Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 18 November 2024 – Thursday, 5 December 2024

Virtual Hearing

Name of Registrant:	**Fiona Lucy Bird**
NMC PIN	09A1009E
Part(s) of the register:	Midwife: RM (18 February 2009)
Relevant Location:	Suffolk
Type of case:	Misconduct
Panel members:	Richard Youds (Chair, lay member) Karen Shubert (Registrant member) Stacey Patel (Lay member)
Legal Assessor:	Ruth Mann (18 November 2024) Ashraf Khan (19 November 2024 – 05 December 2024)
Hearings Coordinator:	Audrey Chikosha
Nursing and Midwifery Council:	Represented by Arran Dowling-Hussey, Case Presenter
Mrs Bird:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 2c, 2d, 2e, 3, 4, 5a, 5b, 6a, 6b, 6c, 6d, 7, 8a, 8b, 8c, 8d, 9, 10a, 11b proved in part, 12a, 12b, 12c, 12d, 12e, 12f, 13a, 13b, 13c, 13e,
Facts not proved:	Charges 10b, 10c, 11a, 13d
Fitness to practise:	Impaired
Sanction:	Strike-off

Interim order: Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Bird was not in attendance and that the Notice of Hearing letter had been sent to Mrs Bird's registered email address by secure email on 24 September 2024.

Mr Dowling-Hussey, 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.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Bird'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 Mrs Bird has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Bird

The panel next considered whether it should proceed in the absence of Mrs Bird. It had regard to Rule 21 and heard the submissions of Mr Dowling-Hussey who invited the panel to continue in the absence of Mrs Bird.

Mr Dowling-Hussey submitted that there had been no engagement by Mrs Bird with the NMC in relation to these proceedings since 3 August 2024. He referred the panel to an email from Mrs Bird to the NMC dated 3 August 2024 which reads:

'…I do not work in any care role. I am a regional manager for a recruitment agency within the construction industry and have no intention of returning to the nhs [sic]*. I will not be attending the hearing....'*

Mr Dowling-Hussey therefore submitted that Mrs Bird had voluntarily absented herself and that there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs Bird;
- Mrs Bird has not engaged with the NMC since 3 August 2024 and has not responded to any of the subsequent letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses have been warned to give live evidence today, and there are others are due to attend;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Dowling-Hussey, on behalf of the NMC, to amend the wording of charge 13b.

The proposed amendment was to correct a typographical error in the quotation, so it reads *'first'* instead of *'fist'*. It was submitted by Mr Dowling-Hussey that the proposed amendment would correct a clear typo and consequently better reflect the evidence.

"13. On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;

a. ….

*b. By stating to Patient D words to the effect of, 'By the way, don't ring ambulances. You've got a number for the midwives team, you ring them ~~fist~~ **first** and get advice. There's people having heart attacks and you're taking up ambulances'.*

c. …

d. ...

e. …"

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Bird and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to amend the charge

On day eight of the hearing during the course of deliberations, the panel noted that the wording of Charge 5a did not accurately reflect the evidence before it. The panel ceased its deliberations at that time and invited submissions from Mr Dowling-Hussey.

The panel proposed amending the charge to insert the words *'attempt to'* to provide clarity regarding the allegation to be considered and better reflect the evidence.

"*5. On or around 27 April 2019, having been informed by Colleague 2 that they were unable to locate Patient B's foetal heart rate at around 06.35;*

*a. Failed to **attempt to** locate a foetal heart rate at this time."*

The panel invited submissions from Mr Dowling-Hussey. Mr Dowling-Hussey submitted that the NMC is neutral with regards to the proposed amendment. He invited the panel to use its power under the rules to make any amendment it sees fair and necessary to provide clarity and accurately reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He reminded the panel of its overarching objective to protect, promote and maintain the health, safety and well-being of the public. The legal assessor referred the panel to the cases of *PSA v (1) HCPC (2) Doree* [2017] EWCA Civ 319 and *PSA v (1) NMC (2) Jozi* [2015] EWHC 764 (Admin).

The panel was of the view that such an amendment, as it had proposed, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Bird and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate make the amendment, to provide clarity and accuracy.

Details of charge

That you a registered midwife;

1. On or around 7 June 2019, the CRISIS Team having reviewed Patient A and being informed by them that Patient A required a medical review, failed to:

    a. Seek a medical review for Patient A, and/or

b. Escalate the situation to your manager, and/or

c. Review Patient A's notes to consider whether a medical review was required or not.

2. On or around 7 June 2019, failed to document in Patient A's notes:

    a. That Patient A was reviewed by Dr 1 and yourself.

    b. Any observations of Patient A after Dr 1 and yourself had reviewed them.

    c. A plan of care for Patient A.

    d. Interactions that took place between the CRISIS Team and yourself, and/or including your reasons / decision as to why a medical review was not required.

    e. Any interactions that you had with Colleague 1 regarding Patient A's care.

3. On or around 7 June 2019, behaved in an unsupportive and/or dismissive manner towards Colleague 1 when they escalated to you that Patient A required a medical review.

4. On or around 7 June 2019 behaved in an unprofessional manner in front of the CRISIS Team by stating in a loud and/or aggressive manner words to the effect of, *'I cannot have a psychiatric patient on my ward'.*

5. On or around 27 April 2019, having been informed by Colleague 2 that they were unable to locate Patient B's foetal heart rate at around 06.35;

    a. Failed to attempt to locate a foetal heart rate at this time.

    b. Delayed any attempt to locate a foetal heart rate until around 06.52.

6. On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or unprofessional manner by;

    a. Stating to Patient B words to the effect of, *'going for another fag, are you?'*.

b. Stating to Patient B words to the effect of, ‘you’ve had a baby before, you know what that is’.

c. Stating to Colleague 2 that Patient B was shedding *‘crocodile tears’* or words to that effect.

d. Demanding that Patient B attempt to pass urine despite them being in discomfort.

7. On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or dismissive manner towards Colleague 2 when they informed you that Patient B was unable to provide a urine sample when stating words to the effect of, *‘I want her to have it and have it now’*.

8. On or around 29 June 2019 prior to performing a suprapubic manoeuvre on Patient C, failed to;

    a. Introduce yourself to Patient C.

    b. Explain the procedure and/or why you were undertaking the procedure.

    c. Seek Patient C’s consent before undertaking the procedure.

    d. Offer support to Patient C.

9. On or around 29 June 2019 failed to document in Patient C’s notes that you had carried out the suprapubic manoeuvre upon Patient C.

10. On or around 29 June 2019 behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient C;

    a. When Patient C pushed your arm away and told you to get off shouted in their face words to the effect of, *‘Are you refusing care?*’

    b. By loudly stating words to the effect of, *‘Is someone documenting that she’s refusing suprapubic pressure’*.

c. When Patient C was worried that she was not feeling contractions and did not feel ready, stated words to the effect of, *'Is someone documenting that Patient C is refusing help'*.

11. On or around 27 April 2019 prior to performing a vaginal examination on Patient D failed to:

    a. Introduce yourself to Patient D.

    b. Explain to Patient D that you were to perform a vaginal examination and/or the reasons why.

12. On or around 27 April 2019 having performed a vaginal examination on Patient D failed to document in Patient D's notes:

    a. Whether Patient D was in pain and/or not coping.

    b. The reason for performing the vaginal examination.

    c. Any abdominal palpation observations / findings.

    d. Whether a fetal heart rate was detected before and/or after the examination.

    e. What the plan of care would be for Patient D.

    f. Whether there was a discussion with Patient D regarding her plan of care and/or pain relief that was required.

