Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 3 January 2023 – Friday 6 January 2023
Monday 9 January 2023 – Thursday 12 January 2023
Thursday 16 November 2023 – Friday 17 November 2023
Tuesday 21 November 2023 – Thursday 23 November 2023
Monday 27 November 2023 – Tuesday 28 November 2023
Tuesday 26 March 2024 – Thursday 28 March 2024 (panel only sitting)
Monday 15 April 2024 – Wednesday 17 April 2024
Friday 19 April 2024
Monday 22 April 2024
Wednesday 29 May 2024 – Thursday 30 May 2024 (panel only sitting)
Monday 29 July 2024 – Thursday 1 August 2024

Virtual Hearing

Name of registrant:	**Parveen Kelly**
NMC PIN:	99I7519E
Part(s) of the register:	Registered Midwife Midwifery – (November 2002)
Relevant Location:	Oxfordshire
Type of case:	Lack of competence
Panel members:	Anthony Mole (Chair, Lay member) Bill Matthews (Lay member) Sophie Kane (Registrant member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Margia Patwary (3 – 12 January 2023) Christine Iraguha (16 – 28 November 2023, 26 – 28 March 2024) Charis Benefo (15 April – 1 August 2024)
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter (3 January 2023 – 30 May 2024) Represented by Amy Taylor, Case Presenter (29 July – 1 August 2024)

Mrs Kelly:	Present and unrepresented at the hearing
Facts proved:	Charges 1, 2, 3a)i), 3a)ii), 3b, 3c, 3d)i), 3d)ii), 3e)i), 3e)ii), 3e)iii), 3e)iv), 3e)v), 3e)vi), 4a)i), 4a)ii), 4a)iii), 4a)iv), 4a)v), 4b, 4c, 5a)i), 5a)ii), 5a)iii), 5a)iv), 5a)v), 6a, 6b, 6c, 6d, 6e, 6f, 6g, 7a, 7b, 7c, 7d, 7e, 8a, 12, 13a, 13b, 13d)i) and 13d)ii)
Facts not proved:	Charges 4d, 7f, 8b, 9, 10a, 10b, 11a, 11b, 11c, 13c)i), 13c)ii), 13c)iii), 13c)iv), 13c)v), 13e and 13f
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge [as amended]

That you, between 27 August 2019 and 31 January 2020 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 6 midwife, in that you.

1) Did not work to an adequate standard during your three week supernumerary period.

2) Did not work to an adequate standard during your extended supernumerary period.

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
a) Failed to pass a Fetal Monitoring Assessment in that you;
i) Failed to pass a Continuous Electronic Fetal Monitoring Assessment.
ii) Failed to pass an Intermittent Auscultation test.

b) Failed to pass/complete the Passport to Practice.

c) Failed to pass a Band 6 progression form/assessment.

d) Failed to attend/pass training sessions regarding;
i) Cannulation and Venepuncture.
ii) Injectables.

e) Failed to undertake the pre-requisite E-learning sessions;
i) Venepuncture E-learning Package.
ii) Blood Transfusion E learning Package.
iii) Cannulation Video.
iv) Anaphylaxis Competency for ‘Age 12 and over’.

v) Anaphylaxis Competency for ‘All Ages’.
vi) Vascular Access Devices E-learning Package.

4) On 14 November 2019, during the third stage of labour for an unknown patient;
a) Attempted to deliver the placenta, before checking for;
i) The lengthening of the umbilical cord.
ii) Whether the uterus had taken on a globular shape.
iii) Whether the uterus had become firmer.
iv) Whether the uterus had risen in the abdomen.
v) A separation bleed.

b) Incorrectly attempted to pull on the umbilical cord before checking the uterus had contracted.

c) Incorrectly asked the unknown patient to bear down as you began to use the controlled cord traction method.

d) Incorrectly prioritised the unknown patient’s blood pressure, before checking/prioritising any suturing requirements/vaginal tears.

5) On or around 25 November 2019;
a) Were unable to demonstrate a full understanding of;
i) Delivering placenta using the controlled cord contraction method, in that you stopped applying traction after a brief pull.
ii) Completing Newborn Early Warning Score observation charts.
iii) The preparation of a birthing bed.
iv) Intravenous infusions during labour.
v) How to set up an Alaris pump for infusions.

6) On or around 26 November 2019;

a) Did not know that you needed to change the position of patients with epidurals every 1 hour.

b) Did not know that bladder care was at 2 hour intervals.

c) Did not know the guidelines for pyrexia in labour regarding a temperature of 37.5 degrees.

d) Considered conducting a vaginal examination for an unknown patient with a dense epidural block on her side, to avoid having to turn the patient.

e) Did not know how to turn a CTG machine off by the front button.

f) Were unfamiliar with how to get a woman onto clean sheets by turning her from side to side.

g) Did not know how perform intermittent catheterization.

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;

a) Were unsure about the loading dose of IV Benzylpenicillin.

b) Were unable to prepare a syntocinon infusion.

c) Were unable to set up syntocinon in an Alaris pump.

d) Did not document any of the care provided to an unknown patient in the clinical notes.

e) Did not keep up to date with the partogram.

f) Were unable to insert the in/out catheter to empty an unknown patient's bladder when her baby's head was low in the pelvis.

8) On or around 4 December 2019 whilst caring for an unknown patient during labour;

a) Did not appropriately titrate the rate of syntocinon whilst the patient had been contracting 5-6:10 for 20 minutes.

b) When warned about the risk of uterine rupture, inappropriately used words to the effect 'I knew a woman who had 12 babies without any problems'.

9) Did not complete the Trusts medicines management assessment.

10) On or around 23 December 2019;

a) Were unable to grasp how to use the fresh eyes stickers.

b) Did not understand the importance of staying with a woman in labour following a suspicious CTG reading.

11) On or around 24 December 2019

a) Were unable to organise a plan of care efficiently.

b) Provided an unclear handover to staff/doctors.

c) Failed to prioritise baby observations/abnormal results in a timely manner.

12) On or around 4 January 2020 did not know how to connect a y-connector.

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;

a) Were unable to make a plan of care for a woman in labour.

b) Did not know how to read/use a CTG.

c) Failed to provide basic care to a new born baby, in that you did not focus on;
i) Keeping the baby warm.
ii) Initiating skin to skin contact with the mother.
iii) Whether the baby was crying.
iv) Checking if the baby was blue.
v) Monitoring the baby's heart rate

d) Failed to demonstrate basic knowledge relating to;
i) Suturing instruments.
ii) Suturing technique.

e) Failed to recognise/escalate a deteriorating CTG.

f) Failed to handover using the SBAR system.

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

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

At the outset of the hearing, Mr Bardill on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partially in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made

pursuant to Rule 19 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

You agreed with the application.

The panel decided that parts of your case and transcript that make mention of [PRIVATE] be held in private to [PRIVATE].

Background

The charges arose whilst you were employed as a registered Band 6 Midwife by Oxford University Hospitals NHS Foundation Trust (the Trust). You were working at the John Radcliffe Hospital (the Hospital), which is part of the Trust.

You qualified as a midwife in the UK in June 2002 after completing your initial training at Oxford Brooks University. Between late 2002 and early 2018, you resided in [PRIVATE]. Initially you assisted in a birth centre and at homebirths alongside midwives, and in 2010 you gained your licence to practise as a midwife in [PRIVATE]. Your primary area of practice as a midwife was in a low risk birthing centre and caring for women during homebirths.

You returned to the UK in February 2018 and were employed by the Trust from 27 August 2019.

When you started your employment at the Trust, you commenced on the Delivery Suite, as you and the Trust determined that this was the most appropriate place for you to refresh your clinical midwife skills.
You initially worked in a supernumerary capacity for three weeks (23 hours a week). At the end of this time, it was agreed that this period be extended for a further four weeks. Towards the end of the extended supernumerary period, following feedback from staff who were supporting you, it was decided that a more formal programme was required to support and upskill you. The Trust considered that you had a wealth of knowledge for caring for women in a low-risk birth centre but not in a tertiary unit.

A formal Performance Improvement Plan (PIP) was therefore put in place on 7 November 2019. The PIP was intended to last six weeks, ending on or around 19 December 2019.

The PIP identified four general areas that required improvement:

1. Electronic Fetal Monitoring (to include completion of Fetal Monitoring assessment);
2. Skills and drills;
3. Evidence of consolidation of clinical skills (to include completion of the Band 6 progression assessment and '*passport to practice*' to the satisfaction of your mentor or manager); and
4. To become familiar with Medicines Management Policy and medicines used on the Delivery Suite.

Over the course of several meetings during the programme it became clear that you were struggling to complete the PIP. In relation to the amount of work you felt was involved in the PIP you told the Trust this was too much to achieve within your two shifts per week. You also informed the Trust that you felt that some of the staff on the delivery suite were not always kind to you and you felt that this had a negative impact on you being able to perform to your desired standard.

Following a PIP review meeting on 16 December 2019, it was agreed that you would be given more support, and the PIP would be extended to 27 January 2020, to enable you to complete outstanding requirements.

You completed the eLearning on Electronic Fetal Monitoring and Intermittent Auscultation but failed to pass either test. Further training was offered but there was no opportunity for this to be carried out.

You [PRIVATE] and did not return to work prior to your resignation on 31 July 2020. The PIP included key metrics and timelines against which progress was to be measured. You did not complete the PIP prior to your resignation.

Hearing adjourned on 9 November 2023

The hearing went part heard whilst you were in the middle of giving your evidence on 12 January 2023.

The hearing resumed on 9 November 2023, and at the start, the panel were informed by the Hearings Coordinator that [PRIVATE].

Mr Bardill submitted that the NMC will contact you to inquire if you would be available for the next listed day, namely 16 November 2023. He submitted that the hearing should be adjourned.

The panel noted that you have engaged throughout this hearing and the NMC proceedings. The panel determined to adjourn the hearing and concluded that it would be fair and in the interests of justice to [PRIVATE] and to afford you an opportunity to continue your evidence under oath and your engagement with the hearing.

The hearing adjourned.

Decision and reasons on application to amend the charge

The legal assessor drew the panel's attention to the formatting of charge 10)b)i) and ii). The proposed amendments were to correct typographical errors to provide clarity and more accurately to reflect the evidence. He submitted that the proposed amendments would not result in prejudice or unfairness to you.

10) On or around 23 December 2019;

a) Were unable to grasp how to use the fresh eyes stickers.

b) Did not understand the importance of~~;~~
~~i)~~ Staying with a woman in labour.
~~ii)~~ Following a suspicious CTG reading.

Mr Bardill and you made no objections.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was satisfied that such an amendment was in the interests of justice. No prejudice to you would arise and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to make the amendments, as applied for, to ensure clarity and accuracy.

Details of charge 10)b)i) and ii) [as amended]

10) On or around 23 December 2019;

a) Were unable to grasp how to use the fresh eyes stickers.

b) Did not understand the importance of staying with a woman in labour following a suspicious CTG reading.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you do not admit to any of the charges.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Bardill and yourself. The panel accepted the advice from the legal assessor.

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

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

- Witness 1: Consultant Midwife at the Trust;
- Witness 2: Band 7 Junior Manager at the Trust;
- Witness 3: Clinical Midwifery Manager for the Delivery Suite, working at the Trust;
- Witness 4: Level 2 Midwife working at the Trust; and
- Witness 5: Band 6 Midwife for the Delivery Suite, working at the Trust;

The panel also heard evidence from you under oath. You said that prior to your commencement at the Trust you went through a comprehensive assessment which included Objective Structured Clinical Examination (OSCE) and skilled based training similar to a return to practice assessment which you passed. The Trust had complimented you on your skills in the mock scenario at your assessment. At the time of your interview and after being offered the post you had made it clear to the Trust that you were working in [PRIVATE] for a private company providing low risk midwifery care within the home setting which required different skills to providing care within a hospital environment. You informed the Trust that you had not used certain skills for a long time, and you were promised further support and training to prepare you for a higher risk setting. You were offered placements in different areas but chose the delivery suite to broaden your experience as your background had been working in the community attending home births and you wanted to focus on your clinical skills. You worked in a supernumerary capacity working alongside other senior midwives, but you often found yourself on the ward working as a full member of the team and at times not in a supernumerary role you had expected.

You stated that the training courses you required were not provided on time and you were unable to demonstrate the core skills required and that your mentors were unavailable to properly mentor you or sign you off. You told the panel that on 10 December 2019, you reported to Witness 3 that you had been involved in a birth where you had noted a suspicious Cardiotocography (CTG) trace, and you had concerns about the care. You told the panel that you were advised that you would be included in the review of the case as a learning experience, but you were excluded from further reviews and attitudes towards you changed.

