Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Tuesday 3 December – Wednesday 11 December 2024

Virtual Meeting

Name of registrant:	Theola A. Marshall-Bernard
NMC PIN:	98F1115O
Part(s) of the register:	Registered Midwife RM – December 2000 Registered Nurse RN1 – June 1998
Relevant Location:	Birmingham
Type of case:	Lack of competence
Panel members:	Gregory Hammond (Chair, Lay member) Sharon Peat (Registrant member) June Robertson (Lay member)
Legal Assessor:	Alain Gogarty
Hearings Coordinator:	Monsur Ali
Facts proved:	Charges 1a), 1b)(i), 1b)(ii), 1b)(iii), 1b)(iv), 1c)(i), 1d), 1e), 1f), 1g)(i), 1g)(ii), 1g)(iii), 1g)(iv), 1g)(v), 1g)(vi), 1g)(vii), 1i)(i),1i)(ii), 1i)(iii), 1j)(i), 1j)(ii), 1j)(iv), 1k)(ii), 1k)(iii), 1k)(iv), 1k)(v), 1k)(vi), 1k)(vii), 1k)(viii), 1k)(ix), 1k)(x), 1l)(i), 1l)(ii), 1l)(iii), 1l)(iv), 1l)(v), 1l)(vi), 1m)(ii), 1m)(iii), 1m)(iv), and 1m)(v)
Facts not proved:	Charges 1c)(ii), 1g)(viii), 1h), 1j)(iii), 1k)(i), and 1m)(i)
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Marshall-Bernard's registered email address by secure email on 24 October 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations and the fact that this meeting was to be heard virtually on or after 28 November 2024.

In the light of all of the information available, the panel was satisfied that Mrs Marshall-Bernard has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

The panel noticed an obvious typographical error in Charge 1 and after receiving legal advice, it decided to amend the charge to rectify the error as there is no injustice to either party. The charge therefore now reads *'Between May 2022 and December **2022'*** instead of ***'**Between May 2022 and December ~~2020~~'*

That you, a registered midwife:

1) Between May 2022 and December 2022 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Midwife in that:

a) On an unknown date in May 2022, failed to complete observations and/or take blood tests for one or more patient on the postnatal unit;

b) Between 22 August 2022 and 30 September 2022:

i) failed to administer Clexane to a patient despite recognising that there was a high venous thromboembolism (VTE)

ii) failed to take a blood glucose test for a newborn baby;

iii) failed to provide key information during a SBAR handover;

iv) on one or more occasion, failed to correctly categorise CTG's

c) On 7 October 2022:

i) incorrectly interpreted an intrapartum CTG;

ii) did not know the correct dose of Vitamin K required for a newborn baby;

d) On 12 October 2022 failed to recognise that a newborn baby had a low temperature:

e) On or before 13 October 2022 did not recognise and/or escalate a fetal bradycardia;

f) On or before 23 October 2022 did not have an adequate understanding around the correct dose/rate of antenatal and/or postnatal syntocinon infusions;

g) On 21 October 2022 failed to act appropriately and/or in a timely manner during an emergency in that you:

i. did not get the patient ready for theatre as quickly as required;
ii. did not understand the immediate need for a CTG to be done when arriving in theatre for a category one caesarean;
iii. did not get ready for the catheter insertion;
iv. did not check the resuscitaire;
v. did not bleep for the paediatrician;
vi. was not adequately prepared to receive a newborn baby following surgery;
vii. did not manage the situation appropriately when the patient became tachycardic;
viii. had to be prompted to complete observations;

h. On 21 October 2022 did not ask for a full handover in relation to a patient you were caring for:

i. On 4 November 2022:

i) incorrectly categorised high variability of the fetal heart rate on a CTG as a bradycardia;

ii) Having made an inaccurate assessment at (i), failed to escalate the CTG result appropriately;

iii) Slept during your shift;

j. On 6 November 2022:

i. failed to make decisions in a timely manner in that you did not respond appropriately when a CTG showed reduced variability;

ii. failed to put up intravenous fluids for the patient in response to the reduced variability;

iii. failed to carry out hourly CTG reviews;

iv. failed to include key information during handover;

k. On 10 November 2022:

i. failed to undertake hourly labour assessment;

ii. failed to complete adequately or at all, the necessary care records/and or paperwork;

iii. required support when providing handovers;

iv. whilst assisting a patient in labour, failed to correctly protect the perineum;

v. required prompting to administer intravenous antibiotics to a patient;

vi. requested to take a break whilst caring for a patient whose placenta was still in situ;

vii. discontinued a patient's CTG when it was abnormal, without any clinical justification;

viii. did not escalate your concerns about an abnormal CTG;

ix. failed to identify and/or escalate when a patient had high blood pressure;

x. failed to provide key information during handover for a patient you had cared for;

l. On 24 November 2022:

i. failed to complete basic tasks in a timely manner;

ii. was unable to cannulate a patient safely and/or appropriately;

iii. was unable to perform ARM safely and/or using the correct technique;

iv. did not know how to administer Oxytocin;

v. did not know or understand why a patient required perineal repair following delivery;

vi. was unable to perform perineal suturing;

m. On 23 December 2022:

i. Made inappropriate comments and/or used abusive language in the presence of one or more patient;

ii. performed a vaginal examination on a patient and did not explain the procedure;

iii. did not obtain consent from the patient before performing the procedure at

(ii) above;

iv. required prompting to listen to fetal heart monitoring every 15 minutes;

v. did not listen to the fetal heart for a full 1 minute as required;

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Employed by the Trust as a Band 5 (Registered Midwife) Line Manager.
- Witness 2: Employed by the Trust as a Registered Midwife.
- Witness 3: Employed by the Trust as a Registered Midwife.
- Witness 4: Employed by the Trust as a Registered Midwife.
- Witness 5: Employed by the Trust as a Registered Midwife on the Homebirth team.
- Witness 6: Employed by the Trust as a Registered Midwife.

The panel also had regard to Mrs Marshall-Bernard's internal reflective pieces and interview notes, although it had not received any direct representations from her.

Background

The NMC's statement of case set out the background as follows:

'Mrs Marshall-Bernard was referred to the NMC on 20 January 2023, by the Director of Midwifery at the Trust, following concerns raised that Mrs Marshall-Bernard had not met the required level of competency for safe practice as a Band 5 midwife. In May 2022, Mrs Marshall- Bernard was put on the Band 5 midwifery pathway, it was at this time that she began her first rotation on the postnatal ward. During this time concerns were raised about Mrs Marshall- Bernard's communication with a student midwife and mission observations from some of the patients.

On 22 August 2022, Mrs Marshall- Bernard began her rotation on the delivery suite. On 8 September 2022, [Witness 1], a Band 5 Line Manager & Preceptorship Practice Development Midwife, checked in with Mrs Marshall- Bernard and had a discussion with her about a reflection they were due to submit following concerns during her previous rotation on the postnatal ward and met with her on this same day for a fetal surveillance study day. Mrs Marshall- Bernard did not achieve the pass mark of 75% at the time on the competency assessment as she scored 65%.

On 15 September 2022, Mrs Marshall- Bernard had a 1:1 with [Ms 3] to review her test answers from the competency test on 8 September 2022 and following the 1:1 session, Mrs Marshall- Bernard retook the competency assessment and again failed to achieve the 75% pass mark as she scored 74%. As Mrs Marshall- Bernard had failed the competency assessment on two occasions she had to attend another fetal surveillance day on 29 September 2022 and retook this assessment. Mrs Marshall- Bernard passed the assessment scoring 82%.

On 30 September 2022, [Witness 1] met with Mrs Marshall- Bernard on to discuss the following concerns that had been raised about her practise between 22 August -30 September 2022:

- *Fetal surveillance/ categorising cardiotocographs ("CTG") (x2 unsuccessful attempts at fetal surveillance test);*
- *Missed dose of clexane, despite recognition of a high venous thromboembolism ("VTE");*

• Missed information in situation, background, assessment and recommendation ("SBAR") handover and unable to provide that information when asked, which can impact on patient safety/ care planning;
• Incorrect management of a baby of a diabetic mother. This was a near miss, as there was low blood monitoring when the next midwife completed the blood monitoring test;
• Arriving late to shift/ training.