13. On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;

    a. By stating in front of Patient D words to the effect of, *'It's her again'*.

    b. By stating to Patient D words to the effect of, *'By the way, don't ring ambulances. You've got a number for the midwives team, you ring them first and get advice. There's people having heart attacks and you're taking up ambulances'*.

    c. By ignoring Patient D's request to cease performing the vaginal examination when she informed you that it was hurting her.

d. By refusing Patient D's request to have a caesarean section.

e. By stating to Patient D words to the effect of, '*I've got to examine you*'.

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

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

During the course of hearing witness evidence, the panel noted that proper exploration of this case would include reference to the health and personal life of some witnesses. It invited legal advice from the legal assessor.

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

The panel therefore determined, using its powers under Rule 19 of the Rules to go into private session as and when any reference to a witness' health and private life is made in order to protect their privacy. [PRIVATE]

Decision and reasons on application to admit evidence of Patient C as Hearsay.

The panel heard an application made by Mr Dowling-Hussey under Rule 31 to allow the written statement and exhibit of Patient C into evidence. Patient C was not present at this hearing, but Mr Dowling-Hussey submitted that the NMC had made reasonable efforts to try and secure her attendance. He referred the panel to an email dated 10 September 2024 from Patient C to the NMC which reads:

'[PRIVATE].'

Mr Dowling-Hussey submitted that Mrs Bird had been given Patient C's evidence ahead of this hearing and given she voluntarily absented herself from this hearing, would not have had an opportunity to test the evidence in any event.

Furthermore, Mr Dowling-Hussey submitted that the evidence of Patient C is not sole and decisive in support of the charges relating to Patient C. He submitted that adducing Patient C's evidence would provide the panel with the greatest scope of evidence to assist it in making its decision. Mr Dowling-Hussey submitted that the evidence is that of Patient C's account of what happened to her and her interaction with Mrs Bird.

Mr Dowling-Hussey submitted that Patient C's reason for not attending today, as set out in her email is a good reason. [PRIVATE] Patient C's resistance to attend is understandable.

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

The panel considered the application and noted that Patient C's statement and exhibit had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether Mrs Bird would be disadvantaged by the change in the NMC's position of moving from reliance upon the live evidence of Patient C to that of a written statement and exhibit.

The panel considered that as Mrs Bird had been provided with a copy of Patient C's statement and exhibit and, as the panel had already determined that Mrs Bird had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was

deprived, as was the panel, from reliance upon the live evidence of Patient C and the opportunity of questioning and probing that testimony.

Furthermore, the panel bore in mind the principles in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). The panel determined that the evidence is relevant to the charges as it is an account from a patient to whom the charges relate. However, it also noted that this evidence is not sole and decisive in respect of the charges.

The panel also considered the reason for Patient C's non-attendance. [PRIVATE]. The panel noted the NMC informed Patient C that the hearing would be virtual and so she would not have to attend in person. [PRIVATE].

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement and exhibit of Patient C as hearsay but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit evidence of Witness 11 as Hearsay.

The panel heard an application made by Mr Dowling-Hussey under Rule 31 to allow the written statement and exhibit of Witness 11 into evidence. Witness 11 was due to give live evidence on day seven of the hearing but informed the NMC on day four that she could no longer attend due to illness.

Mr Dowling-Hussey referred the panel to an email from Witness 11 to the NMC dated 21 November 2024 which reads:

'[PRIVATE]'

[PRIVATE]

[PRIVATE]

Mr Dowling-Hussey also submitted that Mrs Bird was provided with Witness 11's statement and exhibit ahead of the hearing. He submitted that given Mrs Bird's decision not to attend this hearing, there would be no unfairness or prejudice to Mrs Bird in adducing this evidence.

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

The panel noted that Witness 11's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether Mrs Bird would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 11 to that of a written statement and exhibit.

The panel considered that as Mrs Bird had been provided with a copy of Witness 11's statement and, as the panel had already determined that Mrs Bird had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 11 and the opportunity of questioning and probing that testimony.

The panel considered the principles of *Thorneycroft*. [PRIVATE]. The panel found that Witness 11's evidence is relevant to the charges but was not the sole and decisive evidence of any of the charges as the panel heard extensively from Patient D.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement and exhibit of Witness 11 as hearsay but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

On 4 May 2020, a referral was received from the Head of Midwifery and Nursing at West Suffolk NHS Foundation Trust (the "Trust").

It is alleged that on 26 April 2019, Mrs Bird was approached by a junior midwife who was having difficulty locating a fetal heart rate and who requested Mrs Bird's assistance. Mrs Bird instead allegedly instructed the junior midwife to obtain a urine sample from the patient. It was not until 17 minutes later that Mrs Bird attempted to find the baby's heart rate and was unable to do so. A subsequent ultrasound and obstetric review confirmed fetal death.

On 27 April 2019, it is alleged that Mrs Bird was asked to assist in undertaking a vaginal examination on a patient who had become distressed. Mrs Bird is alleged to have not introduced herself to the patient and demanded that the examination be completed without explaining to the patient why it was required. There was also an alleged lack of documentation completed by Mrs Bird.

It is also alleged that on 7 June 2019, Mrs Bird prevented a medical review of a postnatal patient who had been admitted onto the ward due to concerns of acute postnatal depression, despite a mental health team suggesting the patient was not suffering a mental health episode and was more likely experiencing an issue with her physical health. The patient was later diagnosed as having experienced a stroke.

A patient made a complaint via her community midwife that, during her labour on 29 June 2019, Mrs Bird allegedly performed an emergency manoeuvre without introducing herself, without seeking consent or explaining the procedure she was about to undertake. This

was witnessed by a student midwife who felt that Mrs Bird did not communicate to the patient with kindness.

Decision and reasons on facts

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

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

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: The Head of Midwifery and Nursing at the Trust. She conducted the internal investigation.
- Witness 2: Registered midwife at the Trust. Providing evidence in relation to Patient A. Referred to as Colleague 1 in the charges.
- Witness 3: Band 6 nurse at the Trust in the Emergency Department. Providing evidence in relation to Patient A.

- Witness 4: Band 6 midwife at the Trust. Giving evidence in relation to Patient B. Referred to as Colleague 2 in the charges.
- Witness 5: Patient B
- Witness 6: Liaison and Diversion Practitioner at the Trust. Worked as a band 6 midwife at the time of the allegations.
- Witness 7: Registered Midwife. At the time of the allegations was completing a placement at the Trust as part of midwifery studies. Providing evidence in relation to Patient C.
- Witness 8: Band 7 Community Team lead at the Trust. Patient C first reported her concerns to her.
- Witness 9: Patient D
- Witness 10: Band 6 midwife at the Trust. Providing evidence in relation to Patient D.

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 the NMC.

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

Charge 1a)

"1. On or around 7 June 2019, the CRISIS Team having reviewed Patient A and being informed by them that Patient A required a medical review, failed to:

a. Seek a medical review for Patient A, and/or.

b. Escalate the situation to your manager, and/or

c. …"

This charge is found proved.

In reaching this decision, the panel first considered whether there was a duty on Mrs Bird to seek a medical review. The panel noted that there was an obligation through the NMC Code to prioritise the safety of patients. In addition, in Witness 1's witness statement she says:

' [Mrs Bird] should have ensured that Patient A received a medical review.'

The panel was therefore satisfied that there was a duty to seek a medical review.

The panel heard evidence from Witness 2 and Witness 3 who both confirmed that they raised that a medical review should be conducted. The panel also had before it, the medical notes for Patient A and noted that an entry was made by Witness 2 stating that Mrs Bird did not believe a medical review was necessary. Furthermore, during the local investigation meeting on 6 September 2019, Mrs Bird stated that she did not conduct a review as she did not believe anything had changed with Patient A since being reviewed in the Emergency Department (ED) prior to admission to the maternity unit.

