Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 10 October 2022 - Tuesday 18 October 2022

Virtual Hearing

Name of registrant:	Margaret Jurek-Zajdel
NMC PIN:	06G0050C
Part(s) of the register:	Registered Midwife – 12 July 2006
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Avril O'Meara (Chair, Lay member) Laura Wallbank (Registrant member) Barry Greene (Lay member)
Legal Assessor:	Christopher McKay
Hearings Coordinator:	Taymika Brandy – 10 to 17 October 2022 Chantel Akintunde – 18 October 2022
Nursing and Midwifery Council:	Represented by Sharmistha Michaels, Case Presenter
Mrs Jurek-Zajdel:	Present and represented by Malcolm Fortune of Counsel and Aidan Carr, Solicitor [10 October 2022], subsequently present and unrepresented
Facts proved by admission:	All except for charge1b)
Facts not proved:	None
Adjournment application:	Not granted
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months) without review**
Interim order:	No order

Details of charge (as amended)

That you, a registered Midwife:

1) On 15 December 2018, failed to provide adequate care to a patient/acted outside of the scope of your competence in that you:

    a) undertook an Artificial Rupture of Membranes ("ARM') procedure on Patient A;

    b) Alternatively, attempted to undertake an ARM procedure on Patient A;

    c) Undertook a vaginal examination ('VE') on Patient A at, or around, 16:38;

2) Undertook any and/or all of the procedures referred to at charge 1(a)-1(c) above contrary advice/instructions provided by:

    a) Dr A;

    b) Senior Sister A;

    c) Trust policy, BTUH guidelines 'Artificial Rupture of Membranes by Midwives';

3) Provided/made the following inaccurate accounts/statements in relation to the incidents referred to at charges 1(a)- 1(c) above:

    a) On 20 December 2018, in an internal statement, words to the effect that:

        i) Patient A's waters broke naturally/*"waters just gone with contraction"* whilst performing / attempting a vaginal examination ('VE');

        ii) You requested Senior Sister A to help you with the fundal pressure;

iii) Senior Sister A was present in the room during/throughout the VE;

b) 07 January 2019 in a statement/interview account, words to the effect that:

i) Patient A's waters broke naturally/*"waters just gone with contraction"* whilst performing/attempting a VE;

ii) You requested Senior Sister A to help you with the fundal pressure;

iii) Senior Sister A was present in the room during/throughout the VE;

c) 25 April 2019 in a complaint response meeting, words to the effect that:

i) Patient A's waters broke naturally*/"waters rupturing"* whilst performing/attempting a VE;

ii) Senior Sister A was with you during/throughout the VE;

4) Your conduct at any and/or all of charge 3 above, was in breach of the duty of candour;

5) Your conduct at any and/or all of charge 3 above, was dishonest in that you:

a) knew that you were acting outside of your scope of competence;

b) intended to conceal the fact that you had acted outside of the scope of your competence;

c) knew that you were acting contrary to instructions/advice provided not to undertake the ARM procedure;

d) intended to conceal the fact that you had undertaken the ARM procedure;

e) knew that Senior Sister A was not present to help you with the fundal pressure;

f) intended to create the misleading impression that Senior Sister A was present to help you with the fundal pressure;

g) knew that Senior Sister A was not present throughout the VE and/or ARM procedure;

h) intended to create the misleading impression that Senior Sister A was present throughout the VE and/or ARM procedure;

6) On or around 26 December 2018, removed a catheter from Patient B:

a) contrary to Patient B's care plan;

b) against Patient B's wishes;

c) without communicating with Patient B;

7) On 03 February 2018, failed to follow the directions/instructions of the Senior Sister by:

a) taking your lunch break when at a time that you were requested not to do so;

b) not providing 1:1 care to a patient to go on your lunch break;

8) On 6 September 2018, undermined the advice provided by the Senior Sister to high risk patient over the telephone by shouting / speaking over them that the patient should not attend the hospital yet;

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

Decision and reasons on application to amend the charge

At the outset of the hearing the panel invited Ms Michaels, on behalf of the Nursing and Midwifery Council (NMC), to make an application to amend the wording in the stem of charge 6 due to the evidence provided by the NMC in relation to the timing Patient B's catheter was removed during the night shift of 25 December 2018. It invited submissions from the parties, and both accepted that the amendment could be made without injustice and would more accurately reflect the evidence provided.

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

The panel was of the view that such an amendment, as applied for, was in the interests of justice and would more accurately reflect the evidence. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment as follows:

Original charge:

6) On 26 December 2018, removed a catheter from Patient B:

Amended Charge:

6) On **or around** 26 December 2018, removed a catheter from Patient B:

Background

On 12 August 2020 the NMC received a referral from the Women's Health Matron at Basildon and Thurrock University Hospitals NHS Foundation Trust ("the Trust"). At the time the charges arose, you were employed as a Band 6 Midwife on the Delivery Suite at Basildon University Hospital ("the Hospital"), part of the Trust.

The charges mainly relate to failings regarding the care you provided to Patient A and Patient B.

Patient A was identified as a high-risk patient as a result of a number of factors such as her age, body mass index, her pregnancy followed IVF treatment and the diagnosis of polyhydramnios. As a result, a medical plan was devised for Patient A by the consultant obstetrician to induce labour at 39 weeks gestation, in order to avoid an umbilical cord prolapse.

On 15 December 2018 whilst under your care, it alleged that you undertook an Artificial Rupture of Membranes ("ARM') procedure on Patient A and undertook a Vaginal Examination ('VE') on Patient A around 16:38.