You claim the NMC referral was made following concerns that you had raised regarding the CTG trace, and the staff members have subsequently colluded against you as a direct result of your raising internal issues. You said the pressure to complete the training and to demonstrate you were able to work unsupervised increased after you increased the CTG

training to the point where you were told that if you did not complete the agreed training, your services would be terminated, and you would be referred to the NMC and your licence revoked. Despite, your best efforts, you were under pressure, and you [PRIVATE] without completing the training.

You voluntarily resigned because you felt the Trust was not a safe place to work and were surprised five months later when you were referred to the NMC. You said this was designed to protect the Trust and the nurses from the poor training and the CTG complaint you had made since there were a number of direct witnesses to the charges which you said were lies. You stated you did not make a formal complaint at the time because you were told that matters could potentially get worse. You said that some the midwives were known to be bullies and some of them colluded against you, and one NMC witness whilst giving evidence had agreed. You said that the Trust was also known as a bullying organisation.

During the hearing you provided the panel with a number of documents which included the emails you had sent the Trust about the suspicious CTG trace, the NMC referral, a number of testimonials, training certificates, screenshots of feedback from patients, photos of patients and comments from them, study days and eLearning certificates. You explained that you are a fully trained and capable midwife who has been honest and engaged with the Trust about your skills and you had been clear at the time of the accepting the role what your development needs were. However, you ended up without the required training and you were managed out due to the internal concern that you raised regarding the CTG.

You initially told the panel that it was your intention to call Ms 6 and Ms 7 registered midwives with whom you had worked at the Trust and provided the panel with two emails from them giving examples of situations at the Trust. However, you changed your mind and told the panel that it had the emails which you asked it to take into account.

Ms 6 in her email on 7 October 2021 stated, '*Parveen appeared to be placed under a lot of pressure and often faced the challenge to perform as a delivery suite midwife on busy shifts as well as completing competencies in a timely manner. There was a lack of structured framework or orientation period until Parveen herself asked for it… There seemed to be difficulty in assigning her one mentor and with this lack of continuity only lead to more challengers for Parveen … on a positive I was told by one of her mentors that Parveen gave excellent care to women and the women she cared for love her.'*

You also provided the panel with an email you had received from another experienced midwife, Ms 7, regarding feedback that you had requested. Ms 7 in her email on 16 January 2021 stated, *'I can't really remember in detail but I seem to remember that you had experience in normal birth which you demonstrated in your ability to listen intelligently / intuitively to the fetal heart and also demonstrated competence in your decision-making by asking the woman to get out of the pool in response to concerns about FH. And that you were calm and gentle with the woman. And you understood the limitations of your experience and were willing to ask for help. I also remember that it was important for you to be given space to develop your confidence and to demonstrate your experience*.'

Whilst the panel considered the emails from Ms 6 and Ms 7. It noted that the content of the emails did not go directly to the charges nor did the panel have the opportunity to hear the witnesses in evidence and/or ask any questions.

In considering the charges, the panel made the following findings.

You told the panel that you were a qualified and experienced midwife and were not given the opportunity to develop properly and your evidence was that the Trust had made a referral against you to protect itself.

The panel also heard from witnesses called by the NMC. It noted that the witnesses had made statements sometime after the referral, however, many of them had relied on notes made at the time as part of the feedback process to report your progress. The panel had

access to the feedback, the statements and heard from the midwives under oath. The panel considered that their evidence was consistent and measured.

The panel also noted that you relied on the reporting of the CTG as a substantial part of your submissions in that the claims against you were false and intended to manage you out of the organisation by presenting you as an incompetent midwife. The panel accepted that you had informed the Trust of the areas in your practice which required training and support. It also accepted that you had not worked in a pressurised clinical delivery suite for some years. However, the panel found that some of the concerns in your practice arose before the internal referral in respect of the CTG. The panel noted the first supernumerary period was extended after three weeks by mutual consent and that the PIP was put in place on 7 November 2019 where the Trust was highlighting the areas of improvement required. The panel took into account the Trust did recognise the difficulties you were experiencing commenting on your PIP plan as follows:

> *'Parveen has been working as a midwife in [PRIVATE] for 18 years where she is very experienced in normal birth in either a birth centre or at home. She is used to managing emergency situations in these settings and has had very good outcomes. Parveen is now back in the UK and has been successful in gaining employment in the maternity services. As all midwives are expected to work in Delivery Suite it was agreed that this should be her first rotation in order to gain experience in a hospital setting. Unfortunately although Parveen herself had highlighted her lack of experience in this area, this had not been fully appreciated. The aim of this programme is to increase the knowledge and skills required to work in delivery suite*.'

In addition, despite the concerns raised a number of the midwives had provided positive feedback on some areas of your practice, for example midwife Witness 5's feedback note on 14 November 2019 sent to Witness 3.

‘Parveen worked hard at taking notes on the things that I was teaching her. We looked after a P1 who came into the room in 2nd stage. She delivered shortly after arrival and Parveen was competent at the delivery.’

The panel accepted that you had raised issues about the attitude of some staff and there had been some difficulties and personal issues however, it noted no formal complaint had been raised by you.

The panel therefore placed limited weight on your assertion that the feedback and concerns were a direct result of you reporting a suspicious CTG and preferred the evidence of Witnesses 1 to 5 who had supplied notes to the Trust and updated your manager on your progress. The panel considered their evidence to be consistent and balanced. The panel did not consider that there was any real evidence presented to support your assertion that the witnesses had colluded against you. The panel determined, after hearing the evidence that the witnesses were responding to your line manager’s request for feedback as part of the Performance Improvement Plan (PIP) programme and to respond to your development needs and noted that both developmental and positive feedback was recorded.

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

The panel noted the stem of all the charges namely, that you, between 27 August 2019 and 31 January 2020 failed to demonstrate the standards of knowledge, skills and judgement required to practice without supervision as a Band 6 midwife, in that you:

Charge 1

1) Did not work to an adequate standard during your three week supernumerary period.

Charge 1 is found proved.

In reaching this decision, the panel considered the written and oral evidence provided by Witness 3, your oral evidence and your email to Witness 1 on 10 December 2019.

The panel took the word '*supernumerary*' to mean a period where you would require support from another midwife to ensure you are familiar with the Trust and its processes. It noted at the time you were working as a band 6 midwife. Witness 3 in her witness statement stated that because you had not completed your preceptorship with the Trust your skills would need to be assessed as set out in the Passport to Practice during the three-week supernumerary period. This is a standard approach based on the Passport to Practice.

In an email to Witness 1 on 10 December 2019, when you raised the CTG concern, you introduced yourself as, *'I am one of the supernumerary midwives on delivery suite…'* The panel noted this was confirmed by Witness 3 as well as in your oral evidence that you were working in a supernumerary capacity.

Witness 3 in her written statement and oral evidence said that you had approached her and stated that you were struggling and needed help which she was happy to provide, and your supernumerary period was extended for four weeks. Witness 3 also said that other midwives had said that you were struggling. Witness 3 further stated that it took them a while to identify the extent of the problem and she accepted that perhaps the Trust's expectations were too high at this point.

In your oral evidence you said that you had chosen to work in the delivery suite to broaden your experience and that the time and support given to you in that period was not enough. The panel considered all the evidence before it and accepted that you did not work to an adequate standard during your initial three-week supernumerary period. The panel therefore finds this charge proved.

Charge 2

2) Did not work to an adequate standard during your extended supernumerary period.

Charge 2 is found proved.

In reaching this decision, the panel took into account the evidence of the Witness 3. In a letter on 1 November 2019, Witness 3 states *'This extended orientation has been organised to ensure that you were supported; however following our recent discussion you have shared with me that even with this extended orientation you have found it to be a difficult transition.' … You have advised me that you are having communication problems with several members of staff and feel that their behaviour has not been acceptable. We discussed whether you would wish to make this an informal or formal complaint'.*

Witness 3 stated in relation to the extension period … '*It was my decision to extend the supernumerary period in consultation with the Midwife, which was a decision I was happy to make. Following this I had some Band 7 Midwives approach me to say that they did not feel that the Midwife was taking responsibility for patient care. For example, they told me that the Midwife would stand at the back or side of the room and let other Midwives do everything and that the Midwife was reluctant to step up. Some other concerns related to the Midwife being slow, their documentation and their lack of awareness*.'

The panel noted that Witness 3 did not think the problems were necessarily your fault and considered that the Trust and your expectations possibly did not '*match up'*.

In your oral evidence, the panel noted that you raised concerns regarding communication and your relationship with other members of staff, but no formal complaint was made. The panel considered the above letter fully explains the extended orientation given for your supernumerary period. The panel observed the letter to be a contemporaneous record which formally detailed the support given and confirmed that you did not work to an

adequate standard during your extended supernumerary period. The panel therefore finds this charge proved.

Charge 3

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;

The panel first considered the stem of the charge, namely had you fully completed the PIP. In reaching its decision on this matter, it considered the letters on 1 November 2019 and 16 December 2019 from Witness 3, Witness 3's evidence and your oral evidence.

The panel considered the letters to be contemporaneous records which confirmed that you had been placed on a development plan and you had an obligation to complete it:

> '*The objective of this process is to ensure that you are supported to consolidate your reintroduction into the NHS Maternity Services ensuring that you have the knowledge, skills and confidence to work in the Delivery Suite and other settings within the Service*.
>
> *At the beginning of your next shift (Thursday 7th November), we will meet together to discuss your Personal Development Plan and agree the progression for the next 6 weeks. I can confirm that I have provided you with a Passport to Practice and have attached a Band 6 progression plan*.'

In the letter on 16 December 2019, Witness 3 states:

> '*Thank you for meeting with Witness 1, … and myself to discuss how the Performance Improvement Plan you are undergoing is progressing. During the discussion it became apparent that there was still a great deal to achieve in a short*

period of time. Some of it was due to you not being able to book onto the necessary courses and therefore you felt that this was impeding your progress.

…

During the meeting you explained that it is difficult to complete all the assessments when you are required to work clinically and this was a challenge. From our perspective we are expecting you to complete the assessments in your own time so as not to comprise your clinical learning and we would like you to be more proactive in achieving this.

We do understand that there is a lot of work to be done on this plan and have therefore extended it until the 27th January to ensure that you have time to complete the courses and have the opportunity to practice prior to the end of the programme. There is a requirement from yourself to let the DS Co-Ordinator and your mentor know at the beginning of the shift what you need to concentrate on so that they can support you.'

The panel considered the Performance Improvement Plan, period starting 7 November 2019, which shows the areas of concern but noted that in the four areas of concerns highlighted you had completed only one.

In your cross examination, you responded by stating, "*so I asked for something more formal because things were not happening. There was no focus on the fact that I was supernumerary and back on delivery suite after some time*." Furthermore, you said that because Witness 1 was under pressure from the Director of Midwifery, she felt she had no other options, and you were not going to be provided with an extension beyond the final date.

The panel then went on to consider the sub charges.

Charge 3a)i)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
a) Failed to pass a Fetal Monitoring Assessment in that you;
i) Failed to pass a Continuous Electronic Fetal Monitoring Assessment.

Sub charge 3a)i) is found proved.

The panel considered Witness 1's statement which stated:

> '*The Midwife was to attend a Fetal Monitoring study day. This assessment should be completed each year.'*
>
> *The Midwife attended the foetal monitoring study day and completed the electronic foetal monitoring and IA videos but did not pass the test. The Midwife had obtained a score of 45% on their EFM and 65% on their Intermittent Auscultation (part of EFM), which meant that they had failed both elements. The next step would entail a one to one session with the Practice Development Midwife and to retake the test. I would have expected the Midwife to pass the IA more easily then the FEM. The pass mark for EFM was 75% and 85% for the IA.*
>
> *The Midwife said the reason they had failed was because they were too stressed about the test. However as the Midwife was off work we were unable to arrange any further sessions and the Midwife has not to date completed the test*.'

In her oral evidence, Witness 1 said, "*Every single midwife who works in intrapartum care, every single obstetrician, everybody does the CTG training and the CTG assessment. And whilst I could completely appreciate that [PRIVATE], there is CTG training every month."*

In cross examination, you said in response to a question on whether you had failed the test, "*I think that, yes, you have to consider background and context.*" The panel noted that you accepted failing the Fetal Monitoring Assessment and you explained that you demonstrated this skill regularly in your practice. You said that demonstrating the understanding is more important than passing the test.

The panel was satisfied, on the balance of probabilities, that you had failed the Fetal Monitoring Assessment and therefore found this charge proved.

Charge 3a)ii)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
a) Failed to pass a Fetal Monitoring Assessment in that you;
ii) Failed to pass an Intermittent Auscultation test.

Sub charge 3a)ii) is found proved.

