Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 June 2024 – Wednesday, 5 June 2024
Friday, 7 June 2024
Monday, 17 June 2024 – Friday, 21 June 2024
Monday, 24 June 2024 – Friday, 28 June 2024
Monday 1 July 2024 – Tuesday, 2 July 2024
Thursday 19 September 2024 – Friday, 20 September 2024 (panel in-camera)
Wednesday, 11 December 2024 – Friday, 13 December 2024

Virtual Hearing

Name of Registrant:	Rachel Mugechi Muchoki
NMC PIN:	16H0400E
Part(s) of the register:	Registered Midwife – September 2016
Type of case:	Lack of competence/Health
Panel members:	Shaun Donnellan (Chair, lay member) Laura Wallbank (Registrant member) Chantelle Whitehead (Lay member)
Legal Assessor:	Alice Robertson Rickard (3 – 5 & 7 June 2024) Neil Fielding (17 – 21 & 24 – 28 June 2024 & 1 – 2 July 2024, 19 – 20 September 2024, 11- 13 December 2024)
Hearings Coordinator:	Shela Begum (3 June 2024 – 2 July 2024) Yewande Oluwalana (19 – 20 September 2024, 11 – 13 December 2024)
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Ms Muchoki:	Present and represented by Wafa Shah, (instructed by the Royal College of Nursing)
Facts proved by admission:	Charges 1, 2a, 2b, 2c, 2e, 3a, 3b, 3c, 3d, 4a, 4b, 4c, 5, 6a, 6b, 7a, 7b, 7c, 8a, 8b, 10, 11a, 11b, 11c, 11d, 11d(i), 12b(i), 12b(ii), 12b(iii), 12b(iv),

	13(b), 14, 15a, 15b(i), 15b(ii), 17, 18a, 18b, and 18c
No case to answer:	Charge 12a(iv) and 16
Facts proved:	Charge 2d, 2f, 3e, 9a, 9b, 11d(ii), 12a(i), 12a(iii), 15c(i), 15c(ii), 15c(iii), 15c(iv), 15c(v), 15c(vi), 15c(vii), 15d and 15e
Facts not proved:	Charges 12a(ii) and 13a
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Ms Shah made an application on behalf of you that parts of this case be held in private on the basis that proper exploration of your case involves making reference to your [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC) supported the application to the extent that any reference to matters relating to your [PRIVATE] should be heard in private.

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

The panel determined to go into private session in connection with matters relating to your [PRIVATE] as and when such issues are raised.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Hoskins, on behalf of the NMC, to make an amendment to charges 2e, 2g(i), 2g(ii), 2g(iii), 3, 8a, 9b, 10, 11b, 15c(vi), 15(d).

The proposed amendment was to the wording of charges 2e, 3, 8a, 9b, 10, 11b, 15c(vi) and 15d. Mr Hoskins invited the panel to strike out charges 2g(i), 2g(ii) and 2g(iii) and to amend these charges to sit as standalone charges and be reflected as charges 18a, 18b and 18c. It was submitted by Mr Hoskins that the proposed amendment would provide clarity and more accurately reflect the evidence. The proposed amendments were as follows:

> "That you, a registered nurse:
>
> 2) During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;
> […]
> e) Were unable to operate the electronic intravenous pumps on **<u>the</u>** labour ward.
> […]
> ~~g) During a spontaneous vaginal delivery were unable to prioritise tasks in that you;~~
> ~~i) Did not have a delivery pack ready.~~
> ~~ii) Did not check the baby's heartbeat during the second stage of labour using a cardiotachogram.~~
> ~~iii) Put on sterile gloves before opening a delivery pack.~~
>
> 3) Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on **<u>the</u>** Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;

[…]

8) On 20 December 2016;

a) Selected the wrong tool to assess a fetal hear **heart** rate

9) On unknown dates, whilst providing care to one or more new mothers;

[…]

b) Did not explain that formula milk is heavier and could inhibit a new-borns **new-born's** ability to want to feed from the breast.

And in light of the above, **and charges 10-18 below,** your fitness to practise is impaired by reason of your lack of competence.

10) **That you a registered midwife,** have suffered from and/or are currently suffering from the medical condition set out in Schedule 1.

[…]

11) On 16 September 2019 whilst providing midwifery care to Patient X;

[…]

b) Asked one of Patient X's family member**s** to hold the Doppler ultrasound whilst you left the room to contact the labour ward coordinator.

[…]

15) On 11 September 2020:

[…]

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

[…]

vi) Went to look for ~~Colleague X~~ **Colleague Y**/the Midwife in charge of Baby
[…]
d) When asked by ~~Colleague X~~ **Colleague Y** if you had taken any action regarding Baby C colour/breathing difficulties, you responded using words to the effect ‘Nothing it is your lady’.

[…]

AND in light of the above **charges 10-17**, and/or any associated and/or consequential [PRIVATE], your fitness to practice is impaired by reason of your [PRIVATE].

18) On an unknown date between 1 September 2016 and 12 October 2016 during a spontaneous vaginal delivery were unable to prioritise tasks in that you;
a) Did not have a delivery pack ready.
b) Did not check the baby’s heartbeat during the second stage of labour using a cardiotachogram.
c) Put on sterile gloves before opening a delivery pack.”

Ms Shah informed the panel that she did not oppose the application to amend the charges as set out by Mr Hoskins.