It is alleged that Senior Sister A witnessed you conducting a VE and that she could see clear liquor draining form Patient A when she arrived in the delivery room and that she saw you holding an amnihook (a tool used to perform ARM) and there was "show" present on it, indicating that it had been used. This was against what you had been expressly advised by Dr A and Senior Sister A as well as against the 'ARM by Midwives Policy' which states that '*if polyhydramnios has been diagnosed, ARM should not be carried out by the midwife'.*

It is also alleged that you documented within Patient A's records, on the 'VE in Labour' page, that ARM was performed. The ARM box is ticked and "*cord felt after ARM by the he*ad" written.

Patient A and her husband were aware of their medical plan and that you had acted contrary to the plan and subsequently made a complaint to the Hospital on 1 January 2019.

On 20 February 2019, Patient A received a complaint response from the Trust, following an investigation by the Delivery Suite Manager, Ms 1. The findings of the initial investigation by Ms 1, based on the account provided by you, was that you undertook a VE and, at this stage, Patient A's waters broke spontaneously.

Patient A and her husband were not satisfied with the findings of the investigation and on 23 March 2019 a meeting was subsequently arranged with the Obstetric Consultant, the Delivery Suite Manager and the Lead for Governance at the Trust. At this local resolution meeting it was decided that the incident on 15 December 2018 would be re-investigated, and their concerns would be addressed afresh.

It is alleged that you provided a number of different accounts in relation to the incident on the 15 December 2019, on the following dates:

On 20 December 2018, you stated that, although you intended to, you did not perform an ARM as Patient A's waters broke spontaneously when you were conducting the VE and that the Senior Sister 1 was present in the room.

On 7 January 2019, you stated that Patient A's waters broke naturally whilst performing a VE and that you had requested Senior Sister A to help you with the fundal pressure and she had been present in the room throughout the VE.

A further complaint was raised by Patient B to the Trust on 26 December 2018, it is alleged by Patient B that you had acted contrary to the patient's care plan whilst Patient B was under your care. The patient was receiving post-operative care due to complications relating to a bowel obstruction. There was a care plan which specified that Patient B's catheter was to be left in overnight and was to be removed in the morning so that the midwifery team could mobilise her. Patient B indicated to the Trust that she did not like the way she had been handled or spoken to by you and, that you had removed her catheter

when she had thought it should be left in. Patient B alleged that you had removed the catheter whilst she was sitting on a chair as opposed to a bed.

The following concerns were also raised by the Trust:

On 3 February 2018, you allegedly failed to follow instructions when you were working on the delivery suite on a day shift. You were allocated to a patient who was in active labour and required one to one care. During this time, you asked a fellow midwife to cover you and care for your patient so that you could take your lunch break. This was despite being told by the Senior Midwife that there was no one to cover you or anyone to work one-to-one with the patient. You were asked to wait as the unit was busy and another midwife was already on her break.

On 6 September 2018, you undermined the advice provided by the Senior Sister A to a high-risk patient.

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

Mr Fortune, on your behalf, made a request that this case be held partly in private on the basis that matters relating to your health will be referred to. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Michaels indicated that she did not object to the 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 your health, the panel determined to go into private only as and when such issues are raised in order to protect your right to privacy.

Admitted Facts

At the outset of the hearing Mr Fortune informed the panel that you made full admissions to all charges, except charge 1b). Charge 1b) is charged in the alternative to charge 1a) and therefore falls away due to your admission to 1a).

The panel therefore finds all charges, except charge 1b) proved in their entirety, by way of your admissions.

Decision and reasons on application to adjourn

Once the panel had announced all of the charges (except charge 1b) proved in their entirety, by way of your admissions, Mr Fortune made an application to adjourn the hearing. [PRIVATE] The application was made pursuant to Rule 32 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

[PRIVATE]

In response to panel questions, Mr Carr stated that he was instructed by you on 3 September 2020 and represented you at the initial interim order hearing and at various subsequent stages depending on funding.

Mr Fortune further stated that [PRIVATE] if the application to adjourn is denied, then you will become unrepresented. He submitted if you had to proceed without legal representation, as English is not your first language, you would not be in the best position to represent yourself. He also invited the panel to grant the application so that further information could be sought namely, reports from your supervisors, a completed Personal

Development Plan (“PDP”), evidence of Continuous Professional Development (“CPD”), training certificates and testimonials from colleagues.

Ms Michaels submitted that there is a strong public interest in the expeditious disposal of this case as it relates to incidents that occurred in 2018. [PRIVATE]. She referred the panel to the cases of *R v Jones (Anthony William), (No.2)* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

[PRIVATE]

The panel accepted the advice of the legal assessor, who referred the panel to the considerations in Rule 32:

> *‘Rule 32 (2) A practice committee considering an allegation may, of its own motion*
> *or upon the application of a party, adjourn the proceedings at any stage, provided*
> *that –*
> *No injustice is caused to the parties and (b) that the decision is made after hearing*
> *representations from the parties (where present) and taking advice from the legal*
> *assessor…*
> *(4) In considering whether or not to grant a request for… adjournment, the… practice committee shall, amongst other matters, have regard to –*
> *(a) the public interest in the expeditious disposal of the case;*
> *(b) the potential inconvenience caused to a party or any witnesses to be called by*
> *that party; and*
> *(c) fairness to the registrant.’*

The panel gave careful consideration to the application to adjourn this hearing.

The panel considered that there is a strong public interest in the expeditious disposal of the case, particularly due to the nature of the charges found proved which include dishonesty, breach of duty of candour, and serious issues relating to the care of patients, particularly in relation to Patient A.

