Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 29 July – Wednesday 7 August 2024 &
Friday 9 and Monday 12 August 2024

Virtual Hearing

Name of Registrant:	**Shadae Jennifer Mullard**
NMC PIN:	13D0461E
Part(s) of the register:	Registered Midwife – September 2014
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Jude Bayly (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Khadija Patwary (29 July – 2 August 2024) Monsur Ali (5 August – 7, 9 August and 12 August 2024)
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mrs Mullard:	Present and represented by Zahra Ahmed, instructed by Thompsons Solicitors LLP
Facts proved by admission:	Charges 1bi,ii,iii), 1ci,ii,iii), 1di,ii), 1e) 1f), 3b), 5a) and 5b)
Facts proved:	Charges 1a), 2), 3a), 3c), 4), 5d), and 6)
Facts not proved:	Charges 5c), 7a), 7b), 7c), and 7d)
Fitness to practise:	Impaired

Sanction:	**Strike off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered midwife whilst working at Liverpool Women's NHS Trust;

1) On 1 May 2021;
   a) Did not administer Vitamin K to Baby A, as required.
   b) Did not record the administration of Vitamin K to Baby A on; **(proved by admission)**
      i) The EMAR
      ii) Baby A's red book
      iii) Athena K2 system
   c) Did not record that Baby A's parents had granted verbal consent for you to administer Vitamin K to Baby A on; **(proved by admission)**
      i) The EMAR.
      ii) Baby A's red book.
      iii) Athena K2 system.
   d) Did not record that Baby A was born before arrival on; **(proved by admission)**
      i) The EMAR.
      ii) Baby A's red book.
   e) Did not call a second midwife to assist with the birth of Baby A. **(proved by admission)**
   f) Inaccurately recorded that Baby A's parents had not granted consent for the administration of Vitamin K. **(proved by admission)**

2) On 1/2 May 2021 inaccurately informed Colleague Z that you administered Vitamin K to Baby A on 1 May 2021.

3) On 2 June 2021;
    a) At around 11:31 Inaccurately recorded a note on Athena K2 system that you had administered Vitamin K to Baby A on 1 May 2021, namely '*at 01:45 vit k given IM*'.
    b) Did not document that your entry was on K2/Baby A's records was made retrospectively. **(proved by admission)**
    c) Inaccurately informed Colleague Y that you had administered Vitamin K to Baby A on 1 May 2021.

4) Your actions in one or more of charges 2, 3 a), 3 b) & 3 c) were dishonest in that you sought to misrepresent that you had administered Vitamin K to Baby A.

5) On or around 29/30 September 2021 did not;
    a) Send/organise/order blood samples for Patient F to the Liverpool Women's Hospital ('the Hospital') for testing. **(proved by admission)**
    b) Did not log blood samples for Patient F to the Hospital for testing. **(proved by admission)**
    c) Did not dispose of Patient F's placenta appropriately.
    d) Inaccurately informed Colleague Z that you had taken Patient F's blood samples to the Hospital.

6) Your action in charge 5) d) were dishonest in that you sought to conceal your failure to take/log Patient F's blood samples from Colleague Z.

7) On or around 1 October 2021;
    a) Did not complete a growth chart for Patient B;
    b) Did not complete a growth chart for Patient C;
    c) Did not complete a growth chart for Patient D;
    d) Did not complete a growth chart for Patient E.

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

Decision and reasons on application to adjourn

Ms Ahmed, on your behalf, submitted that there is a need to revisit timetabling for this hearing as your current employer did not release you every day of this hearing. She submitted that there are witnesses listed for each day for the next four days and that you had requested your current employer for some time off to attend the hearing. Ms Ahmed submitted that you are hoping to participate in this hearing to the fullest extent possible. She informed the panel that you currently work as an events manager at a hotel and that this position only started approximately two weeks ago. Ms Ahmed submitted that your rota is disclosed to you on a weekly basis and despite putting in a request to attend the hearing, as soon as you reasonably could, upon starting the new role, you had noticed this weekend that you were in fact not released for all the dates this week.

Ms Ahmed submitted that in terms of your availability, you are available on Monday 29 July 2024. However, you were unavailable the next day Tuesday 30 July 2024 as you had been allocated a shift between 10:00 to 18:00. She submitted that you will not be available to participate in the hearing or to observe any cross examination of the NMC witnesses. Ms Ahmed submitted that you would be available on Wednesday 31 July 2024 but had limited availability for Thursday 1 August 2024 and Friday 2 August 2024. On these two days you were working an afternoon shift and were only available on both mornings.

Ms Ahmed submitted that these two dates would raise the most issues as Colleague Z in particular is a very important witness whose evidence is relevant to some of the most serious charges against you. She submitted that in terms of day four which is Thursday 1 August 2024 there are two witnesses for the NMC and given your restrictions as you are expected to work on that day it means that you will not be able to observe cross examination of at least some of the witnesses or some parts of that evidence.

