Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 6 December 2021 – Thursday 23 December 2021
Tuesday 8 March 2022 – Thursday 10 March 2022

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Mrs Claire Louise Roberts
NMC PIN:	11I0067E
Part(s) of the register:	RM: Midwife (19 September 2011)
Area of registered address:	Shropshire
Type of case:	Misconduct
Panel members:	David Evans (Chair, Lay member) Jonathan Coombes (Registrant member) Jude Bayly (Registrant member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Holly Girven (6 – 10 December 2021) Kevin Toskaj (13 – 23 December 2021) Emma Bland (8 – 10 March 2022)
Nursing and Midwifery Council:	Represented by Julian Norman, Case Presenter
Mrs Roberts:	Not present and not represented
Miss Young:	Present and represented by Laura Bayley, instructed by Thompsons Solicitors
Facts proved:	Charges 1a)i), 1a)ii), 1b), 1c), 2, 3, 4, 5a), 5b), 5c), 6
Facts not proved:	Charges 1a)iii)
Fitness to practise:	Impaired

Sanction:	Striking-off order
Interim order:	Suspension order, 18 Months

Decision and reasons on application to adjourn the hearing

The hearing began on Monday 6 December 2021. Due to unforeseen circumstances, the Chair of the panel was able to attend by video link only.

Ms Bayley, on behalf of Miss Young, whose case is being heard alongside Mrs Roberts', made an application to adjourn the hearing until Wednesday 8 December 2021 so that the panel would all be able to attend the hearing physically. She submitted that as this hearing is being heard physically, as opposed to virtually, it was important that the panel are all able to attend.

Ms Bayley stated that although Ms 5 is available on 6 December 2021, Ms 5 also has some availability later on in the dates listed for this hearing, and therefore adjourning the hearing would not cause significant delays. She submitted that proceeding when the Chair is only able to attend by video link would be unfair to Miss Young and Mrs Roberts. She submitted that Ms 5 is the expert witness and her evidence is of vital importance to the hearing.

Ms Norman, on behalf of the Nursing and Midwifery Council (NMC), stated that she did not oppose Ms Bayley's application. She stated that it was important for the panel to be physically present together, particularly during Ms 5's evidence.

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

The panel decided to adjourn the hearing until Wednesday 8 December 2021. The panel determined that it would be unfair to the NMC, Mrs Roberts, and Miss Young, for the Chair of the panel to not be present in the hearing room with the other panel members. The panel considered that adjourning the hearing may cause some inconvenience to the witnesses scheduled to give evidence, but noted that Ms 5 was available to give evidence on another date.

Decision and reasons on service of Notice of Hearing

The panel was informed when the hearing resumed on 8 December 2021 that Mrs Roberts was not in attendance and that the Notice of Hearing letter had been sent to Mrs Roberts' registered email address on 28 October 2021.

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

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

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mrs Roberts

The panel next considered whether it should proceed in the absence of Mrs Roberts. It had regard to Rule 21 and heard the submissions of Ms Norman who invited the panel to continue in the absence of Mrs Roberts. She submitted that Mrs Roberts had voluntarily absented herself.

Ms Norman referred the panel to the documentation from Mrs Roberts which included an email, dated 10 November 2021, to the NMC in which Mrs Roberts states '*not attending*

happy for you to proceed in my absence'. Ms Norman further referred the panel to an email from Mrs Roberts, dated 5 May 2021, in which she states '*I won't be attending*'.

Ms Bayley, on behalf of Miss Young, invited the panel to proceed in Mrs Roberts' absence as not doing so would be unfair to Miss Young.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Roberts. In reaching this decision, the panel has considered the submissions of Ms Norman, the representations from Mrs Roberts, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Roberts;
- Mrs Roberts has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Several witnesses are due to attend this hearing to give evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2016;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Roberts. The panel will draw no adverse inference from Mrs Roberts' absence in its findings of fact.

Details of charge

That you, a registered midwife, on 27 April 2016:

1) At around 02:30, during a telephone conversation with Mother A;
    a) Failed to carry out a comprehensive triage assessment of Baby A in that you;
        i) Failed to ask about Baby A's breathing. **[proved]**
        ii) Failed to ask about Baby A's temperature. **[proved]**
        iii) Failed to ask how Baby A was feeding. **[not proved]**
    b) Failed to refer the new born feeding guidelines. **[proved]**
    c) Failed to refer to the midwifery post-natal notes. **[proved]**

2) Failed to recognise the urgency of medical/midwifery attention for Baby A. **[proved]**

3) Failed to advise Mother A to attend the midwifery led unit immediately for a face-to-face assessment. **[proved]**

4) Failed to make a contemporaneous note of your telephone call with Mother A. **[proved]**

5) Made an inaccurate record of your telephone call with Mother A in that you;
   a) Recorded that Mother A had called “asking for advice/reassurance with regards to breastfeeding”. **[proved]**
   b) Did not record that Mother A had reported to you that Baby A had vomited brown mucous. **[proved]**
   c) Recorded that Mother A had “no other concerns”. **[proved]**

6) Your conduct in Charges 5(a) and/or 5(b) and/or 5(c), above, was dishonest in that you knowingly intended to create a misleading impression of Mother A’s concerns regarding Baby A during the telephone call. **[proved]**

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Norman.

