Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Wednesday, 21 August 2024

Virtual Hearing

Name of Registrant:	**Yvonne Margaret Tasker**
NMC PIN	85B0313E
Part(s) of the register:	RN1: Registered Nurse – Adult (18 April 1988) RM: Registered Midwife (9 March 1991)
Relevant Location:	North Lincolnshire
Type of case:	Misconduct
Panel members:	Peter Wrench (Chair, lay member) Dalvir Kandola (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	Peter Jennings
Hearings Coordinator:	Yewande Oluwalana
Nursing and Midwifery Council:	Represented by Bianca Huggins, Case Presenter
Ms Tasker:	Not present and unrepresented
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (12 months) to come into effect at the end of 15 September 2024 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Tasker was not in attendance and that the Notice of Hearing had been sent to Ms Tasker's registered email address and also her registered address by recorded delivery and by first class post on 19 July 2024.

The panel had regard to the Royal Mail 'Track and trace' printout which showed that they were unable to confirm the status of the item with reference 'KD882390531GB'.

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

The panel accepted the advice of the legal assessor concerning the requirements of service.

The panel took into account that the Notice of Hearing provided details of the substantive order being reviewed, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Tasker's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Tasker has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Tasker

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

Ms Huggins submitted that there had been no engagement at all by Ms Tasker with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Ms Huggins further submitted that there is a strong public interest in the expeditious review of this case.

The panel accepted the advice of the legal assessor on the principles which should inform its decision as to whether to proceed in Ms Tasker's absence.

The panel has decided to proceed in the absence of Ms Tasker. In reaching this decision, the panel has considered the submissions of Ms Huggins, and the advice of the legal assessor. It has had regard to relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Tasker;
- Ms Tasker has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Ms Tasker has not provided the NMC with details of how she may be contacted other than her registered address and email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious review of the case as the current order is set to expire on 15 September 2024.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Tasker.

Decision and reasons on review of the substantive order

The panel decided to make a further suspension order for a period of 12 months.

This order will come into effect at the end of 15 September 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 17 August 2023.

The current order is due to expire at the end of 15 September 2024.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, a Registered Midwife, on 1 October 2017 whilst working at Scunthorpe Hospital, Ward 26;

1) *At around 19:15:*
   a) *...*
   b) *…*
   c) *…*
      i) *…*
      ii) *…*
   d) *Did not record that you had communicated to Patient A, information about the necessity of referring her to consultant led care.*

2) *Did not record an SBAR review of potential Pre-eclampsia in Patient A's records.*

3) *Did not record:*
   a) *A plan of care for/from the Obstetric Team.*
   b) *A date/time of the intrapartum assessment.*

4) *Did not record a risk assessment for the appropriate professional lead, in Patient A's records.*
5) *Before commencing the CTG at around 19:45:*
   a) *Did not document the fetal heart rate following an assessment with;*

i) A pinnard.

ii) A handheld dopplex.

6) *Prior to discontinuing the cardiotocography (CTG) at around 21:37;*
   a) *Did not have the CTG assessed by the Obstetric Team.*
   b) *Did not have the CTG assessed by a Senior Midwife.*
7) *…*

8) *Did not document an assessment when discontinuing the CTG at 21:37.*

9) *After discontinuing the CTG at 21:37 you worked outside the scope of your practice in that you:*
   a) *Incorrectly categorised Patient A as being low risk.*
   b) *Did not request a suitable member of the Obstetric Team to review/categorise Patient A.*

10) *Did not inform Patient A that she had suffered from a minor antepartum haemorrhage.*

11) *Did not adequately explain to Patient A why you decided to break Patient A's waters.*

12) *Did not obtain/record that you had obtained, informed consent from Patient A before breaking Patient A's waters/performing an artificial rupture of membranes.*

13) *Did not discuss a plan of care with Patient A.*

14) *Did not explain to Patient A, that Patient A's baby was 'back to back'.*

15) *Did not conduct/record that you had undertaken, intermittent auscultation at 15 minute intervals once Patient A was confirmed to be in the first stage labour.*

16) *Did not escalate the absence of a fetal heart rate to the Obstetric Consultant Team within a timely manner.*

17)At around 22:15;

a) *Did not escalate/discuss Patient A's fresh blood/ante partum haemorrhaging with the Registrar.*
b) *Did not escalate/discuss Patient A's raised blood pressure with the Registrar.*
c) *Did not immediately commence a continuous CTG following Patient A's fresh blood/ante partum haemorrhaging.*
d) *Performed an inappropriate vaginal examination on Patient A.*
e) *Did not perform an abdominal palpation, prior to the vaginal examination on Patient A.*

18) Incorrectly performed an artificial rupture of membranes.