Ms Ahmed, on your behalf, submitted that the panel may wish to consider in fairness to you that you have a right to attend the hearing and that you have a right to observe any cross examination of NMC witnesses. She submitted that you have made every effort to participate with this hearing and that you have cooperated with the NMC throughout this investigation. She submitted that the panel would see that you have clearly taken this matter very seriously as you produced a statement which deals comprehensively with the allegations and that you are very keen to not delay matters as you have made yourself available.

Ms Ahmed submitted that given that you only started this role recently you have not been able to accrue any leave. She submitted that you may be able to give your evidence on Friday 2 August 2024 as you would want to give evidence and participate in this hearing. However, as you might not be present for the NMC's witness evidence this would deprive you of the ability to observe cross examination and that you would not be able to provide her with any instructions if there is anything arising from the oral testimony of the witnesses. Ms Ahmed submitted that this could potentially impact her submissions going forward and that as there are career ending allegations you would want to participate in this hearing to the fullest extent possible.

Ms Ahmed submitted that it is her application to simply not sit on the times that you are unavailable and that some discussions will be required between Ms Ahmed and the NMC as to whether witnesses can be reorganised on those dates. She submitted that if the witnesses are asked the question whether they could be made available on other dates or other times and if there are any difficulties with this then the panel may need to go onto consider the possibility of adjourning which the panel can do on their own volition.

Ms Ahmed submitted that if the matter were hypothetically to be adjourned to a separate date, it may be possible to have further discussions with your employer as you would have accrued more leave by then. Ms Ahmed submitted that you are at a very delicate stage because you are in a position where you are in a probationary period and therefore have not accrued any rights in terms of leave.

Mr Kennedy, on behalf of the NMC, submitted that the hearing should continue. He submitted that fairness to you is of paramount importance. However, fairness is a two-way street and fairness also applies to the NMC. He submitted that the NMC has warned witnesses to attend at various points during the course of this week and all of these witnesses are professional witnesses with professional commitments. He further submitted that of the two witnesses who are due to attend on day 2, one is a Midwife, and the other is a Matron in Midwifery. He said that both have only been warned to attend day 2 and it is unknown if they would be available to give evidence on other days as they may well have other duties to carry out. Mr Kennedy submitted that there are two doctors scheduled to give evidence this week.

Mr Kennedy submitted that Ms Ahmed is fully instructed and is aware of your position in relation to all of the charges. He submitted that you have produced an extremely detailed statement in answer to the charges and so your position is clear from that. He submitted that the prejudice to you is not so great that we should not sit the days suggested and that the hearing should proceed as scheduled. He submitted that this hearing was scheduled before you accepted your current role.

Ms Ahmed submitted that you did make your employer aware at the first reasonable opportunity of this hearing when you took up employment. She submitted that it appears that this was missed somewhere as your rota does not reflect your request. She submitted that this hearing was listed previously at the beginning of the year in February 2024, when you did make yourself available, but it was adjourned due to the NMC conducting some post investigation work.

The panel accepted the advice of the legal assessor who referred it to Rules 32(4) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules). as follows:

‘32 (4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to-
(a) the public interest in the expeditious disposal of the case;
(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
(c) fairness to the registrant.’

The panel determined not to adjourn the hearing. In reaching this decision, the panel has considered the submissions from Ms Ahmed and Mr Kennedy. The panel had particular regard to the relevant Rules, the NMC guidance on adjournment and to the overall interests of justice and fairness to all parties.

In reaching this decision, the panel bore in mind the public interest in the expeditious disposal of this matter. It noted that you are very new to your current role. However, a number of professional witnesses have been scheduled to attend and also Witness 5 the mother of Baby A. The panel noted that you are legally represented by Ms Ahmed who is no doubt fully instructed and she would be able to cross examine the witnesses comprehensively in your absence. It also noted that you have provided the panel with detailed documentation which includes your reflection and witness statement.

On balance the panel were of the view that not proceeding as scheduled in relation to witness evidence would cause an inconvenience to the NMC and the professional witnesses. It concluded that in relation to your evidence, the panel will review this matter on Thursday to see if you would be able to give your evidence on Friday 2 August 2024.

The panel has borne in mind the importance of fairness to you and the NMC. It concluded that it is in the interest of justice not to adjourn this hearing at this stage and to continue with the NMC’s witness evidence in your absence.

Background

The charges arose whilst you were working as a registered Midwife in the Homebirth Team at the Hospital.

You attended Witness 5's home on 1 May 2021 and she was a planned homebirth. You were the on-call Midwife for the homebirth Team. The parents had telephoned you and had asked you to attend. However, Baby A was born before you arrived. You supported Witness 5 for the delivery of the placenta. You then completed the routine baby checks but it is alleged that you did not administer Vitamin K to Baby A nor did you complete the necessary records.