The panel heard from Witness 3 who told the panel that he tried to explain to Mrs Bird that Patient A was not experiencing a psychotic episode and therefore needed a medical review.

The panel determined that in light of the evidence, there was a duty for Mrs Bird to seek a medical review for Patient A. It noted that by Mrs Bird's own admission during the local investigation, she did not seek a medical review as she did not believe it to be necessary. The panel also noted that multiple healthcare professionals raised this with Mrs Bird but she did not do so.

The panel therefore found that this charge is proved.

Charge 1b)

> *" 1. On or around 7 June 2019, the CRISIS Team having reviewed Patient A and being informed by them that Patient A required a medical review, failed to:*
>
> *a. …*
>
> *b. Escalate the situation to your manager, and/or*
>
> *c. …"*

This charge is found proved.

In reaching this decision, the panel bore in mind the obligations of midwives from the NMC Code and determined that there is a duty for midwives to escalate matters to the appropriate professional.

During the local investigation interview, Mrs Bird stated that she did *'bleep'* the site manager, but did not get a response.

The panel noted in both the documentary and oral evidence of Witness 1 she explains that Mrs Bird did not escalate the situation with Patient A to the manager on call. Furthermore, the panel had the medical notes of Patient A and saw no evidence to suggest that there was any escalation from Mrs Bird.

In light of this, the panel found this charge proved.

Charge 1c)

> *"1. On or around 7 June 2019, the CRISIS Team having reviewed Patient A and being informed by them that Patient A required a medical review, failed to:*
>
> *a. …*
> *b. …*
> *c. Review Patient A's notes to consider whether a medical review was required or not.."*

This charge is found proved.

The panel first considered whether there was a duty on Mrs Bird to review Patient A's medical notes to consider whether or not she required a medical review. The panel considered the NMC Code and determined there was an obligation for Mrs Bird to prioritise the care of the patient and reviewing the notes is part of that duty. The panel also heard evidence from Witness 2 that Mrs Bird should have reviewed the patient notes in light of the developing situation with Patient A.

The panel also had the medical notes before it and noted that they clearly outlined the deterioration of Patient A. The panel was of the view that had Mrs Bird reviewed these notes, she would have been prompted to escalate the situation. Having found charges 1a and 1b proved the panel noted that Mrs Bird did not seek a medical review nor escalate the situation as a result of not reviewing the notes. The panel also noted that there were

no entries from Mrs Bird in the patient notes which, on the balance of probabilities suggests she did not review the notes at all.

The panel therefore found this charge proved.

Charge 2a, 2b, 2c, 2d and 2e

"2. On or around 7 June 2019, failed to document in Patient A's notes:

a. That Patient A was reviewed by Dr 1 and yourself.

b. Any observations of Patient A after Dr 1 and yourself had reviewed them.

c. A plan of care for Patient A.

d. Interactions that took place between the CRISIS Team and yourself, and/or including your reasons / decision as to why a medical review was not required.

e. Any interactions that you had with Colleague 1 regarding Patient A's care.."

These charges are found proved.

The panel noted that the same evidence and rationale applies to the entirety of the charge and therefore determined to consider the limbs of this charge together.

The panel first determined that Mrs Bird was under a duty to document and maintain proper patient records under the NMC Code. The panel had before it Patient A's notes and noted that there were no entries from Mrs Bird. It had an example of Mrs Bird's signature and handwriting from another patient's records.

The panel noted that Witness 2 documented Patient A's nursing observations (Obs) but there was nothing in the notes to suggest that the patient had been reviewed by Mrs Bird. There was no evidence of a care plan in the notes. The panel noted there was entries

from Witness 2 on the interactions with the CRISIS team and the interactions with Colleague 1 but nothing similar from Mrs Bird nor a countersignature from Mrs Bird. The panel also noted the witness statement from Witness 1 which reads:

> *'[Mrs Bird] did not document in Patient A's notes. I would have expected both [Mrs Bird] and the doctor who briefly saw Patient A to complete documentation within the patient's notes. I would have expected [Mrs Bird] to document her own observations of Patient A and to note down the plan of care for the patient'*

The panel also heard oral evidence from Witness 1 that she found it difficult to review this case during the internal investigation due to the lack of documentation from Mrs Bird.

The panel, having had sight of the contemporaneous patient notes of Patient A and noting there were no entries or countersignature from Mrs Bird regarding the areas outlined in the sub-charges, found that this charge is proved in its entirety.

Charge 3)

> "*On or around 7 June 2019, behaved in an unsupportive and/or dismissive manner towards Colleague 1* [Witness 2] *when they escalated to you that Patient A required a medical review..*"

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 2 as well as the evidence from Witness 1. The panel noted that in Witness 2's witness statement she writes:

> *'…I felt that [Mrs Bird] was very dismissive and did not want to look at the bigger picture …I don't feel that [Mrs Bird] was open minded enough to look at other possibilities… I did not feel that [Mrs Bird] was amazingly supportive, but I did not*

question her as to why she was dismissive. I found [Mrs Bird] to be abrupt and not very approachable…'

Witness 2 also reiterated this sentiment in her oral evidence to the panel. She told the panel that Mrs Bird was not supportive and was dismissive regarding the need for a medical review.

The panel also heard from Witness 1 who stated that one of the primary roles of a Band 7 coordinator is to keep the unit safe and be someone that the staff could raise concerns and seek advice from. The panel noted that from Witness 2's statements Mrs Bird failed to do so.

The panel bore in mind that during the local investigation, Mrs Bird denied acting in this way. However, having found Witness 2's evidence to be consistent and clear the panel found that on the balance of probabilities this charge is proved.

Charge 4)

"On or around 7 June 2019 behaved in an unprofessional manner in front of the CRISIS Team by stating in a loud and/or aggressive manner words to the effect of, 'I cannot have a psychiatric patient on my ward."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 who is a senior staff member of the CRISIS team that spoke to Mrs Bird on the relevant shift. The panel heard from Witness 3 that this incident was the first time he had met Mrs Bird. The panel was of the view that this increased the reliability of his evidence as there was no reason for his first impression of Mrs Bird to be biased.

The panel noted that Witness 3 provided a detailed description of his interaction with Mrs Bird which included having to take her to one side and speak to her about it. The panel had the local investigation meeting notes in which Witness 3 and another colleague state that Mrs Bird said '*this lady been sent up to me, she can't be on the ward'.* The panel also noted Witness 3 tried to advise Mrs Bird multiple times that Patient A was not a psychiatric patient. The panel also noted that in the local investigation report it states that:

> *'[Witness 3] explained he was thankful that [Mrs Bird] had spoken with them as they were experienced nurses and felt had it been a more junior member of their team they may have crumbled as [Mrs Bird] was assertive to the point of aggressive...'*

The panel noted that Mrs Bird denied she was aggressive or loud in the local investigation however the panel found the evidence of Witness 3 to be more compelling. The panel noted that Witness 3's evidence is consistent from the contemporaneous meeting notes to his witness statement and the oral evidence given at the hearing.

The panel was therefore satisfied that on the balance of probabilities, Mrs Bird behaved in an unprofessional and aggressive manner and as such this charge is found proved.

Charge 5a)

> *"On or around 27 April 2019, having been informed by Colleague 2* [Witness 4] *that they were unable to locate Patient B's foetal heart rate at around 06.35;*
>
> *a. Failed to attempt to locate a foetal heart rate at this time.*
>
> *b. …"*

This charge is found proved.

In reaching this decision, the panel took into account the NMC Code which establishes a duty to prioritise the care of patients. In addition, the panel noted that one of the

fundamental competencies of midwives is to monitor the wellbeing of both mother and baby. The panel also heard evidence from Witness 1 who told the panel that checking the foetal heart rate in such a situation is a priority. It was therefore satisfied that there was a duty to attempt to locate the heart rate.