[PRIVATE]. The NMC would then need to relist this hearing before this particular panel which is now seized of the matter. The panel was of the view that this is likely to significantly delay these proceedings and would not be in the interest of justice.

The panel noted that you have worked as a midwife in the UK since 2006

[PRIVATE]

The panel took into account the submission from Mr Fortune that English was your second language. Whilst the panel took this into consideration, it noted that you had been practising as a midwife in the UK since 2006 and are currently working in the community at Guys and St Thomas' Hospital. The panel was not persuaded that a lack of knowledge of the English language would prevent you from participating in this hearing.

The panel considered it could allow you time during the hearing to collect further evidence you may require, namely, reports from your current supervisors, a PDP, evidence of CPD, training certificates and testimonials from colleagues and would carefully consider this information at the next stage.

The panel has given careful consideration to the provisions contained in Rule 32 of the Rules, including fairness to you, and the submissions of both parties and have decided to refuse the application for an adjournment.

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to 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.

Submissions on misconduct and impairment

Ms Michaels invited the panel to take the view that your actions amount to a breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) and (2018) ("the Code"). She then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, your actions amounted to a breach of those standards.

Ms Michaels submitted that your actions in the charges found proved, by way of your admissions, amount to misconduct. She referred the panel to the relevant judgments of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Meadow v General Medical Council* [2006] EWCA Civ 1390. She submitted that the allegations are serious, wide ranging and relate to concerns around your clinical judgment, acting outside of your

clinical competency and dishonesty. She further submitted that in relation to your dishonesty, you had provided a false account in relation to what had occurred on 15 December 2018, on three occasions and it was not until 27 May 2019 that you admitted to this dishonesty.

Ms Michaels submitted that your actions mark a significant departure from the professional standards expected of a registered midwife as you have breached fundamental tenets of the profession.

Ms Michaels submitted that your actions in charge 1), went against the specific advice of Dr A and Senior Sister 1, and you had breached both specific instructions and the relevant Trust policy. She submitted that as a result of your actions in this charge, Patient A suffered a cord prolapse which led to patient A having an avoidable Caesarean section ("C-Section").

Ms Michaels submitted that it was not until Patient A complained about the initial Trust investigation outcome and said you were lying, that you made admissions that you had performed the ARM procedure. She further submitted that an aggravating factor was your breach of the duty of candour and your dishonesty, which both related directly to patient care, and such conduct was part of a pattern that persisted over a period of time.

Ms Michaels submitted that the charges in relation to Patient B are attitudinal in nature and that Colleague A had stated that your actions in the charges were in breach of the Code and further that there was no clear communication with Patient B on what you were doing and why. Ms Michaels further submitted that you failed to read the care plan properly or listen to the handover given to you by the midwife on the previous shift.

Ms Michaels submitted that your actions in relation to charge 7 were serious, in that on 3 February 2018, you left a patient to labour on her own while you went to take a lunch break, against specific instructions. She further submitted that by failing to follow the

instructions given by Senior Sister A, you left a patient without one-to-one care, and this could have resulted in harm to a patient and her baby.

Ms Michaels submitted that your actions in relation to charge 8 may be considered attitudinal in nature as with the incident on 6 December 2018, you had undermined the advice of Senior Sister A by shouting over her. She further submitted that Senior Sister A felt that your actions were concerning as your proposed course of action could have put the patient at risk of a scar rupture.

Ms Michaels submitted that you failed to follow instructions on three occasions which demonstrates a worrying pattern of behaviour.

Ms Michaels submitted that your actions above are sufficiently serious to amount to misconduct.

Ms Michaels 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. She referred the panel to the cases of *Cohen v GMC* [2015] EWHC 581 (Admin) *and Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b, c and d of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged by your actions.

Ms Michaels submitted that is your case that you have shown remorse. She also stated that you have provided multiple documents regarding your current position and your statement does provide some reflection around the incidents. She submitted that although you have acted outside of the scope of your practice, it is clear your wanted to assist Patient A the best you could, albeit your actions in doing so were contrary to policy and misguided. Ms Michaels stated this is your first fitness to practise matter and there have been no regulatory concerns since. She referred the panel to your reflection in which you state that you *"acted with good intention".*

Ms Michaels submitted that the issues relating to you to failing to follow instructions are possible to remediate through focused training and supervision. The issues relate to your numerous attempts to cover up what had happened in relation to Patient A, and as a result caused Patient A and her husband stress are difficult to remediate.

In assessing whether you were liable to bring the profession into disrepute, breach fundamental tenets of the profession and act dishonestly in the future, Ms Michaels invited the panel to assess your levels of remediation and insight.

Ms Michaels submitted that despite all the documents you have provided, it does not appear that the training you have undertaken addresses the specific concerns found proved. She submitted that you have addressed communication, working as part of a team and understanding and applying relevant policies.

Ms Michaels submitted that it does not appear that you have fully addressed your dishonesty, albeit you refer to this in your statement. She submitted that you have not reflected on your requirement to uphold the duty of candour and the impact of this on the public and wider profession. She further submitted that as you placed patients at risk of harm you need to demonstrate an in-depth reflection that also discusses why and what you would do in the future, following these incidents.

Ms Michaels submitted that a finding of current impairment should be made individually and collectively, in relation to the charges found proved as these incidents were serious and your actions put patients at risk of unwarranted harm. She submitted that whilst Patient A's baby did not suffer harm, Patient A suffered actual harm, namely, a cord prolapse and avoidable C-Section. She further submitted that both Patient A and her husband suffered for several months trying to prove that your statements of the incident provided to the Trust, were false.