As a result of the concerns raised, the Trust decided that Mrs Marshall- Bernard, was to progress through the informal stage of the Trust's enabling high performance programme and she was further placed on an action plan. Feedback forms were prepared for staff to use that were working with Mrs Marshall- Bernard so that written feedback could be provided at the end of each shift. On 4 October 2022, [Witness 1] conducted a teaching lesson on SBAR handovers before Mrs Marshall-Bernard was seen by [Ms 4] on 13 October 2022 for an interim review in [Witness 1's] absence.

On 21 October 2022, [Witness 2], a midwife that worked with worked with Mrs Marshall- Bernard raised further concerns regarding her practice. It was alleged that Mrs Marshall- Bernard:

a. Did not act quickly in an emergency situation;
b. Had to be prompted to get a patient ready for delivery;
c. Was unable to multitask when a patient became tachycardic and the baby needed caring for;
d. Did not ask for a handover for a patient she was caring for;
e. Had to be prompted to complete observations.

On 28 October 2022, an interim review took place between Mrs Marshall-Bernard and [Witness 1] and a SWOT ('Strengths, Weakness, Opportunities, and Threats') analysis was completed. During the interim review further concerns alleged by midwives who had worked with Mrs Marshall- Bernard since 4 October 2022 were also discussed at this interim review the concerns discussed were as

follows:

a. Mrs Marshall- Bernard required support in clarifying the correct dose of Vitamin K for a baby;

b. Mrs Marshall- Bernard had a lack of knowledge around the correct dose/ rate of antenatal and postnatal syntocinon infusions;

c. There was a lack of escalation of a fetal bradycardia; and

d. There was an inability for Ms Marshall-Bernard to take the lead during a category one caesarean section.

As a result of this concerns it was agreed that Mrs Marshall- Bernard would have a further 4 weeks as supernumerary and continue on stage 1 of the Trust's performance programme. A further interim review was held between by [Witness 1] and Mrs Marshall- Bernard on 9 November 2022 to discuss in more detail the concerns raised by [Witness 6]. Further concerned were raised by [Witness 3], Midwife who worked with Mrs Marshall- Bernard on 6 November 2022, the concerns were as follows:

a. Mrs Marshall- Bernard was slow when making decisions and acting upon a CTG with reduced variability;

b. Had to be prompted to carry out hourly CTG reviews;

c. Did not provide important information at handover.

d. Struggled to do hourly labour assessment and fill out the required documentation every hour;

e. Required support when providing handovers;

f. Did not correctly protect the perineum;

g. Had to be prompted to administer intravenous antibiotics to a patient;

h. Wanted to take a break when a patient's placenta was still in situ.

i. Discontinued a CTG when they should not have done;

j. Required significant support/prompting in timely administration of required medicine;

k. Did not provide important information at handover.

On 10 November 2022, [Witness 3] worked with Mrs Marshall-Bernard where further concerned were raised that Mrs Marshall-Bernard:

a) Struggled to do hourly labour assessment and fill out the required documentation every hour;

b) Required support when providing handovers;

c) Did not correctly protect the perineum;

d) Had to be prompted to administer intravenous antibiotics to a patient;

e) Wanted to take a break when a patient's placenta was still in situ.

Mrs Marshall-Bernard, did demonstrate some good practice by the time a further interim review too place on 24 November 2022. However, the feedback they received showed areas of the following consistent 'themes' they needed to improve on:

a) Time management/pace;

b) Escalation of CTG concerns;

c) Structuring their SBAR handover and not missing information;

d) Occasional prompting for when drugs were due.

Due to the ongoing concerns Mrs Marshall-Bernard's supernumerary time was extended for a further 4 weeks. Mrs Marshall-Bernard then went on sick leave shortly after this interim review.

On 9 December 2022, following Mrs Marshall-Bernard's return to work, as there was not enough time for a full interim review [Witness 1] conducted a brief catch-up took place instead. Mrs Marshall-Bernard then handed in her notice via email after this meeting.

On 23 December 2022, [Witness 5], Midwife worked with Mrs Marshall-Bernard and stated that she did communicate properly with and/or around patients. However, [Witness 5] also alleged that Mrs Marshall-Bernard:

n. Carried out a vaginal examination without fully explaining the procedure to the patient or asking for consent to perform the examination;

o. Did not correctly monitor the fetal heartrate in line with policy.

Mrs Marshall-Bernard and [Witness 1] had a meeting on 23 December 2022 where

it was agreed that Mrs Marshall-Bernard would continue on the Trust's performance programme whilst working their notice period. Given that Mrs Marshall-Bernard wished to leave sooner than the usual period of 12 weeks, it was agreed she would work until 22 January 2023.

On 4 January 2023, at another meeting with [Witness 1] and Mrs Marshall-Bernard told [Witness 1] that she wanted to leave with immediate effect. Human Resources ('HR') agreed, and Mrs Marshall-Bernard's employment was immediately terminated.

On 16 January 2023, a final letter was sent to Mrs Marshall-Bernard with the outcome of Stage 1 of the Trust's performance programme identifying the following areas of concern:

p. Punctuality;
q. Communication with colleagues when leaving the ward for breaks/meetings;
r. Ability to manage the care safely and independently for women on the delivery suite, making appropriate care plans and carrying out clinical skills safely without causing discomfort/trauma;
s. Documenting care safely;
t. Ability to administer medications safely and in a timely manner without prompting;
u. Ability to conduct an effective SBAR handover;
v. Ability to escalate concerns or seek support as required; and
W. Ability to safely interpret a CTG and act on/escalate concerns appropriately.'

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a)

‘That you, a registered midwife:

1) Between May 2022 and December 2022 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Midwife in that:

a) *On an unknown date in May 2022, failed to complete observations and/or take blood tests for one or more patient on the postnatal unit;’*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. In her written statement dated 23 January 2024, Witness 1 stated:

> *‘Patients who are on the postnatal ward sometimes have care plans where doctors have requested that patients have their blood tests completed again, but Ms Marshall-Bernard had not followed that.’*

The panel also took into consideration Mrs Marshall-Bernard’s reflective account provided at her line manager’s request which states:

> *‘It was noted that observations and blood tests were missed during the shift.’*

> *‘That I can plan tasks more effectively and try to complete blood tests before patients go to NICU to stay with their babies’*

The panel noted that, within her reflective account, Ms Marshall-Bernard did not dispute the allegations. Upon careful consideration of the evidence presented before it, the panel concluded that, on the balance of probabilities, this charge is found proved.

Charge 1b(i)

‘b) Between 22 August 2022 and 30 September 2022:

i) failed to administer Clexane to a patient despite recognising that there was a high venous thromboembolism (VTE)’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. In her written statement Witness 1 stated:

‘Missed dose of clexane, despite recognition of a high VTE;’

The panel also took into account Mrs Marshall-Bernard’s reflective account which states:

‘The handover of a patient and baby to the ward following Cesarean section. The patient was gestational diabetic and had a, high VTE score requiring administration of Clexane. I was asked to ward the patient and was assured that all relevant information had been handed over. When I warded the patient it was found that a dose of Clexane had been missed and that a blood glucose test for the baby had been missed.’

The panel noted that, within her reflective account, Ms Marshall-Bernard did not dispute the allegation. Upon careful consideration of the evidence presented before it, the panel concluded that, on the balance of probabilities, this charge is found proved.

Charge 1b(ii)

‘ii) failed to take a blood glucose test for a newborn baby;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. In her written statement Witness 1 stated:

‘Incorrect management of baby of a diabetic mother. This was a near miss

as there was low blood monitoring when the next midwife completed the blood monitoring test'

The panel also took into account Mrs Marshall-Bernard's reflective account which states:

'When I warded the patient it was found that a dose of Clexane had been missed and that a blood glucose test for the baby had been missed. The baby was later tested and found to be hypoglycemic requiring treatment.'

'I have reviewed and familiarised myself with the management of gestational diabetes to ensure that I know when babies of diabetic mothers should be screened.'

The panel noted that, within her reflective account, Ms Marshall-Bernard did not dispute the allegation. Upon careful consideration of the evidence presented before it, the panel concluded that, on the balance of probabilities, this charge is found proved.

Charge 1b(iii)

'iii) failed to provide key information during a SBAR handover;'

This charge is found proved.