The panel heard evidence from Patient B who recalled that Mrs Bird demanded for her to get out of bed and go to the bathroom to pass urine. The panel noted that this is consistent with her witness statement and initial report to the Trust. The panel noted that in the local investigation report it is stated that:

> *'[Witness 4] explained at 06:35am she went outside to ask for help in finding the foetal heartrate, at this point [Witness 4] felt she was rudely told by [Mrs Bird] to get her on the toilet for a urine sample…'*

The panel also had the patient notes of Patient B and found no evidence that Mrs Bird tried to find a foetal heartrate. It noted that Mrs Bird was asked to come and attempt to do so but she instead suggested that it may be a urinary infection.

The panel therefore found this charge proved.

Charge 5b)

> *"On or around 27 April 2019, having been informed by Colleague 2* [Witness 4] *that they were unable to locate Patient B's foetal heart rate at around 06.35;*
>
> *a. …*
>
> *b. Delayed any attempt to locate a foetal heart rate until around 06.52.."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 4 and Patient B. The panel noted that in both the oral and written evidence of both witnesses, Mrs Bird was persistent in wanting Patient B to pass urine for a urine sample. The panel had the patient notes in which it is recorded that at 06:35, Mrs Bird was asked to help find a heartrate, but she asked Patient B to pass urine instead.

The panel also noted that in the notes it is recorded that at 06:52, Mrs Bird re-entered the room and at that point she attempted to find the foetal heartrate. The panel note that Mrs Bird says she did not leave the room from 06:35 however the contemporaneous notes, together with the evidence from Patient B and Witness 4 speak to the contrary. The panel was of the view that given Patient B and Witness 4's evidence is clear, consistent and corroborated; it is more compelling than that of Mrs Bird.

In light of this, the panel found this charge proved.

Charge 6a)

"On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or unprofessional manner by;

a. Stating to Patient B words to the effect of, 'going for another fag, are you?'.

b. ...

c. ...

d. ..."

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Patient B. She told the panel that Mrs Bird made this comment, and it had made her very upset and distressed at the time. Patient B told the panel that she felt as though it was

"*[her] fault"* that her baby was stillborn. The panel noted that Patient B was very clear in giving her evidence and was consistent in her account of the incident.

The panel noted that Mrs Bird said in the local investigation meeting that when Patient wanted to go for a cigarette she told her that she *'couldn't go anywhere at that point'*. The panel was satisfied that there had been an interaction between Mrs Bird and Patient regarding going outside for a cigarette although there is dispute regarding the nature of the comment.

The panel determined that given the context, namely that Patient B had just experienced a stillbirth, it was neither supportive, kind nor professional to make a comment on Patient B smoking. [PRIVATE].

The panel therefore determined that this charge is proved on the balance of probabilities.

Charge 6b)

> *"On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or unprofessional manner by;*
>
> *a. …*
>
> *b. Stating to Patient B words to the effect of, 'you've had a baby before, you know what that is'.*
>
> *c. …*
>
> *d. ..."*

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Patient B. The panel noted that Patient B was clear and consistent with her account of the incident. The panel noted that her evidence captures the full phrase, and she told the

panel that following this, she called her father as she did not want to be alone with Mrs Bird.

The panel was of the view that given the context of Patient B having just had a stillbirth, this comment was unkind, unsupportive and consequently unprofessional.

The panel therefore found this charge proved.

Charge 6c)

> *"On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or unprofessional manner by;*
>
> *a. …*
>
> *b. …*
>
> *c. Stating to Colleague 2 [Witness 4] that Patient B was shedding 'crocodile tears' or words to that effect.*
>
> *d. …*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 4 which reads:

> *'…[Mrs Bird] had also indicated to me that the patient was shedding "crocodile tears" before it had been confirmed that her baby had died. She said this to me when we were in the corridor and not in front of the patient, but [Mrs Bird] should have been more understanding of the situation and should have been more supportive as well…'*

The panel noted that Witness 4 was consistent in her account of this in her local investigation meeting and in her oral evidence. The panel found this to be credible and

reliable. Furthermore, the panel bore in mind that this was Witness 4's first experience of a stillbirth and therefore a significant moment in her memory. As such the panel found Witness 4's evidence to be compelling and determined that Mrs Bird did make this statement.

The panel next considered if it was unkind, unsupportive and unprofessional. The panel noted that in Witness 4's oral evidence she told the panel that midwives are expected to take all patient pain seriously. She said in both her witness statement and oral evidence that she felt that Mrs Bird was not supportive. Given the context, the panel concluded that this comment was unkind, unsupportive and consequently unprofessional.

In light of this, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 6d)

> *"On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or unprofessional manner by;*
>
> *a. …*
>
> *b. …*
>
> *c. …*
>
> *d. Demanding that Patient B attempt to pass urine despite them being in discomfort.."*

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Patient B and Witness 4 who both stated that Mrs Bird was very persistent in getting Patient B to pass urine. Witness 4 told the panel how Mrs Bird was very insistent. The

panel noted that when questioned about this at the local investigation interview, Mrs Bird said she was *'firm and fair'*.

[PRIVATE]

The panel noted that in the patient notes, it states that Mrs Bird *'suggested'* for Patient B to pass urine, and entries follow saying that Patient B did attempt to pass urine. However, in her oral evidence, Witness 4 told the panel that Mrs Bird was *'demanding'* and Patient B said in her oral evidence that Mrs Bird was *'persistent'* in making the request.

Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 7)

> *"On or around 27 April 2019, behaved in an unsupportive and/or unkind and/or dismissive manner towards Colleague 2 [Witness 4] when they informed you that Patient B was unable to provide a urine sample when stating words to the effect of, 'I want her to have it and have it now'."*

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 4. The panel noted in her witness statement she says:

> *'In my opinion, [Mrs Bird's] attitude towards myself and towards Patient B was inappropriate… This was not the only time that [Mrs Bird] had been unkind towards me when I worked with her.'*

The panel noted that in her oral evidence, Witness 4 is clear and consistent in her account of the incident. Witness 4 recalled that Mrs Bird was not supportive and in response to panel questions, said that she felt Mrs Bird was dismissive of her. The panel also noted

that Witness 4 said she was angry at the treatment of Patient B and within her local investigation meeting corroborates this as she states she would not have raised concerns if Mrs Bird's behaviour had been appropriate.

The panel therefore determined that this charge is found proved.

Charges 8a, 8b and 8c

> *"On or around 29 June 2019 prior to performing a suprapubic manoeuvre on Patient C, failed to;*
>
> *a. Introduce yourself to Patient C.*
>
> *b. Explain the procedure and/or why you were undertaking the procedure.*
>
> *c. Seek Patient C's consent before undertaking the procedure.*
>
> *d. ..."*

This charge is found proved.

The panel bore in mind the NMC Code and determined that there is a duty for midwives to introduce themselves, explain any clinical procedures and obtain consent prior to undertaking them. The panel also had sight of the Trust's policy which outlines that these are key elements of the role. Furthermore, it notes that Mrs Bird was a member of the (PROMPT) faculty and as such would have known about the human factors that are key to an obstetric emergency and are emphasised in the PROMPT training.

The panel noted Patient C's witness statement in which she says:

> *'…the registrant was the last one to come into the room. She stormed in and got hold of my stomach and was pulling and pushing my stomach when I was pushing and in labour. She was doing this so vigorously I told her to "stop and get off me". I did not know the registrant at all and she did not introduce herself to me at any*

point or tell me why she was pulling and pushing my stomach. It could have been necessary for her to do this but she didn't explain this to me.'