Witness 1 stated, '*In Oxford we tested over 300 midwives. The Midwife failed the IA paper with 65%. The IA paper has a pass mark of 85%. 14 other midwives had a similar score out of 332 that were tested. This is the aspect of fetal monitoring I would have expected the Midwife to be accurate in as they had 18 years of experience predominately in low risk labours were IA is the central way of monitoring*.'

In your oral evidence, you said, "*yeah, that's true. I failed the test on the day, but it's not as important as doing it in practice, which I've shown to do*."

Based on the evidence of Witness 1 as set out above, and your admission, the panel found this charge proved.

Charge 3b)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
b) Failed to pass/complete the Passport to Practice.

Sub charge 3b) is found proved.

In reaching this decision the panel considered a letter dated 1 November 2019, from Witness 3, your Performance Improvement Plan, and your oral evidence.

The panel first established whether you had a duty to complete the Passport to Practice. It had sight of your Performance Improvement Plan and noted that there was a requirement to complete the Passport to Practice as part of your progression assessment as a Band 6 midwife. It stated '*To complete Passport to Practice'* by 20 December 2019.

The panel had sight of the letter dated 1 November 2019, from Witness 3, which stated '*At the beginning of your next shift (Thursday 7th November), we will meet together to discuss your Personal Development Plan and agree the progression for the next 6 weeks. I can confirm that I have provided you with a Passport to Practice and have attached a Band 6 progression plan.'* The panel noted that you were provided with the Passport to Practice as part of your development plan.

In your oral evidence, you accepted that you had not completed the Passport to Practice because there was no deadline. You said "*As I said before, there wasn't time or focus on getting these boxes checked*. … *Yes, I've agreed with that from the start, that it wasn't completed because I was working as a midwife in practice, and there wasn't time allocated for discussing these things because I was treated as a midwife*."

Based on the evidence before it, and your admission, the panel found this charge proved.

Charge 3c)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
c) Failed to pass a Band 6 progression form/assessment.

Sub charge 3c) is found proved.

In reaching its decision the panel considered your Performance Improvement Plan, the screenshot, and oral evidence.

The Performance Improvement Plan stated, '*To complete Band 6 progression assessment by 20 December 2019'*. The panel noted that there was a requirement to complete and by inference pass your Band 6 progression form/assessment.

You provided the panel with a screenshot of a partially completed form which was signed by you and not counter signed by your mentors, to show that you had completed this assessment. However, it considered that in your oral evidence, you stated that you were working as a midwife in practice, and there was not time allocated to complete such tasks.

The panel was satisfied that on the balance of probabilities, as well as your own admission, that you failed to pass your Band 6 progression form/assessment. It therefore found this charge proved.

Charge 3d)i) and 3d)ii)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;

d) Failed to attend/pass training sessions regarding;
i) Cannulation and Venepuncture.
ii) Injectables.

Sub charges 3d)i) and 3d)ii) are found proved.

In reaching its decision the panel considered your oral evidence, the email on 17 December 2019 from Witness 1, and to Witness 1 on 19 December 2019.

The email from Witness 1 on 17 December 2019 stated:

> '*Hi … Further to our corridor conversation today, please can you enable Parveen to attend cannulation and venepuncture training on 14th January and injectables on 16th January. It is imperative for Parveen to attend training in January as she is on a PIP that needs to be completed by 27th January – this has been extended once and won't be extended again. There are a number of issues regarding why she hasn't booked onto this before which we have addressed...'*

The email on 19 December 2019 to Witness 1 confirmed that extra capacity would be created to allow you to complete the training. In your evidence when asked specifically about this charge, you confirmed that you were not at the Trust on 14 and 16 January 2020, as [PRIVATE] and subsequently resigned.

The panel determined that on the balance of probabilities, you were absent at the time the training sessions in cannulation, venepuncture and injectables had been booked for you and therefore you did not attend/pass. The panel found sub charges 3d)i) and 3d)ii) proved.

Charge 3e)

3) Between 7 November 2019 and 27 January 2020 were unable to fully complete the objectives of a formal Performance Improvement Plan, in that you;
e) Failed to undertake the pre-requisite E-learning sessions;
i) Venepuncture E-learning Package.
ii) Blood Transfusion E-learning Package.
iii) Cannulation Video.
iv) Anaphylaxis Competency for 'Age 12 and over'.
v) Anaphylaxis Competency for 'All Ages'.
vi) Vascular Access Devices E-learning Package.

Sub charges 3e)i), 3e)ii), 3e)iii), 3e)iv), 3e)v), and 3e)vi) are found proved.

The panel considered each of these sub charges separately.

In reaching its decision the panel considered Witness 3's evidence, the email on 19 December 2019 with a screenshot of the pre- requisite courses to be passed, the Oxford Brookes University Midwifery Passport-to-Practice document listing the courses to be undertaken, your oral evidence and training certificates.

The panel noted that the email on 19 December 2019 was clear that before completing the cannulation, venepuncture and injectables training on 14 and16 January 2020, there were a number of pre-requisite courses to attend which were listed in the screenshot, which included 3e)i), ii), iii), iv), v), and vi). The email also stated that these requirements had not been met.

Witness 3 in their oral evidence stated, *'no record of it on the e-learning portal'. So that's all I had to go on.'*

In your oral evidence you confirmed that [PRIVATE] on 14 and 16 January 2020.

You provided a number of other certificates which you stated were similar to the courses mentioned above. However, the panel observed that there were specific courses that had to be undertaken by midwives to show standardised and good practice. It observed that the training was specific and the certificates you provided did not match those required by the Trust.

The panel was satisfied that although you had provided other training certificates which may have content of a similar nature, it was of the view that they were not specified by the Trust. It observed that the pre-requisite E-learning sessions had to be taken before the cannulation, venepuncture and injectables training on 14 and16 January 2020 and by this time as indicated in your evidence [PRIVATE]. It concluded that there was no evidence before it to show that you had completed the pre-requisite E-learning sessions and therefore found sub charges 3e)i), 3e)ii), 3e)iii), 3e)iv), 3e)v), and 3e)vi) proved.

Charge 4a)

4) On 14 November 2019, during the third stage of labour for an unknown patient;
a) Attempted to deliver the placenta, before checking for;
i) The lengthening of the umbilical cord.
ii) Whether the uterus had taken on a globular shape.
iii) Whether the uterus had become firmer.
iv) Whether the uterus had risen in the abdomen.
v) A separation bleed.

Sub charges 4a)i), 4a)ii), 4a)iii), 4a)iv) and 4a)v) are found proved.

In reaching this decision the panel took into account of the evidence of Witnesses 3 and 5, your oral evidence and your positive testimonials. The panel considered each of the sub charges separately.

It considered charge 4a) to be the stem of the charge (attempting to deliver the placenta) and sub charges i), ii), iii), iv) and v) to be the process in the third stage of labour.

Witness 5 in evidence stated, '*I felt Midwife Kelly was competent at delivering the baby. However, I had concerns about Midwife Kelly's delivery of the placenta within the active management of the third stage of labour.'* This was supported by her contemporaneous feedback stating, '*At the third stage, Parveen attempted to start delivering the placenta before checking the uterus*.'

Witness 5 also stated, *'My first concern about Midwife Kelly was that after administration of the uterotonic drug, she attempted to start pulling on the cord to deliver the placenta before checking to ensure that the uterus had contracted. There are four signs that indicate placental separation:*

- *There is a lengthening of the umbilical cord.*
- *The uterus takes on a more globular shape and becomes firmer.*
- *The uterus rises in the abdomen.*
- *There is a separation bleed'.*

In your oral evidence you said, "*I don't remember, yet she's clearly written that these things happened, so it's 'attempted to deliver the placenta before checking.' So, number 4(a)(i) and (ii) – simply untrue. I don't know what else to say. Absolutely untrue*."

You provided the panel with positive testimonials from previous patients to show that you could deliver a placenta and explained in your oral evidence how you would deliver a placenta.

In its consideration, the panel noted that Witness 5 was working with you on 14 November 2019 when '*P1*'/ '*unknown patient*', was admitted in the second stage of delivery. Witness 5 was an experienced midwife charged with assessing you.

It noted that you allege that the allegations are a conspiracy against you; that your relationship with Witness 5 was not positive; she was hard of hearing and put you under pressure speaking loudly and directly in your face. Your response was that the allegations were '*Absolutely untrue'*.

The panel preferred Witness 5's evidence, who was credible, concise and present at the incident and had made contemporaneous feedback. On the balance of probabilities, and from the evidence before it, the panel accepted Witness 5's evidence and therefore found these sub charges proved.

Charge 4b)

4) On 14 November 2019, during the third stage of labour for an unknown patient;
b) Incorrectly attempted to pull on the umbilical cord before checking the uterus had contracted.

Sub charge 4b) is found proved.

In reaching is decision the panel considered Witness 5's evidence and your oral evidence.

Witness 5 stated, '*At the third stage, Parveen attempted to start delivering the placenta before checking the uterus*.'

The panel noted that Witness 5 in her evidence explained the process of delivery in relation to the placenta and highlighted that you were not clear as to the process you were using in relation to active and physiological management, and you attempted to start pulling on the cord before checking that the placenta had separated.

The panel noted that you were working with Witness 5 to care for the patient, Witness 5 in the feedback stated, '*I worked with Parveen on 14th November 2019'.* Witness 5 was present on the day of the incident and had made a contemporaneous record which is

supported in her witness statement and oral evidence. Although in your oral evidence you denied the allegation, "*I've already said it's untrue and I wouldn't do that when an oxytocic has been given. I learnt that in my training in '99, 2002. It's not new – you have to understand that these things are not new to me*."

On the balance of probabilities and from the evidence before it, the panel preferred Witness 5's evidence. It found this sub charge proved.

Charge 4c)

4) On 14 November 2019, during the third stage of labour for an unknown patient;
c) Incorrectly asked the unknown patient to bear down as you began to use the controlled cord traction method.

Sub charge 4c) is found proved.

In reaching its decision the panel considered Witness 5's evidence and your oral evidence.

Witness 5 stated, '*My second concern was that Midwife Kelly asked the woman to bear down (push) as she began CCT. I felt that Midwife Kelly was not clear in her mind about the two different and separate methods (active management and physiological) used to deliver the placenta, and that by asking the woman to actively push whilst she was applying CCT, there was a risk of mismanagement of the third stage*.'

Witness 5 in the contemporaneous feedback wrote, '*She then asked the woman to bear down as she began controlled cord traction. She did check the uterus after the placenta was delivered to ensure that it was well contracted. Afterwards I informed her of the risks of using both physiological and active management of 3rd stage at the same time.*'

You gave an explanation to the panel of the method that you could use and said that you did not feel this incident was clear in Witness 5's mind, "*I've already explained that there are two different managements of the delivery of the third stage – and so if the mother chooses a physiological management, she doesn't have the oxytocic drug and she would bear down and do – yeah, they're two separate managements*."

On the balance of probabilities and from the evidence before it, the panel preferred Witness 5's evidence and therefore found this sub charge proved.

Charge 4d)

4) On 14 November 2019, during the third stage of labour for an unknown patient;
d) Incorrectly prioritised the unknown patient's blood pressure, before checking/prioritising any suturing requirements/vaginal tears.

Sub charge 4d) is found NOT proved.

In reaching its decision the panel considered Witness 5 evidence and your oral evidence.

Witness 5 in her statement, '*I noted that before checking for any vaginal tears, Midwife Kelly made the decision to check the women's blood pressure, explaining that this was because the women was shivering. Postpartum shivering or chills are a fairly common experience after birth and can last anywhere from a few minutes to an hour or two after the baby is delivered. Since there were no other concerns about the woman at the time, I felt that there was no immediate need for Midwife Kelly to take her blood pressure at that moment. I felt that the priority for Midwife Kelly should have been to check for any vaginal tears. When questioned by me, Midwife Kelly explained that she usually takes a patient's blood pressure every 15 minutes during the first hour "to keep on top of it*"....

I was aware that Midwife Kelly's decision to take the woman's blood pressure would only have taken a couple of minutes. It was not a totally inappropriate decision…'

In your oral evidence you explained that your care is patient centred, you said, "*that patient is a priority and their blood pressure and observations would be my priority"* and your reasons for prioritising the blood pressure. The panel determined that whilst Witness 5's opinion was that you should not have prioritised the blood pressure she agreed that your actions were not totally inappropriate. Although she referenced the Trust guidelines in her statement none were available for the panel to make an independent decision.

The panel therefore determined that the NMC had not proved that your actions were incorrect. It therefore found this sub charge not proved.

Charge 5a)i)

5) On or around 25 November 2019;
a) Were unable to demonstrate a full understanding of;
i) Delivering placenta using the controlled cord contraction method, in that you stopped applying traction after a brief pull.