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

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

Details of charge (as finally amended)

That you a registered midwife, between 1 September 2016 and 17 September 2020 failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5/6 midwife, in that you;

1) Did not fully complete your competencies/preceptorship programme which commenced in September 2016.
2) During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;
    a. Were slow in recording documentation.
    b. Prioritised written documentation over providing urgent care.
    c. Did not realise that Patient C had given birth to their baby in a water pool.
    d. Were unable to escalate concerns to senior staff members
    e. Were unable to operate the electronic intravenous pumps on the labour ward.
    f. Were unable to change bags of I.V. fluid in the timeframe appropriate for the clinical situation

3) Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;
    a. Communication with patients
    b. Normal labour & birth
    c. Medicines management
    d. Information from vaginal examinations.
    e. Use of medical equipment

4) On or around 14 October 2016;
    a) Were unable to perform a vaginal examination correctly.
    b) Incorrectly inserted a catheter into an unknown patient's vagina

c) Incorrectly attempted to break the waters of an unknown patient in labour.

5) Between 14 October 2016 and 23 December 2016 worked continuously in a supernumerary role.

6) Between 6 November 2016 and 13 December 2016;
   a. Were unable to comply with a competency checklist.
   b. Were unable to utilise a learning tool.

7) Were unable to successfully complete a 4-week action plan commencing 27 November 2016 as you were unable to;
   a. Create adequate care plans for one or more patients;
   b. Apply guidelines to individual patients.
   c. Identify clinical mistakes

8) On 20 December 2016:
   a. Selected the wrong tool to assess a fetal heart rate.
   b. Were unable to prioritise care needs.

9) On unknown dates, whilst providing care to one or more new mothers;
   a) Did not explain the difference between breastfeeding and formula milk.
   b) Did not explain that formula milk is heavier and could inhibit a new-born's ability to want to feed from the breast.

And in light of the above and charges 10-18, below, your fitness to practise is impaired by reason of your lack of competence.

10) [PRIVATE]

And as a consequence of your [PRIVATE];

11) On 16 September 2019 whilst providing midwifery care to Patient X;

a) Did not provide adequate care/support to Patient X whilst they were in pain due to contractions/labour

b) Asked one of Patient X's family members to hold the Doppler ultrasound whilst you left the room to contact the labour ward coordinator

c) Did not adequately communicate to Patient X/Patient X's family why the Oxytocin drip was resumed.

d) were unable to demonstrate proficiency in;

i) Usage of Oxytocin guidelines

ii) CTG interpretation/Change of care plan

12) Between October 2019 and April 2020, whilst working on the Infant Feeding Team,

a) Did not communicate with colleagues/management adequately, in that you, on one or more occasion;

i) Did not approach your line manager to discuss care plans.

ii) Did not work as part of the team.

iii) Did not discuss or request feedback

iv) Avoided eye contact with one or more colleagues

b) During tongue tie clinics, were unable to demonstrate proficiency in;

i) Securing babies;

ii) Handling babies.

iii) Holdings babies in a towel.

iv) Did not communicate advice adequately with patients.

13) Around 22 January 2020;

a) Provided formula milk to a new mother without attempting to teach/support breastfeeding.

b) Did not know how to operate a breast pump.

14) On 28 April 2020, after having a supervision meeting with Colleague X, left your shift incomplete.

15) On 11 September 2020

a) Incorrectly discharged Patient A with Patient Z's postnatal discharge notes/pack.

b) Did not;

i) Contact the Community Midwife Team regarding Patient A's discharge.

ii) Email a discharge summary to the Community Midwife Team regarding Patient A's discharge.

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

i) Failed to pull/press the emergency call bell.

ii) Did not assess Baby C's breathing.

iii) Did not assess Baby C's airways.

iv) Did not assess Baby C's circulation.

v) Did not move Baby C to the resuscitaire.

vi) Went to look for Colleague Y/the Midwife in charge of Baby C

vii) Went to look for a stethoscope/thermometer

d) When asked by Colleague Y if you had taken any action regarding Baby C colour/breathing difficulties, you responded using words to the effect 'Nothing it is your lady'.

e) Did not know how to use a SATS monitor.

16) On 15 September 2020 incorrectly offered formula milk to a new mother who wanted to breast feed.

17) Were unable to complete a 4-week capability assessment commencing between 17 June 2020 – 29 July 2020.

AND in light of the above charges 10-17, and/or any associated and/or consequential [PRIVATE], your fitness to practice is impaired by reason of your [PRIVATE].

18. On an unknown date between 1 September 2016 and 12 October 2016, during a spontaneous vaginal delivery were unable to prioritise tasks in that you;

a) Did not have a delivery pack ready.

b) Did not check the baby's heartbeat during the second stage of labour using a cardio-tachogram.

c) Put on sterile gloves before opening a delivery pack.

Background

The charges in this case relate to your midwifery practice whilst employed by Wexham Park Hospital (the Hospital) which is part of the Frimley Health NHS Foundation Trust (the Trust).

Within the Hospital, there were a number of units where pregnant women received their care, including the Medical Assessment Unit (MAU), the Antenatal Ward (Ward 21), the Labour Ward, and the Birth Centre. The Hospital also consisted of a postpartum unit which included a neonatal intensive care unit, Postal Natal Ward (Ward 22) and a Transitional Care Unit (TCU).

You commenced employment at the Hospital as a band 5 midwife in the Labour Ward in September 2016. At that time, band 5 midwives were still being employed during the process of continuing education by way of a preceptorship program with the aim of completing that within a period of a year and following an interview taking up a more senior position as a band 6 midwife. The preceptorship program which was run by the practice development team involved approximately two weeks of shadow shifts thereafter, six months of a probationary period, and over the whole course of what was usually 12 months, registrant midwives would be complete their preceptorship booklet. Registrants would spend firstly about six months on the labour ward, if all was well, they would move on for three months on the postnatal ward and three months on the antenatal ward.

