have provided is correct and complete. This was not the case. It also bore in mind that you had admitted 13(a)(i), 13(b)(i), 13(c)(i), and 13(d)(i) and could draw no other conclusion, in light of these admissions and your signed declaration, the you were acting in any other way than dishonestly in your application to Pulse Nursing Agency.

The panel therefore finds these sub-charges proved.

Charge 14

14) In a Pulse investigation meeting on 25 September 2018 you gave inaccurate information to the effect that:

Sub Charge

b) You did not receive any letter regarding a meeting in May 2017 led by someone called Colleague O
c) You were "terminated" at the meeting in May 2017
d) You did not receive any letter confirming your termination of contract
e) You heard nothing from the NMC concerning referral for a year after receiving a letter from the NMC in July 2017

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 4, Colleague O and your evidence.

The panel noted that Ms 4 in her witness statement stated:

> "*The agency had learned that [Ms Foster] had been suspended and dismissed from her previous post with a company called 1-2-1 Midwives, and it appeared that she had not disclosed this to 'Pulse' when making her application for a post with the company*…
>
> …*I carried out a face to face fact finding meeting with [Ms Foster] and during this we discussed the circumstances of her leaving her employment with the 1-2-1 Midwives.*
>
> *She stated that in April 2017 she was told verbally that she was under investigation and she was suspended on full pay. Two weeks later she was invited to an informal meeting where they discussed her expense claims.*
>
> *In the application form completed by [Ms Foster] in June 2017 she had stated that she had not been suspended, investigated or dismissed previously*..."

The panel noted that Ms 4 in her oral evidence could not remember much about this. The panel took account of the Record of the meeting dated 25 September 2018 between yourself and Ms 4. It has been recorded that:

> "…*Then she attended another meeting in June 2017, where a lady called [Colleague O] who was head of the safeguarding led the meeting, she did not receive any letter regarding this*…"
>
> "…*She was terminated in the meeting and states she did not receive any letter confirming her termination of her contrac*t…."

The panel also noted that Colleague O, in her witness statement, stated:

> "…*No decision was made that day at the hearing, but on 26/05/2017 I wrote to [Ms Foster] advising her that she was being dismissed without notice*…"

The panel took account of a letter dated 26 May 2017 addressed to you by Colleague O. This letter explains beings, "*Further to the formal disciplinary hearing held on Monday 22nd May 2017*…."

It also provided an outcome to the investigation where it stated:

> "*Having carefully reviewed all the facts and circumstances I have decided that summary dismissal is the appropriate sanction.*
>
> *You are therefore dismissed with immediate effect; you are not entitled to notice or payment in lieu of notice*…"

In your oral evidence, you stated that you did not receive the dismissal letter from One to One Midwives. You stated that you had received a letter or a text from them asking you to return your equipment. You were not able to expand further regarding this and the panel noted that you were not able to produce this letter.

The panel also noted that the NMC witnesses stated that this letter was sent via "the normal system". Additionally, you confirmed that you had received other correspondence from One to One Midwives prior to this.

The panel preferred the evidence of the NMC witnesses. It noted that the dismissal letter from One to One Midwives, addressed to you, made it clear that there had been a disciplinary meeting in May 2017, and that you had been terminated.

The panel also noted that within the Record of the meeting dated 25 September 2018 between yourself and Ms 4, it reads:

"…*She states she had no idea about the NMC till July 2017. She received a letter from the NMC and she had a conversation with NMC who advised she was not under investigation so she did not need to inform anyone. me* [sic]*…I found out about the NMC referrals in July 2018 – this was a yea*r…"

The panel also took account of the NMC referral you would have received which detailed the concerns raised during your employment at One to One Midwives. This referral was dated 10 June 2017 – which would have been five days before you submitted your application to Pulse Nursing Agency.

The panel also noted that Ms 8 in her witness statement, has provided a chronology detailing the contact between yourself and the NMC between June 2017 and July 2018 and beyond this date. The panel noted the numerous correspondence including letters, emails and telephone notes starting in 11 June 2017 with the referral notice.