The panel has drawn no adverse inference from the non-attendance of Mrs Roberts.

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:

- Mother A: Mother of Baby A;
- Father A: Father of Baby A;
- Ms 1: Women Services Assistant employed by the Trust
- Ms 2: Community Midwife employed by the Trust
- Ms 3: Acting Antenatal and Triage Ward Manager employed by the Trust
- Ms 4: Deputy Head of Midwifery employed by the Trust
- Ms 5: Author of the *'Midwifery Practice Report'* by instruction of the NMC prior to this hearing. Registered Midwife (Qualified in 2005)

The panel also heard oral evidence from Miss Young.

Decision and reasons on application to omit evidence

Following the oral evidence of Ms 5, Ms Bayley, on behalf of Miss Young, made a formal application to remove the following exhibits from Exhibit 1. She also submitted that her application may be relevant in respect of Mrs Roberts.

- Examination of the Newborn Policy (AGP/18)
- Initial Examination of the Newborn (Neonate) Guidelines (v2) (AGP/19)
- Neo NEWS – Enhanced Observations for Babies Policy (v1.3) (AGP/20)
- Intrapartum Care on a MLU or Homebirth (v6.12) (AGP/22)
- Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife-Led Unit Guideline (Version 4.2) (AGP/23)
- Home Birth leaflet (Version 4) (AGP/24)
- Standard Operating Procedure for Telephone Contact (v1.1) (AGP/25)
- Standard Operating Procedure for Telephone Contact (v2.0) (AGP/26)

Ms Bayley submitted that the exhibits outlined are not relevant to the charges drafted by the NMC and are prejudicial to Miss Young's case. Particularly addressing the final two exhibits, Ms Bayley submitted that they are potentially prejudicial. She reminded the panel that the community midwife team Miss Young was working in was not a triage unit. She submitted that the panel have heard evidence from Ms 5 that the two Standard Operating Procedure's (SOP) which are exhibited in the bundle relate to triage units only and therefore its existence within the documentation is prejudicial to Miss Young.

Ms Norman opposed the application. She said that witnesses have already been subject to questioning in respect of the documentation and it is her intention to ask Miss Young questions following her evidence that focus on the exhibits outlined by Ms Bayley.
Ms Norman submitted that it would be prejudicial for the exhibits to be removed prior to Miss Young's evidence.

The panel accepted the advice of the legal assessor. He advised that this is a matter for the panel, however, it could perhaps be appropriate to defer any decision until after the examination of all of the witnesses.

The panel decided to refuse the application.

The panel was of the view that as an experienced panel it would be able to disregard any elements of the bundle which it deemed were not relevant to the charges. The panel also noted that Exhibit 1 had been agreed by all parties prior to the hearing commencing. It was of the view any removal of exhibits would be inappropriate at this juncture.

Background

The charges arose whilst Mrs Roberts was employed by Shrewsbury and Telford Hospital NHS Trust (the Trust) as a Band 6 Midwife on the Midwifery Led Unit (the Unit).

The charges relate to a telephone call on 27 April 2016 between Mrs Roberts and Mother A, who had given birth to Baby A at 08:34 on 26 April 2016 as a planned and successful homebirth.

Ms 3, the Ward Manager of the Unit called and spoke to Mother A in two separate telephone calls, around 15:00 and 18:30 on 26 April 2016.

Mother A called the Unit at around 02:30 (in some documents this is said to be around 02:50) and spoke to Mrs Roberts. Mother A states that she called the Unit following Baby

A vomiting a large amount of brown mucous. It is alleged that during this call Mrs Roberts failed to carry out a comprehensive triage assessment of Baby A and that she failed to recognise the urgency of medical attention for Baby A. It is further alleged that Mrs Roberts failed to make a contemporaneous record of this call with Mother A.

It is alleged that on the morning of 27 April 2016, Ms 3 asked Miss Young to visit Mother and Baby A that morning. Miss Young called Mother A at around 09:00 on 27 April 2016.

Baby A went into cardiac arrest around 11:30 and was transferred to hospital by air ambulance. Baby A subsequently died in hospital on 27 April 2016. Following Baby A's admission to hospital, it is alleged Mrs Roberts made a record of the phone call with Mother A. It is alleged that this record is not accurate.

An inquest into Baby A's death was held in April 2017, during which Mrs Roberts gave evidence.

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

For each of the charges in which failure is alleged, the panel took 'failed' to mean that Mrs Roberts had a duty to perform an action but did not do so. The panel did not consider that it was necessary for any failure to have been deliberate for a charge to be found proved.