It is alleged that you commenced your preceptorship in September 2016 but never completed this whilst employed by the Trust.

When working with another member of staff on a 1:1 basis, concerns were identified in your practice, and it was decided that the preceptorship alone would not be enough to manage those concerns. The concerns involved failures in respect of vaginal examination procedures, the incorrect insertion of a catheter into the patient’s vagina and incorrectly attempting to break the waters of a patient whilst in labour. These concerns gave rise to further intervention at an early stage and by October 2016 strands of support were

implemented which involved the continuation of the preceptorship, supervision from a band 7 midwife, competency checklists and learning tools.

It is alleged that during supervised shifts, you were performing at student level and had to be told what to do. It is alleged that you lacked judgement about when to take notes and when to deal with urgent care, you struggled to remain calm and make rational decisions in response to changing clinical situations and would not ask for help. It is alleged that you did not notice a woman had in fact delivered a baby in a birthing pool.

At the end of December 2016, it was decided that you needed more support, re-teaching and additional training as there were large gaps in your knowledge and you were not ready to make clinical decisions. The Trust instigated competency proceedings and it was decided to give you another chance to complete the competencies in the context of a lower acuity environment away from the labour ward, and instead at the birth centre which dealt with at lower risk women. It was envisaged that the preceptorship program would be completed by the end of 2017 but in September 2017, [PRIVATE].

[PRIVATE]

[PRIVATE]

In April 2019, you returned to work on a phased return and recommenced the capability program on the post-natal ward. Between April 2019 and September 2019, [PRIVATE], combined with annual leave in this period, prevented the completion of the capability program that was originally planned to be completed by the end of 2017.

In September 2019, you allegedly had difficulty determining how much oxytocin, which is a hormone used to induce labour, should be administered to a patient. You also allegedly failed to be flexible and amend a care plan in light of proper interpretation of the CTG.

In October 2019, you had a formal change in employment working as a midwife within the infant feeding team. A band 7 infant feeding leading midwife became your appraiser as part of the competency program and the initial signs in that very discrete and specialised area were that there were positive responses to observation of your practice, academic tests and midwifery audits. However, it is alleged that concerns arose that you were still completing tasks under very strict direction, and you were not able to broaden your knowledge and skill further than that of the level band two or three maternity care assistant.

Between November 2019 and May 2020, [PRIVATE].

In June 2020 there was a plan put into place for four weeks to complete your competencies on the infant feeding team and obtain a recommendation from the OH as to whether you could be phased back into work on the labour ward. The aim was for this to be completed within three months, to determine whether you were competent as a band 6 midwife.

In August 2020, [PRIVATE]. OH could not predict when you would be able to resume your full normal clinical role as a midwife. At the end of August 2020, you rejoined the postnatal ward.

In September 2020, you were assessed on your capabilities within the breastfeeding team and were signed off as competent in a number of areas. There were still concerns about the level of your initiative rather than simply taking directions. After this, in September 2020 [PRIVATE].

Also in September 2020 baby C, who had been transferred to the ward from the special care unit, following breathing difficulties at birth, required light therapy for jaundice. It is alleged that you did not demonstrate any urgency and did not conduct any observations of the baby, when baby C’s mother reported that the baby was blue. It is also alleged that you were unable to monitor oxygen saturation levels.

It is also alleged that on 15 September 2020 you incorrectly offered formula milk to a new mother who wanted to breastfeed. On the same date it was discovered that you had incorrectly discharged a patient A with patient Z's discharge notes, and you did not contact the community midwife team when patient A was discharged.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Shah under Rule 24(7) that there is no case to answer in respect of charges 2d) and f); 3e); 9a); 11d)ii); 12iv) and 16 and under Rule 24(8) in respect of charges 1, 13b and 14. Ms Shah provided written submissions in which she stated:

> *"1. The Nursing and Midwifery Council ("NMC") brings this case and the burden of proof rests with the NMC at all times. Rachel Muchoki ("Registrant") is not required to prove anything. At the close of the NMC's case, it is submitted that the NMC has failed to discharge the persuasive burden and that there is no case for the Registrant to answer in relation to outstanding charges, as follows:*
> *2. During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;*
> *d) Were unable to escalate concerns to senior staff members*
> *f) Were unable to change bags of I.V. fluid.*
>
> *3. Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;*
> *e) Use of medical equipment*
>
> *9. On unknown dates, whilst providing care to one or more new mothers;*
> *a) Did not explain the difference between breastfeeding and formula milk.*
>
> *11. On 16 September 2019 whilst providing midwifery care to Patient X;*

d. ii) CTG interpretation/Change of care plan

12. Between October 2019 and April 2020, whilst working on the Infant Feeding Team,
iv) Avoided eye contact with one or more colleagues

16. On 15 September 2020 incorrectly offered formula milk to a new mother who wanted to breast feed.

1. *It is argued that certain of charges, whether there is a case to answer on the facts or not, would not be capable of supporting a finding of a lack of competence/*[PRIVATE] *or impairment as follows:*
    1. *Did not fully complete your competencies/preceptorship programme which commenced in September 2016.*

13. Around 22 January 2020
b) Did not know how to operate a breast pump.

14. On 28 April 2020, after having a supervision meeting with Colleague Y left your shift incomplete

<u>Legal Test</u>

2. *Application in relation to the facts is made under Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practice) Rules 2004, as amended:*

"Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and - (i) either upon the application of the registrant, or (ii) of its own volition, The Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer…"

3. *The application in relation to current impairment of fitness to practice is made in accordance with Rule 24(8) of the Rules, as follows:*

"Where an allegation is of a kind referred to in article 22(1)(a) of the Order, the Committee may decide,—

(i) either upon the application of the registrant, or

(ii) of its own volition,

to hear submissions from the parties as to whether sufficient evidence has been presented to support a finding of impairment, and shall make a determination as to whether the registrant has a case to answer as to her alleged impairment."