The panel also bore in mind that you accepted charge 14(f) in that you found out about the NMC referrals in July 2018. This would have been two months before the Pulse Nursing Agency investigation meeting in September 2018 where you stated that you had not heard anything for a year after receiving the referrals in June 2017.

The panel found the nature of the content and communication did change overtime. However, the panel preferred the evidence of Ms 8 who set out clearly the correspondence you had with the NMC.

The panel was persuaded by the evidence of the NMC witnesses and on the balance of probabilities, the panel was satisfied that you had in fact heard from the NMC concerning your referrals after July 2017.

Turning to the stem of the charge, the panel was satisfied that all the sub-charges of charge 14 are proved.

Charge 15

15) And your actions specified in charge 14, were dishonest in that:

Sub Charge

a) In respect of 14a)
   (i) you knew that you had received a complaint in relation to your clinical practice from a patient
   (ii) you intended to mislead Pulse Nursing Agency as to the details of your clinical history
b) In respect of 14b)
   (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
   (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
c) In respect of 14c),
   (i) you knew that no decision to dismiss you had been taken at the meeting led by Colleague O
   (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
d) In respect of 14d)
   (i) you were sent a letter dated 26 May 2017 from Colleague O that you had been dismissed with immediate effect
   (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
   (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form
e) In respect of 14e)
   (i) you heard from the NMC when preliminary enquiries had been completed

(iii) you intended to mislead Pulse Nursing Agency as to your knowledge regarding NMC proceedings

f) In respect of 14f)

(ii) you intended to mislead Pulse Nursing Agency as to your knowledge regarding NMC referrals

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague O, Ms 4, Mr 5 and your evidence. It bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 as set out above.

The panel noted that you had already accepted charge 14(a). Colleague O in her witness statement stated:

> "…*The concerns for [Patient B] actually came to light as a result of the incident being referred by Patient B herself and not initially through One-to One*…"

The panel also noted that you stated that in your oral evidence that you had a conversation with Patient B who expressed to you that she did not want you to be her midwife due to the concerns related to the care you provided. You also confirmed that you were aware that there had been a complaint because you had met with the complainant.

The panel took account of the transcript of the interview you had with Colleague M on 26 April 2017 where you discuss these complaints. The panel also noted that you had received a referral from the NMC dated 3 August 2017 in relation to one of the patients. This would have been received before your investigatory meeting with Pulse Nursing Agency.

The panel noted that in your oral evidence that you stated that you struggled to explain why you did not tell Pulse Nursing Agency. You felt that the NMC were at the fact-finding stage, your practice had no restrictions imposed. In your oral evidence you further stated that maybe you had not understood what was going on and that you were burying your head in the sand until the NMC decided that there was a case against you. You accepted in your meeting with Pulse Nursing Agency that it looked dishonest.

The panel had already concluded that you received a letter from One to One Midwives dated 26 May 2017 confirming your dismissal. The panel noted in your oral evidence that you accepted that you knew no decision had been made about your employment following the disciplinary meeting with Colleague O. You also stated that you thought that when the word “terminated” was mentioned in the meeting, you thought that it meant the end of the meeting.

The panel heard oral evidence from Ms 4 and Mr 5 who both confirmed that your explanation of what occurred during and following your meeting with Colleague O that they understood that “terminate” meant dismissal or the end of your employment.

The panel had also already concluded that you would have been aware of the NMC referrals as it saw correspondence between yourself and the NMC. Ms 4 in her oral evidence stated that she accepted what you said regarding the NMC referrals as true and did not seek further clarification.

The panel was persuaded by the NMC evidence. The panel was of the view that by withholding this information from Pulse Nursing Agency, your intention was to mislead them. As a result, it could not draw any other conclusion than that you were acting in any other way than dishonestly.

The panel found these sub-charges proved.

Charge 16

16) In a Pulse disciplinary hearing on 23 October 2018 you gave inaccurate information to the effect that:

Sub Charge

a) One to One Midwives had put you on garden leave

This sub charge is found not proved.

In reaching its decision, the panel took account of the evidence of Ms 4 and your evidence.