Sub charge 5a)i) is found proved.

The panel considered the evidence in relation to each of the sub charges separately.

Witness 5 stated, 'On 25 November 2019, at the start of our shift together, we were asked to take over the care of a women whose delivery was imminent. … Midwife Kelly admitted that she found this situation [PRIVATE] and difficult to take the lead as a new midwife. As a result, I carried out the delivery and Midwife Kelly took over at the third stage. She was not confident about delivering the placenta by CCT, and stopped applying traction after a brief pull. It requires experience and skill to know what the appropriate amount of traction is that can be safely applied to the cord, and she demonstrated a lack of this. I therefore took over the delivery of the placenta.'

In your evidence, you provided a long summary of your experience, and said that Witness 5 was "*basically undermining*" you and that you knew how to do this. The panel noted that elsewhere in Witness 5's evidence she stated that you were confident, competent, and your final assessment was positive. You said the allegations were, "*Untrue, I absolutely can do those things.*"

The panel preferred Witness 5's evidence and determined that you were unable to demonstrate a full understanding of delivering placenta using the controlled cord contraction method, in that you stopped applying traction after a brief pull. It therefore found on the balance of probabilities; this sub charge proved.

Charge 5a)ii)

5) On or around 25 November 2019;
a) Were unable to demonstrate a full understanding of;
ii) Completing Newborn Early Warning Score observation charts.

Sub charge 5a)ii) is found proved.

Witness 5 in her evidence stated, '*Later on in the shift, I showed Midwife Kelly the Newborn Early Warning Score ("NEWS") observation chart that needs to be filled out for all babies post-delivery. I also explained to her which babies needed to be on special observations and when to take them. All of these guidelines are on the Trust intranet and I would have expected Midwife Kelly, as a qualified midwife, to have been knowledgeable about this, but she told me she was unfamiliar with it*.'

Witness 5 in the contemporaneous feedback written on 22 November 2019, stated, '*I showed her the NEWS chart, how and when to take baby obs, and which babies need to be on obs. She was unfamiliar with all this.*

Your response to this charge was that it was untrue.

The panel preferred Witness 5's evidence. It therefore found on the balance of probabilities; this sub charge proved.

Charge 5a)iii)

5) On or around 25 November 2019;
a) Were unable to demonstrate a full understanding of;
iii) The preparation of a birthing bed.

Sub charge 5a)iii) is found proved.

Witness 5 in her evidence stated, '*We practiced preparing a birthing bed in order for a woman's legs to be put into stirrups and for the removal of the bottom section of the bed for the lithotomy position. Midwife Kelly was unfamiliar with this*.'

Your response to this charge was that it was untrue. You also said, *"I don't think that warrants inclusion in the referral, but I can prepare a birthing bed."*

The panel preferred Witness 5's evidence. It therefore found on the balance of probabilities; this sub charge proved.

Charges 5a)iv) and 5a)v)

5) On or around 25 November 2019;
a) Were unable to demonstrate a full understanding of;
iv) Intravenous infusions during labour.
v) How to set up an Alaris pump for infusions

Sub charges 5a)iv) and 5a)v) are found proved.

The panel considered each of these sub charges separately.

Witness 5 in her evidence stated*, 'Midwife Kelly was also not fully knowledgeable about the most commonly used IV infusions during labour, nor how to set up or start the Alaris pump for the infusions. Again, I would have expected this knowledge and skill from a qualified midwife.'*

Your response to this charge was that it was untrue, you also said, "*How to set up an Alaris pump for infusions – that's what Witness 5 was there for as my main mentor. At my interview, I said I haven't been using intravenous infusions. I just hadn't been doing that in the community."* The panel noted that you accepted that you had not used this equipment when you were working in the community in America. You said that it was a matter of training with the help of your mentor, and not one that warrants inclusion in the referral. You emphasised that you had made it clear to the Trust about what you had done and had not done.

The panel considered the contemporaneous feedback from Witness 5, '*22nd November - Elective Section Bay'* and also dated 25 November 2019. The panel noted that Witness 5 was present at the incident on or around the 25 November 2019 outlining her observations.

The panel accepted Witness 5's evidence and on the balance of probabilities, found both sub charges proved.

Charges 6a), 6b), and 6c)

6) On or around 26 November 2019;
a) Did not know that you needed to change the position of patients with epidurals every 1 hour.
b) Did not know that bladder care was at 2 hour intervals.

c) Did not know the guidelines for pyrexia in labour regarding a temperature of 37.5 degrees

Sub charges 6a), 6b), and 6c) are found proved.

The panel considered each of these three sub charges separately.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in evidence stated, '*I had a number of concerns about Midwife Kelly during my shift with her on 26 November 2019. The Trust has specific guidelines for intrapartum care on the intranet, and it is expected that a qualified midwife would be familiar with them. Whilst caring for a woman in labour, Midwife Kelly demonstrated that she was not aware of the guideline advising to change the position hourly for all women who have epidurals, and to check for any evidence of pressure sores. She did not know that the guidelines recommended two hourly bladder care for women in labour, or what the guidelines were for pyrexia in labour if a woman has a temperature of 37.5*.'

Witness 5 in the contemporaneous feedback stated, '*She did not know that she was to change position of woman with epidurals every hour. She did not know that bladder care was 2 hourly. She did not know the guidelines for pyrexia in labour regarding a temperature of 37.5.'*

In your evidence, you denied the allegations and stated that this would not happen and gave an explanation as to how you would have conducted yourself in these circumstances and the actions you would have taken. You said that there were no patient notes in relation to this incident.

The panel preferred Witness 5's evidence to your explanation. Witness 5's contemporaneous feedback was written at the time and, in the panel's opinion accurately

reflected what had happened. On balance of probabilities, the panel found these sub charges proved.

Charge 6d)

6) On or around 26 November 2019;
d) Considered conducting a vaginal examination for an unknown patient with a dense epidural block on her side, to avoid having to turn the patient.

Sub charge 6d) is found proved.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 stated, '*Vaginal examinations are an important means of gaining information about the progress of labour. Midwife Kelly was considering doing a vaginal examination on a woman with a dense epidural block on her side, in order to avoid having to turn the woman on to her back. I explained that she was unlikely to get accurate information in this position. Midwife Kelly appeared to be confused about the difference between moulding and caput when reporting her findings*.'

Witness 5 in the contemporaneous feedback stated, *'She was considering doing a VE for a woman with a dense epidural block on her side, to avoid having to turn the woman. She reported that there was some moulding - she seemed confused about moulding and caput.*'

In your evidence, you denied the allegation and stated that this would not happen and gave an explanation as to how you would have conducted yourself in these circumstances and the actions you would have taken. You explained that your background is in providing comfort and woman-centred care and you would not have suggested examining a woman in an uncomfortable or inappropriate position.

The panel preferred Witness 5's evidence. The contemporaneous feedback was written at the time and, in the panel's, opinion accurately reflected what had happened. On balance of probabilities, the panel found this sub charge proved.

Charge 6e)

6) On or around 26 November 2019;
e) Did not know how to turn a CTG machine off by the front button.

Sub charge 6e) is found proved.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in the contemporaneous feedback stated, *'She didn't know how to turn the CTG machine off by the button on the front.'*

In your evidence you said, "*Yeah, the button's big. It's obvious. It's on the front. I don't know what they're trying to prove with that. That's just – and maybe I looked at it and then checked where the button was. Maybe I asked, but the machines were different sometimes in every room. So it might have taken me a minute to look at where the off button was. It wasn't exactly the same machine in every room. So whether or not it took me a moment to turn it off, I don't think that would ever compromise my colleagues or the patient in my care."*

The panel preferred Witness 5's contemporaneous feedback. The contemporaneous feedback was written at the time and in the panel's, opinion accurately reflected what had happened. On balance of probabilities, the panel found this sub charge proved.

Charges 6f) and 6g)

6) On or around 26 November 2019;
f) Were unfamiliar with how to get a woman onto clean sheets by turning her from side to side.
g) Did not know how perform intermittent catheterization.

Sub charges 6f) and 6g) are found proved.

The panel considered each of these sub charges separately.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in the statement stated, '*During the shift, Midwife Kelly was not competent with the clinical skill of intermittent catheterization. She was not familiar with the method used to transfer a woman on to clean sheets whilst remaining on the bed.*'

Witness 5 in the contemporaneous feedback stated, '*She was unfamiliar with how to get a woman on to clean sheets by turning her from side to side. She was not fully confident with doing an in/out catheter.'*

In your oral evidence you said:

> "*Yeah, I was unfamiliar with that, because I wasn't doing it in practice in the community. So I was unfamiliar with how to use the boards and slip them under the sheets, and then turn the mother on the board. I didn't – she didn't – nothing happened with that. Nobody was injured or – as we know, I was – I had made these things clear that I had and hadn't been doing at interview, when I passed the interview to work there*...

In any setting, whether you're in a birth centre, delivery suite, at home, every midwife needs to know how to perform intermittent catheterisation, and I do know how to do that. So it's untrue"

The panel preferred Witness 5's contemporaneous feedback. The contemporaneous feedback was written at the time and in the panel's, opinion accurately reflected what had happened.

The panel determined, on the balance of probabilities, and on all the evidence before it, these sub charges proved.

Charge 7a)

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;
a) Were unsure about the loading dose of IV Benzylpenicillin.

Sub charge 7a) is found proved.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in her evidence stated, '*During this shift, Midwife Kelly was still not confident in administering the IV Syntocinon infusion, nor what is the loading dose for Benzylpenicillin, a common antibiotic used in labour, nor how to prepare or draw it up. She was also still not confident in delivering the placenta by CCT'.*

Witness 5 in the contemporaneous feedback stated, '*Parveen was still unsure about what the loading dose of IV Benzylpenicillin was, and was not confident about how to draw up the required dose from the 3 vials.'*

In your evidence, the panel noted your acceptance that you were supernumerary although, you could remember the loading dose; it was your mentor's role to go through this process with you and sign you off.

The panel accepted Witness 5's contemporaneous feedback recorded at the time which was supported by her statement. On the basis of your explanation and the evidence before it, the panel found this sub charge proved.

Charges 7b) and 7c)

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;
b) Were unable to prepare a syntocinon infusion
c) Were unable to set up syntocinon in an Alaris pump

Sub charges 7b) and 7c) are found proved.

The panel considered each of these sub charges separately.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in her statement stated, '*During this shift, Midwife Kelly was still not confident in administering the IV Syntocinon infusion, nor what is the loading dose for Benzylpenicillin, a common antibiotic used in labour, nor how to prepare or draw it up. She was also still not confident in delivering the placenta by CCT*.'

Witness 5 in the contemporaneous feedback stated, '*Parveen was still not confident about how to prepare a syntocinon infusion nor how to set it up in the Alaris pump*.'

In your oral evidence you said, "… *that's still a stage where I was supernumerary, so it would be the mentor signing it off … So again, we go back to the infusion. That's for her*

to go through that with me, and then we sign it off. It wasn't a case that I was unable to prepare it. I've prepared many under – with my mentors observing."

You also stated, "*That's for her to go through that with me, and then we sign it off. It wasn't a case that I was unable to prepare it. I've prepared many under – with my mentors observing. Again she mentions, 'Unable to set up the Alaris pump.' It was her job to take the time and make sure I understood it".*

The panel preferred the evidence of Witness 5 who was present with you on the day of the incident. Her evidence is consistent with her contemporaneous feedback and in the panel's view accurately recorded her concerns. On the balance of probabilities, the panel found these sub charges proved.

Charges 7d) and 7e)

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;
d) Did not document any of the care provided to an unknown patient in the clinical notes.
e) Did not keep up to date with the partogram.

Sub charges 7d) and 7e) are found proved.

The panel considered each of these sub charges separately.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in the evidence stated, '*On 3 December 2019, Midwife Kelly was caring for a woman in labour without my direct supervision in the room. I noted that over a period of two hours, Midwife Kelly had not documented any of her care in her written notes, or kept up to date with the partogram (this is a paper hand written document used to record various markers to assess the progress of labour, aspects of care given and medication*

administered). When reminded about the importance of contemporaneous documentation, Midwife Kelly admitted that she found it difficult to keep up with the documentation at the same time as providing the care she wanted to give to the labouring woman, along with the necessary clinical tasks such as administering IV antibiotics.'

Witness 5 in the contemporaneous feedback stated, '*Parveen admitted that she found it difficult to provide the care she wanted to the labouring woman, whilst at the same time attending to the necessary clinical tasks (ie IV antibiotics) and documentation. During the two hours that she cared for the woman before she delivered, Parveen did not document any of her care in the notes, nor did she keep up to date fully with the partogram*.'