4. *In accordance with the principles set out in the criminal case of R v Galbraith [1981] 1 W.L.R. 1039, when considering whether there is a case to answer, the Panel should first determine whether there is any evidence upon which a Panel could properly find the charges proved. Where there is none, the Panel should find no case to answer. Where there is some evidence presented, the Panel should consider the nature and strength of that evidence and decide whether it can properly be relied upon to find the facts proved. Evidence which is inherently weak and vague, or inconsistent with the remaining evidence in the case, ought not be relied upon.*

5. *Lack of competence and current impairment of fitness to practice are matters for the panel's professional judgment, not matters of proof.*

6. *The NMC's guidance (FTP-2B) updated on 4/04/2021 states as follows with respect to a lack of competence:*

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

Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate.

We recognise that nurses, midwives and nursing associates sometimes make mistakes or errors of judgement. Our starting position is that the nurse, midwife or nursing associate is usually a safe and competent professional but something may have happened that got in the way of them delivering safe care.

If concerns are raised about the general competence of a nurse, midwife or nursing associate we'll seek to understand the circumstances at the time. We'll also look at their practising history and not just at the period of time when the concerns arose. This will help us understand if there is a particular area of practice where there may be concerns or whether they are more general in nature.

Where we identify a gap in the nurse, midwife or nursing associate's knowledge or training we'll try to help them understand what they can do to address this gap and demonstrate they're safe to practise.

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation. If there is such evidence we may need to take some additional action, such as sharing information with other regulators or employers.

7. *The principle of proportionality applies to the panel's decision making process. Proportionality requires that the panel's decision must be no more than necessary to meet the legitimate aims of the NMC, as outlined above.*

8. *When considering whether the Registrant's fitness to practice is currently impaired, the panel will have regard to the test adopted by Mrs Justice Cox*

in the seminal case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 76:

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

9. *The panel will be mindful that an assessment of current fitness to practice is a forward looking exercise, as emphasised by Sir Anthony Clarke, Master of the Rolls, in Meadow v. General Medical Council [2007] 462 at [32]:*

"In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practice. The FTP thus looks forward not back. However, in order to form a view as to the fitness of a person to practice today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

Submissions
2. During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;
d) Were unable to escalate concerns to senior staff members

10. *Within the evidence matrix the NMC has identified the following as evidence in support of this allegation: [Witness 6] Para 16 and [Witness 6]/04 as well at the oral evidence of witness [Witness 6], [Witness 7] and [Witness 10]. In para. 16 of her statement [Witness 6] refers to the email of witness [Witness 7] and in [Witness 6]/04 she refers to the evidence of [Witness 10]. While giving evidence [Witness 7] was unable to expand on or give any evidence in respect of what aspect of the CTG trace required escalation and/whether or not this was sufficiently done. This is evident from the following sections of the transcript (quoted for ease). In her evidence in-chief it is apparent that she doesn't remember anything over and above the brief description in her statement. This is apparent from her evidence in chief at Page 23-24 of Day 4 and even after Mr Hoskins specifically asked her what is meant in terms of escalating to a senior midwife:*

Page 30 of Day 4:
Tom Hoskins 33:14
Can I just check within that reference to escalation to a more senior midwife?
[Witness 7] 33:20
Yeah.
Tom Hoskins 33:20
I'm what obligation, if any, in the context of this spontaneous product, […] delivery was there to, to escalate or are you just giving us background information that that's the point of the CTG?
[Witness 7] 33:36
Because I don't remember what?
What was the situation?
It looks like it is more like a background in here.
But I I don't remember the situation.
I'm sorry.
It's.
I don't remember exactly.

Tom Hoskins 33:51
That's fine.

<u>*In cross-examination she confirmed as follows:*</u>

Page 77-78 of Day 4:
Wafa Shah 2:15:04
So we understand you don't remember everything, but am I right to understanding that what you've said is that your concern about the registrant in relation to the CTG as far as you remember is about her failure to communicate as opposed to being able to remember now whether or not she recognized the variability, is that right?
[Witness 7] 2:15:07
Umm.
From what?
From what I remember, I can only concentrate on the communication part and not on the CTG.
Yes, from what I remember, because I don't remember that. Yeah.

Wafa Shah 2:15:36
Now I'm going to I'm going to suggest to you that the registrant did recognise the variability.
Umm.
And she did escalate appropriately on that day.
Would you agree with that?
Or is your answer?
I simply can't remember.
[Witness 7] 2:15:54
Ohh count remember (Must read: I can't remember).

<u>***Panel Questions:***</u>
Page 93 of Day 4:

After questioning by a panel member commencing at page 90, the witness's final answer, despite bring prompted to the relevant section of her email (Main Hearing Bundle page 445) her response was definitively:

'So there must have been then concerns as well about recognizing when the traces to species and the time to escalate.
That's what it says so, but I I I don't really remember in specific.
About the scenario has March, I do remember the room a lot.
The layout of the room, I don't remember exactly.
Umm, about the the classification of the CTG or the CTG itself?'