The panel took account of the "Record of Disciplinary hearing" dated 23 October 2018. You were asked if you could confirm your dates of employment with One to One Midwives. You responded:

"…*I started in October 2014. It's difficult to provide an end date it would be in between April and June 2017. They kept putting me on garden leave. They were still paying me until June though*…"

The panel concluded that you did state in a Pulse disciplinary hearing, on 28 October 2018, that One to One Midwives, had put you on garden leave.

The panel turned to the stem of the charge. It took account of the "Principal Statement of Terms and Conditions of Employment" from One to One Midwives. With reference to garden leave it states:

"…*GARDEN LEAVE: The Company may at its discretion at any time including during any period of notice given by either party amend your duties and/or suspend you from the performance of your duties and/or exclude you from any premises of the Company and/or the Company's clients' premises and/or require you to work from home. During such time the Company reserves the right for you to remain employed and to receive your salary and benefits*…."

The panel bore in mind that you had been suspended before on 22 December 2016 and on 21 April 2017. It also noted that Colleague O and Colleague M stated that you had been suspended as opposed to being on garden leave. Further, the letters sent to you from One to One Midwives dated 22 December 2016 and 9 May 2017 mentioned suspensions and not garden leave.

However, it did note that you stated that you had been paid during these periods. The panel noted that this appears to conform with the definition of garden leave in the terms and conditions of One to One Midwives.

The panel concluded that suspension and garden leave appear to be the same thing. The panel therefore concluded that in a Pulse Nursing Agency disciplinary hearing on 23 October 2018 you did not give inaccurate information to the effect that One to One Midwives had put you on garden leave.

Therefore, this sub-charge is found not proved.

Charge 16

16) In a Pulse disciplinary hearing on 23 October 2018 you gave inaccurate information to the effect that:

Sub Charge

b) You were not able to state when your employment with One to One Midwives ended
d) You were never formally terminated
f) The dismissal letter from One to One Midwives did not refer to any of the issues and/or say that the dismissal was a result of any or all of the issues

These sub-charges are found proved

The panel had already established that you were sent a letter dated 26 May 2017 addressed to you by Colleague O which stated:

"*Having carefully reviewed all the facts and circumstances I have decided that summary dismissal is the appropriate sanction.*

You are therefore dismissed with immediate effect; you are not entitled to notice or payment in lieu of notice…"

The panel was of the view that this letter made it quite clear that you were dismissed following an investigation and summarised the matter of concern, your response to the concern and One to One Midwives' reasons as to why they found your responses unsatisfactory. As a result, from 26 May 2017, you were no longer employed by One to One Midwives.

Turning to the stem of the charge, the panel was satisfied that you did provide inaccurate information to Pulse Nursing Agency during the disciplinary meeting.

Therefore these sub-charges are found proved.

Charge 16

16) In a Pulse disciplinary hearing on 23 October 2018 you gave inaccurate information to the effect that:

Sub Charge

e) When you received the letter from the NMC telling you that you were being investigated, you told Colleague P (at Pulse) straight away

This sub-charge is found proved

The panel took account of the "Record of Disciplinary hearing" dated 23 October 2018 conducted by Mr 5 with you. It reads:

'*[Mr 5] - When did you advise the Company you were being investigated by the NMC?*

[Ms Foster] – *When I received the letter this year. It was a year after the first letter. I told straight away.*

[Mr 5] - *Why did you not notify the Company immediately when you had been made aware by the NMC?*

[Ms Foster] – *The NMC told me I didn't need to as I wasn't under investigation. When I received the letter telling me I was being investigated I told* [Colleague P] *straight away*.'

The panel took account of the witness statement of Ms 8 who provided a chronology of the contact between the NMC and yourself. She stated that on 14 June 2017, you were informed of an NMC referral and provided supporting documentation. The panel noted the NMC referral dated 14 June 2017.

Ms 8's witness statement continued to state that you had called the NMC to discuss this on 20 June 2017. The panel noted the telephone note from the NMC case officer detailing a call made from you, at 08:30, wanting to discuss the case.

Further, Ms 8's witness statement states that the NMC informed you about a second referral on 29 June 2017 providing supporting documentation. The panel noted this referral and the fact that it had included the original referral sent on 14 June 2017. Ms 8 then stated that on 30 June 2017, you called the NMC to confirm that you had received the documentation in relation to the second referral.