Regarding charge 7) d) you denied this allegation in your oral evidence and said that it was untrue and that you were documenting the care of the unknown patient as you went along.

Regarding charge 7) e), the panel noted your evidence was unclear in that, you initially said that you could recall recording on the partogram then later said, *"I would have written notes on the – yeah, I would – yeah, but I – it's three years ago. So I can't tell you about whether I then wrote the notes.*"

Considering both charges 7d) and 7e), the panel preferred the evidence of Witness 5, who was present on the day of the incident and her statement is supported by her contemporaneous feedback. On the balance of probabilities, the panel decided that you did not document any of the care provided to the unknown patient in the clinical notes or keep up to date with the partogram. It therefore found both these sub charges proved.

Charges 7f)

7) On or around 3 December 2019 whilst caring for an unknown patient in labour;
f) Were unable to insert the in/out catheter to empty an unknown patient's bladder when her baby's head was low in the pelvis

Sub charge 7f) is found NOT proved.

In reaching this decision, the panel considered Witness 5's evidence and your oral evidence.

Witness 5 in the contemporaneous feedback stated, '*She was not able to insert the in/out catheter to empty the woman's bladder when the baby's head was low in the pelvis.*'

In your oral evidence, you challenged this and said that although you could not remember the incident, inserting a catheter would depend on how low the baby's head was in the mother's pelvis. The panel noted that there was no specific information from Witness 5 as to the position of the baby's head and was therefore unable to weigh and assess the quality of her evidence in relation to this allegation. The panel could not determine without clearer evidence whether you were unable to insert the in/out catheter to empty an unknown patient's bladder when her baby's head was low in the pelvis.

The panel therefore found this sub charge not proved.

Charge 8a)

8) On or around 4 December 2019 whilst caring for an unknown patient during labour;
a) Did not appropriately titrate the rate of syntocinon whilst the patient had been contracting 5-6:10 for 20 minutes.

Sub charge 8a) is found proved.

In reaching this decision, the panel considered, Witness 5's evidence and your oral evidence.

Witness 5 stated, *'I noted that the woman had been contracting five to six contractions in ten minutes for twenty minutes and Midwife Kelly had not reduced the rate of Syntocinon in response to this*.'

Witness 5 in the contemporaneous feedback stated, '*Parveen still needs help in knowing how to appropriately titrate the rate of syntocinon. At one stage, the woman had been contracting 5-6:10 for 20 minutes and she had not reduced the rate in response to this*.'

In your oral evidence you said, "*So that was the – all of those things were discussed, and Witness 5 was overseeing what I was doing in the supernumerary capacity.*" The panel noted that you were in a supernumerary capacity, and you said from your training that you were aware of not overstimulating a mother's uterus by allowing it to contract more than five or six contractions in 10 minutes.

However, the panel preferred the evidence of Witness 5 who was present at the time and made contemporaneous feedback. The panel was satisfied that on the 4 December 2019, whilst caring for an unknown patient, you did not appropriately titrate the rate of syntocinon whilst the patient had been contracting 5-6:10 for 20 minutes.

On the balance of probabilities, the panel found this sub charge to be found proved.

Charge 8b)

8) On or around 4 December 2019 whilst caring for an unknown patient during labour;
b) When warned about the risk of uterine rupture, inappropriately used words to the effect 'I knew a woman who had 12 babies without any problems'.

Sub charge 8b) is found NOT proved.

In reaching this decision, the panel considered, Witness 5's evidence and your oral evidence.

Witness 5 stated, *'When I explained the risk of a uterine rupture to Midwife Kelly, I felt she showed a lack of appreciation of the risk when she replied to me that "she knew a woman who had 12 babies without any problems*".

In your oral evidence you said, *"So somebody who's had more than one baby is a multiple, and then grand multiparity is five or more. So in that context, it would have been part of a discussion, and it would have been okay, I feel, to have said, 'Isn't it interesting how some women don't bleed at all when they've had six or more babies and others do?' I wouldn't have said it in a nonchalant way, in a confrontational way. I think it would have just been relevant to the discussion.*"

The panel noted the context in which this statement was said and accepted your explanation that it was part of a discussion. It determined that your comment was not inappropriate.

The panel therefore found this sub charge not proved.

Charge 9

9) Did not complete the Trusts medicines management assessment.

Charge 9 is found NOT proved.

In reaching this decision, the panel took into account a letter sent by Witness 3 to you on 16 December 2019 and your evidence.

The letter on 16 December 2019 detailing the progress of your Performance Improvement Plan stated:

'*You have since forwarded to me your certificates for the E-Learning which you have completed. You have also confirmed that you have completed your PGD assessment.*

During the meeting you explained that it is difficult to complete all the assessments when you are required to work clinically and this was a challenge. From our perspective we are expecting you to complete the assessments in your own time so as not to comprise your clinical learning and we would like you to be more proactive in achieving this.'

Your exchange with Witness 3 in their cross examination, stated: "*So you state that I didn't complete the medicines management, or the training. So here it is, it's called – do you agree that your medicines management is called the midwives patient group directions?*
Yes, it is.
That's your Trust medicines management assessment.
Yes.
Isn't it? And I completed it and you have got the certificate on e-learning. So here it is, 'Congratulations, you have passed' and it is on e-learning for health, which I tried to access since all of this has happened. I have an email from them saying that they're working on it. So there we go, I did complete the medicines management, which is listed under 'PGD assessment', for clarification. Following on from that, I was to have an assessment –."

The panel on examination of the evidence, was unable to clarify what the Trust's medicines management assessment was and what it entailed. It found no written policy or documentation that showed what you had to complete.

The panel noted that in your evidence you asserted that you had completed the midwives patient group directions (PGD) which Witness 3 agreed was the equivalent to the Trust's medicines management assessment. The panel had sight of a screen shot that confirmed you had indeed completed the PGD assessment. From the evidence before it, the panel

was not satisfied on the balance of probabilities that you had not completed the Trust's medicines management assessment. It therefore found this charge not proved.

Charge 10a)

10) On or around 23 December 2019;
a) Were unable to grasp how to use the fresh eyes stickers.

Sub charge 10a) is found NOT proved.

In reaching this decision, the panel took into account Colleague 8's email on 23 December 2019 to Witness 1 and 3, Witness 5's evidence and your evidence.

The panel noted that the NMC is relying solely on the email on 23 December 2019 to support this sub charge. The email stated, *'Parveen needed to do fresh eyes but did not seem to grasp how to use the stickers, the importance of restorative measures and then delayed going back to the room for around 10 minutes.'*

The panel noted that prior to this on 4 December 2019, Witness 5 in her statement had stated, '*She showed that she was becoming more competent at the hourly 'Fresh Eyes' review (the routine use of a buddy system to review a CTG trace). She was competent and confident at delivering the baby and of delivering the placenta by CCT.'*

Colleague 8 was not a witness, and the panel was not given the opportunity to question the witness on this incident and explore the context and opinion of the email.

In your evidence, you disagreed that you were unable to grasp how to use the fresh eyes stickers and responded by stating that it was *"nonsense".*

The panel was of the view that having seen the evidence from Witness 5 on 4 December 2019, that you were becoming more competent at the hourly 'fresh eyes', it was not

satisfied on the balance of probabilities, that sufficient evidence had been provided by the NMC to show that you were unable to grasp how to use the fresh eyes stickers. It therefore found this sub charge not proved.

Charge 10b)

10) On or around 23 December 2019;
b) Did not understand the importance of staying with a woman in labour following a suspicious CTG reading.

Sub charge 10b) is found NOT proved.

In reaching this decision, the panel took into account Colleague 8's email on 23 December 2019 to Witness 1 and 3, and your evidence.

The panel noted that the NMC is relying solely on the email on 23 December 2019 to support this sub charge. The email further stated, '*There seemed to be an excuse, not 'my' fault response rather than understanding/acknowledgement of staying with a woman in labour or following on what was a suspicious CTG. Parveen then had a meeting and disappeared from delivery suite for what was a couple of hours.'*

The panel noted that the stem of this sub charge is a lack of understanding of the importance of staying with a woman in labour following a suspicious CTG reading. Throughout your oral evidence, the panel noted that on several occasions you were able to demonstrate your understanding of CTG. You told the panel that you had yourself reported a suspicious CTG to the Trust regarding an earlier incident.

The panel further observed that you had left the delivery suite for a meeting and the woman in labour was with another competent midwife. This was supported by the email on 23 December 2019 from Colleague 8.

The panel considered that there was no evidence supporting your lack of understanding of the importance of staying with a woman in labour following a suspicious CTG reading having previously reported suspicious CTG readings and you had left the room for a legitimate reason. Furthermore, Colleague 8 was not a witness, and the panel was not given the opportunity to question them on this incident.

The panel was not satisfied on the balance of probabilities that you did not understand the importance of staying with a woman in labour following a suspicious CTG reading. It therefore found this sub charge not proved.

Charge 11a)

11) On or around 24 December 2019
a) Were unable to organise a plan of care efficiently.

Sub charge 11a) is found NOT proved.

In reaching this decision, the panel took into account the email from Witness 4 sent on 24 December 2019, Witness 4's evidence and your evidence.

The email from Witness 4 sent on 24 December 2019, stated:

> *'I have some concerns about PK following our day together.*
>
> *Her ability to plan ahead and plan care efficiently, lack of thought as to how she could use me as her second midwife (eg to make up drugs or support with tasks) resulting in a significant delay to putting up syntocinon'.*

The panel noted that the NMC is relying on this email from Witness 4 to support this sub charge. Witness 4 in her statement stated, '*Due to a lapse of time, I cannot remember anything specific that happened on this particular shift or the woman we cared for on this*

day. I remember being asked to send an email … about the shift. ... However I am unable to add any further details about what happened on this shift.' In addition, Witness 4 in her oral evidence stated that she could not remember the incident and did not want to speculate. During extensive questioning from the panel, Witness 4 said that she was unable to clarify or add to the email sent on 24 December 2019.

The panel noted that Witness 4 during her oral evidence had agreed that as you were supernumerary, she may have left you unsupervised. "*So I cannot remember from this shift. But in general terms, with a supernumerary midwife, then yes, at times, indirect supervision could be appropriate …*" The panel also noted that witness 4 had stated there was confusion at the time she worked with you over what you could and could not do during a shift.

In your oral evidence, you stated that Witness 4 had left the room and asserted that the feedback was inaccurate as she had not witnessed much of your care. Witness 4 was unable to confirm or deny this when asked, stating that she could not remember the incident and did not want to speculate, she agreed that she may have left you unsupervised, but the feedback was a summary of a whole 12-hour shift.

From the evidence before the panel, it was not satisfied on the balance of probabilities that it could safely rely solely on the email sent on 24 December 2019 from Witness 4. It therefore found this sub charge not proved.

Charge 11b)

11) On or around 24 December 2019
b) Provided an unclear handover to staff/doctors.

Sub charge 11b) is found NOT proved.

In reaching this decision, the panel took into account the email from Witness 4 sent on 24 December 2019, Witness 4's evidence and your evidence.

The email from Witness 4 sent on 24 December 2019, stated:

'I have some concerns about PK following our day together.

- Unclear handovers to other staff and doctors.'

The panel noted that the NMC is relying on this email from Witness 4 to support this sub charge. Witness 4 in her statement stated, '*Due to a lapse of time, I cannot remember anything specific that happened on this particular shift or the woman we cared for on this day. I remember being asked to send an email … about the shift. ... However I am unable to add any further details about what happened on this shift.'* In addition, Witness 4 in her oral evidence stated that she could not remember the incident and did not want to speculate. During extensive questioning from the panel, Witness 4 said that she was unable to clarify or add to the email sent on 24 December 2019.

The panel noted that Witness 4 during her oral evidence had agreed that as you were supernumerary, she may have left you unsupervised. "*So I cannot remember from this shift. But in general terms, with a supernumerary midwife, then yes, at times, indirect supervision could be appropriate …*" The panel also noted that witness 4 had stated there was confusion at the time she worked with you over what you could and could not do during a shift.

In your oral evidence, you stated that Witness 4 had left the room and asserted that the feedback was inaccurate as she had not witnessed much of your care. Witness 4 was unable to confirm or deny this when asked, stating that she could not remember the incident and did not want to speculate, she agreed that she may have left you unsupervised, but the feedback was a summary of a whole 12-hour shift.

From the evidence before it, the panel was not satisfied on the balance of probabilities that it could safely rely solely on the email sent on 24 December 2019 from Witness 4. It therefore found this sub charge not proved.

Charge 11c)

11) On or around 24 December 2019
c) Failed to prioritise baby observations/abnormal results in a timely manner.

Sub charge 11c) is found NOT proved.