11. *The panel is therefore left with the contents of witness [Witness 7]'s email at page 445 of the bundle. The concern raised here is entitled Fetal Monitoring and decision making. Within the statement itself it is obvious the Registrant sought to change something (i.e. Oxytocin drip), that it and of itself suggests she recognized something on the trace. Within this statement it is clear the Registrant also referred to [Witness 7] before recommencing the drip. Therefore, there was some level of 'escalation'. Beyond that there is simply insufficient evidence following hearing from the witness what further escalation to a senior midwife was required and to what extent the registrant fell short. It is evident from her oral evidence that her concern was more about communication rather than a failure to escalate.*

12. *Equally [Witness 10] stated she remembered nothing more than what was recorded in her statement and therefore could not provide the panel with any evidence upon which to decide whether or not there was a duty or reasonable expectation to escalate or whether or not it was done. She provides no dates and no instances when this concern became apparent to her. To accept such vague and inherently weak evidence as sufficient to go beyond this stage would amount to the panel simply accepting a conclusion drawn by a witness rather than being able to analyse the evidence upon*

which that conclusion was based to decide whether or not an allegation is proved or not proved. It is therefore submitted this is just the sort of evidence that falls under the second limb of the Galbraith test and that no properly directed panel ought to rely on.

13. *The above evidence does not amount to 'sufficient' evidence as it neither enables the panel to determine why the duty to escalate arose, who the Registrant was under a duty to escalate to and whether or not it was done. This is precisely the sort of vague and inherently weak evidence that ought never to be relied on by a panel, notwithstanding the fact that without any details as to what was wrong with the trace and what level of escalation was required it is blatantly unfair to expect the Registrant to be able to mount a defence to such vague information for such a serious charge.*

2. During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;

f) Were unable to change bags of I.V. fluid.

14. *The NMC rely on [Witness 5]'s evidence which comprises of her statement and oral evidence. When Mr Hoskins asked what the issue was with the Registrant's ability to change an IV fluid bag, she made it very clear it was the speed and slowness that she was concerned with (Transcript Day 2, page 122). The height of the evidence provided by the NMC is that the Registrant was 'slow' in changing bags of IV fluid and not that she was 'unable' to. This was confirmed in cross-examination at Page 128 of Day 3) as follows:*

Wafa Shah 1:06:56
Thank you very much, [Witness 5].
I'm going to start by asking you about.
When specific allegation and for the benefit of the panel, I'm dealing with allegation to F it's about IV fluids.

And one of the allegations against the registrant is that she was unable to change bags of IV fluids.
OK, now my understanding of what you've told us about all of her Ivy related practice is that your assessment was it was too slow.
Not that she was unable to do it.
Am I right in understanding that?
[Witness 5…]
And yeah, from what I recall, it was more and those kind of clinical skills, it was more
the speed that she was able to do then.
The NMC has there furnished no evidence that the Registrant was 'unable' to change bags of IV fluid and there this charge does not get past Limb 1 of the Galbraith test as cited above.

3. Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;

e) Use of medical equipment

13. The NMC relies on the following to prove this charge: [Witness 5] Para 16 [Witness 5]/03 [Witness 5]/04 [Witness 5]/05 [Witness 5]/06; [Witness 3] para 15 [Witness 3]/06 [Witness 3]/07; [Witness 7] para 11; [Witness 7]/5. However none of these witnesses have been in a position to provide the panel with any level of detail as to what the medical equipment was, when the Registrant demonstrated she could not complete it or any specifics that would enable the panel to describe the evidence as anything more than vague and inherently weak.

9. On unknown dates, whilst providing care to one or more new mothers;
a) Did not explain the difference between breastfeeding and formula milk.

15. *Here the NMC relies on witness [11]s evidence in para. 10. This is in contrast to an identical, but more specific (as it has a date), allegation at 16 of the amended charge sheet which relates to paragraph 13 of [Witness 11]'s witness statement. When [Witness 11] gave oral evidence she was unable to provide any details as to when these instances occurred, what the Registrant said, how long she was observing the patient for and whether the Registrant had any other interaction with the mother before she observed the Registrant do as alleged. The evidence for this charge at its height is vague and inherently weak. It is therefore submitted this is the sort of evidence a panel ought not to rely on. For one, it leaves the panel with no ability to scrutinize what [Witness 11] said she witnessed. If the panel were to accept this evidence as 'sufficient' it would amount to the panel deferring its decision-making power to a witness. All we have is [Witness 11]'s conclusion of what she observed but no primary facts upon which the panel can base a decision as to whether or not what the Registrant said or did was indeed not per the guidelines.*

11. On 16 September 2019 whilst providing midwifery care to Patient X; d. ii)) were unable to demonstrate proficiency in CTG interpretation/Change of care plan

16. *The panel are invited to refer to the sections of the transcript quoted in respect of allegation 2 above (para. 11 onwards of these submissions). As witness [Witness 7] was unable to give any specifics the panel has no primary evidence, short of [Witness 7]'s, conclusion that the Registrant was unable to demonstrate the relevant proficiency as alleged. We know from [Witness 7]'s email ([Witness 6]/04) that the Registrant sought to change the Oxytocin drip rate which would amount to a change of care plan. [Witness 7]'s evidence clearly was that her concern was more about communication and she remembers no specifics to assist the panel to make a decision as to whether or not this charge should be found proved. It is submitted this is just the sort of evidence that amounts to inherently vague or inconsistent. Rather*

than being able to consider any of the facts (e.g, what was the CTG, what was missed by the Registrant, what ought she have changed in the care plan that she failed to change), the panel have insufficient evidence to consider this charge, let alone evidence which establishes a case to answer.