The panel also noted that Colleague P in her witness statement stated that she recalled receiving a telephone call from the NMC on 2 May 2018 in relation to you regarding employment references to assist with an investigation. She stated that the telephone call from the NMC was the first time she or Pulse Nursing Agency had any knowledge of your referral to the NMC.

The panel also noted that Colleague P had sent an email on 2 May 2018 in relation to this which stated:

"*…I have received this from the NMC this morning re [Ms Foster].*

They have called me to and asked if we can respond to this by tomorrow…"

The panel noted that Colleague P had attached the email from the NMC, dated 2 May 2018, which details the two aforementioned referrals. The panel noted that you had sent an email to Pulse Nursing Agency, dated 28 June 2018, to Colleague P. The supposition is that this was in response to the NMC's contact.

The panel was persuaded by the evidence of the NMC. You were sent two referrals in June 2017. However, in the Pulse Nursing Agency investigation meeting, in October 2018, you stated that you told Colleague P about the NMC referrals straight away. The panel noted that you would have had notice of the NMC referrals for a long period of time and, based on the evidence of Ms 8, concluded that you did not tell her straightaway.

Therefore, the panel found this sub-charge proved.

Charge 17

16) And your actions specified in charge 16 were dishonest in that:

Sub Charge

a) In respect of 16a) and 16c)
    (i) you knew that you had been suspended by One to One Midwives
    (ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history
    (iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form

b) In respect of 16b) and 16d)

(i) you knew that you had been dismissed by One to One Midwives with immediate effect from 26 May 2017

(ii) you intended to mislead Pulse Nursing Agency as to the details of your employment history

(iii) you intended to mislead Pulse Nursing Agency as regards your state of knowledge when you had completed the application form

c) In respect of 16e)

(ii) you intended to mislead Pulse Nursing Agency as to your knowledge of NMC proceedings

These sub-charges are found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. It bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 as set out above.

The panel already found 16(d) and 16(e) proved. The panel had also concluded that the letter dated 26 May 2017 would have made it clear to you that you were dismissed with immediate effect.

The panel also bore in mind that it found 16(e) proved and that you accepted charge 17(c)(i). The panel preferred the evidence of the NMC in that, you knew the NMC were investigating you in June 2017 but you did not tell Colleague P straightaway.

The only reasonable explanation that could be inferred from your failure to inform Pulse Nursing Agency was to ensure that it did not negatively impact on your employment with them.

In light of all this, the panel was of the view that by withholding this information from Pulse Nursing Agency, your intention was to mislead them. As a result, it could not draw any other conclusion that you were acting in any other way than dishonestly.

The panel found these sub-charges proved.

Fitness to Practice

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel heard evidence from you under affirmation.

You accepted that your actions amounted to misconduct but you do not accept that you are currently impaired.

You said you had reflected after your meeting with Pulse Nursing Agency, you said that it even if you were not sure, you document everything. You also stated that you should have been open and honest regarding your NMC referrals.

Since that time, you said that you have worked at various Trusts to re-skill in different areas. These Trusts included North Manchester, Oldham, Preston and Glen Clwyd. You said that working at these different Trusts exposed you to different escalation processes.

You said that in the last few years you decided to work full time at Royal Oldham Hospital. The reason for this was because you started a personal development plan and the staff at the hospital were aware of your situation and were prepared to support you. You stated that you worked at Royal Oldham Hospital with no concerns raised against you.

You said that you work on an antenatal, postnatal ward and the labour ward and are responsible for your own patients. You said that you are no longer a case loading midwife working in the community.

You said that at Royal Oldham Hospital, antenatal records are handwritten. If you are updating safeguarding, this is done electronically. You also said that on the labour ward, records are updated electronically. All records are done immediately.

You said you were often involved in work with a team that only undertakes safeguarding cases and updated the records appropriately.

You told the panel that you have successfully completed safeguarding training levels 1, 2 and 3 as recently as last year. You have also undertaken documentation courses and completed one as recently as this year. You also participated in training undertaken at Royal Oldham Hospital.

You also drew the panel's attention to the positive testimonials colleagues have written about you.