In reaching this decision, the panel took into account the Trust's policy titled, Handover of Care and Transfer Guidelines for Maternity (the Policy), the evidence of Witness 1 and Ms Marshall-Bernard's reflective account.

The Policy states:

'Handover and transfer of care should be from one health care professional (midwife or medical staff) to another directly, ideally in person, but if this is not possible, by telephone.

Effective communication is central to promoting patient safety. Evidence states that communication between healthcare professionals improves when handover involves the woman and uses a structured reporting format (NICE 2018). A structured and consistent handover and transfer of care between staff can be achieved using the SBAR tool.

An example of SBAR:
Situation: Woman's name, age, gestation at delivery, high or low risk
Background: Obstetric, medical, social history, parity, treatment to date
Assessment: Current status, progress in labour, complications, baby's needs
Recommendation: Plan of care, review, monitoring, referral and progress.'

In her written statement, Witness 1 states:

'Ms Marshall-Bernard was asked to take a patient upstairs and handed over [sic] to another midwife, [Ms 5]. When handing over, Ms Marshall-Bernard allegedly missed a lot of important information from the handover. When Ms Marshall-Bernard was asked for the missing information, there was a lack of acknowledgment for the importance of the clinical information that had not been provided in the handover, and she did not know the information. Ms Marshall-Bernard should have known how to hand a patient over when they are being transferred. This is because Ms Marshall-Bernard had worked on the postnatal floor prior to the delivery suite, so she should have had an understanding of what was required in a postnatal handover. The relevant guidelines for the handover of care and transfer of patients can be seen in the Trust's Handover of Care and Transfer Guidelines for Maternity, which I produce a copy of at ***Exhibit AL/05****.'*

In her reflective account Mrs Marshall-Bernard states:

'I have also improved my ability to write an accurate and concise SBAR form.'

The panel noted that, within her reflective account, Ms Marshall-Bernard did not dispute the allegation. Upon careful consideration of the evidence presented before it, the panel concluded that, on the balance of probabilities, this charge is found proved.

Charge 1b(iv)

'iv) on one or more occasion, failed to correctly categorise CTG's'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, and the Meeting Notes between Ms Marshall-Bernard and her supervisor dated 30 September 2022.

In her written statement, Witness 1 states:

'The discussion with Ms Marshall-Bernard took place on 30 September 2022 where the following concerns were discussed:

i. Fetal surveillance/ categorising CTGs (x2 unsuccessful attempts at fetal surveillance test);

…'

In the meeting notes, which the panel noted is an identified area of development agreed by Mrs Marshall-Bernard, it states:

'To be able to correctly categorise CTG's using the CTG review badgernet tool, escalations of concerns and input regular fresh eyes'

Having considered the above evidence, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1c(i)

'*c) On 7 October 2022:*

i) incorrectly interpreted an intrapartum CTG;'

This charge is found proved.

In reaching this decision, the panel took into account the Feedback Form dated 7 October 2022 which states:

> *'Theola incorrectly interpreted an intrapartum CTG. The classification was correct that did not acknowledge the presence of discolorations. Theola also required prompting .. to seek fresh eyes CTG review'*

Having considered this evidence, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1c(ii)

'ii) did not know the correct dose of Vitamin K required for a newborn baby;'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the Feedback Form dated 7 October 2022. In her written statement, Witness 1 states:

> *'Ms Marshall-Bernard required support in clarifying the correct dose of Vitamin K for a baby'*

In the Feedback Form it is stated:

> *'Theola required clarification regarding correct dose for new born vitamin K'*

Having considered the evidence before it, the panel concluded that seeking support to clarify the correct dose does not equate to not knowing and further considered that

checking was a sensible thing to do for a midwife who was new to the delivery suite. Accordingly, the panel determined that this charge is found not proved.

Charge 1d)

> *'d) On 12 October 2022 failed to recognise that a newborn baby had a low temperature:'*

This charge is found proved.

In reaching this decision, the panel took into account the feedback from Ms 1. In her email sent to Witness 1 dated 12 October 2022, Ms 1 states:

> *'While we were working together I was concerned that the low temperature of a baby hadn't been recognised. When we discussed this, there was then a lack of awareness on Trust policies for addressing this.'*

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

Charge 1e)

> *'e) On or before 13 October 2022 did not recognise and/or escalate a fetal bradycardia;'*

This charge is found proved.

In reaching this decision, the panel took into account the feedback from Ms 2. In her email dated 13 October 2022, Ms 2 states:

> *'I left the room to up date the board & find a midwife to help with the linking of badger net I was only away for about 3 minutes to walk back in to a bradycardia and I had to pull the emergency bell immediately. When I question [sic] Theola about this later why she had not pulled the bell she said she was going to put the*

patient in the left lateral. But I said looking at the CTG it had been down over 2 minutes & not making any signs of recovery she should have pulled the emergency bell for some help then got the patient in left lateral.'

Having considered the evidence before it, the panel determined that on the balance of probabilities, Ms Marshal-Bernard did not escalate the emergency and the panel made the inference that she did not recognise the bradycardia as an emergency situation. The panel therefore found this charge proved.

Charge 1f)

'f) On or before 23 October 2022 did not have an adequate understanding around the correct dose/rate of antenatal and/or postnatal syntocinon infusions;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the Feedback Form dated 23 October 2022. In her written statement, Witness 1 states:

'Ms Marshall-Bernard had a lack of knowledge around the correct dose/ rate of antenatal and postnatal syntocinon infusions;'

The Feedback Form states:

'Improve knowledge of AN [antenatal] vs PN [postnatal] synto [syntocinon] as this could have been a serious drug error'

Having considered the evidence before it, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1g(i)

‘g) On 21 October 2022 failed to act appropriately and/or in a timely manner during an emergency in that you:

i) did not get the patient ready for theatre as quickly as required;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 Witness 2 states:

‘The decision was made because for [sic] the patient to have a category 1 caesarean section because there was a bradycardia, which resulted in a crash call being put out. Bradycardia is where there is fetal distress and the baby's heart rate has slowed down and it is not recovering. A crash call is put out to notify the theatre team. It was from that point that we had 30 minutes to get the patient to theatre and get the baby out.’

‘When there is a crash call for bradycardia, it is a midwife's role to reassure the patient and to act in a practical way. This includes getting a gown and stocking on the patient, administering omeprazole (an anti-acid given before anaesthetic) and to get a cot ready for when the baby is out.’

‘As there was both me and Ms Marshall-Bernard, the tasks shout [sic] have been carried out swiftly. However, because I was trying to let Ms Marshall-Bernard lead, this was not the case. I soon realised that none of the tasks were being completed by Ms Marshall-Bernard, so I had to take the lead. I had to delegate and say things such as 'do you mind getting this' and 'do you mind getting this ready'. I do not recall Ms Marshall-Bernard doing any of the tasks without me asking her to do them. Ms Marshall-Bernard did not show any initiative.’

The panel determined that this evidence demonstrates that Mrs Marshall-Bernard was failing to act appropriately and did not get the patient ready for theatre as quickly as required. It therefore concluded that this charge is found proved.

Charge 1g(ii)

> *'ii) did not understand the immediate need for a CTG to be done when arriving in theatre for a category one caesarean;'*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 she states:

> *'Once we were in theatre, I asked Ms Marshall-Bernard to put on the cardiotocography ("CTG") to measure the baby's heartbeat. Instead, Ms Marshall-Bernard proceeded to help me move a bed out of theatre.'*

> *'The CTG was needed urgently to tell us what the baby's heartbeat was doing. I was concerned that Ms Marshall-Bernard's priority was to help me with a one-person job, being moving a bed, when I wanted her to listen to the heartbeat of the baby which was much more important.'*

Having considered evidence before it, the panel determined that this is sufficient to demonstrate that Mrs Marshall-Bernard failed to act in an appropriate or timely manner during the emergency situation. It therefore concluded that this charge is found proved.

Charge 1g(iii, iv, v and vi)

> *'iii. did not get ready for the catheter insertion;*
> *iv. did not check the resuscitaire;*
> *v. did not bleep for the paediatrician;*
> *vi. was not adequately prepared to receive a newborn baby following surgery;'*

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 Witness 2 states:

> *‘I also had to prompt Ms Marshall-Bernard to get ready for the catheter insertion, check the resuscitaire, bleep the paediatrician, and to put her gloves on to receive the baby. If this was Ms Marshall-Bernard's first week on the delivery suite, then I would not have necessary expected Ms Marshall-Bernard to know that those steps needed to be taken. However, I think she had been working on the delivery suite prior to our shift, so she should have known.’*

The panel determined that this evidence sufficiently demonstrates that Mrs Marshall-Bernard failed to act appropriately and/or in a timely manner during the emergency situation in the ways listed in the charges. It therefore concluded that these charges are found proved.