In reaching this decision, the panel took into account the email from Witness 4 sent on 24 December 2019, Witness 4's evidence and your evidence.

The email from Witness 4 sent on 24 December 2019, stated:

> '*I have some concerns about PK following our day together.*
>
> *- Lack of prioritising baby observations, acting on abnormal results quickly and remembering when next set due'*

The panel noted that the NMC is relying on this email from Witness 4 to support this sub charge. Witness 4 in her statement stated, '*Due to a lapse of time, I cannot remember anything specific that happened on this particular shift or the woman we cared for on this day. I remember being asked to send an email … about the shift. ... However I am unable to add any further details about what happened on this shift.'* In addition, Witness 4 in her oral evidence stated that she could not remember the incident and did not want to speculate. During extensive questioning from the panel, she said that she was unable to clarify or add to the email sent on 24 December 2019.

The panel noted that Witness 4 during her oral evidence had agreed that as you were supernumerary, she may have left you unsupervised. "*So I cannot remember from this shift. But in general terms, with a supernumerary midwife, then yes, at times, indirect supervision could be appropriate …*" The panel also noted that witness 4 had stated there was confusion at the time she worked with you over what you could and could not do during a shift.

In your oral evidence, you stated that Witness 4 had left the room and asserted that the feedback was inaccurate as she had not witnessed much of your care. Witness 4 was unable to confirm or deny this when asked, stating that she could not remember the incident and did not want to speculate, she agreed that she may have left you unsupervised, but the feedback was a summary of a whole 12-hour shift.

From the evidence before it, the panel was not satisfied on the balance of probabilities that it could safely rely solely on the email sent on 24 December 2019 from Witness 4. It therefore found this sub charge not proved.

Charge 12

12) On or around 4 January 2020 did not know how to connect a y-connector.

Charge 12 is found proved.

In reaching this decision, the panel took into account the feedback contained in the email sent on 3 January 2020 from Colleague 9 and your oral evidence.

The feedback from Colleague 9 in the email sent on 3 January 2020, stated; *'I feel you need more support with intravenous drugs as you did not know how to connect a y-connector.'*

In your oral evidence, you denied not knowing how to connect a y-connector and said that although you did not undertake the training, you knew how to connect a y-connector.

The panel noted that the NMC is relying on the feedback from Colleague 9 contained in the email on 3 January 2020 to support this charge. Whilst Colleague 9 was not a witness and the panel did not hear from the colleague, it was of the view that the email on 3 January 2020 was detailed and balanced. The panel further noted that Colleague 9 had known you for a number of years and had worked with you when you first started and, in the feedback, had stated that you had made massive progress since then. The feedback provided was in the context of your professional development and the panel determined that it was balanced and informative.

Taking all the above into account, the panel determined that the information contained within Colleague 9's email, was more likely than not to be accurate and was therefore satisfied on the balance of probabilities that on or around 4 January 2020, you did not know how to connect a y-connector. It therefore found this charge proved.

Charge 13a)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
a) Were unable to make a plan of care for a woman in in labour.

Sub charge 13a) is found proved.

In reaching this decision, the panel took into account the Witness 2's evidence, feedback from Witness 2 in an email sent on 19 November 2020, and your evidence.

The panel noted that the evidence for charge 13 relied solely on Witness 2's account. The panel also noted that there was a strong disagreement between you and Witness 2 on a variety of matters. Witness 2 had been requested to provide feedback which she

explained in her evidence*, 'I was asked to write an email of my concerns to [Witness 3], which is one of the exhibits in my statement, that said what my concerns were. In terms of concerns directly to the midwife, that was kind of an ongoing process, so literally, as you come across these things, you question somebody's practice and you ask questions about why they do what they do or have they done this before? So at those times, that's when you get the opportunity to say actually, that perhaps could have been done better or we need to do this or we need to do that. It was an ongoing process, but the report I sent to [Witness 3] by email was just a collection of things.'*

Witness 2 in their statement stated, '*I observed that the Midwife was not able to make a plan for the care of a woman in labour nor were they able to think past what was happening at the time. The Midwife should have been thinking about the 'what ifs', for example what if things go wrong, but the Midwife did not have the foresight to do this.*'

In her oral evidence she stated, "*I think, again, coming to this as an experienced midwife, I think it's perhaps a lack of awareness. You have to be aware of what your boundaries as midwife, and so there was a lot of prompting to think more than just the next 10 minutes. It's an awareness of what the situation is*."

The panel noted that Witness 2 had provided feedback on 19 November 2020, which stated, '*I did not feel confident that she was competent to be left in a room alone to care for a woman in labour.*'

You disagreed with Witness 2's evidence stating that you could care for a woman in labour.

Notwithstanding your disagreement with Witness 2 on a variety of matters, the panel noted Witness 2 had worked with you on a number of shifts and was a very experienced midwife. The panel found Witness 2's evidence to be clear, consistent, and corroborated by the contemporaneous feedback provided at the time. Witness 2 was robust during

cross examination and maintained a balanced and professional position. The panel preferred Witness 2's evidence and therefore found this sub charge proved.

Charge 13b)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
b) Did not know how to read/use a CTG.

Sub charge 13b) is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, feedback from Witness 2 in an email sent on 19 November 2020, and your evidence.

Witness 2 in their statement, stated, '*By way of further example, the Midwife struggles with foetal monitoring. As we are a high risk unit, the Hospital often cares for high risk women and it is important that the Midwife knows how to use and read the CTG … I think the Midwife's intention was to move on and provide community care but monitoring using a CTG is a basic skill needed before they would be able to do this.'*

Witness 2 in her oral evidence gave a detailed explanation, *"In defence for the midwife, CTG interpretation has changed ever such a lot over the last 20 years, and we're probably on the fifth different type of interpretation since I qualified. So from the point of view of expecting the midwife to be on top of her game in terms of interpreting a CTG printout, perhaps that is too much to expect. But there are certain themes throughout those CTG interpretations that have always stayed the same, such things as decelerations, which are just when the heart rate dropped. Being able to recognise what that could potentially mean is really important and that hasn't changed from the day that CTG monitoring was invented. So it's missing things like decelerations when they happen, understanding what they are when they're happening and why they're happening. Those were things that needed to be prompted. Also things like changes in baseline and variability within that*

graph, again, is something that's always been really important to interpret the wellbeing of the foetus. Those things have never changed."

Witness 2 in the feedback contained in the email on 19 November 2020, stated; *'Her CTG interpretation was poor and needed much guidance.'*

You disagreed with Witness 2's evidence stating that you could care for a woman in labour.

Notwithstanding your disagreement with Witness 2 on a variety of matters, the panel noted Witness 2 had worked with you on a number of shifts and was a very experienced midwife. The panel found Witness 2's evidence to be clear, consistent, and corroborated by the contemporaneous feedback provided at the time. Witness 2 was robust during cross examination and maintained a balanced and professional position. The panel preferred Witness 2's evidence and therefore found this sub charge proved.

Charge 13c)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
c) Failed to provide basic care to a new born baby, in that you did not focus on;
i) Keeping the baby warm.
ii) Initiating skin to skin contact with the mother.
iii) Whether the baby was crying.
iv) Checking if the baby was blue.
v) Monitoring the baby's heart rate

Sub charges 13c)i), 13)ii), 13c)iii), 13c)iv) and 13c)v) are found NOT proved.

Whilst the panel has grouped these charges together for the purposes of this determination, it considered them individually.

In reaching this decision, the panel took into account Witness 2's evidence, feedback from Witness 2 in an email sent on 19 November 2020, and your evidence.

Witness 2 in their statement, stated; '*On one shift that I worked with the Midwife, I observed a lack of basic care by the Midwife in respect on a new-born baby. For example the Midwife did not focus on keeping the baby warm, initiating skin to skin contact with the mother or checking on how well the baby was doing. The Midwife was not thinking about whether the baby was crying, whether they were blue or whether they had a good heart rate, which are all basic things to check when a baby has been delivered. These are all things you would expect of a band 6 Midwife. As the Midwife was not reviewing this I stepped in to review it.'*

You disagreed with Witness 2's evidence. You said that there was a clash of personalities and disagreed with Witness 2's course of action. You stated that you did give basic care stating that you had completed a thesis on this and that what Witness 2 had said was untrue. You explained in detail the care that you gave.

The panel noted the feedback from Witness 2 in an email sent on 19 November 2020 and noted that the NMC is relying on this email to show that you had failed to provide basic care to a newborn baby. This included keeping the baby warm, initiating skin to skin contact with the mother, whether the baby was crying, checking if the baby was blue and monitoring the baby's heart rate. On further observation, the panel noted that this incident and examples were not included in the feedback on 19 November 2020. Witness 2 in her evidence was not clear what the risk was, and her response was more general.

The panel was of the view that Witness 2's evidence for this particular incident was not detailed enough on what basic care you did and did not provide. It was of the view that the NMC has not provided sufficient evidence to support this charge. The panel therefore found these sub charges not proved.

Charge 13d)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
d) Failed to demonstrate basic knowledge relating to;
i) Suturing instruments.
ii) Suturing technique.

Sub charges 13d)i) and 13d)ii) are found proved.

In reaching this decision, the panel took into account Witness 2's evidence, feedback from Witness 2 in an email sent on 19 November 2020, and your evidence.

Witness 2 in her statement, stated: '*On that same occasion, the Midwife said that they wanted to complete the suturing (stitching after labour). However, when the Midwife went to assess the mother, their skills in terms of suturing were below the level expected of a band 6 midwife. The Midwife did not have any basic idea on how to manage the instruments used to carry this out let alone how to do it. I had to talk the Midwife through the wound and suturing. These were two occasions where I needed to talk the Midwife through the suturing which surprised me as I was under the impression that they had provided care to low risk women in labour, which would involve being able to suture. This was a concern to me as it made me wonder what they had been doing considering they needed guidance the whole way through.'*

During oral evidence Witness 2 gave a detailed explanation of her observations and the standard she expected. She stated, *"No, I would assume that absolutely that she would know that. I did ask the question about the environment that the midwife had been working in because I was surprised at how difficult, especially when it came to the suturing, how difficult she found suturing a perineum. So I had expected that actually, even if you work in the community, you should be competent at suturing a perineum. That is fundamental that you don't deliver a baby then have to transfer somebody into a hospital to finish off the*

suturing. So you would expect that person, had she been working for all of those years in the community, that she would be able to do that. That does surprise me."

In the feedback from Witness 2 contained in an email sent on 19 November 2020, stated; '*She had little confidence in clinical skilled [sic] such as suturing and cannulation, and had to be guided by me throughout'*.

In your evidence, you said that were not given the opportunity to complete the task, as Witness 2 was over supervising you and did not need to interfere at this stage.

Notwithstanding your disagreement with Witness 2 on a variety of matters, the panel noted Witness 2 had worked with you on a number of shifts and was a very experienced midwife. The panel found Witness 2's evidence to be clear, consistent, and corroborated by the contemporaneous feedback provided at the time. Witness 2 was robust during cross examination and maintained a balanced and professional position. The panel preferred Witness 2's evidence and therefore found this sub charge proved.

Charge 13e)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
e) Failed to recognise/escalate a deteriorating CTG.

Sub charge 13e) is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and your evidence.

Witness 2 in her statement, stated, *'The Midwife also had very little awareness of when things were going wrong, for example not recognising a deteriorating CTG. They had little knowledge of when to escalate to the medical teams and I often found myself leading the*

care the whole time, but I do not know if this is just how I am. The Midwife's feedback to me about this was that I took over the care of patients too quickly, which could be fair criticism but I could not just sit back and let things escalate without intervening.'

In your oral evidence, you gave examples of inappropriate CTG, and the panel accepted that you had reported such incidents to the Trust.

The panel considered that Witness 2 during their oral evidence, did not cover this incident in sufficient detail for it to assess whether on that occasion you had failed to recognise/escalate a deteriorating CTG. The panel further noted that in both her oral and written evidence, Witness 2 accepted that she may have intervened too quickly.

The panel noted that there was insufficient evidence to show that you had failed to recognise/escalate a deteriorating CTG and recognised that Witness 2 may have interjected in your care too early. It was satisfied that the NMC has not discharged its burden proof in respect of this allegation and therefore found this sub charge not proved.

Charge 13f)

13) Between 9 November & 27 December 2019, during a period of 4 supervised shifts with Colleague A;
f) Failed to handover using the SBAR system.

Sub charge 13f) is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, feedback from Witness 2 in an email sent on 19 November 2020, and your evidence.

The panel noted the evidence relied on by Witness 2 in their interpretation of the Situation, Background, Assessment and Recommendation (SBAR) system. In evidence, Witness 2

explained the importance of handover and why matters relating to patients' care should be outlined for other healthcare providers.