19) Performed an artificial rupture of membranes outside the scope of your practice.

20) Did not press/raise the emergency buzzer when you could not detect a fetal heart rate, in a timely manner.

21)Did not press/raise the emergency buzzer at around 22:15 when Patient A suffered from bleeding/ante partum haemorrhaging.

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

The original panel found that some charges did not amount to misconduct.

The original panel determined the following with regard to impairment:

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

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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*

The panel finds that Patient A and her baby were put at risk as a result of Ms Tasker's misconduct. The panel further found that Ms Tasker's misconduct had breached fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being remedied. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Tasker has taken steps to remedy and strengthen her practice. The panel took into account an undated reflective piece written by Ms Tasker at the request of her employer at the time of the incidents, addressing her emotions and how she could have handled the situation differently. However the panel, in light of the factors set out below, determined that Ms Tasker had not in fact remedied her misconduct.

The panel is of the view that there is a risk of repetition as the nature of the charges are wide ranging and there is no evidence before it of strengthened practice after this incident. The panel acknowledged that Ms Tasker had worked from October 2017 until leaving in 2019 and had completed training on CTG interpretation whilst still employed by the Trust. However, the panel has no evidence of Ms Tasker's work since leaving the Trust, nor testimonials or references relating to her current skills, as she has not engaged with the NMC. There is also no evidence as to whether Ms Tasker's knowledge has been kept up to date or whether she undertook any further relevant training to support strengthened practice.

Regarding insight, the panel considered that Ms Tasker had recognised some of her failings, had some understanding of how her actions put Patient A and her unborn baby at a risk of harm, and had demonstrated some understanding of what she did wrong and what she would do differently. However, the panel determined that this was limited and did not cover all aspects of the charges found proved. In addition, the panel was of the view that Ms Tasker only reflected on her own practice, but not on the impact on Patient A and her family, the public and the wider profession. The panel is also of the view that there is no evidence before it of remorse.

Therefore, the panel determined that the risk of repetition is high and decided that a finding of current 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 current impairment on public interest grounds is required because any fully informed member of the public or the profession who knew of the circumstances of this case would be concerned if Ms Tasker was allowed to practise unrestricted as a midwife given the charges found proved.

Having found misconduct across a wide ranging set of charges, the panel determined that not to make a finding of current impairment would significantly undermine trust and confidence in the midwifery profession.

Having regard to all of the above, the panel was satisfied that Ms Tasker's fitness to practise is currently impaired.'

The original panel determined the following with regard to sanction:

'The panel next considered whether placing conditions of practice on Ms Tasker's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *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;*

The panel determined that the misconduct all related to Ms Tasker's clinical practice and, although it is wide ranging, it would be possible to formulate conditions appropriately to restrict Ms Tasker's practice and protect the public. However, the panel noted that there is no evidence before it regarding Ms Tasker's employment history since 2019, limited evidence of insight and no recent evidence of strengthening practice. The panel acknowledged that although there is no evidence of any deep seated personality or attitudinal problems, Ms Tasker has not engaged at any time with the NMC relating to this case. The panel therefore determined that, while it would be possible to create appropriate conditions, they would not be workable as there is no indication that Ms Tasker would engage with the conditions.

Furthermore, the panel concluded that the placing of conditions on Ms Tasker's registration would not adequately address the seriousness of this case from a public interest perspective.

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

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

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with Ms Tasker remaining on the register. It determined that the misconduct, whilst wide ranging, had occurred on one shift and there was no evidence of deep-seated personality or attitudinal problems. The panel also noted that it had no evidence before it of any repetition during the time Ms Tasker continued to work for the Trust until 2019.