Charge 1g(vii)

> *‘vii. did not manage the situation appropriately when the patient became tachycardic;’*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 she states:

> ‘*However, the patient became tachycardic, meaning that her heartrate was raised. At this time, Ms Marshall-Bernard was unable to multitask and care for both the patient and her baby. As soon as the patient became unstable, the baby was forgotten about, 'but the baby’s observations still needed to be done. Ms Marshall-Bernard needed to notify the doctor, repeat observations sooner than the usual time, and potentially start fluids if recommended by the doctor.’*

The panel found that the evidence demonstrates that Mrs Marshall-Bernard did not manage the situation appropriately when the patient became tachycardic. It therefore concluded that this charge is found proved.

Charge 1g(viii)

> *'viii. had to be prompted to complete observations;'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 Witness 2 states:

> *'When a baby is an hour old, we do a set of observations. Sometimes, these need to be done hourly if there are any risk factors involved. I think I remember maybe having to prompt Ms Marshall-Bernard to complete the baby observations or there being some difficulty when doing this, but I cannot say with certainty that the observations were not done. I recall definitely having concerns· regarding Ms Marshall-Bernard's ability to multi-task.'*
>
> *'I had to prompt Ms Marshall-Bernard to do the required observations and to document her observations.'*

The panel reviewed the evidence before it and found that the use of the words *'I think I remember maybe…'* indicated a lack of clarity regarding the events described in the scenario. As a result, it found that the NMC had not discharged the required burden of proof for this charge. Accordingly, the panel determined that this charge is found not proved.

Charge 1h)

> *'h. On 21 October 2022 did not ask for a full handover in relation to a patient you were caring for:'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2. In her written statement dated 7 November 2022 Witness 2 states:

> *'By the time Ms Marshall-Bernard joined me after her break, the new patient I had collected from triage was in the second stage of labour. This meant that she. was fully dilated.'*
>
> *'Ms Marshall-Bernard did not ask me for a formal handover to find out information about the new patient, so she did not know anything about the patient. When she entered the room, she took a back seat. Ms Marshall-Bernard had a lack of enthusiasm and did not seem to know what was going on.'*

Having considered the evidence before it, the panel noted that Mrs Marshall-Bernard was not responsible for the patient at the time as they were being cared for by another midwife, Witness 2. The onus was therefore on Witness 2 to provide any handover, not on Mrs Marshall-Bernard.

The panel therefore determined that this charge is found not proved.

Charge 1i (i and ii)

> *'i. On 4 November 2022:*
>
> *i) incorrectly categorised high variability of the fetal heart rate on a CTG as a bradycardia;*
>
> *ii) Having made an inaccurate assessment at (i), failed to escalate the CTG result appropriately;'*

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 6. In her written statement dated 12 March 2024, Witness 6 states:

‘Ms Marshall-Bernard also commenced two cardiotocography's (CTG) for a patients [sic] throughout the shift. A CTG monitors the baby's heartrate and it is our local process that women in the induction suite have these performed every 6 hours.’

‘I enquired why she hadn't discontinued one of the CTGs, at which point she reported that there had been a fetal bradycardia (sustained drop in the fetal heart). This should have prompted an immediate escalation.’

‘I went to review the CTG and woman immediately. There was no fetal bradycardia, and the CTG was classifiable as normal. There were periods of increased variability resulting from the baby being active. I discontinued the CTG as per plan.’

‘Ms Marshall-Bernard 's misinterpretation of the CTG and lack of escalation was of immediate concern to me. I would expect any midwife who was concerned about a CTG to follow our internal escalation process. In the case of a fetal bradycardia this would be activation of the emergency buzzer to summon immediate senior medical and midwifery support. The misinterpretation of the CTG and lack of escalation posed a patient safety issue. Even as a band 5 midwife at the time, Ms Marshall-Bernard should have acted up on this and escalated her concerns.’

Having considered the evidence before it, the panel determined that these charges are found proved.

Charge 1i (iii)

‘iii) Slept during your shift;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6. In her written statement dated 12 March 2024, Witness 6 states:

'During the shift on 4 November 2022, I also found Ms Marshall-Bernard asleep at the nurses station and had to wake her on two occasions. On both occasions I offered her a break, of which she declined. The nurses station is positioned outside induction of labour suite on one of the main corridors of delivery suite (the delivery suite is a large square). This is a desk where women from the induction suite can come and speak to the midwives, and where we use the phone and computers.'

Witness 6 also stated in an email sent to Witness 1 dated 7 November 2022 as follows:

'She had said throughout the night that she was tired and was unable to sleep through the day, between 5-7 I found her sleep at the desk. She was continue to sleep when I was communicating with patients and felt uncomfortable to wake her up.'

In her written statement dated 23 January 2024, Witness 1 states:

'However, in relation to falling asleep, [Mrs Marshall-Bernard] initially denied it, but then she went on to say that she noticed herself drifting off but that she did not ever fall asleep for two hours.'

Having considered the evidence before it, the panel found it more likely than not that Mrs Marshall-Bernard did fall asleep during her shift. It therefore determined that this charge is found proved.

Charge 1j(i)

'j. On 6 November 2022:

i. failed to make decisions in a timely manner in that you did not respond appropriately when a CTG showed reduced variability;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement dated 18 October 2023 Witness 3 states:

> *'On the delivery suite, situations can change very quickly, and midwives need to be able to act upon changing situations. For example, if a baby's heart rate drops, it needs to be acted upon quickly. On this particular shift with Ms Marshall-Bernard, the CTG monitoring for a baby showed that the baby's heartbeat had gone a bit flat. This meant there was reduced variability. Reduced variability is where the beat to beat of the heartbeat reduces and there are less beats per minute. When this occurs, a midwife should start conservative measures. Guidance for classifying and managing CTG traces is included within the Intrapartum Fetal Monitoring, including Fetal Blood Sampling Guideline ("Fetal Monitoring Guideline") from page 7. I produce a copy of the Fetal Monitoring Guideline at Exhibit [Witness 3]/01. Ms Marshall-Bernard was slow in acting upon this and she was slow when making decisions.'*

Having considered the above evidence, the panel determined that Ms Marshall-Bernard failed to make decisions in a timely manner in that she did not respond appropriately when a CTG showed reduced variability. It therefore concluded that this charge is found proved.

Charge 1j(ii)

> *'ii. failed to put up intravenous fluids for the patient in response to the reduced variability;'*

This charge is found proved.

In reaching this decision, the panel took into account the Feedback Form for Mrs Marshall-Bernard dated 1 November 2022 and the written statement of Witness 3. The Feedback Form states:

> *'Had to be prompted occasionally to carry out hourly CTG's reviews and prompted to put up IV fluids for reduced variability'*

Witness 3 states in her written statement:

> *'Ms Marshall-Bernard also needing prompting to put up intravenous ("IV") fluids for the patient in response to the reduced variability. Not only is it standard practice to start IV fluids when there is reduced variability but there is also a document used when CTG reviews take place and which assists with what actions to take. Within the document, there is a tick list which asks if you have tried position change, or if you have tried IV fluids. Therefore, Ms Marshall-Bernard should have known to start IV fluids for the patient, and should not have needed prompting. Once I prompted Ms Marshall-Bernard, she got on and started the IV fluids. I also explained to Ms Marshall-Bernard why they needed to be put up for the patient.'*

Having considered the evidence before it, the panel determined that Mrs Marshall-Bernard failed to put up intravenous fluids for the patient in response to the reduced variability. It therefore concluded that, on the balance of probabilities, this charge is found proved.

Charge 1j(iii)

> *'iii. failed to carry out hourly CTG reviews;'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

> *'CTG reviews should take place every hour, and another medical professional should also be asked to come and review the CTG every hour. This is included within the Fetal Monitoring Guideline. The relevant guidance can be found on page 9 at flowchart 5, as well as at 4.4.4 on page 22. However, during my shift with Ms Marshall-Bernard, she had to occasionally be prompted to carry out hourly CTG reviews. When I prompted Ms Marshall-Bernard to carry out hourly CTG reviews, she did not say anything in response that I can recall, and she just got on and did*

it.'