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

Charge 1a) i) and ii)

1) At around 02:30, during a telephone conversation with Mother A;
    a) Failed to carry out a comprehensive triage assessment of Baby A in that you;
        i) Failed to ask about Baby A's breathing

ii) Failed to ask about Baby A's temperature.

These charges are found proved.

The panel first considered if Mrs Roberts had a duty to ask these questions.

Irrespective of whether Mother A mentioned any concerns about brown mucous to Mrs Roberts, a call at 02:30 should have, in itself, been sufficient to create the need for a full assessment of Baby A. The panel was of the view that Mrs Roberts, at that time, would have had the duty to ask questions of a more detailed nature in order to ensure that there was nothing wrong with Baby A. The panel also noted that Mother A was an experienced mother who had previously breastfed her other child and would have understood areas of potential concern in Baby A.

The panel took note of the evidence of Ms 5 at paragraph 10.3.4, *'To ascertain wellbeing over the telephone, the midwife must ask a series of probing questions …'* and at paragraph 6.8 where she details the questions to be asked, including:

- How does the baby sound when breathing?
- What is the baby's temperature?

The panel was of the view that asking these questions would have assisted Mrs Roberts in carrying out a comprehensive triage assessment of Baby A.

As the panel was satisfied that Mrs Roberts more likely than not failed to ask these questions and that she had a duty to ask these questions during her call with Mother A. The panel finds charges 1(a)i) and ii) proved on the balance of probabilities.

Charge 1a) iii)

1) At around 02:30, during a telephone conversation with Mother A;
   a) Failed to carry out a comprehensive triage assessment of Baby A in that you;
      iii) Failed to ask how Baby A was feeding.

This charge is found NOT proved.

In reaching this decision, the panel took into account the account given on 5 June 2016 by Mrs Roberts which stated,

> '*I asked Mother A to describe how baby had been feeding since delivery, to which Mother A said baby had fed "fine" during the day but last had a "good" feed around 17:30 hours.'*

In this account Mrs Roberts makes it unequivocal that her account of the events in question was that she did indeed ask *how* Baby A was feeding. The panel noted that Mrs Roberts had been consistent that she asked how Baby A was feeding during her phone call with Mother A.

The panel also considered Mother A's evidence in relation to this charge. It bore in mind her NMC witness statement where she states,

> *'I'm certain that I expressed concerns to Midwife Roberts about Baby A's feeding … but Midwife Roberts was telling me that everything was normal …'*

The panel was satisfied that Mother A's account of the phone call, specifically about Baby A's feeding, corroborated with the response from Mrs Roberts.

While Mrs Roberts did not escalate matters in relation to Baby A's feeding, the panel was of the view that it is more likely than not that feeding was discussed during the phone call and that Mrs Roberts asked *how* Baby A was feeding. Therefore, the panel did not find charge 1(a)iii) proved on the balance of probabilities.

Charge 1b)

1) At around 02:30, during a telephone conversation with Mother A;
    b) Failed to refer the new born feeding guidelines.

This charge is found proved.

Prior to reaching its decision on charge 1b) the panel took the word *'refer'* to indicate that Mrs Roberts simply needed to have an understanding of the guidelines and have them in mind as a reference point while responding to the concerns raised by Mother A during the phone call. The panel did not take *'refer'* to mean that Mrs Roberts was required to have a physical copy in front of her when speaking to Mother A nor have any electronic copy immediately available.

In reaching its decision on charge 1b), the panel took into account Mrs Roberts' Trust interview, on 3 May 2017, when she was asked *'… did you have any written guidance or prompts about what specific questions you should ask?'* to which Mrs Roberts replied '*No.'*

The panel considered that Mrs Roberts' responses in the Trust interview establish that Mrs Roberts was not aware at the time that there was clear written guidance about effective feeding, namely the new born feeding guidelines. This is contrary to the oral evidence of Ms 3 who told the panel that the new born feeding guidelines was enacted policy at the time of Mrs Roberts phone call with Mother A. The panel bore in mind that due to the existence of the guidelines at the Trust, Mrs Roberts could and should have been able to refer to it.

Furthermore, the panel has found that Mrs Roberts had not initiated a review of Baby A over the telephone as per the new born feeding guidelines, and if she had referred to the guidelines, she would have done so. As such, the panel finds charge 1b) proved on the balance of probabilities.

Charge 1c)

1) At around 02:30, during a telephone conversation with Mother A;
    c) Failed to refer to the midwifery post-natal notes.

This charge is found proved.

The panel first considered whether Mrs Roberts had a duty to refer to Mother A's midwifery post-natal notes during their phone call. The panel determined that there was a duty to refer to the notes in order to gain a complete history of a mother who was phoning with concerns regarding her baby.