The panel therefore determined that a suspension order would both protect the public and mark the seriousness of the facts found proved on public interest grounds. The panel determined that the suspension order should be for a period of one year. This will provide Ms Tasker with sufficient time to demonstrate the steps she has taken to develop her insight and strengthen her practice to a reviewing panel.

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

Balancing all of these factors the panel has concluded that a suspension order for a period of one year, with a review, would be the proportionate sanction and was appropriate in this case to protect the public and mark the seriousness of the misconduct.

The panel noted the hardship such an order will inevitably cause Ms Tasker. 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 required of a registered midwife.

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, including a strike-off order.

The panel noted Mr Kewley's submission that, should a suspension order be imposed, the onus would be on Ms Tasker to reflect on these findings and decide on her future career in midwifery. Any future panel reviewing this case would be greatly assisted by information provided by Ms Tasker regarding her future intentions. If she would like to

continue to practise as a midwife in the future, the reviewing panel would be assisted by:

- *Ms Tasker's attendance at the review hearing;*
- *A reflective piece from Ms Tasker that addresses all of the categories of failings in her practice, together with the effect that her failings had on Patient A and her family, colleagues, and the wider profession;*
- *Evidence of up to date training;*
- *Recent testimonials or references from any employer including either voluntary or paid employment; and*
- *Anything else that Ms Tasker feels that the panel would be assisted by.*

If Ms Tasker no longer wishes to practise as a midwife, she should contact the NMC regarding her options for the future.'

Submissions

Ms Huggins took the panel through the background of the case and referred the panel to the relevant pages within the bundle. She submitted that Ms Tasker's fitness to practise remains impaired on public protection and public interest grounds.

Ms Huggins submitted that from the substantive hearing, the previous panel set out what Ms Tasker needed to provide to a reviewing panel. She submitted that there is nothing before today's panel that demonstrates Ms Tasker has addressed the concerns. Ms Huggins said that the charges found proved fall below the standard expected of a midwife, they identified multiple clinical failings by Ms Tasker, her insight was limited to her practice, and she had not addressed the impact her actions had on Patient A, her colleagues or the profession. Ms Huggins said there is no evidence that shows Ms Tasker has strengthened her practice.

Ms Huggins submitted that there is a risk of repetition of the matters found proved as there is a lack of learning and insight from Ms Tasker. She has not engaged with the NMC since the matters were referred or at the substantive hearing. Ms Huggins submitted that there is significant risk of harm to patients and the public as Ms Tasker has not addressed the concerns in her clinical practice.

Ms Huggins highlighted Ms Tasker's lack of engagement with the NMC and that she has also not provided any further information as to her future intentions in the profession. She said that the prospect of Ms Tasker engaging in any future reviews would be "fanciful". Ms Huggins submitted that a further suspension order would not sufficiently protect the public interest since it would merely perpetuate the cycle of reviews.

Ms Huggins invited the panel to consider a striking-off order, and she referred it to the aggravating features listed by the previous panel: lack of full insight into failings or of any remediation/strengthening of practice; conduct which put Patient A and her unborn baby at an increased risk of harm; and absence of remorse. Due to Ms Tasker's lack of remorse, the serious clinical failings, and the lack of evidence that Ms Tasker intends to strengthen her practice, Ms Huggins submitted that Ms Tasker should be removed from the register.

The panel heard and accepted the advice of the legal assessor on impairment and on its powers and the approach it should take to the question of sanction.

Decision and reasons on current impairment

The panel has considered carefully whether Ms Tasker's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle. It has taken account of the submissions made by Ms Huggins on behalf of the NMC and the observations of Ms Tasker during the internal investigation.

In reaching its decision, the panel was mindful of the need to protect the public, to maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel noted that the original panel found that Ms Tasker had limited insight. Ms Tasker was not present at this hearing and has not submitted any documentation before this panel. As a result, the panel had no evidence from Ms Tasker of her addressing the clinical failings identified or evidence of her insight into the impact her actions had on Patient A, her colleagues or the wider profession.

The panel is of the view that there is a high risk of repetition of the matters found proved and a risk of harm if Ms Tasker were allowed to practise unrestricted. The panel has no evidence of Ms Tasker's work since leaving the Trust, nor testimonials or references relating to her current skills, as she has not engaged with the NMC throughout the proceedings. There is also no evidence as to whether Ms Tasker's knowledge has been kept up to date or whether she has undertaken any further relevant training to support strengthened practice.