Colleague Z attended Witness 5's home later the same day to carry out the routine baby examination and postnatal checks. She noted that the administration of Vitamin K had not been documented and asked the parents and their response was that they could not recollect seeing the administration of Vitamin K or being told by you that you had administered Vitamin K. She telephoned you to check with you whether you had administered Vitamin K to Baby A. It is alleged that you confirmed that you had administered Vitamin K to Baby A.

On 1 June 2021 Baby A was admitted to a specialist paediatric hospital, with a history of vomiting, a weak left arm and eye rolling. A Computed Tomography (CT) imaging of his head found a large intracranial haemorrhage graded as "*catastrophic*" and the clotting screen results were consistent with severe Vitamin K deficiency. The clotting parameters normalised after Vitamin K was administered to Baby A and this meant that the most likely diagnosis was late Haemorrhagic disease of the Newborn (HDN).

On the morning of 2 June 2021, Colleague Y was contacted by the safeguarding team to check whether Vitamin K had been administered to Baby A, as there was no record in Baby A's red book. Colleague Y contacted you by telephone at 10:47 on the same day and explained to you that Baby A had been admitted to hospital with vomiting and

bruising. Colleague Y further stated that the safeguarding team were asking whether Vitamin K had been administered. It is alleged that during this call, you confirmed to Colleague Y that you had administered Vitamin K to Baby A as far as you could remember.

Subsequently, on 2 June 2021 at 11.31, it is alleged that you logged onto Baby A's record and made an entry in the notes. The entry was for the administration of Vitamin K as being given on 1 May 2021 at 1.45, but you did not document the dosage you had given. The entry was *'vit k given IM'.*

The Trust carried out an internal investigation and a Serious Incident investigation, in parallel, independent of each other. During the local investigations, Witness 4 stated that it was extremely unlikely that Vitamin K was administered at or soon after birth. Witness 3 came to the same conclusion having sought the advice of two consultant haematologists.

You were suspended from the Hospital on 30 September 2021. On 18 January 2022, a disciplinary meeting was held, and the outcome was summary dismissal with immediate effect.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Ahmed, on your behalf, who informed the panel that you made admissions to charges 1bi,ii,iii), 1ci,ii,iii), 1di,ii), 1e) 1f), 3b), 5a) and 5b). The panel noted that the admission to Charge 5a was a qualified one as Ms Ahmed indicated you accepted you had organised the blood samples but has not sent or ordered them.

The panel therefore finds charges 1bi,ii,iii), 1ci,ii,iii), 1di,ii), 1e) 1f), 3b), 5a) and 5b) proved, by way of your admissions.

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

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: Midwife at the Hospital at the time of the allegations;
- Colleague Z: Community Midwife at the Hospital at the time of the allegations;
- Colleague Y: Team Leader in Community Midwifery at the Hospital at the time of the allegations;
- Witness 3: Consultant in Clinical Genetics at the Hospital at the time of the allegations;
- Witness 4: Consultant Paediatric Haematologist at Alder Hey Children's Hospital at the time of the allegations;
- Witness 5: Baby A's mother; and

- Witness 6: Head of Midwifery at the Hospital at the time of the allegations.

The panel also heard evidence from you under affirmation.

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

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

Charge 1)a)

1) On 1 May 2021;
    a) Did not administer Vitamin K to Baby A, as required.

This charge is found proved.

The panel heard from Witness 4, a paediatric haematologist, who stated in his oral evidence*, "it is therefore extremely unlikely that Vitamin K had been administered at or soon after birth."* The panel also heard evidence from Witness 3, who stated that having consulted with two paediatric haematologists *'it is their opinion that it is extremely unlikely that Vitamin K was administered and the most plausible explanation is that Vitamin K was not administered'*. The panel noted that one of the consultant haematologists did not give evidence but it was satisfied that, having heard evidence from Witness 4, that he had access to the laboratory results and reports, the panel accepted the conclusions of Witness 3 and Witness 4.

During his oral evidence Witness 4 stated that *"there was less than one percent likelihood of Baby A receiving Vitamin K,"* leading to his conclusion that Baby A did not receive Vitamin K at or soon after birth.

As part of its consideration, the panel assessed the likelihood of a defective dose of Vitamin K being administered to Baby A at or soon after birth. The panel noted that two batches of vitamin K were withdrawn from use across the Hospital to investigate if Baby A's Vitamin K deficiency was due to a faulty batch. The manufacturing company investigated these batches and found that none of the batches tested were compromised in any way. The Hospital was informed by the manufacturers that the batch allegedly administered to Baby A was within normal range. Additionally, Baby A's condition improved after the administration of Vitamin K at a later time during an emergency admission to hospital on 2 June 2021, supporting the evidence provided by Witnesses 3 and 4.

In reaching this decision, the panel considered your evidence alongside the testimonies of Witnesses 3 and 4. It determined that your accounts of the events were inconsistent and that your oral evidence did not resolve these inconsistencies. Furthermore, you mentioned that you were left alone with Baby A whilst the mother had shower upstairs accompanied by her husband which is when you claimed to have administered the Vitamin K in the absence of the parents. You remarked that this scenario was unusual in your practice. However, the panel found that this was unlikely, on balance, as there was no urgency to continue with baby checks or administer Vitamin K in the absence of the parents. You still had to set up your laptop, input data for the birth and unpack some equipment. Consequently, the panel found it improbable that you did so.