Having considered the evidence before it, the panel noted that Mrs Marshall-Bernard had to be occasionally reminded. However, there is no evidence that demonstrates she did not carry out the hourly CTG reviews on those occasions she needed reminding or when she did not need reminding. It therefore concluded that this charge is found not proved.

Charge 1j(iv)

'iv. failed to include key information during handover;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

> *'At the end of the shift on 6 November 2022, Ms Marshall-Bernard forgot to provide important information at the handover. There was a patient who Ms Marshall-Bernard had been providing care to, and the patient was Group B strep positive. As a result of this, the patient required antibiotics every four hours whilst in labour. During the handover, Ms Marshall-Bernard forgot to say that the patient was Group B strep positive, and she did not say when the patient's next set of antibiotics were due. This is information that should have absolutely been included in the handover. Therefore, I had to step in and re-do the whole handover myself to ensure that all the necessary information was handed over to staff members.'*
>
> *'By not giving a clear handover, there can be negative consequences for patients. This can include medications being missed and pro-longed hospital stays as unclear handovers can result in delays in care and/or inadequate care being given.'*

Having considered the evidence before it, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1k(i)

‘k. On 10 November 2022:

i. failed to undertake hourly labour assessment;’

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

> *‘However, I had some concerns with Ms Marshall-Bernard's time management. She struggled to do hourly labour assessments and fill out the required documents for that every hour. She also struggled to sort out the plans for the day for each of the patients, and make sure that she had a plan in place and follow that plan.’*

However, the panel also referred to the Feedback Form from Witness 2 dated 10 November 2022 and noted that there was no reference in that contemporaneous document to show that Mrs Marshall-Bernard failed to undertake the hourly labour assessment. The panel therefore determined that the NMC had not discharged its burden of proof in relation to this charge. It therefore concluded that this charge is found not proved.

Charge 1k(ii)

‘ii. failed to complete adequately or at all, the necessary care records/and or paperwork;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

> *‘Ms Marshall-Bernard also failed to record the SBAR handover on Badgernet. SBAR is the tool we use when handing over, and Badgernet is our electronic notes*

system. There is a handover tool on Badgernet which is where the SBAR handover is recorded.'

'Ms Marshall-Bernard should have definitely known that she needed to record the handover on Badgernet as we do this for every transfer for every patient.'

In her Feedback Form dated 10 November 2022, Witness 4 states:

'No SBAR on Badgernet – no info given or HB, blood group, History had to be prompted.'

Having considered the evidence before it, the panel determined that on the balance of probabilities, Mrs Marshall-Bernard failed to complete adequately or at all, the necessary care records/and or paperwork. It therefore concluded that this charge is found proved.

Charge 1k(iii)

'iii. required support when providing handovers;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 3 and 4. In her written statement, Witness 3 states:

'I felt that Ms Marshall-Bernard continued to require support at handovers. During handovers, the SBAR tool is used. This is a standard tool that is used in midwifery to hand over. This is used to lay out the handover in a particular way, so that when the next midwife comes on shift it is clear for them to see the history of the patient, and what needs to be done next.'

'I am sure that Ms Marshall-Bernard was aware of the SBAR tool. It is also on the system that is used by staff members where everything is documented. However, it is not always filled out on the system because of timing, but an informative verbal

handover would always be given.'

'I cannot recall that Ms Marshall-Bernard missed any information out in particular during her handover, but it was all over the place. Using the SBAR tool would have helped Ms Marshall-Barnard with that. I recall that one patient, a postnatal mother, needed to be handed over to another midwife on the delivery suite. This was because, although the patient was a postnatal patient, she remained on the delivery suite as she was not ready to be taken the postnatal ward yet. Ms Marshall-Bernard's handover to the midwife was just all over the place. The risks associated with failing to give a clear and informative handover are included in my statement above at paragraph 14.'

In her Feedback Form dated 10 November 2022, Witness 3 states:

'still requires support with handover, using the SBAR tool as sometimes information from Theola isn't always clear or in order.

In her written witness statement, Witness 4 states:

'Ms Marshall-Bernard also failed to record the SBAR handover on Badgernet. SBAR is the tool we use when handing over, and Badgernet is our electronic notes system. There is a handover tool on Badgernet which is where the SBAR handover is recorded.'

Having considered the evidence before it, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1k(iv)

'iv. whilst assisting a patient in labour, failed to correctly protect the perineum;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

> *'I also considered that Ms Marshall-Bernard needed to develop further when it came to perineal protection. This is the guarding of the perineum when the baby's head is crowning, and it is done to prevent serious tears. During the shift, there was a patient who was giving birth. When the patient was giving birth, Ms Marshall-Bernard was not protecting the perineum in the correct way. As midwifes, we are taught to use our thumb and forefinger of our dominant hand to pull down the outer labia and the other three fingers rest against the perineum. The other, nondominant hand is there to protect the head as it comes out. From what I can remember, Ms Marshall-Bernard was using her thumb and forefinger to pull down the outer labia, but she was not using her other three fingers to rest them against the perineum. A warm compress can also be used for extra protection of the perineum, but I cannot recall if she used a warm compress.'*

In her Feedback Form dated 10 November 2022 from Witness 3 *'perineal protection'* is listed in the section titled *'In relation to the expected competence of a Band 5 midwife working on DS [Delivery Suite], what does Theola need to develop further?'*

The panel noted that Witness 3's statement was supported by the contemporaneous Feedback Form. Having considered the evidence before it, the panel determined that on the balance of probabilities this charge is found proved.

Charge 1k(v)

> *'v. required prompting to administer intravenous antibiotics to a patient;'*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

‘During the shift, a patient required IV antibiotics. I cannot recall why the patient needed antibiotics. I had to prompt Ms Marshall-Bernard when the IV antibiotics were due for the patient. I do not think that I had to prompt Ms Marshall-Bernard every time that they were due, but I certainly had to prompt her on some occasions throughout the shift. I would have expected Ms Marshall-Bernard to know when the IV antibiotics were to be given.’

In her Feedback Form dated 10 November 2022, Witness 3 states:

‘Had to be prompted when IV ABX were due and couldn’t explain why the woman was having IV ABX.’

The panel noted that Witness 3’s statement was supported by the contemporaneous Feedback Form. Having considered the evidence before it, the panel determined that on the balance of probabilities this charge is found proved.

Chare 1k(vi)

‘*vi. requested to take a break whilst caring for a patient whose placenta was still in situ;’*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3. In her written statement, Witness 3 states:

‘My final concern during the shift on 10 November 2022 related to a patient who had given birth to her baby and we were waiting for the placenta to deliver. Whilst the placenta was still in situ, Ms Marshall-Bernard was keen to go on a break. Ms Marshall-Bernard said she was hungry and that she had not yet had her second break. I had also not had my second break by this point in the shift, but we were working together and we could not go for a break at that point because it was not appropriate.’

‘Midwives are required to be present when the placenta is still in situ. This is because there is a risk of bleeding. I recall that this placenta took a while to deliver, but we needed to be there to make sure she was not bleeding and, after 30 minutes, we would ask the patient to sit on the toilet to assist with delivering the placenta.’

Having considered the evidence before it, the panel determined that on the balance of probabilities, this charge is found proved.

Charge 1k(vii and viii)

‘vii. discontinued a patient’s CTG when it was abnormal, without any clinical justification;
viii. did not escalate your concerns about an abnormal CTG;’

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

‘During the shift, I had concerns with Ms Marshall-Bernard’s urgency, management and understanding the need to escalate to senior staff or a doctor. These concerns related to the fact that Ms Marshall-Bernard discontinued a patient's cardiotocography ("CTG"), used to monitor the fetus's heartrate. I cannot recall the name of the patient.’

‘Although the CTG had met the Dawes Redman criteria, there were two decelerations which meant that the CTG was abnormal. Despite this, Ms Marshall-Bernard did not escalate the CTG to me or a doctor and discontinued the CTG.’