The panel acknowledged that this was an emergency situation with a need to act fast. However, the panel heard from Witness 7, who stated that she was surprised by the fact that Mrs Bird did not introduce herself to the patient. The panel noted that Witness 6 stated that she could not recall if Mrs Bird introduced herself but drew no adverse inference to this given the passage of time. The panel found Witness 7's evidence to be more compelling as this was her first experience of this procedure and as such clearer in her memory.

The panel also noted that in the local investigation meeting notes, Mrs Bird is recorded to have stated that she cannot recall if she did introduce herself, explain the procedure nor obtain consent as it was an emergency. The panel was not satisfied that this mitigated the need introduce oneself, explain the procedure and obtain consent. It heard from Witness 8 that it is possible to introduce yourself, explain the procedure and get consent while starting the procedure.

The panel therefore found these charges proved.

Charge 8d)

"On or around 29 June 2019 prior to performing a suprapubic manoeuvre on Patient C, failed to;

a. …

b. …

c. ...

d. Offer support to Patient C.."

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Patient C, in particular:

> *'There was no communication between us, she couldn't even look at me.…'*

and;

> *'It was such a horrible and awkward situation. The registrant did not even speak to me afterwards.'*

The panel also noted that Patient C stated:

> *'The registrant is not compassionate or reassuring. She is very rude and aggressive. I don't understand how you could be a midwife and be like that. She should not work with women in pain. It was not professional of her to come at me like that and pull and push at my stomach without explanation. She would have known full well that her actions could have stopped my labour and that's what she did. My experience was really awful.'*

The panel also heard from Witness 8 who described the situation as *'confrontational'* which the panel determined cannot be reflective of a supportive environment. It also noted that both in Patient C's witness statement and in the meeting notes with Witness 7 it is stated that no pain relief was given to the patient.

The panel, taking all the evidence together, concluded that this charge is proved.

Charge 9)

> *"On or around 29 June 2019 failed to document in Patient C's notes that you had carried out the suprapubic manoeuvre upon Patient C.."*

This charge is found proved.

The panel noted that under the NMC Code, Mrs Bird had a duty to ensure proper record keeping and documentation of Patient C while she was under her care.

The panel had Patient C's patient notes before it. It noted there were no entries in the notes from Mrs Bird. The panel heard evidence from Witness 1 that in an emergency situation, such as this, midwives would typically have a scribe however the panel saw no evidence of Mrs Bird countersigning the noted taken. In addition, Witness 1 stated that there is an expectation of nurses to provide an entry following the procedure even when there was a scribe. The panel saw no entries made by Mrs Bird regarding the suprapubic manoeuvre.

The panel therefore determined that this charge is proved.

Charge 10a)

"On or around 29 June 2019 behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient C;

a. When Patient C pushed your arm away and told you to get off shouted in their face words to the effect of, 'Are you refusing care?'

b. …

c. …"

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 6 as well as the statement of Patient C.

The panel noted that Witness 6 said she did not witness Mrs Bird shouting in Patient C's face. It also noted that Witness 6 in her statement said that Mrs Bird used the words:

'is [Patient C] declining care'

However, in her oral evidence, Witness 6 said that she could not recall what happened. The panel then reviewed the evidence of Patient C. It noted that in her statement to Witness 8 during the local investigation and her statement to the NMC her account is consistent. Patient C says in her statement that it was as if Mrs Bird wanted a *'face-off'* and that Mrs Bird *'shouted in [Patient C's] face'.* The panel also considered that the nature of the procedure Mrs Bird was giving Patient C, she would have been close to her face and taking into account the context of the emergency situation it is more likely than not that Mrs Bird shouted in Patient C's face.

The panel then considered the context of the situation and determined that it was not supportive nor kind nor professional to shout in a patient's face. In particular it noted that this was a stressful and frightening situation for the patient and thus required Mrs Bird to act with kindness and compassion.

Given the clarity and consistency of Patient C's evidence, the panel found it to be more compelling and thus on the balance of probabilities determined that this charge is proved.

Charge 10b)

"On or around 29 June 2019 behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient C;

a. …

b. By loudly stating words to the effect of, 'Is someone documenting that she's refusing suprapubic pressure'.

c. …"

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6 and 7. The panel noted that the statement was directed to members of staff in the room. The panel noted that both witnesses attest to the fact that Mrs Bird did use the words stated in the charge. The panel was of the view that given that this was an emergency situation, that the room may have been noisier than usual due to the number of staff present, and that Patient C stopped Mrs Bird from doing the manoeuvre it was not unkind nor unprofessional. Furthermore, the panel understood that in this situation there would have been a scribe to whom Mrs Bird would be directing this comment.

As such, the panel found this charge not proved as she was not acting in an unkind and/or unsupportive and/or unprofessional manner towards Patient C.

Charge 10c)

> *"On or around 29 June 2019 behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient C;*
>
> *a. …*
>
> *b. …*
>
> *c. When Patient C was worried that she was not feeling contractions and did not feel ready, stated words to the effect of, 'Is someone documenting that Patient C is refusing help'.."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 7. It noted that in her witness statement she said:

'…Patient C then told [Mrs Bird] to get off her and [Mrs Bird] said loudly to everybody in the room, "is someone documenting that Patient C is refusing care?" I heard [Mrs Bird] say this twice…'

The panel determined that that this was an emergency situation where a scribe was being utilised. Similar to the reasons for the panel's decision at Charge 10b, Mrs Bird making this statement loudly was not being unkind, unsupportive or unprofessional. Furthermore, the panel noted that this comment was made for the scribe to take down in the notes and not directed towards Patient C.

The panel therefore found that this charge is not proved.

Charge 11a)

"On or around 27 April 2019 prior to performing a vaginal examination on Patient D failed to:

a. Introduce yourself to Patient D.

b. ..."

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Patient D. The panel noted that in her witness statement she says:

'I first met [Mrs Bird] when I attended the maternity unit of the West Suffolk Hospital ("the hospital") at the beginning of April 2019…'

and;

'I recognised [Mrs Bird] from when she checked me over previously. [Mrs Bird] is quite distinctive in the way she looks and speaks so I knew it was her...'

The panel noted that in both her oral and written evidence, Patient D stated that she recognised Mrs Bird when she attended to her on this date. Patient D told the panel that Mrs Bird was very distinctive and thus knew it was her when she went to the hospital.

The panel was of the view that given that Mrs Bird was known to Patient D and Patient D said herself that she recognised and knew it was Mrs Bird, the panel did not find there to be a duty for Mrs Bird to introduce herself on this occasion.

The panel therefore found this charge not proved.

Charge 11b)

> *"On or around 27 April 2019 prior to performing a vaginal examination on Patient D failed to:*
>
> *a. ...*
>
> *b. Explain to Patient D that you were to perform a vaginal examination and/or the reasons why.."*

This charge is found proved in part.

In reaching this decision, the panel bore in mind the NMC Code and The West Suffolk NHS Foundation Trust *'Putting You First'* policy. It determined that there is duty on midwives to explain the procedures they undertake on patients.

The panel heard from Patient D who gave a clear account in her oral evidence of the incident which was consistent with her witness statement. The panel noted Patient D recalls Mrs Bird had said that she had to examine Patient D, but no reasons were given as to why. This is corroborated by the evidence of Witness 11 who in her statement says:

'The next thing I knew was that Fiona ripped back the curtain and came bundling into the bay, saying something along the lines of "I've got to examine you." I felt that this was not professional, and Fiona didn't even say who she was to the patient…'

The panel noted that Patient D knew that Mrs Bird was going to give her a vaginal examination. However, taking into account the evidence of both Patient D and Witness 11 the panel determined that Mrs Bird did not explain the reasons why.

The panel therefore determined that this charge is found proved so far as that Mrs Bird failed to explain the reasons why she was performing a vaginal explanation.