You stated that your actions would have made other midwives mistrust you. You also said that not recording your employment history accurately would affect the reputation of Pulse Nursing Agency and the midwives employed through that agency.

You stated that if your practice was impaired, it would have an impact on patients and the public. Therefore, you are going to ensure that your practice is not impaired. You also said that you would never be dishonest again and there will be no repetition of this conduct.

You said you manage things differently now. You monitor things closely, have supportive supervision which you access when needed and escalate issues more readily.

Submissions on misconduct and impairment

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

Ms Quinton-Carter invited the panel to take the view that the facts found proved amount to misconduct as your actions fell below the standards expected of a registered midwife. She submitted that the most serious charge found proved was charge 4 as it was dishonesty relating to your clinical practice. She directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Quinton-Carter moved onto 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. Ms Quinton-Carter referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She reminded the panel of the Dame Janet Smith test from the Fifth Shipman report and submitted that limbs b, c and d are most certainly engaged.

Ms Quinton-Carter also submitted that it can be argued that limb a is also engaged in light of the charge pertaining to Patient A. She reminded the panel of the concern Ms 3 had regarding the abnormal GTT result. While both Ms 3 and yourself believed that this was likely to be an anomaly, the difference in approach to this situation was clear. She submitted that you relied on an assumption and took no further action. Ms

3, aware of the potential dire consequences if this was not an anomaly, took steps to verify the abnormal GTT result.

Ms Quinton-Carter submitted that the charges considered span a two-year period. She submitted the facts proved raised public protection and public interest concerns. She also submitted that there is also dishonesty in concealing a clinical omission and concealing employment matters in order to secure a job. She submitted that this is concerning considering that you are a senior midwife, who is extremely experienced and a former Head of Services. She submitted that you have breached fundamental tenets of the profession by failing in numerous areas of the Code.

Ms Quinton-Carter submitted that it is clear that you have taken steps to remediate your practice, whilst accepting dishonesty is a difficult aspect in which to provide evidence of remediation. She also submitted that the panel will need to consider any reflection or insight you have demonstrated.

Ms Quinton-Carter invited the panel to find that your fitness to practise is impaired on both public protection and public interest grounds.

You submitted that it has been four years since these incidents and if your practice was impaired or if there was a risk of repetition, then it would have been apparent in the last four years whilst working on busy units. You referred the panel to your positive testimonials and stated that there have been no issues with your record keeping and documentation.

You submitted that you are not a danger to anyone and you are constantly updating your practice.

The panel accepted the advice of the legal assessor and adopted a two stage process accepting that there was no burden or standard of proof in determining these questions.

Firstly, the panel must determine whether the facts both admitted and proved amount to misconduct.

Misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances. He directed the panel in particular to the case *Roylance v GMC* (2000) AC 311 (331D) which states that the conduct must be serious, by omission or commission, of the standards of conduct expected. These are often best found in the Code. Further, in this context he drew the panel's attention to the words of Dame Janet Smith (*Grant*) in that it is:

> '*conduct falling seriously short of what the public have a right to expect from a registered nurse or midwife, hence I say, it is based on your own expertise'*.

Further, he directed the panel to the case of *Calhaem v GMC* (2007) EWHC 2606 which identifies that while mere negligence does not amount to misconduct, nevertheless and depending on the circumstances, negligent acts and omissions which are particularly serious may amount to misconduct.

Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Impairment, he reminded the panel, is a registrant's suitability to be on the register without restriction. He drew the panel's attention to the four limbs identified by Dame Janet Smith in the Fifth Shipman Report and of the fundamental considerations namely the need to protect the public and the need to uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession (*Grant*).

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 your actions did fall significantly short of the standards expected of a registered midwife, and that your actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

11 Be accountable for your decisions to delegate tasks and duties to other people

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times […]

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted that you accepted your behaviour amounted to misconduct. The panel identified three areas of concern:

- Clinical concerns related to safeguarding;
- Clinical concerns related to risk assessment and record keeping;
- Dishonesty.

The panel considered whether your conduct relating to safeguarding amounted to misconduct.