Ms Michaels submitted that you have not set out why you did not follow instructions and that this suggests a lack of insight and therefore, there remains a likelihood and risk of repetition. She further submitted that you brought the midwifery profession into disrepute.

Ms Michaels submitted that in light of your documents and testimonials that speak to your practice prior to the concerns and subsequently, the panel may take the view that you do not pose a risk to the public. However, she submitted that there is a clear public interest in this case and that a fully informed member of the public would be concerned by the facts found proved. She further submitted that public confidence would be undermined if a finding of impairment was not made.

The panel then heard live evidence from Ms 2, Matron at Guy's and St Thomas' NHS Foundation Trust under affirmation, attesting to your character and professionalism.

Ms 2 told the panel that she had known you for over a year and that she had first met you when you were introduced as a candidate for a Maternity Support Worker ("MSW"). She stated that she was fully informed of these NMC proceedings and that you had shared the documentation from the NMC, relating to these proceedings with her. She explained your role currently as a midwife in the community team, where you are supervised whilst running antenatal and postnatal clinics. Ms 2 explained that she does not directly line manage you, however she receives general reports of your work. She explained she has received very positive reports of your work and that you are a very loved member of the community team. Ms 2 spoke to your integrity and confirmed that since employed by Guy's and St Thomas' NHS Foundation Trust you had not acted outside the scope of your practice. She also stated that you have not attempted to mislead others or conceal anything since you were employed in your previous position as an MSW, or in your current position as a midwife within the community team.

The panel then heard live evidence from you under affirmation.

You explained that you started your position as a community midwife at Guy's and St Thomas' NHS Foundation Trust on 1 August 2022.

You told the panel that you accept the allegations, and you hope that your reflective pieces do not contradict your admissions.

You explained the factors that you believe, contributed to your behaviour at the time of the incidents. You explained that you have reflected on how your actions affected the patients involved, colleagues, the Trust, the wider profession and public confidence. You referred the panel to your CPD and PDP and your reflective accounts. You explained that you will not repeat your behaviour and actions in the future and that you hope the evidence provided offers reassurance of this to the panel.

You explained that in your roles before you worked at the Trust, you brought a lot of positive energy and skills to the teams you in which you worked, and you had positive feedback from staff and managers. You referred the panel to the numerous testimonials provided by you from former colleagues, including at the Trust.

You accepted that you did not listen properly to the instructions of Dr A and Senior Sister A and that you were not actively listening at the time. You explained that you had attempted to perform the ARM as at the time, you thought that Patient A would deliver her baby. You went on to explain that whilst Patient A was under your care, you had been called to theatre to look after another high-risk patient, and the baby of that patient required resuscitation. You explained that your understanding was that, the senior midwife would oversee the care of Patient A, however when you returned, it appeared to you that no one had provided any care to Patient A. In response to a question from the panel you explained that you did not receive a proper handover on your return from theatre. You explained that Patient A did not want to be assessed and appeared to be very distressed. You also explained that it was your intention to perform an ARM, but you were unsure whether it was you that actually ruptured Patient A's membranes or if it happened during the VE as it all happened very quickly and was difficult to assess the situation at the time.

You accepted that you had acted outside the scope of your practice, however you had done this with good intention and wanted to provide the most effective care for Patient A. You explained that you understood by not following the instructions of your colleagues you demonstrated a lack of respect, but it was an 'impairment' of your communication and understanding of what was said at the time.

You explained that you had never acted in that way before and you would never act like that again and described your actions as *"extremely stupid".*

You explained that in relation to your dishonesty, that you were traumatised and fearful of the consequences and as a result you tried to protect yourself rather the Trust, your managers or Patient A and her family, by giving misleading information.

You explained that since the incidents, you have maintained your professionalism, worked on your behaviour and demonstrated your ability to carry out your duty as a midwife.

In relation to leaving a patient without one-to-one care on 3 February 2018 (charge 7), you explained that this incident occurred in the context of a busy shift, and you had not had a break since starting work at 07:30 and at the time it was just before 14:00. In response to questions from the panel, you explained that from your experience of working with Senior Sister A, it was unlikely that you would be given any proper break during your shift. You explained that you had asked a colleague to oversee your patient so you could get some food before the canteen closed, so that you had food to eat during your shift. You explained that your patient was not in established labour, and before you left you had completed the patients' observations, monitored the baby and given the patient the buzzer and told her to press it if she needed anything.

You explained that in your role as a MSW and a midwife you always ask questions to ensure you do not act outside of your scope of competence to ensure you are practicing safely.

In relation to the incident on or around 26 December 2018 (charge 6), you accepted that you did not understand Patient B's care plan. You explained that the doctor had agreed that the patient should be mobilised, and the catheter removed. However, Patient B had made a verbal agreement with the midwife on the previous shift that the catheter would be left in overnight, and this was not documented in a handover summary. You further explained that Patient A asked you 'to remove this' and you mistakenly thought she meant the catheter, rather than the urine bag to enable her to change her underwear.

You explained that you had only received a verbal handover from the midwife on the previous shift relating to Patient B's care. You told the panel that verbal handovers were usual practice and the Trust did not use handover communication tools such as ("Situation, Background, Assessment, Recommendation") SBAR. You explained that you found this difficult as there was verbal information being relayed to you about all five of your patients and you may have missed relevant information about Patient B's catheter. You said that prior to this incident, you had been off sick and had returned to work whilst still feeling unwell because you were aware of staffing issues.

The panel accepted the advice of the legal assessor.