12. Between October 2019 and April 2020, whilst working on the Infant Feeding Team,

iv) Avoided eye contact with one or more colleagues

17. *It appears the evidence the NMC seeks to rely on for this charge is the evidence of witness [Witness 8]. In cross-examination she confirmed that she herself never experienced the Registrant avoiding eye contact with herself. The panel are therefore left with anonymous hearsay (namely, [Witness 8] saying unknown others on the team raised this with her). The panel are invited to consider the anonymous hearsay the NMC seeks to rely on in respect of this charge as inadmissible, even if the panel is of the view it ought to be admitted, the panel are invited to give no weight whatsoever to anonymous hearsay. This is because it has long been thought that the evidence of an anonymous witness, particularly hearsay from an anonymous other is unfair to admit. This principle was confirmed in White v NMC [[2014] EWHC 520 (Admin)] when the High Court concluded that and NMC Fitness to Practice tribunal's decision to include anonymous hearsay evidence as having probative value was wrong. It is submitted that following the principles established in White v the NMC, the panel ought not to ascribe any probative weight to anonymous hearsay as even the person relating the anonymous hearsay was unable to provide any dates or details such that the panel can ascertain she was 'avoiding' eye contact. There is nothing presented to the panel to enable them to decide whether the Registrant was simply looking at something else that legitimately required her attention, was doing something else, was busy attending to something urgent or was engaged in another activity when it is alleged she 'avoided' eye contact. This is with the utmost respect the most ridiculous allegation this Registrant faces*

and there is simply no evidence to which the panel can ascribe probative weight to when properly directed presented by the NMC. It is therefore submitted the NMC has provided insufficient evidence to establish a case to answer in respect of this charge.

15. On 15 September 2020 incorrectly offered formula milk to a new mother who wanted to breast feed.

18. It has become apparent that the only evidence the NMC has furnished after closing its case on this charge is anonymous hearsay. The panel are invited to find the hearsay evidence of an unknown midwife ought not to be given any probative value. The panel are invited to apply the same principles and arguments presented in respect of charge 12. It is submitted that following the principles set out in the case of White v the NMC it would be fundamentally unfair to attach any probative weight to anonymous hearsay, especially when there are no details that [Witness 11] was able to provide and she further did not record anything at the time or conduct an investigation. She was unable to tell us how long the midwife was observing the Registrant, whether she overheard the complete interaction or came in the middle of it or any other information that would enable the panel to form their own judgement.

Submissions under Rule 24(8)

19. Upon the conclusion of its consideration of the above applications, the panel is invited to further consider whether there is a case to answer on misconduct and current impairment of fitness to practice, in accordance with Rule 24(8).

<u>Allegation 1 (charged as a lack of competence)</u>

1) Did not fully complete your competencies/preceptorship programme which commenced in September 2016.

20. *It was clear from [Witness 12]'s evidence that but for the OH report recommending the Registrant could not return to the Labour Ward, it was her intention to allow her further time to complete her outstanding competencies all of which could only be completed on the Labour Ward. The NMC have charged this as a lack of competence matter. Looking at the guidance quoted above in respect of a lack of competence, it is submitted a failure to complete anything on account of being unable to do it due to being unable to go back and work on a particular ward does not amount to a lack of competence but a failure that arises out of force majeure. The NMC's witness [12] confirmed she had thought it proper to extend the Registrant's time to complete her competencies after the first capC meeting as there was not enough evidence that the PD team and the organization had done everything they could to support the Registrant. It is therefore submitted a charge of lack of competence cannot follow when a member of the Trust themselves acknowledges there wasn't sufficient evidence of support the first time it came to a capability hearing and then further extended the time after a second capability hearing to complete competencies as in light of the competencies remaining (surturing)* [sic] *it was appropriate to give the Registrant further time. Had the Registrant ever returned to the Labour Ward and still not completed her completencies* [sic]*, it is submitted that may have been capable of amounting to a lack of competence that goes to current impairment.*

21. *It is therefore submitted the evidence presented by the NMC is insufficient to establish a case in respect of current impairment for this allegation.*

13. Around 22 January 2020

b) Did not know how to operate a breast pump.

22. *This charge is incapable of establishing a case against the registrant on current impairment of fitness to practice. [Witness 4] was clear there was*

nothing out of the ordinary when the Registrant sought advice on how to use the breast pump and indeed it was in the context of the Registrant being specifically invited to raise anything she felt unconfident with. If such a set of circumstances were capable of establishing a case against the Registrant on impairment, indeed it would put many midwives off raising matters they needed extra help with which is neither in the public interest, nor proportionate. This charge is clearly the product of a misguided interpretation of [Witness 4]'s documentation by the NMC.

14. On 28 April 2020, after having a supervision meeting with Colleague Y left your shift incomplete

23. *The height of the NMC's evidence in respect of this charge is that following a meeting with [Witness 8] and [Witness 4], the registrant requested annual leave and was granted annual leave. Therefore she left the shift with permissions. [Witness 4] said she thought it was positive the Registrant was able to ask for leave when she needed it. Nothing the NMC has presented suggests this charge is capable of establishing current impairment."*

Mr Hoskins provided written submissions in response to the application in which he stated:

"1. Following the conclusion of the NMC's case the Registrant makes a submission of no case to answer: Pursuant to Rule 24(7) in respect to of charges 2d) and f); 3e); 9a); 11d)ii); 12iv) and 16 on the basis that insufficient evidence has been presented to find the facts proved; and,
Pursuant to Rule 24(8) in respect of charges 1, 13 and 14 on the basis that insufficient evidence has been presented to support a finding of impairment.

2. This application is opposed on the basis that the Registrant's submissions really amount to asserting that the evidence is not sufficiently credible to find a case proved, as such issues of credibility are best left to the conclusion of the case.