In reaching this decision, the panel took into account Mrs Roberts Trust interview on 3 May 2017. When asked, *'would you have the baby's notes and the mum's notes with you?'* Mrs Roberts replied *'No. No. They would have been in the community room.'*

Mrs Roberts response suggests that she had not had any sight of Mother A's post-natal notes at all and was thus unaware of its contents. The panel was of the view that during the phone call, Mrs Roberts should have sought to access the post-natal notes either electronically or find the physical version. The panel also had regard to Mrs Roberts response when asked,

> *'after you'd spoken to Mother A do … do you then refer to the notes at all or look at Medway …* to which she replied *'if there was a concern, I would have done … So, no, I didn't.'*

Here, the panel bore in mind that Mrs Roberts accepted that she did not refer to the post-natal notes. Taking all of the above into account, the panel determined that it was more likely than not that Mrs Roberts did not refer to the post-natal notes and had a clear duty to do so. It therefore finds charge 1c) proved on the balance of probabilities.

Charges 2 and 3

2) Failed to recognise the urgency of medical/midwifery attention for Baby A.

3) Failed to advise Mother A to attend the midwifery led unit immediately for a face-to-face assessment.

These charges are found proved.

When deciding whether there was a failure by Mrs Roberts to carry out the above, the panel was required to determine if Mrs Roberts had a duty to do so. The panel found that Mrs Roberts did not perform these actions when she had a duty to do so. The panel determined that any midwife would have a duty to recognise the urgency of medical attention and once recognised, would have the duty to ensure an immediate face to face assessment. The panel accepted the evidence of Ms 5 which supports these conclusions.

In reaching this decision, the panel took into account its finding of charge 1a) in that Mrs Roberts failed to ask all of the relevant questions required to ascertain the wellness of Baby A. By not asking these questions it follows that Mrs Roberts could not have adequately assessed Baby A to identify that she was unwell. Furthermore, it has been established that Mrs Roberts gave assurances to Mother A that all was well with Baby A, *'I reassured Mother A with regards to breastfeeding, and that she should carry on with skin to skin contact and keep trying to put baby to the breast.'* In addition, Mrs Roberts stated *'From what told me over the telephone, there was no indication to bring Mother A and her baby into the Midwife Led Unit (MLU) for assessment.'*

Therefore, Mrs Roberts did not recognise any need for urgent medical/midwifery attention because she had not asked the questions regarding Baby A's breathing and temperature as referenced in charge 1. As such, the panel finds charge 2 on the balance of probabilities.

As a result of Mrs Roberts' failure to recognise the urgent need for medical/midwifery attention, consequently she was unable to advise Mother A to attend the unit immediately for a face-to-face assessment. Mrs Roberts could only have advised Mother A to have a face-to-face assessment of Baby A if there was an urgent requirement for one, which the panel established was not recognised. Accordingly, the panel finds charge 3 proved on the balance of probabilities.

Charge 4

4) Failed to make a contemporaneous note of your telephone call with Mother A.

This charge is found proved.

The panel first assessed whether Mrs Roberts had a duty to make a contemporaneous note of her phone call with Mother A. The panel concluded that there was a requirement to make a contemporaneous note and to record the matters spoken about during the call. It was of the view that contemporaneous documentation of patient contact is extremely important for the continuity of quality care. The panel accepted Ms 5's evidence in this regard.

The panel had regard to the timing of the note made by Mrs Roberts which was at 18:44 beginning, *'Written in retrospect at 18:30hrs* called MLU during the night at approximately 02:30hrs, 27/4/16 was asking for advice/reassurance with regards to breast feeding.'*

The panel took into account Ms 3's explanation for the retrospective note; she states in her NMC witness statement, '*I rang Claire* [Roberts] *… and asked her to retrospectively document the call she had with Mother A on Medway.'* This indicates that Mrs Roberts had not made a contemporaneous note of the call and only did so following the direct instruction from Ms 3 to return to a Trust computer and document the phone call.

The panel further referred to Mrs Roberts Trust interview on 3 May 2017 where she was asked,

> *'… following the telephone conversation, did you document that or record that anywhere?'.*

Ms Roberts replied

> *'Not at the time. Again, like I said, for the reasons that it wasn't … it was normal practice at the time, between all midwifery staff, just to document … um, antenatal phone calls, potential labourers or anything that there was ever any concern; and obviously, at the time of that conversation there wasn't any of those … um, so I didn't document it …'*

The panel bore in mind that Mrs Roberts accepted that she did not make a contemporaneous note of her phone call with Mother A because she did not, in her view, believe there to be any concerns regarding Baby A. Accordingly, the panel finds that Mrs Roberts, more likely than not, failed to make a contemporaneous note of the phone call and thus finds charge 4 proved on the balance of probabilities.

Charge 5a)

5) Made an inaccurate record of your telephone call with Mother A in that you;
   a) Recorded that Mother A had called "asking for advice/reassurance with regards to breastfeeding".

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of mother A. In her evidence, Mother A told the panel that she was "*terrified"* about the brown mucous and therefore called the MLU for assistance. Mother A explained that during the phone call there was some discussions about breastfeeding but that this was not the sole reason for her call.