In assessing the reliability of your evidence, the panel also observed that you had presented different accounts of events across different forums, summarised as follows:

1. Written Statement (22 June 2021): You claimed to have documented the administration of Vitamin K in the contemporaneous baby notes for Baby A, bypassing the documentation boxes until gaining consent.
2. Disciplinary Hearing: You stated that you had rushed your statement and failed to clarify that the clinical record made on 2 June 2021 was a retrospective entry.

3. Informal Meeting (26 July 2021): You indicated that you checked the 'no' box in error. After contact from Witness 2, you attempted to update the record for Baby A on K2 but faced technical issues. At the hearing, you retracted this statement, admitting that you did not attempt to update the record on 1 May 2021, and did not challenge this statement upon receiving the meeting record.
4. At the investigation meeting on 13 October 2021, you stated that you had not documented the administration of Vitamin K at the time because you had not adjusted the resolution on your screen and could not see the 'contemporaneous' section.

The panel accepted the evidence of Witnesses 3 and 4, and the Vitamin K batch analysis and having regard to the inconsistencies in your account, the panel rejected your evidence that you had administered the Vitamin K on 1 May 2021 and therefore found this charge proved.

Charge 2)

2) On 1/2 May 2021 inaccurately informed Colleague Z that you administered Vitamin K to Baby A on 1 May 2021

This charge is found proved.

In reaching this decision, the panel considered the evidence provided by Colleague Z. It concluded that Colleague Z's testimony was clear and consistent throughout her NMC witness statement, and oral evidence. The panel determined that Colleague Z's account was unwavering and highly credible. The panel noted that you accepted her account in relation to this charge.

The panel, having concluded (for reasons set out under Charge 1) that you had not administered Vitamin K to Baby A on 1 May 2021, it therefore concluded that you had

inaccurately informed Colleague Z that you had. Therefore, the panel found this charge proved.

Charge 3a)

3) On 2 June 2021;
    a) At around 11:31 Inaccurately recorded a note on Athena K2 system that you had administered Vitamin K to Baby A on 1 May 2021, namely '*at 01:45 vit k given IM*'.

This charge is found proved.

The panel noted that you accepted that you recorded in the Athena K2 system that you had administered Vitamin K to Baby A on 1 May 2021. Having regard to the panel's findings relating to Charge 1a, that you had not administered Vitamin K, and by recording that you had, you inaccurately recorded this information. Therefore, the panel found this charge proved.

Charge 3c)

3) On 2 June 2021;
    c) Inaccurately informed Colleague Y that you had administered Vitamin K to Baby A on 1 May 2021.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Colleague Y. You stated in your statement to the NMC dated 22 July 2024, which you confirmed during your oral evidence:

‘My colleague called me the following afternoon, around school pick-up time as I was in the car. She asked if had I given vitamin K as the parents could not remember, I reiterated that I had given it and explained when. I also said that I intended to correct the K2 document to reflect this as soon as could. Unfortunately, I forgot to go back into the system and correct it.’

In her written statement to the NMC dated 25 October 2022, Colleague Z stated:

‘…Ms Mullard confirmed to me that it had been administered when the mother… was taking a shower, so everything was fine. I had no reason to believe that vitamin K had not been administered to Baby A. I took Ms Mullard at her word.’

Having regard to the panel’s findings in relation to Charge 1a, the panel determined that you inaccurately informed Colleague Y that you had administered Vitamin K to Baby A on 1 May 2021 when you had not. Therefore, the panel found this charge proved.

Charge 4)

4) Your actions in one or more of charges 2, 3 a), 3 b) & 3 c) were dishonest in that you sought to misrepresent that you had administered Vitamin K to Baby A.

This charge is found proved.

In reaching this decision, the panel considered the test set out in the case of *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67. It also considered the NMC guidance on dishonesty referenced DMA-8.

The panel was of the view that you knew that you had not administered Vitamin K to Baby A on 1 May 2021 when you informed your colleagues that you had and also when you documented that you had administered Vitamin K in the clinical records for Baby A. This conduct continued on 2 June 2021 where an entry was made on the K2 System but you

did not make it clear that it was being made retrospectively. The panel concluded that you recorded that the entry was made contemporaneously because you wanted to give the false impression that the record was made at the time. This false entry was compounded by your local written statement dated 22 June 2021 in which you stated… *'I completed the baby check and gave Vitamin K injection while the baby was on the scale. I documented on the contemporaneous baby notes as I had bypassed the boxes for the documentation until I gained consent.'*

The panel was of the view that you knew full well that you had not administered Vitamin K to Baby A, and could find no innocent explanation for your lies to colleagues and in clinical records.