In light of this, this panel determined that Ms Tasker is liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is not only to protect patients but also to meet the wider public interest which includes maintaining confidence in the nursing and midwifery profession and upholding proper standards of conduct and performance.

The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required because any fully informed member of the public or the profession who knew of the circumstances of this case would be concerned if Ms Tasker were allowed to practise unrestricted as a midwife given the charges found proved. They would also be concerned to know that Ms Tasker has not engaged with the NMC as her regulator in the proceedings.

For these reasons, the panel finds that Ms Tasker's fitness to practise remains impaired on both public protection and public interest grounds.

Decision and reasons on sanction

Having found Ms Tasker's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel was aware it had the option of taking no further action. This would have the effect of Ms Tasker ceasing to be on the register after the current order expires on 15 September 2024. If Ms Tasker subsequently sought to return to the register, the Registrar would consider her application in the light of this panel's finding that her fitness to practise is currently impaired. The panel was conscious that it had no information about whether Ms Tasker had any wish to return to practice at any point in the future. In these circumstances it was satisfied that it would not be appropriate simply to allow Ms Tasker's registration to lapse. 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 Ms Tasker's 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 Ms Tasker's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on Ms Tasker's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and what that panel said. The original panel found that the misconduct was remediable but due to the non-engagement of Ms Tasker a conditions of practice order would not be appropriate in the circumstances.

Today's panel concluded that due to Ms Tasker's non-engagement with the NMC a conditions of practice order would not be appropriate or workable and would not adequately protect the public or satisfy the public interest at this time.

The panel considered the imposition of a further period of suspension. This was a single episode, though involving a number of clinical failings. While Ms Tasker has not engaged with the proceedings, the panel has borne in mind that NMC proceedings can be very stressful for a registrant, and it is not of the view that Ms Tasker's misconduct indicated deep-seated attitudinal problems. There is no evidence of repetition since the incident, although the panel appreciates that Ms Tasker has been suspended for the last year and it is unclear whether she had been working as a midwife since leaving her former employment in 2019. The panel considered that she has shown some, though limited, insight.

In the panel's judgement a suspension order is, at this stage, both sufficient to protect patients and to uphold standards and maintain confidence in the midwifery profession.

The panel was of the view that a suspension order would give Ms Tasker a further opportunity to make clear whether she has any wish to return to practice as a midwife. This would also provide her with an opportunity to strengthen her practice by doing relevant training, reflecting more fully on her previous failings and gaining a fuller understanding of the impact her actions had on Patient A, her colleagues and the professions. The panel concluded that a further 12 month suspension order would be the appropriate and proportionate response and would afford Ms Tasker adequate time to further develop her insight and take steps to strengthen her practice.

The panel considered whether a striking-off order would be appropriate. The panel was not convinced that it would be appropriate at this stage to impose a more serious sanction on Ms Tasker simply because of a lack of engagement during the last 12 months, when the previous panel found that Ms Tasker's misconduct was not fundamentally incompatible with her remaining on the register.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly,

the panel determined to impose a suspension order for the period of 12 months, which would provide Ms Tasker with an opportunity to engage with the NMC and provide further information in regard to her future intentions for her career. It considered that this order, for this period, is the appropriate and proportionate sanction.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 15 September 2024 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may extend the order or make a different order, it may revoke the order, or reduce its length, or it may replace the order with another order for the rest of its current term. A future panel can consider all orders available to it, including a striking-off order. It would assist the panel if Ms Tasker contacted the NMC and notifies it of her future intentions for her career and if she intends to return to midwifery and nursing.

Any future panel reviewing this case may be assisted by:

- Ms Tasker's engagement with the NMC and her attendance at the review hearing;
- A reflective piece from Ms Tasker that addresses all of the categories of failings in her practice, together with the effect that her failings had on Patient A and her family, colleagues, and the wider profession;
- Evidence of up to date training; and
- Recent testimonials or references from any employer including either voluntary or paid employment.

If Ms Tasker no longer wishes to practise as a midwife, she should contact the NMC regarding her options for the future.

This will be confirmed to Ms Tasker in writing.

That concludes this determination.