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

The panel was of the view that your actions amounted to a breach of the Code. The panel considered that the following sections of the Code were engaged in this case:

‘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

…

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

8.6 share information to identify and reduce risk

…

13 Recognise and work within the limits of your competence

…

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

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

…

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice To achieve this, you must:

…

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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…

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

….

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider whether your actions, both individually and collectively, amounted to misconduct.

Charges 1a) and 1c)

In determining whether your actions amounted to misconduct in relation to charges 1a) and 1c) the panel considered that you had made admissions in respect of these charges.

The panel carefully considered all the relevant evidence in relation to charges 1a) and 1c) including your evidence, the witness statements, the documentary evidence, the Trust's 'Artificial Rupture of Membranes by Midwives' Policy and Patient A's notes.

The panel determined that your conduct in relation to charge 1a), in performing an ARM amounted to misconduct as you went against the express instructions of your Senior Sister A and Dr A and the Trust's policy in conducting an ARM on a woman with polyhydramnios. The panel determined that your actions breached paragraphs 13 and 19 and 19.4 of the Code.

The panel considered your oral evidence in which you explained that you had spent a number of hours with another high-risk patient and that patient A had been left in the care of a colleague. The panel further considered that there is no record of anyone having attended Patient A between 11:30 and 15:00, whilst you were in theatre attending to another patient. The panel was of the view that the NMC has not provided sufficient evidence to demonstrate that carrying out a VE on Patient A was a sufficiently serious falling short of the standards expected to amount to misconduct. The panel considered that it was reasonable for you to make a full clinical assessment of Patient A and her baby, after you had been absent in theatre for a significant period of time. The panel also noted that there was no evidence provided that performing a VE on a patient with polyhydramnios was contrary to the Trust's policy.

In the circumstances, the panel concluded that your actions in relation to charge 1c) did not fall significantly below the standards expected of a midwife and do not amount to misconduct.

Therefore, the panel determined that your actions in charge 1a) amount to misconduct and your actions in charge 1c) do not amount to misconduct.

Charge 2

In determining whether your actions amounted to misconduct in relation to charge 2, the panel considered that you had made admissions to this charge in its entirety. The panel considered and accepted the evidence of Dr A and Senior Sister A that they had both told you specifically not to perform an ARM as this could have led to serious consequences for Patient A. The panel also noted that in your oral evidence you could not remember exactly what was said to you by both colleagues. However, the panel were of the view that the Trust policy *BTUH guidelines 'Artificial Rupture of Membranes by Midwives'* clearly states that an ARM is not to be performed on a patient with polyhydramnios and that you had failed to follow specific instructions and the Trusts policy. The panel therefore considered that your actions in charge 2, in carrying out an ARM, contrary to advice and instructions provided by Dr A, Senior Sister A and Trust policy, fell significantly below the standards expected of midwives and amount to misconduct.

The panel determined that your actions breached paragraphs 8, 8.1, 8.2,8.5 and 8.6 of the Code.

Charge 3

In determining whether your actions amounted to misconduct in relation to charge 3, the panel considered that you had made admissions to providing dishonest or misleading information on three different occasions as set out in the charges. The panel also noted the evidence provided of each account, on each occasion. The panel was of the view that there had been misleading statements identified in your accounts and that you had later made admissions to providing these misleading statements. The panel considered that it was your intention to mislead as you had stated in your oral evidence that you had felt

traumatised, were fearful of the consequences of telling the truth and sought to protect yourself.

The panel therefore determined that your actions in charge 3 did fall significantly short of the standards expected of a registered midwife, and that your actions amounted to a breach of the Code. The panel determined that your actions breached paragraphs 14, 14.1, 14.2 and 14.3 of the Code.

In light of this, the panel determined that your actions in charge 3 were serious, fell significantly below the standards expected of midwives and amount to misconduct.

Charges 4 and 5

In determining whether your actions amounted to misconduct in relation to charges 4 and 5, the panel considered your admissions to the charges. The panel determined that on three occasions you failed to be open and honest in relation to the events of 15 December 2018 and uphold the duty of candour.

The panel was of the view that honesty and the duty of candour are integral to the midwifery profession. The panel determined that your dishonesty and breach of the duty of candour undermines the public confidence in the profession. As a registered midwife, it is important that you are open and honest at all times, particularly regarding your clinical practice and when caring for patients. The panel was of the view that your actions in respect of charges 4 and 5, in seeking to mislead colleagues, the Trust and Patient A about what you had done were serious and would be regarded as deplorable by fellow colleagues. The panel therefore considered that charges 4 and 5 amounted to misconduct.

The panel determined that your actions breached paragraphs 14, 14.1,14.2,14.3, 20, 20.1, 20.2, 20.3 and 20.5 of the Code.

Charge 6

In determining whether your actions amounted to misconduct in relation to charge 6, the panel considered your admissions to this charge and your oral evidence in which you set out the context of this incident. You had explained this was a very busy shift and that you had been allocated five patients some of whom were identified as high-risk. The panel did not have sight of Patient B's records, however from the witness statements and your oral evidence it considered that the consultant obstetrician planned for Patient B to mobilise and her catheter was to be removed. The panel considered that there was a failure in the communication with the day shift midwife who gave you a verbal handover, that she had agreed to leave the catheter in overnight. The panel also accepted that you misunderstood Patient B's request to 'take this out', thinking that she was asking for the catheter to be removed when she was actually asking for the urine bag to be disconnected so that she could change her underwear. The panel accepted that this caused Patient B some distress. However, in all the circumstances, the panel did not consider that your actions in in relation to this incident were sufficiently serious to amount to misconduct.