The panel further concluded that an ordinary member of the public would find your conduct to be dishonest. Accordingly, the panel found this charge proved.

Charge 5a)

5) On or around 29/30 September 2021 did not;
    a) Send/organise/order blood samples for Patient F to the Liverpool Women's Hospital ('the Hospital') for testing

This charge is found proved in its entirety.

Ms Ahmed, on your behalf, accepted that you did not organise the blood samples due to insufficient time following your suspension. Colleague Z, in her written and oral evidence stated that she had checked the system and there was no log or record of the blood test. You stated that the reason for you not sending, organising or ordering the blood samples was due to a combination of a busy night and you were being suspended. The panel found this charge proved in its entirety.

Charge 5c)

c) Did not dispose of Patient F's placenta appropriately.

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 2. You stated in your statement to the NMC:

> *'I had every intension of taking the placenta to the hospital later in the day after getting some sleep. The placenta was stored in a clinical waste bag in a sealed placenta bucket in my car, ready to be taken to the hospital. This was how we transported the placenta to the hospital from the home if the family did not want to keep it. Some families choose to keep the placenta for encapsulation for example.'*

In her written statement to the NMC, Colleague Z stated:

> *'I asked Ms Mullard if she had managed to arrange for Patient 's blood testing and whether she had disposed of the placenta. Ms Mullard said she had sorted the blood testing but had forgotten to arrange for the disposal of the placenta. The placenta was still in her car. I told her to give it to me and I would take it to the hospital to be disposed of. I have to say that I found it very odd that Ms Mullard had been to the hospital and had arranged for 's bloods to be testing, but that she had not disposed of the placenta. It played on my mind all night.'*

The panel noted that you did not dispose of the placenta and had instead stored it in a Trust-approved container. The panel considered the testimony of Colleague Z, who confirmed that when asked about the samples retained, you highlighted that you still possessed Patient F's placenta from your previous shift and you arranged with Colleague Z to dispose of it appropriately. Consequently, the panel found this charge not proved.

Charge 5d)

5) On or around 29/30 September 2021 did not;
    d) Inaccurately informed Colleague Z that you had taken Patient F's blood samples to the Hospital.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and that of Witness 2. You stated in your written statement dated 22 July 2024 that:

> *'When my colleague arrived I arranged for her to take the samples to the hospital'*
>
> *'I collected the blood samples from Mother F, I made sure to label them accurately and record pertinent details such as the time of collection, the sample type, and any observations about the condition of the samples. During a conversation with Colleague Z, I cannot confirm if I conveyed that the blood samples had been taken to the hospital, the specifics of the conversation are hazy. I remember discussing the placenta and retrieving it from the car, but the details about the blood samples were not as clear.'*

Colleague Z stated in her written statement:

> *'…I asked Ms Mullard if she had managed to arrange for Patient 's blood testing and whether she had disposed of the placenta. Ms Mullard said she had sorted the blood testing but had forgotten to arrange for the disposal of the placenta.'*

During your oral evidence you told the panel that you had disposed of Patient F's blood in a sharps box, having found it in the car a few days later which is a different account than your earlier accounts and statement. You were unable to inform the panel why you had not mentioned this before or included this in your statement dated 22 July 2024.

Furthermore, you were asked about the associated risk of the blood test not being processed and you claimed there would not be any because you were sure that the patient would receive the correct treatment. The panel deemed that this was not the case as it had accepted the evidence from Colleague Z of the importance of the blood test being processed and the result for the patient to receive the correct treatment.

Having considered the above, the panel determined that this charge is found proved.

Charge 6)

6) Your action in charge 5) d) were dishonest in that you sought to conceal your failure to take/log Patient F's blood samples from Colleague Z.

This charge is found proved.

In reaching this decision, the panel took into account the panel considered the evidence of Colleague Z, who stated that she felt you had lied to her face. She was troubled by your assertion that you had taken the blood samples to the hospital but had forgotten to take the placenta. This inconsistency preoccupied her thoughts throughout the night because, logically, if the blood samples were taken to the hospital, the placenta should have been as well. Consequently, she concluded that you were not truthful. Colleague Z articulated her concerns in her written statement:

> *'I have to say that I found it very odd that Ms. Mullard had been to the hospital and had arranged for the bloods to be tested, but that she had not disposed of the placenta. It played on my mind all night.'*

The panel accepted the evidence of Colleague Z, and further determined that you had not dealt with Patient F's blood samples and deliberately lied to Colleague Z. The panel further determined that there was no innocent explanation for your deceit and that, an

ordinary member of the public would find this behaviour dishonest. Consequently, the panel found this charge proved.

Charge 7)

7) On or around 1 October 2021;
    a) Did not complete a growth chart for Patient B;
    b) Did not complete a growth chart for Patient C;
    c) Did not complete a growth chart for Patient D;
    d) Did not complete a growth chart for Patient E.

These charges are found NOT proved.