The panel had already determined that on numerous occasions, with different patients, you had failed to identify safeguarding concerns. With Patient D particularly, it bore in mind that you had documented that she had dyslexia. However, despite noting this, you did not act on your duty to explore any safeguarding needs identified. Additionally, it noted that you did not complete and send a safeguarding notification for Patient D in a timely manner. The panel bore in mind that you stated, in your oral evidence, that you were not trained and did not understand the safeguarding notification process. However, it noted that you did not seek advice or training regarding these safeguarding matters. In light of this, the panel concluded that your actions in this respect did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

The panel considered whether your conduct relating to risk assessment and record keeping amounted to misconduct.

The panel had already determined that with multiple patients and on numerous occasions, you failed to identify the relevant risks pertaining to each patient. The panel also noted that you did not fully document the risks identified. Further, within each of the patient's records, there is insufficient records of any discussion with the patients who had risks. Where risks had been identified, the panel noted that there were little or no records made with regard to any plans for care. The panel was of the view that the failure to make accurate records would give a misleading impression to colleagues reading the notes and potentially adversely impact the future care of the patients.

Further, your cavalier response to your travel expense claims, in the panel's view, was part of a wider concern in relation to your record keeping.

The panel concluded that your actions in this respect amounted to serious misconduct.

The panel considered whether your dishonesty amounted to misconduct.

The panel had already determined that you were dishonest with regards to the GTT of Patient A. It noted that you did not actually undertake a repeat GTT as instructed and instead informed your colleagues that this had in fact been undertaken by the hospital – despite no documentary evidence to support this. The panel also noted that you attempted to conceal your failings in this regard. It was of the view that in doing this, you attempted to give a misleading impression to your colleagues so they would think that Patient A had undertaken a repeat GTT and the results were normal. Your actions could have potentially put Patient A at a risk of serious harm.

The panel concluded that your actions in this respect clearly amounted to serious misconduct.

The panel also noted that you failed to disclose your employment history in your application form to Pulse Nursing Agency and in their subsequent investigation. It was of the view that as an experienced registered midwife, you should have known an employer would need to know about this. Further, you signed the declaration on the application form knowing you were not being transparent with your employment history. The panel could draw no other conclusion than that you were intentionally withholding the truth from your employers so that it would not impact negatively on your employment with them. Therefore, you were dishonest with Pulse Nursing Agency for financial gain.

Therefore, the panel concluded that your actions relating to the identified areas of concern, jointly and separately, amounted to misconduct**.**

Decision and reasons on impairment

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that 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 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 finds that all limbs are engaged in this case regarding your past conduct.

The panel concluded that your misconduct had in the past put patients at unwarranted risk of harm – particularly Patient A. Further, it involved multiple acts of dishonesty carried out over a period of time. Additionally, your misconduct had breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute. In the panel's judgement, the public do not expect a midwife to act as you did as they require midwives to adhere at all times to the

appropriate professional standards and to act to safeguard the health and wellbeing of patients and to behave with honesty and integrity.

The panel was satisfied that the clinical concerns arising from your misconduct, namely those relating to risk assessment, safeguarding and record keeping, should be capable of remediation. It now had to consider whether they have been remediated and whether there is a risk of repetition of similar concerns occurring at some point in the future.

Regarding insight, the panel did acknowledge that you had admitted a large number of the charges including a number of those alleging dishonesty. It also noted that you admitted that your actions amounted to misconduct.

However, during your oral evidence, the panel noted that you had little insight into the clinical areas of concern. During the panel's questions, your answers appeared superficial and lacked depth. You are an experienced midwife who was in a senior position. Additionally, the panel noted that you provided limited reassurances that the clinical concerns identified would not be repeated. There was no comprehensive acknowledgment or recognition of the impact your actions had on the patients, your colleagues or the midwifery profession.

The panel also took account of the statement you prepared for the misconduct and impairment stage. It noted that there was insufficient reflection and it not address the concerns identified in a structured and detailed manner.

Further, it appeared to the panel that you did not grasp the seriousness of the facts the panel found proved. It bore in mind that the NMC proceedings began in 2017 and noted that you have not reflected on what you had learned during this period. In light of this, the panel was of the view that your insight has not fully developed.