Charge 7

In determining whether your actions amounted to misconduct in relation to charge 7, the panel considered your admissions to the charge, in that you failed to provide one to one care. In your oral evidence you set out the context of the shift, the panel accepted your evidence, that at the time it was around 14:00, shortly before the canteen closed and you had not yet had a break since starting your shift at 07:30. You told the panel that you often went without breaks on a shift with the delivery suite coordinator that was in charge on that

day, and due to the busy nature of the unit. The panel considered that you had taken reasonable steps in the circumstances, by asking a colleague to oversee your patient (who was not in active labour) and by completing the patient's observations and giving her a buzzer before leaving her. The panel considered that although you should not have gone against the instructions of Senior Sister A, that in the circumstances, going to get food before the canteen closed to ensure you had food during your 12.5-hour shift and leaving your patient to be overseen by another midwife, is not a sufficiently serious falling short of the standards expected of a midwife, to amount to misconduct.

Charge 8

In determining whether your actions amounted to misconduct in relation to charge 8, the panel considered your admissions to the charge and the evidence before it. The panel considered that you had been unprofessional, and your behaviour was undesirable, particularly towards your senior colleague and it had the potential to undermine her, as this may have been within hearing of a patient. However, the panel also considered that your actions did not affect patient care as it was your colleague, Senior Sister A speaking to the patient on the telephone. The panel noted this was a single incident relating to speaking over a senior colleague and is not a sufficiently serious falling short of the standards expected of a midwife, to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct found proved, 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 and to work within the Code. Patients and their families must be able to

trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct 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* [2011] EWHC (Admin) 97 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 includes 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*

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

The panel considered that all four limbs of the above test were engaged by your past actions. The panel considered that your actions brought the profession into disrepute as a result of you acting outside your scope of practice and putting Patient A at unwarranted risk of harm. It considered that acting with honesty and upholding the duty of candour at all times is a fundamental tenet of the profession, which you breached through your past behaviour.

The panel however, recognised that it had to make a current assessment of your fitness to practice, which involved not only taking account of past misconduct but also what has happened since the misconduct came to light. The panel had regard to the case of *Cohen* and considered whether the concerns identified were capable of remediation, whether they have been remedied and whether there was a risk of repetition at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you had provided evidence of insight and remorse.

The panel considered your misconduct in relation to you acting outside the scope of your competence. The panel had regard to your oral evidence, your witness statement and your reflective piece and considered that you had shown significant insight into the concerns identified in your practice. It further considered that you were able to reflect on the impact of your actions on Patient A, the Trust, your colleagues and the wider profession. The panel considered your updated Curriculum Vitae ("CV") and your oral evidence, in which you confirmed that you had been working as a MSW at Guy's and St Thomas' NHS Foundation Trust, in the community from March 2021 to July 2022. The panel noted that you are now employed as a Midwife in the community since 1 August 2022. The panel had regard to the references before it, from colleagues at the Trust, and those who have worked with you over the course of your career as a midwife, which were

complementary of your clinical practice and performance and the care you provide to patients, and which have raised no concerns in relation to your fitness to practise.

The panel also had sight of a letter from your current line manager in which she states:

> *'I have worked alongside Malgorzata in both work roles as MSW and Midwife. She is very keen to do well on her role and to provide safe, suitable care to women and their families. Malgorzata is kind to the women offers good support and makes appropriate referral where needed. Malgorzata possesses a good attitude towards her work and interacts effectively with women and colleagues. Malgorzata and I meet regularly to review her progress and reflect and offer support when needed.'*

The panel had regard to your training certificates and considered that you had completed training on communication and have demonstrated an understanding of the importance of communicating more effectively, particularly with colleagues and patients. The panel further considered that you had acted outside of your scope of practice once by performing an ARM procedure on a high-risk patient and it accepted that this was a serious error of judgment but a single incident. The panel considered there was no evidence to suggest that patients were placed at risk of harm before or since this incident. Therefore, the panel was satisfied that that a finding of impairment on public protection grounds is not necessary.

The panel next considered the charges in relation to your dishonesty and breach of the duty of candour and assessed your levels of insight, remorse and remediation in relation to these charges.

The panel reminded itself that misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However, in the panel's judgment, 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 had regard to your previous practice, prior to this incident, as well as your subsequent practice. It noted that prior to this incident, no concerns had been raised regarding your honesty and integrity. It noted that there was no evidence of any concerns of this nature raised during the course of your recent employment as a MSW and as a midwife. The panel also considered the oral evidence of Ms 2, who state that she was fully informed of these proceedings and all of the charges including those relating to dishonesty and breach of the duty of candour. The panel was of the view that Ms 2 provided clear and positive evidence in relation to your practice.

The panel had regard to your statement in which you state:

> *'I have recognised the negative impact this has caused on Patient and her family, and my work colleagues as well. I genuinely apologise to the couple, and my work colleagues who were involved in this case as a result of my action. I empathise with the couple for their traumatic experience.'*
>
> *'I would like to apologise for this […] I am fully aware by my lack of integrity and lack of consistency in my statements making me to fail to promote proper professional standards.*
> *I deeply regret and I feels remorse, that I gave my managers misleading information about the incident.'*

The panel also had regard to your oral evidence and the extracts from the Care Quality Commissions findings regarding the Trust's maternity services, published on 19 August 2020, relating to an inspection on 12 June 2020, included in your reflection. You noted that:

"Doctors, midwives and other healthcare professionals did not always work well together, and the absence of an open culture meant that staff did not always feel able to raise issues or report incidents so that learning could be effectively shared to help embed improvements."