The panel was content that advice or reassurance about breastfeeding was secondary to Mother A's priority concern. The panel took note of Mother A's statement in June 2016 where she stated, *'at 02:50 on 27/04/16 she brought up a lot of brown mucous. I immediately called MLU (02:55) as I was concerned about this and the non feeding …'* In her oral evidence, she told the panel that her primary reason for telephoning the MLU at 02:55 or thereabouts was about her concern following a large brown mucous vomit by Baby A.

Therefore, the panel determined that Mrs Roberts recording that Mother A called for breastfeeding advice was not accurate as it suggested that Mother A had *only* called regarding breastfeeding.

The panel was therefore satisfied that the record by Mrs Roberts of the call was inaccurate as this was not the only matter directly spoken about in the phone call. As such, the panel found charge 5a) proved.

Charge 5b)

5) Made an inaccurate record of your telephone call with Mother A in that you;
   b) Did not record that Mother A had reported to you that Baby A had vomited brown mucous.

This charge is found proved.

In reaching its decision on charge 5b), the panel preferred Mother A's recollection of the phone call. She explained in her NMC witness statement that she *"panicked because it was really shocking"* when Baby A brought up large amounts of brown mucous. The panel also bore in mind the photographs of Baby A's babygrow evidencing the brown blotches which were caused by the mucous. The panel found it plausible that after witnessing Baby A vomiting, Mother A immediately called the MLU for advice about the mucous and that this was the sole and urgent reason for her call. The panel also considered that even with

the passage of time, Mother A would be able to adequately recall a phone call she made in haste during the middle of the night.

The panel noted that in Mother A's oral evidence, she told the panel that she had been reassured by Mrs Roberts. In her statement on or around June 2016, Mother A states that '*the midwife said it was normal for babies to do this as they breathe fluid in in the birth canal'.* The panel considered that Mother A would not have specialist medical knowledge and could only have known this if this had been discussed during her phone call with Mrs Roberts.

Given all of the reasons outlined above, the panel was satisfied that on the balance of probabilities, Mother A did report the brown mucous to Mrs Roberts. Accordingly, it concluded that Mrs Roberts record was inaccurate as she did not document that Mother A had reported that Baby A had vomited brown mucous. The panel therefore finds charge 5b) proved.

Charge 5c)

5) Made an inaccurate record of your telephone call with Mother A in that you;
    c) Recorded that Mother A had "no other concerns".

This charge is found proved.

Noting its finding of charge 5b), the panel was satisfied that Mrs Roberts' did not record that Mother A had concerns that Baby A had brought up large amounts of brown mucous. The panel concluded that Mother A did indeed have concerns other than about feeding, specifically in relation to Baby A's brown mucous vomit which the panel considered to be the sole reason for her call to the MLU.

By recording that Mother A had no other concerns, Mrs Roberts failed to document any discussion about the brown mucous and therefore was an inaccurate record. The panel therefore finds that charge 5c) is proved on the balance of probabilities.

Charge 6)

6) Your conduct in Charges 5(a) and/or 5(b) and/or 5(c), above, was dishonest in that you knowingly intended to create a misleading impression of Mother A's concerns regarding Baby A during the telephone call.

This charge is found proved.

The panel considered whether the actions in charge 5(a) and/or 5(b) and/or 5(c), which are found proved, amounted to dishonesty.

The panel applied the test for dishonesty set out in the judgement of *Ivey v Genting Casinos* (UK) [2017] UKSC 67. The test applied by the panel was:

1. What, subjectively, was the registrant's actual state of knowledge or belief as to the facts?
2. Was the registrant's conduct, in the light of that knowledge or belief, dishonest according to the objective standards of ordinary, decent people?

The panel accepted that Mrs Roberts is to be treated as a person of good character. This weighs in her favour when considering her credibility and whether she had the propensity to be dishonest.

Notwithstanding her good character, the panel was satisfied that Mrs Roberts' actual state of knowledge or belief in respect of the actions in charge 5 consisted of a deliberate intention to conceal the discussion with Mother A relating to the large amount of brown mucous. The panel was satisfied that Mrs Roberts' failure to make an accurate record in

the notes was dishonest in that it was motivated by a desire to deflect responsibility for her failure to ask further, relevant questions during the phone call. When asked by Ms 3 to come back into work to make a full note on Medway, Mrs Roberts had the opportunity to record each of Mother A's concerns but knowingly, and deliberately, only mentioned breastfeeding.

In reaching this conclusion, the panel had regard to Mrs Roberts' interview with the coroner where she said that she had been aware that there was an incident regarding Baby A but did not know '*the extent'*. Mrs Roberts had also said that being told of an incident *'can be quite ambiguous'* and that she *'didn't know anything at all'*. The panel considered it implausible that Mrs Roberts did not recognise the significance of being asked to return to work in order to make a retrospective record of the phone call with Mother A. Mrs Roberts would have understood that the reason why she was asked to return to work to make a note about her telephone call with Mother A was because there had been a serious incident regarding Baby A. The panel noted its finding of charge 4 that Mrs Roberts failed to make a contemporaneous record of her phone call with Mother A.