The panel was satisfied that the misconduct in this case is capable of remediation, whilst recognising the difficulties posed by findings of dishonesty. Therefore, the panel carefully considered the evidence before it in determining whether or not you had remedied your practice.

The panel noted that, in your oral evidence, you stated that you had undertaken some relevant training in the areas of concern like safeguarding and documentation. It also took account of the professional development plan you started with Royal Oldham Hospital. While the panel are encouraged that it touches on documentation, record keeping and safeguarding, there is no reflection within this plan and it appears to be very limited in substance.

Misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However, in the panel's judgement, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all highly relevant to any consideration of the risk of repetition, as is the nature and duration of the dishonesty itself.

The panel noted that you have been working at Royal Oldham Hospital for four years with no complaints being made against you. It bore in mind that they are aware of the NMC restrictions and are supporting you. It noted that in your role on the labour ward, postnatal ward and antenatal ward, you undertake risk assessments, you escalate concerns and have an ongoing responsibility for patients. It took account of the positive testimonials from colleagues, senior to you, who speak to your professionalism, being a pleasure to work with and attest to the fact that you are an experienced midwife. It appeared to the panel that as long as you remain in this setting, in a supportive environment, the risk you pose to patients is low.

The panel considered if this would be the case in a different setting, for example, a community setting. In this setting, working independently, the panel considered that you may not have the same support you currently have at Royal Oldham Hospital. It bore in mind the lack of insight demonstrated regarding the concerns raised when you were working independently as a case loading midwife in the community. Notwithstanding the fact that you have practised for four years without incident, the panel was not persuaded that you would not pose a risk to patients in the future working autonomously with little or no supervision.

The panel was therefore of the view that a risk of repetition remains. It determined that until such time that you can demonstrate to the panel that you understand the

seriousness of the concerns raised and your dishonesty, it decided that a finding of impairment is necessary on the grounds of public protection.

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

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

The panel was satisfied that having regard to the nature of the misconduct in this case, "the need to uphold proper professional standards and public confidence in the profession would be undermined" if a finding of current impairment were not made. For all the above reasons the panel decided that your fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Addendum to Misconduct and Impairment

The panel having handed down its determination to the parties, upon reading the determination, Ms Quinton-Carter brought to the panel's attention her understanding from the evidence that you had been in continual work with Royal Oldham Hospital for the previous four years without any issues arising. Upon questioning by the panel you clarified that, in respect of your working life, you have been employed, however, this was not full time employment but rather through Pulse Nursing Agency. Further, you explained that you have chosen not to work since February 2021 as you were awaiting the result of these proceedings.

Sanction

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

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

Submissions on sanction

Ms Quinton-Carter informed the panel that the sanction bid from the NMC is a striking-off order. She referred the panel to the NMC SG and reminded the panel that the overarching objective is to protect the public. She outlined the aggravating and mitigating factors of the case.

Ms Quinton-Carter informed the panel that you have been under an under an interim conditions of practice order since 2 October 2019. She told the panel that there was a short period where this was an interim suspension order between 8 February 2021 and 23 February 2021, however that changed after an early review requested by you. Ms Quinton-Carter reminded the panel that its determination on impairment was produced on the basis that you have been working at the Royal Oldham for the past four years and that you had been supported through your interim conditions of practice order throughout this period. However, the panel is now aware that you have only ever been working as an agency midwife and the hospital was never in a position to support you with the restrictions on your practice. You provided the NMC with an undated and unsigned PDP completed with another agency midwife and you have not worked since February 2021.

Ms Quinton-Carter stated that the most serious element of your misconduct was the dishonesty but also included failures in relation to risk assessments, safeguarding referrals and record keeping errors.

Ms Quinton-Carter submitted that you intentionally withheld the truth about your failings from Pulse Nursing Agency so that it would not negatively impact on your employment with them, therefore being dishonest for your own financial gain. You put patients at direct risk of harm as Pulse Nursing Agency were not fully aware of your employment history and the clinical concerns that had arisen. Further, you maintained your position throughout your application, investigation and disciplinary meetings at Pulse Nursing Agency.