‘Decelerations on a CTG are an indication of fetal distress. It means that the CTG is abnormal so the CTG should not be discontinued without there being a length of

time with a normal CTG or without discussing the CTG with a doctor or a senior midwife. Therefore, Ms Marshall-Bernard should not have discontinued the CTG.'

In her Feedback Form dated 10 November 2022, Witness 4 stated:

'Discontinued CTG in triage that had met Dawes Redman but had 2 decelerations but explained she had discontinued as criteria met.'

Having considered the evidence before it, the panel determined that on the balance of probabilities, these charges are found proved.

Charge 1k(ix)

'ix. failed to identify and/or escalate when a patient had high blood pressure;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

'A patient had high blood pressure but Ms Marshall-Bernard did not highlight that the patient needed labetalol to treat the patient's high blood pressure. Therefore, I escalated the patient to the doctor to get the medication prescribed for the patient. Ms Marshall-Bernard failed to recognise that medication was needed for the patient to treat her high blood pressure.'

'*Hypertension, being high blood pressure in pregnancy, is serious as it can result in pre-eclampsia and cause eclamptic fits. This is why we medicate quite quickly when a patient has hypertension so, even if there is a one-off high blood pressure reading, we will medicate straight away.'*

'*If hypertension is left untreated, the patient may not even be symptomatic but then end up with pre-eclampsia.'*

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1k(x)

'x. failed to provide key information during handover for a patient you had cared for;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

'During the verbal handover, Ms Marshall-Bernard failed to give any information to the delivery suite midwife regarding the patient's hemoglobin levels, blood group and history. Hemoglobin levels are an important measurement of the blood for when a patient is going into labour or have problems in pregnancy as they change and will provide information to establish whether a patient may or may not bleed after labour.'

'I would have expected Ms Marshall-Bernard to be able to competently give a handover to the delivery suite midwife. The information that Ms Marshall-Bernard missed out of the handover was a significantly basic part of the handover which is always the information we start with when handing over.'

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1l(i)

‘l. On 24 November 2022:

i. failed to complete basic tasks in a timely manner;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6. In her written statement, Witness 6 states:

‘*When we admit women on the delivery suite for ARM, we commence a CTG, site a cannula, and take bloods. It is important to do this timely so the ARM can be performed . After approximately 2 hours Ms Marshall-Bernard had yet to complete these tasks causing a delay in care.’*

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1l(ii)

‘ii. was unable to cannulate a patient safely and/or appropriately;’

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

‘Every time I work with a supernumerary midwife, I enquire what level of support they require in cannulation should this be required . I asked Ms Marshall-Bernard who reported that she was feeling confident to cannulate. However, when observing Ms Marshall-Bernard I had major concerns regarding her technique.’

‘When inserting the cannula, Ms Marshall-Bernard missed the vein. This was as a result of positioning the cannula at the wrong angle as it was inserted into the skin. This caused trauma to the skin layer. There was also an error when removing the cannula as she did not withdraw the needle first and put pressure on the cannula

when the needle was still in situ and the end of cannula was sharp. When Ms Marshall-Bernard put the cannula in the patient's hand and it tissued, she should have removed the needle and the cannula plastic tube, but she started pressing on it when the needle and cannula remained in situ. I asked Ms Marshall-Bernard twice to remove the needle and plastic cannula, but she kept the pressure on the cannula. This caused more trauma and distress to the. As a result of these concerns, I approached and rem oved the cannula/needle myself.' [sic]

'I discussed the event with Ms Marshall-Bernard, she explained that she missed the vein and she need more practice with cannulation. She lacked insight into my concerns and unsafe technique.'

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1l(iii)

'iii. was unable to perform ARM safely and/or using the correct technique;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

'When the woman was ready for ARM, as per my usual practice I enquired as to Ms Marshall-Bernard's confidence in performing. The woman in question was 3-4cm dilated already and as such should have been an easy ARM to perform. Ms Marshall-Bernard reported she was confident to perform and wished to proceed.

Ms Marshall-Bernard continued to have multiple attempts to perform the ARM, which was causing the woman additional discomfort and distress. When a patient is displaying discomfort, you should stop after one or two attempts and communicate

with women if she is happy for us to continue. I expected Ms Marshall-Bernard to stop when she saw that the patient was uncomfortable. I did ask Ms Marshall-Bernard if she wanted me to take over and asked her if I should have a go, but she said 'no' and tried again.

Ms Marshall-Bernard finally agreed for me to take over after about five minutes. However, when removing the amnio hook from the patient, she removed her fingers first and then amnio hook which is poor technique as this may cause vaginal trauma and bleeding. I expected Ms Marshall-Bernard to be fluent with the technique of how to use an amnio hook or ask for support if unsure.

I performed the ARM with ease.

I feedback [sic] my concerns to Ms Marshall-Bernard about her performing the ARM and asked if she knows what went wrong, Ms Marshall-Bernard explained that she believed she must be able to perform the ARM at that particular cervix dilation and position, Ms Marshall-Bernard did not realised that my main concern was her unsafe technique when performing the procedure. [sic]

I spoke to Ms Marshall-Bernard about my concerns with her technique. She was receptive, but she didn't confirm that she needed help to develop.'

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1l(iv)

'iv. did not know how to administer Oxytocin;'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4. In her written statement, Witness 4 states:

‘Following the ARM the woman required augmentation via Oxytocin infusion to progress her labour, in line with local guidance. Ms Marshall-Bernard was not sure about the regime and how we administer Oxytocin. This included how or when to increase the Oxytocin rate. I would have expected Ms Marshall-Bernard to know this as a qualified midwife.’

‘Where a midwife is unable to follow the regime and does not increase to the right dose or at right time, it can either cause hyperstimulation or even delay the labour, which both can affect the outcome for the patient.’

‘As part of local guidance, women on Oxytocin infusions have venous blood gases (VBG) performed and repeated 8 hourly during administration. This is to check the woman's sodium levels and lactate in the blood during induction of labour to prevent hyponatremia and pick up early sign of infection. Ms Marshall-Bernard had no knowledge of the requirement of this and the reason for performing. She had no knowledge of expected limits of a VBG and what action to take should the results be outside of these limits.’

Having considered the evidence before it, the panel determined on the balance of probabilities, this charge is found proved.

Charge 1l(v and vi)

‘v. did not know or understand why a patient required perineal repair following delivery;
vi. was unable to perform perineal suturing;’

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 5. In her written statement, Witness 5 states:

‘Following the birth of the baby, the woman required perineal repair which includes a per rectum examination prior to commencement and following completion of suturing. This follows local guidance and is to exclude 3rd or 4th degree tears or any trauma to the rectum. Ms Marshall-Bernard did not attempt to complete this. I requested this was completed. Ms Marshall-Bernard had no understanding as to why this was required. Performing a per rectum examination prior to and after suturing is covered as a part of a midwife's training in university, and it is also taught to students and band 5 midwives during placement and supernumerary period, and during training days. This is also in the evidenced based guidelines of the Royal College of Midwives (RCM).’

‘Ms Marshall-Bernard was keen to perform the perineal suturing, although she did inform me that she had very limited experience to date. I was there to talk Ms Marshall-Bernard through it, however she kept using the needle to tell me where she wanted to put the suture in. This meant that she kept going in and out of tear/skin with the needle which was resulting in further trauma and bleeding. This was clearly uncomfortable for the woman, despite having had local anaesthetic and using Entonox. I asked Ms Marshall-Bernard many times to show me with her finger or tip of the instrument where she wanted to put the needle and start suturing, rather than going in and coming back out with the needle itself. I had to do this quietly because the woman and her husband were witnessing this conversation. I had also already explained and demonstrated to Ms Marshall-Bernard what to do. I had to take over from Ms Marshall-Bernard a few times to ensure of accurate results of suturing.’

Having considered the evidence before it, the panel determined that on the balance of probabilities, these charges are found proved.