Witness 2 stated in oral evidence, *"So everybody has to conduct a handover. You hand over the care of the patient to the next shift or when the doctors are doing the ward round, you have to hand over the case to the doctors so a shared decision-making process can take place. We have a thing called an S-Bar which aids handovers, so they're safe and that there isn't any information missed, which may have been alien to the midwife because it's something that's a relatively new thing, but there are different versions of the same thing. But the handovers, be it to the doctors or the next team of midwives, was a bit ad hoc, a bit random. You have to set the scene, talk about the history, talk about what has happened in this episode of care and then what you expect to be done moving on, moving forward. And there was just no method to it. It was ad-hoc, is all I can say. It was a bit ad-hoc in that if you are the person listening to this handover, you get lost in which direction we're going in. And that's a safety issue."*

In your evidence, you accepted that handover is important and said that you had provided enough information during handovers.

The panel noted that Witness 2 in their statement indicated that you did not use any kind of tool or recognisable method to handover. However, the panel noted that Witness 2 in their account accepted the system was relatively new and in particular did not state what you said or did not say during handover that implied that patients' care was not planned or that it did not relate to the SBAR system. Witness 2 described your handover as ad-hoc but did not give detail on what you said or did not say.

In view of the evidence before it, the panel determined that there was insufficient evidence to support this charge. It was of the view that the NMC has not discharged its burden of proof in respect of this allegation. It therefore found this sub charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence 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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Your witness evidence on lack of competence and impairment

The panel heard the oral evidence of your witness, Ms 6. Ms 6 worked at the Hospital at the time of the concerns. Her role involved developing and managing the Oxford Spires Birth Unit (the Birth Unit).

Ms 6 gave oral evidence under affirmation. Ms 6 confirmed that she would be referring to her written statement dated 7 October 2021, which had already been provided to the panel at the fact-finding stage. In relation to the context of what was taking place on the Delivery Suite at the time, Ms 6 told the panel that it was "*unfortunately*" not uncommon for staff members to be moved to areas that they were not necessarily familiar with, if those areas were busy. She stated that she was aware that you perhaps did not get the support that

you were supposed to get when you were supernumerary because she saw you in other areas that you should not have been in. She said that when you were in these busy areas that you were unfamiliar with, there was no one there to help you.

Ms 6 informed the panel that she completed her midwifery training with you and then went straight into working at the Hospital in 2002. She said that at the time of the concerns, she was a Band 7 and the Team Lead for the Birth Unit. Ms 6 stated that she was at the Hospital for just over 20 years and she knew most of the "*characters*" there. She said that one of her roles was as Operational Manager, where she held a bleep which would provide information on what was going on in the Hospital, and part of her job involved moving staff from one area to another where the needs of the services had to be met.

You then referred Ms 6 to the fact that your mentor on the Delivery Suite was also the shift coordinator on some shifts. Ms 6 stated that from an operational manager's point of view, the shift coordinator did not need the added stress of being a mentor for the day as it was a "*huge job*", and for the person who was on supernumerary, it was inappropriate to be accessing support from the coordinator, because if they were dealing with anything on the Delivery Suite, they could not be fully engaged with the supernumerary midwife. Ms 6 stated that it was "*bad management*" for your mentor on the day to have also been the shift coordinator.

Ms 6 said that no one had ever said to her that you were unsafe. She stated that one of your mentors had said to her that your patients were really well cared for, and she did not recall anyone saying that you were incompetent.

In response to your questions about formal complaints of bullying in respect of Witness 2 and Colleague 8, Ms 6 stated that she knew that there had been at least two accusations of bullying about one of the two, and that both of them "*could be challenging*".

Ms 6 indicated that she stood by her written evidence that '...*This has occurred not due to impairment or poor care but mismanagement, time constraints and a lack of clear, focused*

discussion and support'. She stated that it was unfortunate that there was no decent and robust programme put in place for you and that it was a lost opportunity.

Ms 6 accepted that you started in the role with great enthusiasm and that she was open with you about how challenging and under pressure they were on the Birth Unit. She said that she had even asked you at the time whether you were sure that you wanted to join them and that when you were working there, she noticed a decline in your mental wellbeing.

In response to questions from the panel, Ms 6 said that she had never directly witnessed you delivering care in the Delivery Suite, but that she had spoken to Colleague 10 who told her how good you were.

The panel also had sight of a written statement from Ms 11 dated 19 April 2024. Ms 11 had worked with you at [PRIVATE] between 2012 and 2018. She provided positive evidence about your experience and competency as a midwife during that period.

Submissions on lack of competence by Mr Bardill

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Mr Bardill invited the panel to take the view that the facts found proved amount to a lack of competence.

Mr Bardill referred the panel to the NMC guidance on lack of competence which indicated that a single clinical incident, unless exceptionally serious, would not indicate a general lack of competence. Mr Bardill reminded the panel that it had been raised by you that

there were potential issues in the workplace, and he submitted that the guidance allowed the panel to take into account what you may well have been dealing with at the time when assessing your level of competence.

Mr Bardill referred to case of *McDermott v Health and Care Professions Council* [2017] EWHC 2899 (Admin) and submitted that any lack of competence must be serious. He also referred to the case of *GMC v Holton* [2006] EWHC 2960 (Admin) and submitted that external factors such as the pressure of work, lack of resources and professional isolation due to an absence of colleagues are relevant to the panel's consideration.

Mr Bardill submitted that notwithstanding your personal circumstances at the material time, the seriousness of the incompetence was aggravated by the fact that it was multifaceted and over a period of time, rather than one or two single incidents or issues.

Mr Bardill identified the specific, relevant standards where your actions amounted to a lack of competence. He submitted that the nature of your lack of competence could be separated into two areas:

1. Training, skills and comprehension
    i. Failure to work to an adequate standard during supernumerary periods, including after an extension and additional support.
    ii. Failure to pass the required assessments or tests as part of a formal PIP.
    iii. Failure to attend or pass training sessions in relation to those outstanding competencies.
    iv. Failure to undertake the required e-learning modules/package.
    v. Being unable to demonstrate a full understanding of various tasks, procedures and process which one is required to have a full understanding of in order to safely practice.
    vi. A lack of knowledge of tasks, requirements, practices, processes or procedures which she was required to have.
    vii. Lack of knowledge in reading, interpreting, using CTGs.

2. Patient care
    i. Unsafe procedures on patients.
    ii. Incorrect prioritisation of actions.
    iii. Failures in recognising deteriorating patients.
    iv. Lack of knowledge in basic care (e.g. lack of knowledge or certainty about loading doses of IV Benzylpenicillin, etc.).
    v. Lack of ability to make a plan of care for some patients (e.g. a woman in labour).

Mr Bardill submitted that you demonstrated a low standard of professional performance which was observed by colleagues and trainers; a lack of knowledge and skill; and questionable judgement which put patients at a real risk of serious harm.

Submissions on impairment by Mr Bardill

Mr Bardill 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) and *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin).

Mr Bardill highlighted that you are self-representing in this case. He submitted that it was of particular importance to note that a registrant has the right to a strong defence and that maintaining innocence does not necessarily indicate a lack of insight, as set out in the case of *Ahmedsowida v GMC* [2021] EWHC 2466 (Admin).

Mr Bardill submitted that the panel's findings of fact in respect of your deficient professional performance showed that your fitness to practise is impaired in the sense that you acted and are liable in the future to act so as to put patients at unwarranted risk of

harm. He submitted that there had been no evidence that the concerns have been addressed, and in the absence of such evidence, there was a real risk that these and similar incidents putting patients at risk of harm, would be repeated.

Mr Bardill highlighted that the conduct found proved was repeated on numerous occasions and multifaceted in that it affected multiple areas of practice.

Mr Bardill submitted that there were attitudinal issues going to insight in this case. He asked the panel to consider the evidence of your colleagues, the fact that you did not follow training processes and procedures, and your approach and response to those points. Mr Bardill submitted that for example, you failed to complete some training or failed a test, but still maintained to the panel that you were nonetheless competent, as if to not appreciate the importance of having those training competencies completed.

Mr Bardill submitted that you made accusations against not just fellow staff members, but in these proceedings claimed that the hearing and panel had not been impartial. He submitted that the panel might think that this was exactly the kind of behaviour that your colleagues dealt with. Mr Bardill submitted that this represented a deep-seated attitudinal issue going to a total lack of insight and extending beyond it into an inability to reflect at all.

Mr Bardill referred the panel to the NMC guidance on insight and strengthened practice and submitted that your lack of insight makes this a very difficult case to correct or put right. He submitted that there had been facts found proved where patients had been placed in harm's way.

Mr Bardill invited the panel to consider the following questions set out in the guidance:

- Can the concern be addressed?
- Has the concern been addressed?
- Is it highly unlikely that the conduct will be repeated?

Mr Bardill submitted that the concerns in the charges have not been addressed, but disputed. He reiterated that the lack of insight in this case was not because you have denied and disputed the charges, but the way in which you have disputed the charges, your response to them, and the way in which you have made allegations against people you do not see eye to eye with.

Mr Bardill submitted that there is a public interest in a finding of impairment, particularly where patients have been harmed or placed at risk of harm and staff put in difficult or risky situations in their own practice. He submitted that you have not demonstrated how you are going to allay any of the risks or fears going forward. He submitted that you have not accepted responsibility, or provided evidence of the competencies having been reached to the required standard.

Mr Bardill invited the panel to take into account that you have had no adverse findings against you since joining the register in November 2002. He also reminded the panel that between 2002 and 2018, you were working overseas in [PRIVATE].

Your submissions in relation to lack of competence and impairment

You submitted that the reason you denied and disputed the charges at the very beginning was because you wanted to wait for the opportunity to explain the context. You submitted that you did not make a complete denial of everything, but had accepted that there were certain things that you did not do and were open and transparent about that at the interview stage, before you were employed by the Trust to work on the Unit. This was the reason you were placed on a supernumerary basis and provided with a training and support plan prior to the commencement of your employment as a midwife.

You submitted that you could not have been able to represent yourself throughout this process without very clear insight and in-depth reflection, and that you had demonstrated

it in a number of ways, including your evidence under oath, your references from patients, previous employers and colleagues, and your reflective email correspondences.

You submitted that you deny Mr Bardill's submissions about attitudinal problems and felt it was very unfair to state that you lack insight and remorse because you do not. You submitted that you are very critical of yourself and you self-reflect. You submitted that had you made a mistake and harmed a patient in your care or their baby, that would be very hard on you because you relate to them very well.

You submitted that the panel's findings on the facts did not reflect any consideration of the written medical records or the contemporaneous email communications that related directly to the matters in issue. You highlighted the findings that you disputed and described the circumstances of those incidents. You reminded the panel of the contextual circumstances on the Birth Unit at the time, which included in your submission, poor management, collusion and the setting of unattainable deadlines. You drew the panel's attention to the fact that whilst the environment was pressured, you caused no patient harm.

You referred to the evidence of the NMC witnesses and your witness, Ms 6. You submitted that there were inaccuracies in the written statements of the NMC witnesses, which had been submitted three years after you worked at the Trust.

You also submitted that some of the panel's findings on the facts conflicted with each other. An example of this being that the panel had found charge 10a and 10b not proved, but found charge 13b proved. You submitted that this needed "*to be looked at*" because it was unfair, an offence against natural justice, and amounted to slander and defamation.

You submitted that you thoroughly enjoy midwifery work and miss it, although the dilemma was the negative midwifery culture. You stated that in relation to working on the Birth Unit, "*you'd better be ready for the backlash because if you... raise complaints, you're a sitting duck*". You submitted that you did not expect it to "*come down*" on you like it did.

You submitted that you had demonstrated remediation and full responsibility for your role by removing yourself from the environment through voluntary resignation.

You highlighted that your patients were very happy, felt safe in your care and really liked you. You submitted that an incompetent and "*underconfident*" midwife would be obvious as women in labour are highly attuned to their care givers. You submitted that there would have been at least one complaint from a patient for such an incompetent midwife, as had been described, but there were none.

You submitted that the panel held the ultimate power over your ability to work which would impact on [PRIVATE]. You invited the panel to consider the evidence before it cautiously, fairly and honestly. You submitted that in considering the context and intent of the complaint, you hoped that the panel would consider your previous training, background, history, documented records of safe outcomes, and your knowledgeable and professional approach to midwifery.

In conclusion, you submitted that you could assure the panel that you have always complied with the NMC's requirements and regulations, and would only go into environments where you could provide a safe level of care and "*speak up for anything outside of that*".

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Holton v GMC*, *Calhaem v GMC* [2007] EWHC 2606, *Cohen v GMC* [2008] EWHC 581 (Admin) and *CHRE v NMC and* Grant.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of 'The Code: Professional standards of practice and

behaviour for nurses and midwives (2015)' (the Code). In particular, the following standards:

*'**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

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

22 Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'.