The panel was satisfied that, when retrospectively documenting her phone call with Mother A, Mrs Roberts prioritised protecting her own position over recording the truth of what had been discussed.

The panel also had regard to Mrs Roberts denial when asked, *'Is it possible that you could have omitted some information because of the passage of time?'* The panel had heard evidence from Ms 3 that it was a quiet evening at the MLU and therefore there would be no scope for confusion or any reason why Mrs Roberts could be unable to report that Mother A had significant concerns about the brown mucous vomited by Baby A. Notwithstanding, Mrs Roberts maintains in her accounts that Mother A had no other concerns apart from breastfeeding. The panel found Mother A to be a credible and reliable witness. The panel was convinced that her detailed description of events was accurate and compelling. Where her evidence differed from the accounts given by Mrs Roberts, the panel preferred Mother A's evidence.

The panel considered whether Mrs Roberts state of knowledge or belief as to the facts as set out above would, objectively, be regarded as dishonest according to the standards of ordinary, decent people. The panel was satisfied that it would be so regarded.

In light of all of the reasons above, the panel finds that, on the balance of probabilities, Mrs Roberts' actions in 5a), 5b) and 5c) amounted to dishonesty. As such, it finds charge 6 proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Norman informed the panel that Mrs Roberts was not in attendance today, neither was she represented. Mrs Roberts has not engaged with the NMC process and did not attend the earlier hearing or give evidence. As such, Ms Norman submitted that the panel does not have the benefit of knowing whether she agrees with the findings, and further, is not able to assess the extent of her insight, if any. Ms Norman referred the panel to evidence within the documentation which raises concerns with regard to the level of insight of Mrs Roberts.

Ms Norman invited the panel to take the view that the facts found proved amount to misconduct. Ms Norman reminded the panel of the key issues in this matter:

(a) a failure by Mrs Roberts to listen to Mother A when she called and was worried about the brown mucus which Baby A had vomited;
(b) a failure by Mrs Roberts to carry out a comprehensive triage assessment which would have revealed how seriously ill Baby A was;
(c) a failure to refer to guidelines which should have been in mind as a reference point while responding to Mother A;
(d) subsequent to these two issues, a failure to recognise how seriously ill Baby A was and therefore how urgent medical attention was for her;
(e) failures of contemporaneous record-keeping; and
(f) on the part of Mrs Roberts, inaccurate and dishonest records.

Ms Norman submitted that the key issues outlined indicate that the NMC's Code of Conduct is engaged, and in particular:

(a) Section 2, in respect of not properly listening to how concerned Mother A was when she telephoned;
(b) Section 6, in respect of not referring to the guidance and the top to toe assessment, or carrying out the full assessment which would have allowed earlier identification of how serious Baby A's condition was;
(c) Section 8, in respect of not leaving proper records for colleagues;
(d) Section 10, in respect of contemporaneous record-keeping; and
(e) Section 20, in respect of Mrs Roberts' dishonesty in making an inaccurate record.

Ms Norman invited the panel to find that the conduct of Mrs Roberts has fallen short of the standards to be expected among midwives and that such a falling short was serious.

Submissions on impairment

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

Ms Norman invited the panel to find that as a consequence of the proven misconduct of Mrs Roberts, her fitness to practise is impaired.

Ms Norman outlined the relevant law in this matter. She reminded the panel of the four reasons given by Dame Janet Smith in the Fifth Shipman Report which enable a decision-maker to conclude that a registrant's fitness to practise was impaired:

(a) that the practitioner presented a risk to patients;
(b) that the practitioner had brought the profession into disrepute;
(c) that the practitioner had breached one of the fundamental tenets of the profession;
(d) that the practitioner's integrity could not be relied upon.

Ms Norman noted that an assessment of the fitness to practise of Mrs Roberts must be judged not by past matters alone, although these may reasonably inform the panel's assessment of future risk, but by reference to how the practitioner is likely to behave or perform in the future, as per *Zygmunt v GMC* [2008] EWHC 2643 (Admin).

Ms Norman submitted that Mrs Roberts did not attend the hearing at the facts stage and did not give evidence. She further noted the lack of engagement by Mrs Roberts prior to this. She therefore submitted that it is not possible to establish whether Mrs Roberts has insight into her failings.

Ms Norman submitted that the following matters arise with regard to an assessment of Mrs Roberts' impairment:

(a) lack of insight, which means that there is a real risk of repetition;
(b) attitudinal failings, which can be difficult to remediate and this is particularly so in respect of Mrs Roberts dishonesty;
(c) breadth of charges found proved: this is not a case in which there is a narrow or singular point of failure but rather a spectrum of failings, each of which presents a risk to the public if repeated; and
(d) risk to the reputation of the profession, particularly in respect of Mrs Roberts' dishonesty.