The panel was of the view that this supported your oral evidence, in which you explained that you had found it difficult to speak up as you were fearful of the consequences for you. It also considered how a blame culture, rather than and open and honest culture within the Trust may have impacted on how you behaved. The panel also considered that although your dishonesty was repeated on three occasions, in that you provided differing statements in relation to the events on 15 December 2018, your dishonesty related to one incident. The panel acknowledged that your actions caused distress to Patient A and her husband. Given your developed insight, the evidence regarding your previous and subsequent practice, and the positive references before it including from your current employer, the panel was satisfied that the misconduct in relation to your dishonesty and breach of the duty of candour, was highly unlikely to be repeated. The panel was satisfied that you had learned a difficult lesson and you understood how important it was to be open and honest including when things go wrong.

The panel moved on to carefully consider whether a finding of impairment was required to mark your misconduct, to maintain public confidence in the nursing profession and to uphold proper professional standards.

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

The panel considered that your actions displayed a lack of integrity and professionalism on your part. It was of the view that a fully informed member of the public would be

concerned by your professional conduct in being dishonest and failing to uphold your duty of candour, the distress caused to Patient A and her husband by your actions on 15 December 2018 and thereafter and would expect it to be appropriately marked as unacceptable. The panel considered that public confidence in the nursing profession and the NMC as a regulator would be undermined if a finding of impairment were not made in the circumstances. The panel therefore determined that a finding of impairment is necessary on public interest grounds.

For all the above reasons, the panel decided that your fitness to practise is currently impaired by reason of misconduct on public interest grounds only.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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.

Submissions on sanction

Ms Michaels informed the panel that in the Notice of Hearing, dated 25 August 2022, the NMC had advised you that it would seek the imposition of an 8-month suspension order or striking off order if it found your fitness to practise currently impaired.

Ms Michaels informed the panel that you are currently subject to an interim conditions of practice order, and she provided the panel with a copy of the order. She referred the panel to the NMC guidance on sanction, where it advises that when considering a sanction, you should start off with the least serious sanction then move onto the next if necessary.

Ms Michaels submitted that both aggravating and mitigating circumstances should be taken into account when considering an appropriate sanction. With regard to aggravating factors, Ms Michaels submitted that these were as follows: there was risk of potential harm to Patient A as a result of you acting beyond the scope of your practice and failing to adhere to instructions; there was repeated dishonesty on your part on three occasions by not disclosing the errors that occurred; and your actions caused stress to Patient A and her husband. With regard to mitigating factors, Ms Michaels submitted that these were as follows: you made local admissions to the allegations, you provided reflective statements demonstrating your insight into the matter; you experienced pressure working within the ward at the time; and you provided positive testimonies which attest to your character.

Ms Michaels referred the panel to the NMC guidance on considering sanctions for serious cases. She submitted that the proven concerns in your case are in fact serious and involved you acting beyond the scope of your practice, breaching the duty of candour, repeated dishonesty and seeking personal gain by failing to speak up at the time due to fear of the consequences, particularly the risk of losing your job.

Ms Michaels took the panel through the available sanctions and the NMC's position in relation to each one. With regard to taking no action, she submitted that this would neither be proportionate nor in the public interest given the panel's findings on impairment. Ms Michaels submitted that the failings identified undermine public trust in the midwifery profession, and involved dishonesty along with a lack of duty of candour.

With regard to the imposition of a caution order, Ms Michaels submitted that the NMC guidance sets out that such an order is only appropriate if the panel has decided that there is no risk to the public or patients, and that the misconduct falls at the lower end of the spectrum. She submitted that a caution order would not be appropriate in this case due to the seriousness of the matter, and that your misconduct does not fall at the lower end of the spectrum of impaired fitness to practise. Ms Michaels submitted that given the public

interest issues and dishonesty identified, such an order would not be appropriate in these circumstances.

With regard to imposing a conditions of practice order, Ms Michaels submitted that the NMC guidance sets out that any conditions imposed must be relevant, measurable and workable, and at the same time sufficiently protect the public and maintain public confidence in the profession. She also submitted that any conditions imposed must also address the concerns that led to the panel's finding of impaired fitness to practise. Ms Michaels submitted that such an order would not be appropriate in this case as it would not address the public interest identified by the panel.

With regard to the imposition of a suspension order, Ms Michaels referred the panel to the NMC guidance checklist on sanction which outlines factors the panel may wish to consider when determining whether a suspension order is appropriate in this case. Ms Michaels submitted that a suspension order would be appropriate in this case for the reasons the panel determined in their findings on impairment, which she quoted as follows:

> *"The panel considered that your actions displayed a lack of integrity and professionalism on your part. It was of the view that a fully informed member of the public would be concerned by your professional conduct in being dishonest and failing to uphold your duty of candour, the distress caused to Patient A and her husband by your actions on 15 December 2018 and thereafter and would expect it to be appropriately marked as unacceptable. The panel considered that public confidence in the nursing profession and the NMC as a regulator would be undermined if a finding of impairment were not made in the circumstances…"*

She therefore submitted that public confidence may be sufficiently met by the imposition of a suspension order for a period of 9 months.

With regard to the imposition of a striking off order, Ms Michaels submitted that the NMC guidance sets out that such an order is likely to be appropriate when a midwife's conduct is fundamentally incompatible with remaining on the register. She submitted that the panel should consider whether regulatory concerns about a midwife's conduct raises fundamental questions about their professionalism. Ms Michaels submitted that this was addressed in the panel's findings when it took the view that your actions displayed a lack of integrity. She submitted that the panel should also consider whether public confidence in the midwifery profession can be maintained if you were not removed from the register. Ms Michaels submitted that a striking off order is open to the panel, and that it should consider the seriousness of the case when considering whether such an order is proportionate, taking into account all the factors set out in her submissions.