FACTUAL BACKGROUND

3. The factual allegations and case advanced by the NMC will now be very familiar to the Committee, having heard the case being opened (see Day 1 of the Transcript) and having heard all of the NMC's witnesses be called and cross examined.

LEGAL FRAMEWORK:

4.The test to be applied upon submissions of no case to answer is drawn from criminal proceedings in the case of R v. Galbraith [1981] 1WLR 1039. Although familiarly cited, in light of the summary citation of the legal principle of central importance provided by the Registrant at §5 of the Skeleton Argument, it is worth restating and emphasising the central "test" provided by Lord Lane CJ (emphasis added):

> *(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case.*
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
>> *(a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.*
>> *(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury" (per Lord Lane CJ at p 127).*

5. It is respectfully submitted that by emphasising the headnote of paragraph 2 and erecting that as the "test" that outlined at §5 of the Skeleton Argument, the Registrant fallen into error. First, to characterise the relevant question as being whether "evidence is inherently weak and vague, or is inconsistent with the remaining evidence in the case" as being determinative of the submission is not correct since, as outlined above, that is a pre-requisite and there then comes the ancillary question of which side of the line that evidence falls; the real question is whether the issue is one of whether the reliability of witnesses (generally a matter for the jury) could on one possible view be substantiated. If so the submission will be rejected notwithstanding that the evidence is inherently weak, vague or inconsistent. Secondly, the suggestion that the focus of the question is "ought not to be relied upon" is absent from the decision in Galbraith.

6. The NMC guidance in respect of the issue of strengths or weaknesses of evidence (see limb 2(b) of Galbraith) is:

> *Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.*

7. The test in Galbraith was further clarified in the case of R v. Shippey and another [1988] Crim LR 767, again a criminal case. Here it was clarified that the requirement to take the prosecution evidence at its height did not mean 'picking out all the plums and leaving the duff behind'. It is necessary to look at the evidence as a whole, not merely parts of it, and assess whether a reasonable jury could (but not would) come to the conclusion on that evidence that the defendant is guilty.

8. The submission relating to no case to answer on facts rests on the second limb of Galbriath. Within that within that limb, the phrase 'a jury properly directed' as applied to the present regulatory context would include the following directions of law (in respect of the 'facts' stage within the meaning of Rule 24(7):

a. That the burden of proof rests with the NMC to prove the allegations and the burden of proof is the ordinary civil standard. The requirement at this stage is that the NMC must have produced sufficient evidence to allow a properly directed tribunal to properly find the matters proved. It is impermissible to take a 'wait and see' approach to the evidence i.e. by seeking to hear what Ms Muchoki may say about the allegations. To do so would impermissibly apply to her an evidential burden to disprove allegations.

b. Ms Michoki [sic] *has no previous regulatory of disciplinary findings against him and should, therefore, be regarded as not having demonstrated a propensity towards the sort of conduct alleged factually. The exception to this is that if the Registrant admits a fact similar to one which is denied and part of this application, where the Committee is satisfied that that admission (and consequent factual finding pursuant to Rule 24(5)) establishes a propensity act in a certain way, that propensity can be taken into account in determining facts Khan v. GMC [2021] EWHC 374 (Admin) at §132-136.*
c. Determining the extent of the evidence's reliability (a central matter in limb 2b) of Galbraith) reliability requires a detailed assessment of the evidence adduced Suddock v. NMC [2015] EWHC 3612 (Admin) by Mrs Justice Andrews at paragraph 59, where she states (emphasis added):

> *Experience has taught us that the way in which someone behaves while giving evidence is not a reliable indicator of whether he or she is telling the truth. Whilst demeanour is not an irrelevant factor for a court or tribunal to take into account, the way in which the witness's evidence fits with any non-contentious evidence or agreed facts, and with contemporaneous documents, and the inherent probabilities and improbabilities of his or her account of events, as well as consistencies and inconsistencies (both internally, and with the evidence of others) are likely to be far more reliable indicators of where the truth lies. The decision-maker should therefore test*

the evidence against those yardsticks so far as is possible, before adding demeanour into the equation.

9. In respect of the sorts of proper "jury" directions at impairment stage which are relevant to the Registrant's submission on Rule 24(8), the Committee should bear in mind:

a. That there is no burden placed on either party at this stage, it is a matter of professional judgment. This is not changed because a submission of no case is, quite permissibly pursuant to Rule 24, made at a stage in the case where in respect of "facts" only there is a burden placed on the NMC. In short, to defeat the submission of no case to answer, it is not incumbent on the NMC to demonstrate that the Committee on one possible view of the evidence could be satisfied it is more likely than not that the registrant is currently impaired.

b. One of the allegations of impairment is by virtue of lack of competence pursuant to Article 22(1)(a)(ii) of the 2001 Order.

i. The Registrant's citation of the NMC's guidance on of lack of competence is correct. The central kernel for this application is whether Ms Muchoki, on one possible view of the view of the evidence, presented "an unacceptably low standard of professional performance, judged on a fair sample of [her] work, which could put patients at risk".

ii. One relevant consideration to the issue of lack of competence specifically mentioned in the guidance is whether there exists "a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation".

c. [PRIVATE

d. The Registrant's citation at §9 of the Skeleton argument of the relevant "test" for current impairment whether looked at through the lens of lack of

competence or [PRIVATE] *as outlined in CHRE v. NMC and Grant [2011] EWHC 927 (Admin) is entirely appropriate and correct. So too is the citation and guidance from Meadow about the approach of taking account of actions in the past in order to form a view of Ms Muchoki's fitness to practise today. The only gloss on the case of Grant (a misconduct case) when applied to allegations of impairment by reason of* [PRIVATE] *comes from the NMC's published guidance which provides: "There are very few circumstances where we decide that a nurse, midwife or nursing associate who has (or used to have) a* [PRIVATE]*, but is currently able to practise safely without any risk to patients, is impaired on the basis of public confidence in the professions alone."*

e. The Registrant has made an erroneous reference to misconduct at §20 of their skeleton argument. This should be disregarded, no part of this case concerns misconduct.