The panel concluded that there is insufficient evidence to determine, on the balance of probabilities, that these growth charts were not completed by you. It observed that there was no evidence of patient notes relating to these growth charts, and the evidence presented was based to a large extent on hearsay from Witness 1. Furthermore, the panel did not hear testimony from any of the patients involved, nor was there any witness statements from them.

The panel noted that in your witness statement dated 22 July 2024 you stated that you could not remember whether or not you completed these growth charts. Additionally, you stated that very often the paper growth charts were lost, which was corroborated by other witnesses.

The panel determined that it was for the NMC to prove that you had not completed the growth charts and it was not for you to prove that you had.

The panel concluded that there was insufficient evidence to prove that you had not completed the growth charts. Therefore, the panel determined that these charges are not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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 ability to practise kindly, safely, and professionally.

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

Submissions on misconduct

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

Mr Kennedy invited the panel to take the view that the facts found proved amount to misconduct. The panel should have regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015 updated 2018) (the Code) in making its decision.

Mr Kennedy identified the specific paragraphs of the Code where he said your actions amounted to misconduct. He reminded the panel to carefully evaluate witness testimony, considering both the content and delivery to determine potential biases or inconsistencies. The panel was also advised to scrutinise how witness statements align with other evidence, and to consider whether any lapses in memory might be due to the passage of time or suggest a lack of truthfulness, particularly in the context of your role in a busy homebirth team using a newly implemented computer system.

Mr Kennedy highlighted the importance of the Trust's policy on Vitamin K administration, noting that the failure to follow this protocol and accurately document consent is central to the case. It was acknowledged that you, as the attending midwife, may have prioritised immediate care over documentation, discrepancies in recorded consent.

Mr Kennedy submitted that the panel may find that not all the matters found proved were serious enough so as to amount to misconduct.

Mr Kennedy highlighted that not administering Vitamin K to Baby A resulted in serious actual harm.

Ms Ahmed submitted that when the panel evaluates the case, it should focus on the admissions you made regarding various charges. She emphasised that since the panel has already reviewed all relevant evidence, the panel's focus should be on determining whether these admissions indicate intentional deceit or are the result of procedural errors. The primary issues at hand include discrepancies in record-keeping and the timing of Vitamin K administration.

Ms Ahmed highlighted that Witness 6 provided testimony about the difficulties associated with the Trust's record-keeping systems, especially the transition to the new K2 System introduced in January 2021. Despite some training, many staff members were still familiarising to the K2 System, which led to inconsistencies in its application. This context is essential for understanding the record-keeping issues mentioned in the charges,

including the problems with the availability of Red Books and the unusual use of the EMAR system for documenting Vitamin K administration.

Ms Ahmed also pointed out that the time elapsed since the events in question, particularly regarding Vitamin K administration, presents challenges for witnesses. Witness 5 recalls consenting to Vitamin K but cannot recall specific details; however, her account remains consistent. Her observations about your actions and the presence of a black bag align with the handling of Vitamin K, suggesting that any record deficiencies might be due to delays rather than intentional dishonesty.

Ms Ahmed explained that while the effectiveness of Vitamin K and its rapid metabolism are well-established, the lack of medical records between birth and 2 June 2021, creates a gap in the evidence. Although experts like Witnesses 3 and 4 have commented on Vitamin K's efficacy, their assessments were limited by the absence of specific medical records for Baby A. She invited the panel to consider whether the discrepancies in records suggest late administration or simply an oversight.

Regarding the charges related to dishonesty, particularly those concerning Patient F and the handling of blood samples, Ms Ahmed argued that the evidence implies any inconsistencies might be due to miscommunication or record-keeping issues rather than deliberate deceit. Ms Ahmed concluded that the panel must decide whether your actions reflect genuine dishonesty or are the result of procedural and record-keeping challenges.

Submissions on impairment

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

Mr Kennedy submitted that impairment is for the panel's independent judgment, without any specific burden or standard of proof. He said the panel needs to make its own decision based on the evidence and submissions.

Mr Kennedy submitted that the guidance on impairment comes from *Grant* and Dame Janet Smith's fifth Shipment report. He said the four-point test from *Grant* is:

> *'a. Has the individual put patients at unwarranted risk of harm in the past or is likely to do so in the future?*
> *b. Has the individual brought or is likely to bring the profession into disrepute?*
> *c. Has the individual breached or is likely to breach fundamental tenets of the profession?*
> *d. Has the individual acted or is likely to act dishonestly?'*

Mr Kennedy submitted that in this case, all four limbs are engaged. He said your conduct caused serious actual harm to Baby A, breached professional tenets, brought disrepute to the midwifery profession, and involved serious dishonesty.

Mr Kennedy submitted that when assessing impairment, the panel should consider:

1. **Public Protection and Wider Public Interest:** Ensuring high standards and protecting the public, as highlighted in *Cohen v GMC* [2008] EWHC 581.
2. **Remediation:** Whether the conduct can be remediated, has been remediated, and is likely to recur, following Justice Silber's guidance.
3. **Insight:** Evaluate if you have shown genuine remorse and understanding of the impact of your behaviour, based on Justice Cox's comments in *Grant*.