In light of her submissions and taking into account the NMC guidance, Ms Michaels invited the panel to consider the imposition of either a suspension order or striking off order.

The panel had sight of your written submissions on sanction and confirmed it had been read in its entirety, some of which were as follows:

"I was able communicate effectively, learn new skill and follow protocols and procedure. In view of my whole save practice before and after incident on the 12th of December 2018 I would kindly ask if NMC Panel would be able to take to consideration mitigation of the hearing penalties in view of facts that

- *There was not harm to patient A and her baby,*
- *I have admitted all allegations and I deeply regret all my actions,*
-
- *[PRIVATE]*
- *Please take to consideration pressure of heavy workload, I have been facing most of the time in the Basildon Hospital,*
- *Testimonies of work colleagues from previous jobs and current post which shoving my good character, honesty, positive attitude and work with good intention and aim for improvement,*

- *My CPD and PDP,*

Reflections that may not covered all area which should be improved, but I attempt to find ways to approve to the public that I will work on my behaviour to never cause any harm to reputation of my profession in the future." (sic)

You confirmed that you had no further oral submissions to make at this stage.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your misconduct was repeated three times over approximately five months;
- You abused your position of trust in failing to follow Patient A's consultant obstetrician care plan, and failing to be honest about the errors that occurred in order to protect yourself from the consequences;
- You sought to implicate another staff member in the misconduct by reporting she was present during the ARM;
- Your misconduct caused actual physical and emotional harm to Patient A at time of birth as she had to have an emergency C-section, and it also caused emotional harm to Patient A's husband; and
- Your dishonesty caused further distress to Patient A and her husband.

The panel also took into account the following mitigating features:

- You made full admissions to all charges at the outset of this hearing;
- You provided reflective pieces demonstrating significant insight into the incidents;
- You described a pressured working environment (i.e. staff shortages on the delivery suite);
- You described a poor culture within the maternity unit (i.e. lack of openness which prevented staff from reporting concerns and a consequential lack of learning opportunities);
- You provided positive testimonials from colleagues attesting to your character, particularly from your current employer; and
- [PRIVATE]

The panel had regard to the NMC guidance on dishonesty and considered the relevant information before it. The panel considered the dishonesty and breach of the duty of candour in your case to be very serious, particularly it noted the following:

- The dishonesty in this case was serious, involved a breach of the duty of candour and at the higher end of the spectrum;
- Although this was a one-off incident, your dishonest conduct was repeated three times;
- Your dishonest conduct caused direct harm to Patient A and her husband, who was considered a vulnerable patient with her pregnancy being identified as high risk; and
- Although there was no direct financial gain, there was personal gain in that you were dishonest in order to protect yourself, your job and reputation.

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular that for a conditions of practice order to be appropriate some or all of the following factors should be apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *[PRIVATE]*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that although some of the relevant factors above are apparent, there are no practical or workable conditions that could be formulated to address the concerns in this case, which are not related to your clinical practice. The panel was of the

view that conditions of practice would not satisfy the public interest, given the serious nature of the proven charges in this case which involves dishonesty.

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

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

The panel was satisfied that in all the circumstances of this case, the misconduct was not fundamentally incompatible with remaining on the register, nor did the concerns raise fundamental questions around your ongoing practice. It determined that a suspension order would sufficiently mark the seriousness of this case and maintain public confidence in the midwifery profession, and promote and maintain proper professional standards and conduct.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, it considered that this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the dishonesty and the facts found proved, and the public interest. The panel considered that a longer period would be punitive and that 6 months was a sufficient period to mark the seriousness of the misconduct and satisfy the public interest concerns in this case.

The panel bore in mind that it found there were no public protection concerns and that your fitness to practise is impaired only on the grounds of public interest. The panel was satisfied that the substantive order will satisfy the public interest in this case, will maintain public confidence in the midwifery profession, and the NMC as the regulator, and will declare and uphold proper professional standards.

In accordance with Article 29 (8A) of the Order the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary. The panel determined that a review of the order was not necessary in the circumstances of this case, as the suspension order will satisfy the public interest concerns and the panel considered that a further review would serve no useful purpose.

Accordingly, the current substantive order will expire, without review, at the end of the 6 month suspension order.

This will be confirmed to you in writing.

Interim order

As the suspension 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 suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Michaels. Given that the suspension order will not take effect immediately due to the 28-day appeal period, and the previous interim conditions of practice order on your practice has lapsed, she submitted that it would be appropriate and necessary, given the panel's findings in this case, to impose an interim suspension order.

Ms Michaels requested that an interim suspension order be imposed for a period of 18 months to cover the 28-day appeal period and any subsequent appeal.

The panel also took into account your submissions. You explained to the panel that, during the NMC proceedings, you complied with and successfully worked under the interim conditions of practice order imposed on your practice. You told the panel that an interim suspension order will further extend the period you are unable to work by another month, making your suspension period 7 months in total.

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

Decision and reasons on interim order

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 on whether an interim order is necessary. The panel bore in mind that it should only impose an interim order if it

was satisfied that an order was necessary in the public interest, following the case of *The Queen on the application of Shiekh v General Dental Council* [2007] EWHC 2972 (Admin). It was not satisfied that an interim order is necessary in the public interest as it considered that the high bar was not met in this case.

If no appeal is made, the substantive suspension order will come into effect 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.