Charges 12a, 12b, 12c, 12d, 12e and 12f

"On or around 27 April 2019 having performed a vaginal examination on Patient D failed to document in Patient D's notes:

a. Whether Patient D was in pain and/or not coping.

b. The reason for performing the vaginal examination.

c. Any abdominal palpation observations / findings.

d. Whether a fetal heart rate was detected before and/or after the examination.

e. What the plan of care would be for Patient D.

f. Whether there was a discussion with Patient D regarding her plan of care and/or pain relief that was required.."

These charges are found proved.

The panel noted that the same evidence is relied upon for all elements of this charge and thus decided to consider this charge together in its entirety.

The panel first determined that there was a duty on Mrs Bird to properly document Patient D's care in her notes in accordance with the NMC Code.

The panel had Patient D's patient notes before it. It noted that the only entry made by Mrs Bird in Patient D's patient notes was at 04:45 stating that she had gained consent for a vaginal examination. The panel had no notes from Mrs Bird regarding:

a. Whether Patient D was in pain and/or not coping.
b. The reason for performing the vaginal examination.
c. Any abdominal palpation observations / findings.
d. Whether a fetal heart rate was detected before and/or after the examination.
e. What the plan of care would be for Patient D.
f. Whether there was a discussion with Patient D regarding her plan of care and/or pain relief that was required.

The panel therefore found this charge proved.

Charge 13a)

"On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;

a. By stating in front of Patient D words to the effect of, 'It's her again'.
b. …
c. …
d. …
e. …"

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Patient D.

The panel was satisfied that Patient D was a credible witness as it was of the view that she had been clear and consistent in her account. The panel found her evidence to be compelling and provided a detailed description of the incident for the panel in her oral evidence. The panel noted that there was no corroborative evidence before it however there was no evidence that obviously contradicted it. Mrs Bird stated at local level that she did not remember anything about Patient D and therefore made no comment.

The panel was of the view that given the context, in that Patient D had attended the hospital in pain and in need of care, this comment was not supportive nor kind. Furthermore, it considered that the duty of midwives is to take all patient pain seriously and thus making such a comment in the proximity of the patient was unprofessional.

The panel therefore found this charge proved.

Charge 13b)

> *"On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;*
>
> *a. …*
>
> *b. By stating to Patient D words to the effect of, 'By the way, don't ring ambulances. You've got a number for the midwives team, you ring them first and get advice. There's people having heart attacks and you're taking up ambulances'.*
>
> *c. ...*
>
> *d. …*
>
> *e. …*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient D. The panel noted that she was very clear and consistent in her evidence regarding this incident. In her witness statement, Patient D stated:

> *'…When [Mrs Bird] said this, I felt like I could have killed someone… When [Mrs Bird] said there was people out there like my dad who needed an ambulance, it hurt my feelings that I could have hurt someone…'*

The panel found Patient D's evidence to be compelling. The panel found her to be consistent in oral evidence with her statement. It noted that this comment had an emotional impact on Patient D and is a significant memory she was able to recall clearly to the panel.

The panel was of the view that given the context and the personal attachment to the comment made by Mrs Bird, it was unsupportive, unkind and unprofessional. The panel therefore found this charge proved.

Charge 13c)

> *"On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;*
>
> *a. ....*
>
> *b. …*
>
> *c. By ignoring Patient D's request to cease performing the vaginal examination when she informed you that it was hurting her.*
>
> *d. ….*
>
> *e. …."*

This charge is found proved.

The panel took into account the written and oral evidence of Patient D. The panel noted that in Patient D's witness statement she wrote:

'..it really hurt and I told her to "get her fucking hands out of me"..'

The panel found Patient D's oral evidence to be consistent with this statement. In her oral evidence, Patient D also told the panel that she was scared at the time and felt like she could not say no to Mrs Bird when she continued to examine her after she had asked her to stop.

The panel considered Patient D's evidence to be compelling and clear. The panel was satisfied on the balance of probabilities that Mrs Bird ignored Patient D's request to stop.

The panel then considered whether it was unkind, unprofessional and unsupportive. It noted that Patient D was distressed and in pain, but Mrs Bird did not accommodate her nor aid her in the process. The panel therefore found this charge proved on all three elements.

Charge 13d)

"On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;

a. …

b. …

c. …

d. By refusing Patient D's request to have a caesarean section.

e. …."

This charge is found NOT proved.

In reaching this decision, the panel took into account evidence from Patient D. The panel noted that Patient D provided two different accounts with regards to this incident. It noted that in her written statement, Patient D says:

> *'…I said give me a caesarean section then as I'm tired. [Mrs Bird] then said no, as it would take 15 minutes to prepare me'*

However, in her oral evidence, Patient D told the panel that Mrs Bird said 'yes' to the caesarean section but warned that it would take 15 minutes to prepare. The panel also had Patient D's patient notes before it which state that Mrs Bird explained the process of a caesarean section. In light of this the panel was satisfied that Patient D had made a request for a caesarean section, to which Mrs Bird provided a response. However, the panel noted that given that there was a doctor in the room, and that it is out of the remit of a midwife's duty to perform caesarean sections, it was not a request that Mrs Bird could consent or refuse. Therefore, while the panel is unclear whether Mrs Bird said yes or no, it was neither unkind, unsupportive nor unprofessional as Mrs Bird was not the authority on the matter.

The panel therefore did not find this charge proved.

Charge 13e)

> *"On or around 27 April behaved in an unkind and/or unsupportive and/or unprofessional manner towards Patient D;*
>
> *a. …*
>
> *b. …*
>
> *c. …*
>
> *d. …*
>
> *e. By stating to Patient D words to the effect of, 'I've got to examine you."*

This charge is found proved.

In reaching this decision, the panel bore in mind the evidence of Patient D. The panel noted that both in her statement and oral evidence she clearly recalls Mrs Bird making this statement and it is corroborated by the statement of Witness 11. Furthermore, having found charge 11b proved, the panel was satisfied that Mrs Bird had used these words or something to that effect. It then considered the evidence of Patient D in which she states that she was scared and did not get any explanation from Mrs Bird regarding the need of the procedure. Taking into account the intimate nature of the procedure and the wider context of Patient D's feelings at that time and Mrs Bird's attitude, the panel determined that Mrs Bird was unkind, unsupportive and unprofessional.

The panel therefore found this charge 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 Mrs Bird's 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 the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mrs Bird's 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 Dowling-Hussey 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' (the Code) in making its decision.

Mr Dowling-Hussey submitted that given the facts found proved, Mrs Bird has demonstrated basic failures of midwifery practice and fallen short of the standards expected of a registered midwife.

Mr Dowling-Hussey invited the panel to review section 20 of the Code as a starting point in relation to upholding the reputation of the profession. He submitted that there are other considerable failures to act in a professional manner within the standards set out in the Code. Mr Dowling-Hussey submitted that the charges found proved indicate discourtesy, a lack of support and lack of professionalism to patients and fellow colleagues.

Mr Dowling-Hussey submitted that the charges found proved are very serious and relate to core issues of midwifery. He submitted that the volume of charges suggest that this was not an isolated situation but instead multiple instances of misconduct.

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

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code and the NMC Guidance (reference FTP-3).

The panel was of the view that Mrs Bird's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Bird's actions amounted to a breach of the Code. Specifically

> *'**1 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*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.3 encourage and empower people to share in decisions about their treatment and care*
> *2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*
> *2.5 respect, support and document a person's right to accept or refuse care and treatment*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*

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

4 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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

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

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore took each charge in turn and considered whether it amounted to misconduct.

Charges 1a, 1b, 1c

The panel noted that the conduct in charges 1a and 1c put patients at risk of harm. It noted that the charges found proved are serious and that a Band 7 Coordinator should act in a way that prioritises the health of patients under their care. The panel was therefore of the view that these charges amount to serious misconduct.