Ms Quinton-Carter submitted that a pattern of varied dishonest conduct is incompatible with remaining on the register, particularly when a midwife deliberately breaches the professional duty of candour to be open and honest when things go wrong in their care. She submitted that the incident at One to One Midwives posed a real risk of harm to Patient A and misled colleagues. Following this, Pulse Nursing Agency were prevented from taking appropriate actions to inform any hospitals that you worked for or taking appropriate steps to protect patients. She submitted that this would have been even more important given the large number of clinical deficiencies identified whilst working at One to One Midwives.

Ms Quinton-Carter therefore submitted that the misconduct in this case is fundamentally incompatible with remaining on the register and upholding confidence in the profession.

You returned to the point of the NMC regarding your previous employment status and that you were not misleading anybody regarding your PDP. You stated that you have always been clear that it was your agency colleague who was supporting you in that regard and that Royal Oldham Hospital were not able to support you as you were not in a contract with them. However, you stated that you had been working there full time for the last four years, through the agency. You stated that it was clear that you had been solely working for Pulse Nursing Agency.

You had nothing more to add regarding sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Pattern of misconduct over a significant period of time, involving a number of patients on numerous occasions;
- Insufficient insight into your failings;
- Clinical concerns and dishonesty in the context of being an experienced midwife in a senior position and the impact your behaviour would have on the profession;
- Conduct which put patients at risk of suffering harm;
- Lack of remediation;
- Lack of remorse; and
- Pattern of dishonest behaviour relating to both clinical practice and also personal and financial gain.

The panel also took into account the following mitigating features:

- No previous regulatory concerns;
- Some admissions at the outset of and during the hearing; and
- No further regulatory findings since these matters came to light.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case.

The panel was of the view that whilst a conditions of practice order would be able to address the clinical failings in your case it would not be able to address the dishonesty. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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 panel was conscious that this was not a single instance of misconduct or dishonesty. It noted that the dishonesty was premeditated in relation to your employment with Pulse Nursing Agency for financial gain and in relation to Patient A you deliberately breached the professional duty of candour to cover up your failings. The panel was further concerned with regard to the dishonesty you displayed to colleagues in relation to the care of Patient A. The panel considered that you had shown inadequate remorse into your actions, but for the effect your actions had on yourself, nor were you able to demonstrate insight into the result your actions could have potentially had for the patient, their family, your colleagues and the reputation of the profession. The panel could therefore not be satisfied that you would not repeat your actions should you be allowed to remain on the register.

The panel determined that your dishonesty with Pulse Nursing Agency spanned a significant period of time. Further, the evidence demonstrated that you did not take full responsibility for your actions, you sought to apportion fault to colleagues and systems which were in operation at the time. The panel was therefore of the view that this was evidence of deep seated attitudinal issues. The panel particularly considered the following from *Atkinson v GMC* [2009] EWHC 3636 (Admin):

> '*There are cases where the panel, or indeed this court on appeal, have concluded in the light of the particular elements that a lesser sanction may suffice and it is the appropriate sanction bearing in mind the important balance of the interests of the profession and the interests of the individual. It is likely that for such a course to be taken, a panel would normally require compelling evidence of insight and a number of other factors upon which it could rely that the dishonesty in question appeared to be out of character or somewhat isolated in its duration or range, and accordingly there was the prospect of the individual returning to practice without the reputation of the profession being disproportionately damaged for those reasons.*'

Further, the panel was of the view that you have continued to fail to grasp the seriousness of the facts found proved and that despite the long period of time since the start of the NMC proceedings in 2017 you have not been able to demonstrate that you have reflected on what you have learned during this period or understood

the risk you put patients and colleagues in, due to your clinical failings, poor record keeping and your dishonesty.

The conduct, as highlighted by the facts found proved, was a most serious departure from the standards expected of a registered midwife. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel 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?*

Your actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would put the public at risk due to the risk of repetition of the conduct found proved. This would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how

a registered midwife should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to you 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 your own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the submissions made by Ms Quinton-Carter. She submitted that an interim order is necessary to protect the public for the reasons identified earlier by the panel in its determination until the striking off order comes into effect. She therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the ongoing public protection concerns. It determined for the same reasons as set out in its decision for the striking-off order to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, and would be inconsistent due to the reasons already identified in the panel's determination for imposing the substantive striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

That concludes this determination.