Charge 1m(i)

‘m. On 23 December 2022:

i. Made inappropriate comments and/or used abusive language in the presence of one or more patient;’

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 5. In her written statement, Witness 5 states:

> *'When midwives are caring for labouring women on the delivery suite, we tend to be in the room with the patient for the whole time. When Ms Marshall Bernard was in the room with the patient, she was complaining about personal ailments. She was walking around the room and complaining about her back. Ms Marshall- Bernard was telling the patient that her back was really hurting and she kept moaning.'*
>
> *'Within Ms Marshall-Bernard's general conversation when talking to me or the patient in the patient's room, Ms Marshall-Bernard was using swear words. This was directly in front of the patient, which was completely inappropriate.'*

The panel also considered the notes from a meeting between Mrs Marshall-Bernard and her line manager, Witness 1, dated 23 December 2022 which state:

> *'Another feedback form stated that Theola used swearwords and was complaining about personal ailments in front of a patient. I discussed this with Theola and stated that this is not appropriate or professional. Theola denied that this had occurred.'*

The panel noted that Mrs Marshall-Bernard denied that this had occurred and, in the absence of it being able to test Witness 5's evidence, the panel was unable to find this charge proved. It therefore determined that this charge is found not proved.

Charge 1m(ii and iii)

> *'ii. performed a vaginal examination on a patient and did not explain the procedure;*
> *iii. did not obtain consent from the patient before performing the procedure at (ii) above;'*

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 5. In her written statement, Witness 5 states:

> *'During the shift, Ms Marshall-Bernard also performed a vaginal examination without fully explaining the procedure to the patient and asking the patient if it was ok to perform it. Ms Marshall-Bernard also kept touching the patient's stomach without telling her why she was doing that. She was palpating contractions and was not asking the patient first if that was ok.'*
>
> *'When a procedure needs to be carried out which requires a patient's consent first, it is important. to explain to the patient why we want to perform the procedure. We need to explain the risks and the benefits of the procedure, and ensure that the patient understands. We then say that when they are ready we can carry out the procedure and make sure she is happy with that.'*
>
> *'Ms Marshall-Bernard would have known that she needed to explain procedures and obtain the patient's consent before carrying them out. This is something that is taught to student midwives, so even student midwives would know to do that. This is also known by anyone working in the healthcare profession, so even non-registered members of staff would be aware that consent needs to be obtained from patients before carrying out procedures.'*

Having considered the evidence before it, the panel determined that on the balance of probabilities, these charges are found proved.

Charge 1m(iv and v)

> *'iv. required prompting to listen to fetal heart monitoring every 15 minutes;*
> *'v. did not listen to the fetal heart for a full 1 minute as required;'*

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 5. In her written statement, Witness 5 states:

> *'Whilst caring for the patient, I had to prompt Ms Marshall-Bernard to listen to the fetal heart every 15 minutes. I did not expect to need to prompt Ms Marshall-Bernard as I would not even expect to need to prompt a student who was in the later stages of their training.'*
>
> *'When auscultating the fetal heart, Ms Marshall-Bernard did not listen for a full minute. As per the Trust's intrapartum Fetal Monitoring guideline the fetal heart needs to be listened to for one full minute every 15 minutes. I would have expected Ms Marshall-Bernard to know that she needed to do that.'*

Having considered the evidence before it, the panel determined that on the balance of probabilities, these charges are found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and, if so, whether Mrs Marshall-Bernard'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 suitability to remain on the register without restriction.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Mrs Marshall-Bernard's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

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

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence. It drew the panel's attention to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where it said Mrs Marshall-Bernard's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three stage process:

- Is there evidence that Mrs Marshall-Bernard was made aware of the issues around their competence?
- Is there evidence that they were given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mrs Marshall-Bernard's competence at the time was below the standard expected of a Band 5 registered midwife.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The NMC referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and any other cases referred to.

The NMC invited the panel to find that Mrs Marshall-Bernard's conduct amounted to a lack of competence and made the following written submissions:

> *'The NMC submits that the facts proved amount to lack of competence and that Mrs Marshall-Bernard lacks the knowledge, skill, judgment and basic midwifery skills required to practice safely as a midwife.*
>
> *Lack of competence includes a nurse demonstrating a lack of knowledge, skill or judgement showing that are incapable of safe and effective practice. In Holton v General Medical Council [2006] EWHC 2960 a case in which lack of competence was alleged against a doctor, the court said: "When judging competence, the standard to be applied is that applicable to the post to which the registrant has*

been appointed, regardless of the sufficiency of their training. Deficiency is to be judged against the standard of his professional work that is reasonably to be expected of the practitioner."

Mrs Marshall-Bernard was appointed as a Band 5 midwife her competence falls to be judged against the standards expected of a Band 5 midwife and the standard of professional work reasonably expected of such a practitioner.

Mrs Marshall-Bernard's repeated failings over a wide range of areas and a significant period of time are serious and fall short of what would be expected of a registered midwife in the circumstances. The mothers and babies under Mrs Marshall-Bernard care, have been exposed to an unwarranted risk of harm.

The concerns raised in this case also relate to basic, but fundamental aspects of midwifery/nursing practice. The concerns are wide ranging and occurred on more than one occasion. Despite the Trust provided Mrs Marshall-Bernard with additional support, repeat training and continued reflection and despite all this Mrs Marshall-Bernard was still unable to pass the necessary competency assessments, she further failed to grasp basic midwifery task and was still unable to reach the required standard of practice required of her to deliver safe and effective care as a midwife. This indicates a pattern demonstrating a lack of competence.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Calheam v The General Medical Council* [2007] EWHC2606 (Admin), and *Holton v The General Medical Council* [2006] EWHC2960 (Admin).

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, it found the following standards were engaged in this case:

'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

Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

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

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

Always practise in line with the best available evidence

To achieve this, you must:

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

Work cooperatively

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

8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

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

8.6 share information to identify and reduce risk

Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

10.2 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

Recognise and work within the limits of your competence

To achieve this, you must:

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

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

13.5 complete the necessary training before carrying out a new role.

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

To achieve this, you must:

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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'

The panel bore in mind, when reaching its decision, that Mrs Marshall-Bernard should be judged by the standards of the average Band 5 registered midwife carrying out the work she was performing and not by any higher or more demanding standard.

The panel determined that the charges found proved establish deficiencies in Mrs Marshall-Bernard's practice across five themes which are:

1. Medicines administration, including intravenous cannulation, drugs and fluids.
2. Communication with colleagues verbally and written, including handovers and the SBAR tool.
3. Taking and recording of observations for women and babies.
4. Risk assessment and escalation of emergencies.
5. Perineal care, protection, assessment and suturing.

The panel determined that the charges found proved demonstrate a lack of competence in fulfilling essential midwifery duties during the period from May to December 2022. The panel concluded that this period represented a fair sample of Mrs Marshall-Bernard's work. The evidence presented establishes that Mrs Marshall-Bernard lacks the necessary knowledge, skills, and judgment expected of a practising midwife. Despite receiving substantial additional support and training, she consistently failed to meet the required

professional standards, with her performance remaining below the competence expected of a Band 5 midwife.

While there were isolated instances where Mrs Marshall-Bernard met specific standards, such as completing handovers in the correct SBAR format, these were not consistent and not representative of her overall performance. Reports from medical professionals and direct observations highlighted recurring and wide ranging deficiencies in her practice. Her underperformance occurred despite her operating under continuous supervision in a supernumerary capacity on a development plan, with no evidence of mitigating circumstances such as extraordinary workplace pressures.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mrs Marshall-Bernard's practice was below the standard that one would expect of the average registered midwife acting in Mrs Marshall-Bernard's role.

In all the circumstances, the panel determined that Mrs Marshall-Bernard's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the lack of competence, Mrs Marshall-Bernard's fitness to practise is currently impaired.

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

a. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b. *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d. *...'*

The panel determined that Mrs Marshall-Bernard's actions have placed patients at risk of harm. It found that her actions breached fundamental tenets of the profession as set out in the Code, and so also brought the profession into disrepute.

The panel considered the case of *Cohen,* in particular the three matters which are described as being *'highly relevant'* to the determination of the question of current impairment:

i. Whether the conduct that led to the charge(s) is easily

remediable.

ii. Whether it has been remedied.

iii. Whether it is highly unlikely to be repeated.

Regarding whether Mrs Marshall-Bernard's deficiencies are remediable, the panel considered that the shortcomings identified pertain to technical midwifery skills. Accordingly, these failings are capable of remediation. However, the panel noted that, while there is evidence of some progress—such as a satisfactory SBAR handover reported towards the end of the relevant period— Mrs Marshall-Bernard has not remedied the deficiencies overall.