With regards to charge 1b, the panel determined that Mrs Bird had the necessary experience to deal with the situation herself and therefore while she did fail to escalate the matter, the panel did not find this amounted to serious misconduct.

Charges 2a, 2b, 2c, 2d, 2e

The panel noted that ensuring that documentation is completed fully and correctly is a fundamental element of midwifery practice as set out in section 10.1 and 10.2 of the Code. The panel noted that Mrs Bird failed to properly document and identify a deteriorating patient. The panel also heard evidence at the Facts stage from multiple professionals who attested to the fact that there is a duty to document in the patient notes when providing care to a patient. The panel also took into account the fact that there had been a clear difference in opinion on the care to be given to the patient which heightened the importance to provide the proper documentation.

The panel therefore determined that all five limbs of this charge amount to misconduct.

Charge 3

The panel noted that this charge is serious as it relates to dismissing concerns regarding a deteriorating patient. The panel noted that this is fell below the standards expected of a registered midwife and increased the risk to patient safety. Furthermore, the panel found that the misconduct in this charge is aggravated by the fact that Mrs Bird was the most senior midwife on shift and she not only failed to identify a deteriorating patient, but also failed to support a junior colleague.

The panel therefore determined that this charge amounted to serious misconduct.

Charge 4

The panel noted that Mrs Bird's conduct was unprofessional and demonstrated a lack of respect for her fellow colleagues and patients. The panel was of the view that this fell seriously short of the standards expected of a registered midwife. The panel noted that there is an expectation for registered midwives to be professional at all times and communicate well with others which Mrs Bird failed to do.

The panel therefore determined that this charge amounted to misconduct.

Charge 5a and 5b

The panel noted that this charge relates directly to patient safety. It was of the view that Mrs Bird's conduct suggested attitudinal issues rather than lack of knowledge or skills. The panel considered the delay in finding the foetal heart rate put the patient's safety at risk. It noted that this was a breach of fundamental responsibilities of midwifery and other registrants would find this conduct deplorable.

As such the panel found these charges to amount to misconduct.

Charges 6a, 6b, 6c and 6d

The panel found all limbs of this charge to amount to serious misconduct. The panel noted that Mrs Bird's conduct fell seriously short of the standards expected of a registered midwife in accordance with the Code. The panel was of the view that Mrs Bird at each stage of the charge did not demonstrate kind, safe or professional practice. The panel considered that other registrants would find this conduct to be deplorable and as such found this charge to amount to misconduct.

Charge 7

The panel noted that the charge found proved was serious. It bore in mind that Mrs Bird was in a position of seniority and power. The panel considered that Mrs Bird's failure to support a junior colleague was in breach of the Code and did not demonstrate kindness. Furthermore, the panel determined that Mrs Bird's conduct fell short of the standards expected of a registered midwife. It therefore concluded that this amounted to serious misconduct.

Charges 8a, 8b, 8c and 8d

The panel bore in mind that this was an emergency situation, however it noted that multiple professionals gave evidence to the fact that regardless of the emergency nature, midwives should always introduce themselves prior to undertaking any procedure. The panel was also of the view that the misconduct in this charge is exacerbated by the fact that Mrs Bird was a PROMPT faculty member and well aware of the need to introduce herself, explain the procedure, obtain consent and provide support. In addition, the panel noted the profound and ongoing effects on Patent C's wellbeing as a result of Mrs Bird's actions in particular, that she could not attend the hearing to give live evidence.

The panel determined that other registrants would find Mrs Bird's conduct to be deplorable and that it fell seriously short of the standards expected of a registered midwife. The panel therefore concluded that these charges amount to misconduct.

Charge 9

The panel note that ensuring proper documentation is an important part of midwifery practice. However, in these circumstances, the panel noted that the documentation was not key to subsequent care. The panel took into account that it was a busy shift, and it was an emergency situation where a scribe was utilised. The panel therefore determined that while Mrs Bird demonstrated poor practice, it was not sufficiently serious to amount to misconduct.

Charge 10a

The panel noted that Mrs Bird's conduct fell far below the standards of care expected of a registered midwife. The panel noted that Mrs Bird's conduct was not kind nor professional. It bore in mind that while the room was likely to be loud, the words used were combative and confrontational. The panel noted that Mrs Bird retaliated to the patient's actions rather than calming the situation. Given the context and that Patient C was in a vulnerable situation, Mrs Bird's conduct did amount to serious misconduct.

Charge 11b

The panel noted that the charge is serious. It considered the nature of the examination and the evidence of Patient D that she felt obliged to undergo the examination although she wanted Mrs Bird to stop. The panel noted that the charge relates to a serious breach of the Code and Mrs Bird's conduct would be considered deplorable by other registrants. The panel noted that obtaining informed consent is key to midwifery practice especially in these circumstances.

The panel therefore determined that this charge amounted to serious misconduct.

Charges 12a, 12b, 12c, 12d, 12e and 12f

The panel bore in mind section 10 of the Code. It considered the nature of the examination and determined that it should have been written in the notes by Mrs Bird as the professional who undertook It. The panel noted the volume of key information missing from the notes and was of the view that it was key to subsequent patient care. The panel noted that this documentation was important in providing effective care for Patient D during her labour in order to identify the wellbeing of the mother and baby.

The panel noted that as a Band 7 coordinator, Mrs Bird's conduct fell well below the standards expected of a registered midwife as it was not an emergency situation and therefore there is no mitigation for a lack of documentation. The panel considered that each limb of this charge singularly amounts to misconduct and the seriousness of the misconduct is exacerbated when taken all together.

Charges 13a, 13b, 13c and 13e

The panel noted that the charges are serious. It was of the view that Mrs Bird's conduct at charges 13a and 13b to be unkind and unprofessional. The panel noted that there were lasting effects on Patient D as she told the panel that following that experience, she questioned her desire to have more children. The panel determined that this indicated a failure to provide safe and kind care.

In addition, the panel noted that in Charge 13c, Mrs Bird did not stop the vaginal examination when told to by Patient D. It was of the view that this is very serious especially during a vulnerable time for the patient. The panel found this to be a serious breach of the Code and put the patient's safety at risk of harm.

Furthermore, Charge 13e demonstrated a lack of respect for Patient D and illustrated a lack of kindness and professionalism. The panel therefore concluded that all proven limbs of this charge amounted to serious misconduct.

The panel found that Mrs Bird's actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Submissions on impairment

Mr Dowling-Hussey 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 Dowling-Hussey referred the panel to an email dated 3 August 2024 from Mrs Bird which reads:

> *'…I do not work in any care role. I am a regional manager for a recruitment agency within the construction industry and have no intention of returning to the nhs* [sic]*…'*

Mr Dowling-Hussey submitted that there has been no recent communication or documentation from Mrs Bird regarding her current fitness to practice. He submitted that there is no evidence of reflection or insight from Mrs Bird. Mr Dowling-Hussey submitted that given the panel's findings on misconduct there are clear behavioural and attitudinal concerns. Furthermore, he submitted that the misconduct in this case is not an isolated incident and thus invited the panel to find that Mrs Bird cannot practice kindly, safely or professionally at this time.

Mr Dowling-Hussey then addressed the likelihood of repetition. He submitted that there is no evidence before the panel to suggest that there has been any remediation or strengthened practice. Mr Dowling-Hussey referred the panel to a disciplinary letter from the Trust dated 7 June 2016 in which Mrs Bird was issued a final written warning for

conduct similar to that of the charges of this case. He submitted that Mrs Bird has repeated this conduct in the past and in the absence of any insight or reflection, there remains a high risk of repetition in the future.