In concluding, Ms Norman invited the panel to find that the fitness to practise of Mrs Roberts is currently impaired. She submitted that Mrs Roberts is unable to safely return to practise unrestricted at this stage as her level of insight is unknown and secondly, due to her attitudinal failings related to her dishonesty and absence of any

information with regard to remediation. Thirdly, Ms Norman noted that the failings identified span a number of clinical issues, and this is not a case where there is only one discrete or narrow area of concern.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Grant* (above) and *Cohen v GMC* [2007] EWHC (Admin).

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 nurse or 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*

   2.2 *recognise and respect the contribution that people can make to their own health and wellbeing*

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

6. **Always practise in line with the best available evidence**

To achieve this, you must:

6.1 *make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services*

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

7. Communicate clearly

To achieve this, you must:

7.4 *check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*

8. Work cooperatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

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

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

10.3 *complete all records accurately and without any falsification…*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

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, treating people fairly and without discrimination, bullying or harassment*

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

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

The panel determined Charge 1 amounts to misconduct. In reaching this conclusion, the panel was of the view that this charge and the constituent sub-charges found proven, are serious. The panel was of the view that failure to undertake a proper triage assessment of Baby A and failure to escalate this concern appropriately did amount to serious misconduct.

The panel determined Charge 2 amounts to misconduct. The panel was of the view that Mrs Roberts' failure to recognise a medical emergency goes to the core of patient safety and does amount to misconduct. The panel considered that this failure relates to fundamental nursing and midwifery skills. The panel further considered that the context of a 2.30am call to the maternity led unit from a concerned, experienced mother ought to have prompted a proper and thorough triage assessment. The panel was mindful of midwives' overarching responsibility to triage appropriately.

The panel noted the view of the coroner in relation to the outcome for Baby A, but also acknowledged the wider impact upon the parents of Baby A and others. In particular, the panel was mindful of the experience of Baby A and her parents in her final moments and the impact of her mother witnessing the absence of her daughter's breathing, her father having to perform CPR, an air-ambulance arriving and police having to inspect the suitability of the family home of the parents of Baby A. Considering these factors together, the panel was of the view that this was sufficiently serious to amount to misconduct.

The panel determined that Charge 3 amounts to misconduct. The panel was of the view that this was a failure which related to appropriate escalation and was sufficiently serious to amount to misconduct.

The panel determined that Charge 4 amounts to misconduct. The panel was of the view that documentation is a fundamental nursing skill which is also reflected in the Code. It noted the responsibility of midwives to contemporaneously record clinical information, or to do so within a reasonable period of time. The panel was of the view that failure to document important information relayed by the Parents of Baby A was serious and amounted to misconduct.

The panel determined that Charge 5 amounts to misconduct. The panel was of the view that the inaccurate content of this subsequent record, made some time after the incident, was a serious departure from the standards expected of a midwife and therefore amounted to misconduct. The panel was mindful that accurate record-keeping is a fundamental nursing and midwifery skill. It was of the view that inaccurate record-keeping, including the effective falsification of records, presents a danger to patients and colleagues.

The panel determined that Charge 6 was sufficiently serious to amount to misconduct. The panel determined that Mrs Roberts was aware that something serious had happened to Baby A when she was called in later from home to make an entry in the medical record. The panel was of the view that the only plausible motive for Mrs Roberts making an inaccurate record of her telephone call with Mother A was to protect herself from disciplinary action. The panel determined that this dishonesty would be regarded as deplorable by fellow practitioners.

The panel did consider the context of the organisation that Mrs Roberts was working in. It was clear from the evidence submitted to the panel that the Trust had a number of shortcomings in leadership, management of policies and procedures, communication, and record systems. However, the panel determined that Mrs Roberts' failures were in basic midwifery practice and were not attributable to systemic problems in the organisation.

In concluding, the panel found that the actions of Mrs Roberts did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision and reasons on impairment

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

Nurses 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 nurses with their lives and the lives of their loved ones. To justify that trust, they must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

The panel finds that all four limbs of the test are engaged by the circumstances of this case. The panel noted that Mrs Roberts' has not engaged with the NMC nor attended any hearings, and as such, the panel has no information to suggest that Mrs Roberts has undertaken any reflection, felt any remorse, undertaken remediation to strengthen her practise, considered the impact upon the Parents of Baby A, nor developed any insight.

Given the absence of any information from Mrs Roberts, the panel determined that she is liable to repeat matters of the kind found proved. The panel considered that Charges 1 – 4 are remediable. It further considered that Charges 5 – 6 are remediable, but acknowledged the apparent difficulty in doing so as these charges relate to deliberate acts involving attitudinal concerns and dishonesty. With regard to remediation by way of further learning or training that Mrs Roberts may have undertaken, the only information before the panel is contained in a supplementary statement dated 10 February 2017 to the coroner, in which Mrs Roberts stated

'*As an individual, I have enhanced my practice by reading the patient information leaflet to make myself aware of what information parents are given and expect of us as a midwifery service*'.