The panel bore in mind, when reaching its decision, that the issue of competence or lack of it is to be assessed against the standard reasonably to be expected of a midwife of your qualifications and experience.

The panel had regard to the NMC guidance on lack of competence which states:

'*Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.*

...

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation. If there is such

evidence we may need to take some additional action, such as sharing information with other regulators or employers.'

The panel found that your conduct at the charges found proved could be categorised into the following:

1. Training, skills and comprehension
    i. Failure to work to an adequate standard during supernumerary periods, including after an extension and additional support.
    ii. Failure to pass the required assessments or tests as part of a formal PIP.
    iii. Failure to attend or pass training sessions in relation to those outstanding competencies.
    iv. Failure to undertake the required e-learning modules/package.
    v. Being unable to demonstrate a full understanding of various tasks, procedures and process which one is required to have a full understanding of in order to safely practice.
    vi. A lack of knowledge of tasks, requirements, practices, processes or procedures which she was required to have.
    vii. Lack of knowledge in reading, interpreting, using CTGs.

2. Patient care
    i. Unsafe procedures on patients.
    ii. Failures in recognising deteriorating patients.
    iii. Lack of knowledge in basic care (e.g. lack of knowledge or certainty about loading doses of IV Benzylpenicillin, etc.).
    iv. Lack of ability to make a plan of care for some patients (e.g. a woman in labour).

The panel had regard to your training certificates and witness evidence. It took into account your submissions that you did not lack competence, but were put under pressure on the Birth Unit as it was a busy and stressful unit and at times, there was a lack of support.

The panel considered that you are a qualified midwife with experience in the UK and particularly in [PRIVATE]. It noted that upon your return to the UK, you took up employment at the Trust, after passing the assessment during the recruitment process. During your interview, you had raised your lack of recent experience in a high-pressure clinical environment. As a result of this, it was agreed that you would complete an initial supernumerary stage alongside a development plan.

The evidence before the panel was that during this period, various nurses who were working with you noticed (in some cases but not all) a pattern of behaviour which suggested a lack of competence in the areas set out above. The panel had heard that in those areas, there was a potential risk to patients and you were not practising at the standard required at the Trust. As a result, additional performance measures were put in place but those measures were never completed.

The panel heard and accepted the evidence from the direct witnesses to your performance as a midwife during this time. The panel accepted that there was some degree of expectation in relation to the skills you were supposed to display, however in hindsight, this may have been over-ambitious. The panel noted that there was some tension between you and the Trust because of the pressure you were placed under to complete your development programme. However, it took account of the witness evidence, for example and in particular that of Witness 3 who had stated in her witness statement that:

> ‘*Because the Midwife had not completed the PIP we could not let them work independently. The Midwife demonstrated to us that they are not able to work on a high risk delivery suite unsupervised. At the point of leaving the Trust, the Midwife did not possess the clinical skills required of a band 6 midwife. That is to say that while they had completed the basic training of a newly qualified midwife (band 5), they had not then demonstrated the clinical skills that would normally be obtained during the preceptorship year and which traditionally would be recorded in the*

passport to practice. My concerns about the Midwife's clinical ability remain despite the positive feedback received to show that that they are caring to the women and had an excellent knowledge of the birth centre.

We were also not confident that the Midwife could recognise when something was wrong and escalate concerns appropriately and this presents a risk to patient safety.

...

I have no doubt that the Midwife is able to complete the PIP as they were lovely, caring and supportive to the women in labour but they just needed to back with up with clinical skills and that is what was hard from my perspective. If the Midwife was to complete the PIP, or another similar PIP, I would no longer have concerns about their ability to practise at band 6 level.'

The panel determined that despite your submission that you were competent, there was a safety issue stemming from the lack of competence in key areas of your practice. It was clear that you did not complete the development programme set by the Trust and in a number of areas failed to demonstrate the required level of competence that would keep patients safe and allow you to work independently without supervision.

The panel's duty is to patient safety and their protection under the care of nurses and midwives. Taking into account the reasons given by the panel for the findings of the facts, the panel concluded that your practice was below the standard that one would expect of the average registered midwife of your qualifications and experience.

In all the circumstances, notwithstanding the high-pressure nature of the environment in which you found yourself, the panel determined that your performance in the areas set out above demonstrated a lack of competence.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated 27 February 2024, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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) *...’*

The panel determined that limbs a), b) and c) are engaged.

The panel found that patients were put at risk of harm as a result of your lack of competence. Your lack of competence had breached the fundamental tenets of the nursing profession, namely that in some areas of key midwifery practice you failed to demonstrate the required standard to deliver safe and effective clinical care on the Birth Unit, and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that upon taking the post at the Trust, you demonstrated a level of insight into your level of competence by accepting a supernumerary role, as you had not practised in a high-pressure clinical hospital environment within the UK for a number of years. The panel accepted that you had

previously demonstrated the required standards to qualify as a midwife. However, since the issues had been highlighted and the specific charges had been found proved, you had not accepted that you demonstrated a lack of competence. Further, you have not taken any reasonable steps to rectify the specific issues raised.

The panel was not satisfied that you had sufficiently demonstrated an understanding of how your actions put patients at a risk of harm, how this impacted negatively on the reputation of the midwifery profession, and how you would handle a situation relating to your identified lack of competence in a clinical environment differently in the future.

The panel noted the evidence that you were unable to listen and take on feedback at the time of the concerns.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the references and training certificates you submitted during this hearing.

However, the panel noted that you failed to fully engage and complete the competencies set by the Trust at the time of the concerns. It considered that despite efforts from management to implement plans, give extensions, communicate policies and procedures, and give instructions to you, the issues continued and you sought to blame others and accept minimal responsibility. The panel was not satisfied that you had provided sufficient evidence to satisfy it that those areas of concern had been addressed or your practice had been strengthened to the required standard, either by training and/or by any observed clinical practice in similar environments. The panel was of the view that during the hearing, you actively resisted any suggestion that you lacked competence.

The panel had heard and accepted evidence that you were kind to patients. However, the panel concluded that you cannot currently practise safely and professionally as you have not been able to demonstrate your competence in the identified key areas of your practice.

The panel therefore found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel bore in mind 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/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was required. This is because a well-informed member of the public would be concerned to learn that you lacked competence in fundamental areas of midwifery practice which put patients at risk of harm, and provided no evidence to show that these concerns had been meaningfully addressed.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months with a review. 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

In the Notice of Hearing, dated 1 December 2022, the NMC had advised you that it would seek the imposition of an 18-month conditions of practice order if the panel found your fitness to practise currently impaired. During the course of the hearing, Ms Taylor, on behalf of the NMC, informed the panel that the NMC revised its proposal and submits that a suspension order for a period of six to 12 months with review, is more appropriate in light of the panel's findings.

Ms Taylor submitted that such an order was required to mark the seriousness of this case. She highlighted that at the time of the concerns, you were working in a supernumerary capacity and were unable to show competence in the identified areas of concern. Ms Taylor submitted that within this hearing, you had denied a lack of competence and had not taken steps to address the concerns. She submitted that you therefore still pose a risk to the public and conditions of practice would not be workable. Ms Taylor invited the panel to provide you adequate time to reflect and develop insight into the concerns.

Ms Taylor proposed that the following aggravating features were present in this case:

- You had demonstrated lack of insight, remorse and remediation in relation to the concerns;
- The issues in this case involve conduct which put patients at risk of suffering harm;
- The issues in this case relate to fundamental areas of midwifery practice;
- You failed to demonstrate competency despite support and a formal performance improvement plan;
- The failures took place despite you being an experienced midwife with over 18 years' experience.

Ms Taylor submitted that it was a matter for the panel to decide what, if any, mitigation is in this case.

In relation to a suspension order, Ms Taylor referred the panel to the relevant factors in the SG and submitted that there were numerous failings linked to your competence, such that you require supervised re-entry into the midwifery profession. She referred to your lack of insight and submitted that the seriousness of this case requires a suspension order to protect the public and the public interest. Ms Taylor submitted that there would be a risk to patient safety if you were allowed to practise without restriction.

Ms Taylor submitted that if the panel was not minded to impose a suspension order, then it may impose conditions of practice. She submitted that any conditions formulated must be workable, appropriate and stringent as you will require close supervision in the areas of concern until you can demonstrate competence.

The panel also bore in mind your submissions that the NMC had invited the panel to impose a suspension order with no facts or solid reasons as to how that would change anything. You referred to the SG which states that any order imposed should be supportive of the registrant and not purely punitive.

You referred to Ms Taylor's submission that you should be allowed more time to remediate, reflect and show remorse. You submitted that you have had four years to do so and from your statement and your very careful responses to the material and case, it was clear that you have fulfilled those requirements.

You submitted that you have reflected on what happened and how you could have acted differently. You submitted that you had attempted to rectify the issues with the people involved but you were managed out of your role. You referred to your voluntary resignation from the Trust after being bombarded with allegations, and that you were asked to return to the role by your manager and HR. However, you chose not to return as it was a hostile environment.

You submitted that it was not fair to claim that there were attitudinal problems without the facts. You submitted that the suspension order sought by the NMC was harsh and you did not think the reasons provided were fair. You submitted that such an order would be disproportionate.

You submitted that you have attended conferences and workshops, and keep up to date with evidence-based care in your own time. You highlighted that you had sent evidence of such during the hearing. You submitted that a suspension order would prevent you from doing anything, including research and teaching, and that this was not reasonable. You reminded the panel that you have never harmed a patient, mother or baby, and have never been told that you need to leave a midwifery role.

You told the panel that "*until this is resolved*", you will review your plans on what you want to do, but you have no intentions of returning to clinical practice under your NMC PIN.

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:

- You demonstrated an abject lack of insight throughout the process into the failings identified.
- You did not show remorse or recognition for your lack of competence in the areas of practice identified.
- There was no evidence of strengthened practice in relation to the areas of concern.

- The lack of competence and lack of recognition of such poses a risk to patient safety.

The panel also took into account the following mitigating features:

- There were positive testimonials from your former colleagues, particularly in respect of other areas of your practice.
- There was some evidence of a lack of support in aspects of your development plan at the time of the concerns.

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.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your lack of competence 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 was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG:

- *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;*
- *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 was satisfied that there are identifiable areas of your practice in need of assessment and retraining, and there was also no evidence of general incompetence. It therefore found that workable conditions of practice could be formulated to protect patients and give you the opportunity to address the areas of concern and strengthen your practice.

However, the panel considered that you did not understand the issues identified in this case and you had shown no insight into your failings and how you could and would rectify them. It was of the view that your behaviour throughout these proceedings and your lack of understanding of the panel's findings into the identified areas of your practice, pointed to an attitudinal problem. Further, the panel was not satisfied that you would be willing to respond positively to retraining. In addition, the panel took account of your submission that you did not intend to return to midwifery practice.

The panel therefore concluded that the placing of conditions on your registration at this stage would not be workable and would not protect the public.

The panel then went on to consider whether a suspension order, which is the maximum sanction available in this case, would be an appropriate sanction. The SG suggests that the following considerations are appropriate in deciding upon a suspension order:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel recognised the evidence that in other areas of midwifery practice, you are a capable midwife who practises well. However, in the areas of concern identified, it noted that there was a lack of insight, no recent supporting evidence of strengthened practice, and no evidence that you are willing to retrain in those areas. The panel also found that there was an attitudinal problem, which you had also demonstrated within the hearing, particularly around recognising the areas that require development. In light of this, the panel was of the view that you pose a significant risk of repeating your mistakes.

The panel noted that a suspension order would temporarily prevent you from working as a registered nurse. It was satisfied that such an order would give you time to:

- reflect on the areas of practice where you demonstrated a lack of competence and provide meaningful insight into this;
- decide on your future intentions as to your midwifery career;
- demonstrate a willingness and formulate a proposed action plan to strengthen your practice through training courses and workplace development, etc.

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

The panel noted the hardship such an order may cause you. However 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 and practice required of a registered midwife.

The panel determined that a suspension order for a period of six months was appropriate in this case to provide you with the opportunity to develop insight into the clinical areas of concern; and reflect on the future of your midwifery practice and communicate your intention to a future reviewing panel.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement and attendance at the substantive order review hearing.
- A detailed written reflective account which demonstrates your insight into the key issues identified in your clinical practice.
- Your willingness to engage in retraining or a development programme in relation to the areas identified.
- A clear plan of action in respect of your midwifery practice.

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 interests until the

suspension 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 Taylor. She invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

You indicated that you had no submissions in relation to an interim order.

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 ensure that you cannot practise unrestricted before the substantive suspension order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.