The panel noted that there is limited evidence before it demonstrating Mrs Marshall-Bernard's insight into her failings. In her last email to the NMC dated 25 September 2024 she said:

> *'I never hurt any patients or administered wrong medication during my tenure at Birmingham Women's Hospital. I did my best to cope under constant intense scrutiny in a busy and often chaotic clinical environment. However, I found the constant scrutiny unbearable as it caused increasing nervousness which eroded my confidence. I had a spotless clinical performance record of over 20 years prior to working at Birmingham Women's Hospital.'*

Furthermore, while some local documentation suggests a degree of insight, it is insufficient to provide assurance that she fully understands the nature and extent of her deficiencies, or the steps required to address them. In addition, the panel has not been provided with evidence from Mrs Marshall-Bernard of any reflection or remediation, and in her 25 September 2024 email she said that she had:

> *'… no intention of EVER practicing as a midwife again and as such I want to be removed from the midwifery register. I did not revalidate midwifery as a result.'* [sic]

Since the incidents in 2022, Mrs Marshall-Bernard has not practised midwifery and, as such, she has not been able to demonstrate any practical improvement or addressed the

concerns raised through her practice. In the absence of evidence of insight or remediation, the panel is satisfied that there is a risk of repetition of the failings should she be permitted to practise without restriction. The panel has therefore determined that Mrs Marshall-Bernard's fitness to practice is impaired on the grounds of public protection.

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

The panel considered that a well-informed member of the public would reasonably expect a finding of current impairment, given the wide-ranging nature of the deficiencies found proved. Failure to find impairment would undermine public confidence in the profession and its regulatory processes. Consequently, the panel finds Mrs Marshall-Bernard's fitness to practice impaired on the grounds of public interest as well as public protection.

Having regard to all of the above, the panel was satisfied that Mrs Marshall-Bernard's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that Mrs Marshall-Bernard's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

Representations on sanction

The panel noted that in the statement of case enclosed with the Notice of Meeting the NMC had advised Mrs Marshall-Bernard that it would seek the imposition of a conditions of a practice order for a period of 18 months if the panel found Mrs Marshall-Bernard's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Marshall-Bernard'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 NMC's Sanctions Guidance (SG) and accepted the advice of the legal assessor. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Limited insight
- Risk of patient harm
- No evidence of strengthened practice

The panel also took into account the following mitigating features:

- There is evidence to demonstrate Mrs Marshall-Bernard established a good rapport with her patients

The panel also noted a testimonial describing Mrs Marshall-Bernard's good practice in the period 2007-2008.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the need to protect the public. 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 Marshall-Bernard's practice would not be appropriate in the circumstances. 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 a conditions of practice order on Mrs Marshall-Bernard's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel took into account the SG, in particular the following guidance for when conditions of practice could be appropriate:

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

In considering this guidance, the panel carefully reviewed the matter and found no evidence of harmful deep-seated personality or attitudinal problems.

The panel noted that there are numerous identifiable areas of Mrs Marshall-Bernard's practice requiring assessment and retraining, but did not consider that these amounted to 'general incompetence' in the context of Mrs Marshall-Bernard's long prior career as a midwife. The panel determined that appropriate conditions could be devised, implemented, and monitored effectively to ensure patient safety during the period in which the conditions are in force. These conditions, the panel decided, would adequately protect patients from harm.

The panel also acknowledged concerns regarding the breadth of the areas requiring improvement and strengthening. However, it took into account that Mrs Marshall-Bernard's employer had continued to support her until her resignation, and the evidence presented indicated limited but discernible improvements in her practice.

The panel noted Mrs Marshall-Bernard's email stating that she did not intend to practise as a midwife again, but decided it would be unfair at this stage not to give her the option to remediate her practice.

The panel determined that imposing a suspension order would be disproportionate, as it would prevent Mrs Marshall-Bernard from having the opportunity to strengthen her practice and would result in her being entirely out of practice during the suspension period. The panel further noted that suspension would also apply to Mrs Marshall-Bernard's role as a nurse because the register covers both professions indivisibly.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order. It concluded that this order will adequately protect the public, mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered midwife.

The panel decided that the following conditions should be imposed in this case:

> *'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'*

1. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

2. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a written copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

4. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

5. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

6. You must send the NMC a report two weeks in advance of your next NMC hearing or meeting, detailing your general performance within the areas 7a-g below, from your:

- Ward or unit manager
- Deputy ward or unit manager
- Practice development midwife

7. You must not:

a) Monitor and review CTG traces independently until such time as you are assessed as competent by a supervisor and your employer to categorise and respond to CTG traces.
b) Cannulate patients unsupervised until you have been confirmed as competent by a supervising midwife and your employer.
c) Deliver a baby through the second or third stage of labour without a supervising midwife continually present until you have been confirmed as competent by a supervising midwife and your employer.
d) Attempt to assess and suture the perineum without prior learning, planning and direct instruction from a supervising midwife until you have been confirmed as competent by a supervising midwife and your employer to do so.
e) Commence Oxytocinon or Syntocinon administration without a supervising midwife checking the details and observing the

commencement of treatment until you have been confirmed as competent by a supervising midwife and your employer to do so.

f) Perform ARM without direct supervision until you have been confirmed as competent by a supervising midwife and your employer to carry out this procedure.

g) Provide SBAR handovers without the oversight of a supervising midwife until you have been confirmed as competent to do so by a supervising midwife and your employer.

8. Until you are signed off as competent, you must ensure that you are supervised by a midwife who is identified as a learning mentor anytime that you are working.

Your supervision must consist of:

a) Working under direct supervision and in the same room as the supervising midwife when working on:

- Delivery suite
- Induction area
- Theatres

b) Work on the same shift as and under indirect supervision when working on:

- Antenatal clinic or ward
- Post natal ward

9. You must send your case officer evidence that you have been assessed as competent by your employer to carry out each of the following interventions independently. This maybe in the form of an assessment sheet, letter or email from the assessor that includes the details of the assessment, the date of assessment, their signature, email address and telephone number:

a) Monitoring and reviewing CTG

b) Intravenous cannulation of adult

c) Delivering a baby through the second and third stage of labour following the local & national procedure / guidelines
d) Assessment and suturing of the perineum following the local & national procedure / guidelines
e) Commencing Oxytocinon or Syntocinon administration and maintaining aftercare and monitoring following the local and national procedure / guidelines
f) Performing ARM following the local and national procedure / guidelines
g) Provide handovers using the SBAR tool to provide all relevant information in a logical sequence

10. You must keep a personal development log that provides the details of each time you observe, participate and/or undertake one of the processes in condition 7) above. The details to record are:
Date & time, brief description and feed back obtained form your supervisor. These records should link to your personal reflective profile.

11. The reflective profile must contain the same detail as the personal development log, but you must add your own reflections on the event. You should note your achievements, points for improvement and things that you would do differently next time. A summary, deduced from this profile, should be sent to your case manager two weeks before the next hearing/meeting demonstrating your developing insight and learning.

12. You must work with your line manager/unit manager or deputy/supervising midwife/development midwife or equivalent to develop your PDP and this must reflect the concerns listed at condition 7a-g above. It must document the learning processes and interventions needed to enable your achievement and remediation of each of the concerns listed at condition 7a-g.

13) You must meet with your line manager/unit manager or deputy/supervising midwife/ development midwife or equivalent every 6 weeks to review progress towards the aims of the PDP.

You must send your case officer your PDP within three months of commencing your employment and at 6-month intervals after your reviews showing the progress being made towards the aims.

The period of this order is for 18 months, which the panel decided should be sufficient to gain employment and make meaningful progress towards remediation.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Marshall-Bernard has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Mrs Marshall-Bernard's attendance at the first review
- A reflective piece
- Evidence of compliance with the conditions as set out.

This decision will be confirmed to Mrs Marshall-Bernard in writing.

Interim order

As the conditions of practice 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 Marshall-Bernard's own interest until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC which are as follows:

‘An interim order is required to protect patients and is also in the public interest. This is because any sanction imposed by the panel will not come into immediate effect but only after the expiry of 28 days beginning with the date on which the notice of the order is sent to the registrant or after any appeal is resolved. An interim order of 18 months is necessary to cover any possible appeal period. An interim conditions of practice order is appropriate as this would be consistent with the sanction imposed by the panel and would address public interest concerns already identified in this document.’

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Marshall-Bernard is sent the decision of this hearing in writing.

That concludes this determination.