Mr Kennedy submitted that, although you admitted some charges, you denied the more serious allegations of dishonesty. Your reflection and evidence do not clearly show full

insight or remorse. He said the record-keeping issues can be remediated, but dishonesty is harder to address.

Mr Kennedy submitted that, given the serious actual harm caused by you and the risk of repeat behaviour, a finding of current impairment is crucial to protect the public, maintain professional standards, and uphold public confidence in the NMC.

Ms Ahmed submitted that the determination of impairment is a matter for the independent judgment of this panel. She emphasised that the starting point should be the admissions made at the outset, which have consistently addressed the failures and breaches of the NMC code.

Ms Ahmed highlighted a number of cases including *Sawati v GMC* [2022] EWHC 283. She submitted that as a result of those cases, the panel should not take into account your rejected defence in deciding whether or not you had any insight into the matters found proved. She said it is unrealistic to expect a professional who has firmly denied allegations to suddenly demonstrate insight after a factual finding against them. Such an expectation could undermine their right to appeal and contribute little to determining culpability.

Ms Ahmed stated that the panel should evaluate your attitude toward the allegations based on all evidence presented. While you maintain your innocence regarding certain findings, this should not be mistaken for a lack of insight. You acknowledge that the panel's findings are against you and that your defences have been rejected, as reflected in your statement.

Nonetheless, Ms Ahmed submitted that the panel should assess your insight based on your reflective statements and not on your rejected defence.

Ms Ahmed acknowledged that while some of the allegations meet the threshold of seriousness, others may not. Both public protection and the wider public interest are relevant to assessing current impairment. She said, your reflective statements address the

broader impact of these allegations on public trust and confidence. Despite your denial, Ms Ahmed submitted that these statements should not be used to increase culpability or imply a lack of insight into your conduct.

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

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breaches of the Code. Specifically:

> ***'Treat people as individuals and uphold their dignity.***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion.*
> *1.2 make sure you deliver the fundamentals of care effectively.*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***Act in the best interests of people at all times.***
> *To achieve this, you must:*
> *4.2 make sure that you get properly informed consent and document it before carrying out any action.*
>
> ***Work cooperatively.***
> *To achieve this, you must:*

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

8.6 share information to identify and reduce risk.

Keep clear and accurate records relevant to your practice.

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

To achieve this, you must:

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

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

Uphold the reputation of your profession at all times.

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It also took note of the NMC Guidance on seriousness. The panel was of the view that your actions were a serious departure from the standards expected of a registered midwife.

The panel considered each charge separately and determined that some charges amounted to serious misconduct and some do not. The panel found that the following charges amounted to misconduct: 1a), 1biii), 1ciii), 2), 3a), 3b), 3c), 4), 5a), 5b), 5d), and 6).

The panel found the following charges found proved did not amount to serious professional misconduct: 1bi), 1bii), 1ci), 1cii), 1di), 1dii), 1e) and 1f).

The panel determined that your failure to administer Vitamin K to Baby A which caused actual serious harm and your failure to process Patient F's blood samples had the potential to cause serious actual harm. Your subsequent actions to cover up your omission resulted in you undertaking a deceitful course of conduct which included telling repeated lies to your colleagues and making an entry on Baby A's clinical record which you knew to be false. The panel considered that these actions were particularly serious and other members of your profession would find them deplorable. It therefore decided that these amounted to serious professional misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, 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 be honest and open

and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel determined that all four limbs of Dame Janet Smith's test of impairment are engaged in this case.

The panel found that you caused actual harm to Baby A and a patient was put at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the midwifery profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel noted that you have developed a level of insight, have reflected on your actions and you have accepted responsibility for many of your actions from the outset. The panel also noted that you have submitted evidence of additional training and considered your submitted reflective statements, and testimonials.

The panel however, determined that there was little evidence of practice strengthening and your lack of insight and therefore found there to be a risk of repetition of your misconduct which poses a real risk of harm to the public.

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

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

The panel determined that a finding of impairment on public interest grounds is also required because public confidence in the profession and the NMC as the regulator would be undermined if a finding of impairment were not made in this case.

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 striking-off order. It directs the registrar to strike you off the NMC register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

Mr Kennedy submitted that the main purpose of a sanction is to protect the public and serve the public interest, not to punish, although some sanctions may have a punitive effect. He said the panel must balance public protection and public interest with your right to practice as a midwife, ensuring any sanction is proportionate. Mr Kennedy emphasised that the panel should first determine how far your behaviour fell below the standard expected of a midwife and start by considering the least restrictive sanction that would still protect the public.

Mr Kennedy highlighted the importance of weighing aggravating and mitigating factors. In terms of mitigation, he said you fully engaged with the NMC process, have no prior NMC referrals, and made early admissions, showing some insight. However, in respect of

aggravating factors, there was a gross breach of trust, actual harm to Baby A, and potential harm to another patient.