Mr Dowling-Hussey also submitted that a finding of impairment in this case is otherwise in the public interest to uphold the professional standards. He submitted that given the nature of the misconduct; public confidence would be undermined if a finding of impairment is not made.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Yeong v General Medical Council* [2009] EWHC 1923 (Admin) and Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Bird's 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. 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) …'

The panel determined that that the first three limbs of the Grant test are engaged in this case.

The panel finds that patients were put at risk and were caused harm as a result of Mrs Bird's misconduct. It noted that it had no evidence of insight, reflection or remediation before it from Mrs Bird and therefore determined that she remains liable to do so in the future.

With regards to the second limb of the test, the panel noted that a significant number of the charges found proved relate to patient safety, as well as acting in an unkind, unsupportive and unprofessional manner. The panel was of the view that this raises attitudinal and behavioural concerns which undermines the reputation of the midwifery profession.

Furthermore, the panel considered that it found Mrs Bird to have breached several areas of the NMC Code and core responsibilities of midwifery practice. The panel was of the view that Mrs Bird's misconduct had breached the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute. It bore in mind that there has been no evidence of strengthened practice which leaves Mrs Bird liable to breach these fundamental tenets in the future.

Regarding insight, the panel noted that it had no evidence before it to demonstrate that Mrs Bird has reflected on her conduct, shown remorse or taken steps to remediate her practice. The panel bore in mind that Mrs Bird no longer works in a caring role however taking into account the previous concerns in 2016, the panel was satisfied that Mrs Bird

has no insight into her actions. Furthermore, the panel noted Mrs Bird's comments during the local investigation interview in which she denied many of the charges and appeared to show no remorse or provide an apology.

The panel was of the view that the misconduct in this case is very difficult to address. It noted that some of the charges (Charges 2 and 12) relate directly to documentation failings that are capable of being addressed and remediated.

However, the panel determined that the rest of the charges found proved, while some are of a clinical nature, the underlying concern is Mrs Bird's attitude and behaviour. The panel bore in mind that Mrs Bird was a Band 7 coordinator with significant experience and seniority within the maternity unit. It was satisfied that Mrs Bird's clinical skills and knowledge were not the fundamental concerns in the charges but instead deep-seated attitudinal issues. The panel also took into account that Mrs Bird received a final written warning from the Trust in 2016 for similar concerns to that which arose in 2019. The panel noted that issues regarding Mrs Bird's behaviour and attitude towards patients and colleagues were repeated on four separate occasions subject to these charges found proved, and therefore there remains a high risk of repetition for similar incidents to occur in the future.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection. The charges relate directly to patient safety and put patients at risk of harm. The panel heard evidence at the Facts stage from patients who have had ongoing long-lasting emotional effects as a result of Mrs Bird's behaviours and actions. In light of this, the panel was satisfied that there is a risk to 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 was of the view that Mrs Bird's unkind, unsupportive and unprofessional conduct towards both colleagues and vulnerable patients increases the public interest in this case. The panel considered that the public would be concerned if a registered midwife with these charges and findings of misconduct against them is permitted to practise without restriction. The panel bore in mind the multiple breaches of the Code and fundamental tenets of midwifery and determined that a finding of impairment is necessary to reaffirm the proper standards of the profession.

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

Having regard to all of the above, the panel was satisfied that Mrs Bird's fitness to practise is currently impaired by reason of her misconduct.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Bird off the register. The effect of this order is that the NMC register will show that Mrs Bird has 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 Dowling-Hussey referred the panel to the disciplinary investigation report and outcome letter dated June 2016 from the Trust. He submitted that Mrs Bird has in the past repeated similar misconduct. Furthermore, he submitted that Mrs Bird's position as a senior member

of staff is a significant aggravating factor in this case. He submitted that Mrs Bird had a duty to support the members of her team and a duty to ensure kind, safe and supportive care to patients during a significant moment of their lives.

Mr Dowling-Hussey submitted that given Mrs Bird's failure to adhere to her duties, members of the public would be shocked and concerned to find she is permitted to practise without restriction.

Mr Dowling-Hussey submitted that the misconduct in this case is serious and not an isolated incident. He then took the panel through the various sanctions available to it today. Mr Dowling-Hussey submitted that no further action and a caution order would not be appropriate given the findings of serious misconduct and impairment. He submitted that neither sanction would protect the public nor meet the public interest given the panel's findings.

Mr Dowling-Hussey then addressed the panel on a conditions of practice order. He submitted that the lack of engagement of Mrs Bird means the panel has no information before it regarding her willingness and ability to comply with any conditions. Mr Dowling-Hussey also referred the panel to the email dated 3 August 2024 from Mrs Bird which sets out that Mrs Bird is no longer in a care role, nor does she have intentions to return to the NHS. He submitted that there is therefore no information regarding Mrs Bird's strengthened practice. In addition, he submitted that there are no practical or workable conditions that could be formulated to protect the public and meet the public interest in these circumstances given the behavioural and attitudinal issues identified.

Mr Dowling-Hussey therefore invited the panel to consider either a suspension order or strike-off order. He submitted that there has been previous disciplinary action taken against Mrs Bird at local level regarding similar misconduct. He submitted that there are clear attitudinal concerns dating back to 2016 and given the lack of insight, reflection or remediation, there is a high risk of repetition. Mr Dowling-Hussey submitted that Mrs Bird

breached fundamental tenets of the midwifery profession and therefore her remaining on the NMC register would undermine public confidence in the profession.

Mr Dowling-Hussey therefore submitted that a striking-off order is the only appropriate sanction to protect professional standards and protect the public.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Mrs Bird has had previous disciplinary findings for similar misconduct
- Mrs Bird was in a position of leadership and seniority
- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm.

The panel determined that there were no mitigating factors in this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not

restrict Mrs Bird'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 Mrs Bird's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Bird's 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 noted that the documentation failings could be addressed with a conditions of practice order, however the remaining charges are fundamentally linked to Mrs Bird's behaviour and attitude. As such the panel concluded that the placing of conditions on Mrs Bird's registration would not adequately address the seriousness of this case and would not protect the public.

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 noted that the misconduct in this case occurred on four separate occasions and therefore not an isolated instance. It also bore in mind that Mrs Bird was unkind, unsupportive and unprofessional towards junior colleagues and

patients in a vulnerable state. The panel heard evidence at the facts stage from two of Mrs Bird's patients who told the panel about the long-lasting emotional impacts of Mrs Bird's actions in particular her behaviour and attitude. The panel noted that it had no evidence of repetition since the incident, however noted that in the email from Mrs Bird on 3 August 2024, she has not been working in a care role. The panel did not have evidence of any insight and reflection and therefore determined that Mrs Bird continues to pose a significant risk of repeating the behaviour.

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

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mrs Bird's actions were significant departures from the standards expected of a registered midwife and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Bird's actions

were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel specifically considered the evidence it heard from the patients during the facts stage and noted that Mrs Bird failed to demonstrate kindness and compassion to patients during a very significant moment in their lives. The panel considered Mrs Bird's lack of support and professionalism in these instances to be fundamentally incompatible with her remaining on the register. It in particular noted her seniority in the unit and her experience as a Band 7 coordinator and determined that her misconduct not only put patient safety at risk but also the babies. The panel was therefore of the view that should Mrs Bird remain on the register, public confidence in the profession would be seriously undermined.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered midwife.

This will be confirmed to Mrs Bird in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the

protection of the public, is otherwise in the public interest or in Mrs Bird's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Dowling-Hussey. He submitted that an interim order is in the public interest and necessary to protect to the public. Mr Dowling-Hussey invited the panel to impose an interim suspension order for a period of 18 months

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the period of appeal and allow the appeal to run its course.

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

That concludes this determination.