In the absence of any updated information from Mrs Roberts, the panel considered this to be a very early stage of remediation.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case and therefore also finds Mrs Roberts' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel is satisfied that Mrs Roberts' fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. The effect of this order is that Mrs Roberts' entry on the NMC register will show that she is subject to a striking-off order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Ms Norman reminded the panel that any sanction imposed must be proportionate and not go further than it needs to protect the public and the public interest.

Ms Norman submitted that it is difficult to identify aggravating and mitigating features of this case as Mrs Roberts has not engaged with the NMC and there is an absence of

information from her. Notwithstanding this difficulty, Ms Norman submitted that the following are aggravating features of this case:

- a lack of insight; and
- conduct that puts patients at risk of suffering harm – not only with regard to her dishonesty, but also a lack of proper record-keeping and a failure to conduct an assessment in the circumstances identified.

Ms Norman submitted that it is not possible to identify any mitigating factors due to the non-engagement of Mrs Roberts. As such, there is no evidence of insight or understanding, nor is there any evidence of personal mitigation.

Ms Norman addressed the panel on dishonesty. She highlighted the element of dishonesty that exists in this case, specifically, the finding of the incomplete note for the purpose of deflecting or avoiding any disciplinary procedure and avoiding any investigation into her own misconduct. She submitted that this amounted to a more serious type of dishonesty as defined in the NMC Sanctions Guidance (SG): *"The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care."* Ms Norman submitted that the dishonesty found falls within this category of the SG.

Ms Norman noted that charges 1 – 4 have been found to be remediable, and further noted that it was found that charges 5 and 6 relating to dishonesty would perhaps be more difficult to remediate as they are attitudinal in nature. Ms Norman submitted that the NMC bid is a striking-off order on the basis that a proven charge of dishonesty in the absence of any mitigating factors was not compatible with ongoing registration.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Roberts' 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 noted the absence of any engagement of Mrs Roberts with the NMC investigation and the consequent lack of information from her. Based on the available information before it, the panel took into account the following aggravating features:

- serious dishonesty stemming from the falsification of midwifery records to cover up her failings in order to protect herself from disciplinary action;
- potential risk of harm to patients caused by the serious dishonesty;
- potential risk of harm to patients caused by concerns around failures in clinical skills relating to triaging a patient accurately, assessing findings appropriately and accurate record-keeping;
- lack of insight;
- lack of remorse; and
- lack of remediation around identified areas of regulatory concern.

The panel were unable to identify any mitigating factors due to the lack of engagement of Mrs Roberts.

The panel had regard to the dishonesty that has been found proven in this case. The panel were mindful of the potential risk of direct physical harm to the vulnerable patient, Baby A, and the psychological harm to her mother and father. The panel noted that there was an element of personal gain with regard to the dishonesty, in that Mrs Roberts had done so to cover up her own failings and that this was also pre-meditated. The panel also

noted that the dishonest account was repeated by Mrs Roberts throughout subsequent investigations including the Coroner's Inquest. Mrs Roberts has not engaged with the NMC and so there is no evidence of reflection, remediation, remorse or the development of insight in relation to her dishonesty. As such, the panel determined that the dishonesty in this case was at the high end on the scale of seriousness.

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

The panel next considered whether placing conditions of practice on Mrs Roberts' registration would be a sufficient and appropriate response. The panel is of the view that conditions of practice are capable of addressing deficiencies in discrete areas of clinical skill, such as record-keeping and triage assessments. However, the panel determined that the dishonest conduct found proven in this case could not be addressed through re-training. The panel is of the view that there are no practical or workable conditions that could be formulated to address the serious dishonesty and attitudinal concerns which stem from the falsified, dishonest note that was placed on Baby A's patient record. With no engagement from Mrs Roberts, the panel could not in any event determine if any conditions imposed would be adhered to. Furthermore, the panel concluded that the placing of conditions on Mrs Roberts' registration would not adequately address the

seriousness of this case, would not protect the public, nor would it maintain public confidence in the profession.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel noted that the dishonesty found proven in this case was repeated. Given the seriousness of the matters found proved in this case, the panel was not satisfied that temporary removal from the register would adequately address public protection concerns or maintain public confidence. The panel was mindful that there was no information before it to suggest that Mrs Roberts had taken steps to remediate her clinical practice skills or attitudinal concerns. Whilst a suspension order would protect the public for the duration of the order, there seems little prospect of Mrs Roberts addressing the failings in her practice and attitude in order to return to safe practice at the end of the suspension order.

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?*

Mrs Roberts' actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Roberts' actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel noted that Mrs Roberts has not engaged with the NMC process. Consequently, the panel have no specific information as to the likely effect of such an order on her. However, whatever impact a striking-off order may have, the panel was satisfied that the public interest outweighs the interests of Mrs Roberts.

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 Mrs Roberts' in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Norman. She invited the panel to impose a suspension order for a period of 18 months, pending any possible 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 reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.