Mr Kennedy submitted that your insight seems limited, there was dishonesty, and there is no evidence of strengthening your practice. He said that the NMC recommends a striking-off order. Despite some charges not being proved, the seriousness of the behaviour warrants significant action. He said the behaviour is too serious for a lesser sanction, and combining dishonesty with limited insight makes conditions of practice insufficient.
Mr Kennedy submitted that your removal from the NMC register is necessary to protect the public, and the key question is whether this should be permanent or temporary. He cited NMC guidance that emphasises the seriousness of dishonesty, especially when it breaches the duty of candour and causes harm. He said in this case, there was a deliberate breach of candour, a vulnerable victim, and a direct risk to Baby A, with longstanding deception. According to NMC guidance, those who have acted dishonestly should show remorse, acknowledge their wrongdoing, and assure the panel it will not happen again.

Mr Kennedy submitted that given the lack of insight and remorse, your dishonesty, and the absence of evidence that your practice has improved, the panel may find your conduct is incompatible with you remaining on the register. Mr Kennedy encouraged the panel to follow the Sanctions Guidance, starting with the least restrictive sanction, and work its way up to find the appropriate one for the circumstances.

Ms Ahmed submitted that all options remain open for the panel's decision. She agreed with Mr Kennedy’s advice on the approach to sanctions, emphasising that the panel should consider all sanctions in ascending order, starting with the least restrictive one. She acknowledged that, given the serious findings, including dishonesty, this case realistically requires the panel to deliberate between a suspension and a strike-off order.

Ms Ahmed said that you accepted the panel's findings including dishonesty and fully acknowledged the seriousness of the charges found proved. In addition to Mr Kennedy's

references to mitigating factors, which she supports, she highlighted your good history, with no previous NMC referrals, your active engagement with the regulator, early admissions to some of the charges, and evidence of some insight. She also pointed out that you have provided reflection, despite denying some of the more serious allegations.

Ms Ahmed urged the panel to consider that while this case is serious, it does not fit neatly into categories such as sexual predatory behaviour. She acknowledged that harm was caused to a patient, but emphasised that this case is distinct from others involving deliberate intent to harm or harass. She said the panel should distinguish this case from those cases involving more serious dishonesty mentioned in the guidance.

Ms Ahmed also noted that whilst a baby was caused harm and another patient faced potential harm, there was no evidence of malicious intent or premeditated dishonesty. She said these are factors the panel should take into consideration, although it is accepted that the findings are serious and require careful deliberation.

Ms Ahmed reiterated that you recognise the gravity of the situation and that the final decision rests entirely with the panel's judgment.

Decision and reasons on sanction

Having found your fitness to practise is 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 determined that the following were aggravating features:

- Actual serious harm caused to Baby A

- Risk of harm to Patient F
- Repeated pattern of dishonesty over a period of time that included telling lies to colleagues and a false clinical record
- Lack of practice strengthening
- Limited insight into your misconduct

The panel also determined that the following were mitigating features:

- No previous regulatory concerns
- Your full engagement with the NMC proceedings
- Early admissions to some of the charges
- Positive testimonials

The panel considered the NMC guidance on 'Considering sanctions for serious cases' reference: SAN-2 which states:

> *Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care.*
> - *…*
> - *vulnerable victims*
> - *…*
> - *direct risk to people receiving care.*
> - *premeditated, systematic or longstanding deception.*

After carefully considering the NMC guidance, the panel determined that your actions were deliberate and constituted a serious breach of your professional duty of candour. You attempted to conceal your misconduct, compromising the care of vulnerable patients,

Baby A and Patient F. Your conduct caused actual harm to Baby A and also posed a direct risk to Patient F. Moreover, the panel found that your misconduct was part of a prolonged pattern of deception, involving repeatedly telling lies to your colleagues over a period of time.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel determined that the dishonesty charges found proved demonstrated an attitudinal concern which was not something that can be addressed through a conditions of practice order. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public or satisfy the public interest.

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

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

The panel found that none of these factors applied in your case.

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

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate, or proportionate sanction to protect the public nor satisfy the public interest.

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

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

The panel determined that your actions were a significant departure from the standards expected of a registered midwife. They raise fundamental questions about your professionalism, were so serious that public confidence could not be maintained if you were not removed from the NMC register and that a strike-off is the only sanction sufficient to protect the public and address the wider public interest.

The panel therefore imposed a striking-off order.

Interim order

The striking-off order cannot take effect until the end of the 28-day appeal period, or the conclusion of any appeal that is lodged. 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 is in your own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim suspension order for a period of 18 months should be made on the ground that it is necessary for the protection of the public and is otherwise in the public interest, in order to cover any appeal to be lodged and determined.

Ms Ahmed did not make any submissions.

Decision and reasons on interim order

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

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 the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months. This order is for a period of 18 months in order to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.

This decision will be confirmed to you in writing.