SUBMISSIONS

RULE 24(7) ARGUMENTS:

Charge 2)d):

10. The primary source material comes from [Witness 10] from her account of working 5 shifts with the Registrant in which she states at 2/448 §1) "Rachel does not seem to escalate to senior staff when there is any deviation from normal". It is clear that this near-contemporaneous observation of the relevant period matches the charge and it is therefore the charge is capable of proof.

11. The Registrant relies at §13 of the skeleton argument on the very limited recollection now of [Witness 10] when giving evidence. That is flawed since:

a. Firstly, issues of reliability are best left to the close of the facts stage per the Galbriath test and the interpretation of that test advanced by the registrant that all that needs to be shown is the evidence is weak etc is not correct as outlined above.

b. Secondly, the process of giving evidence is not a memory test and where, as here, a near contemporaneous document for a specific similar purpose is provided and is confirmed as being accurate at the time could on one possible view be sufficient.

c. Thirdly, there is no suggestion of any reason to be inaccurate in that near contemporaneous document.

As such, a witness's concession of a limited recall in looking back some significant length of time does not detract from the reliability of their observation and could in fact enhance their credibility by their willingness to make concessions.

12. Secondary evidence for reported concerns comes from [Witness 6] at §15 [1/76] erroneously listed as §16 in the evidence matrix: "[Witness 10] was concerned that the Registrant was unable to escalate their concerns to senior staff members". Although given this witness also exhibits the same statement (and it to be expected for there to exist similarity as there is the single source), the fact that there is no evidence of a subsequent conversation between [Witness 10] and [Witness 6] notwithstanding the process that was gone through which contradicts that concern suggests that [Witness 10]'s concern was consistently held and not contradicted after it was raised.

13. The Registrant relies at §13-14 of the skeleton argument on the lack of detail in this assertion made by [Witness 10], yet all that is required is the charge is capable of proof. The charge does not allege this level of detail and there has been no objection to that charge on a point of law. The Registrant is therefore erecting a straw man argument.

14. Corroboration of [Witness 10]'s evidence also comes from the other observer at that time, [Witness 5] when she states at §11 [1/20] that the Registrant would "Often when… struggling, she would not let me know. I would opten [sic] *have to step in and start providing care to a woman".*

15. The fact that this was evidently an area of concern at the time upon which work needed to be completed is evidenced by the fact of its inclusion as a specific comment at the time in the "Competency Checklist" E/23 (bottom of page) and consequently in the "Learning Too"l which arose from the specific first six weeks of observed shifts E/265-266 "appropriately escalated to the correct team…" and, additionally, [Witness 3]'s evidence at E/278 §4 in which she provided supporting comment in the Transcripts at D2 p.148-149 this was direct observation arising from the single shift worked by [Witness 3] as well as the information reported to her.

16. The Registrant asserts that the evidence of [Witness 7] was such that she cannot recall evidence of the concern of failure to escalate at §9 of her statement [1/89] "If there are concerns with the CTG, there is an expectation that a midwife escalates this to a more senior midwife on the Labour Ward". Given the fact that this is phrased in the 2016 instances as a general requirement rather than a specific failure and, given the answers of the witness in live evidence on this issue D4 p.30, this cannot be said to provide any more than background evidence to this charge.

17. However, the references in the Skeleton Argument at §11 and §12 to evidence and transcripts that refer to the September 2019 CTG instance at D4 77-78 (which specifically mentions 2019 incidents in the start of the questioning in cross examination) and D4 93 (in which E/445 is referred to) are simply not relevant to this charge and were never intended to be, as they relate to Charge 11d)ii). Charge 2 relates to the "supervised shifts commencing on 12 October 2016", which is intended to be limited to those supervised shifts on the labour ward in 2016.

Charge 2f):
18. The Registrant makes no reference to the evidence of [Witness 10] at E/448 in which at §2 she makes specific reference to the Registrant "did not seem able to

change a bag of fluids as well-this has improved" . This is sufficient evidence for the same reasons given in the preceding section.

19. The Registrant accurately cites the information provided by [Witness 5] on this charge also E/37 at "clincial skills" [sic]*, second bullet point in which this concern is specifically mentioned, and was confirmed in evidence of the transcripts D3, 122.*

20. The complaint is that the process was slow rather than being unable. It is submitted that the natural wording of the charge is that to be "able" it must be done in a reasonable time, not least because of the fast-paced nature of the Labour Ward. That is caught by the head of the charge, concerning "knowledge, skill and judgment to practise without supervision". To take the argument advanced by the registrant to its natural conclusion, the charge would not cover a situation where the Registrant was only able to change IV bag until after the time for its change was necessary. Such a reading is absurd. In any case, this argument only relates to [Witness 5]' concerns and ignores that of [Witness 10] (see above).

Charge 3e)
21. The Registrant does not dispute that the evidence cited by the NMC in its evidence matrix does not contain information relevant to this charge nor that it is contradicted following cross examination. Instead, the assertion is that the evidence lacks detail. This is wrong in principle because the charge provides the four corners of the level of detail required to prove it. It does not require specifics and there has been no complaint to that charge on a point of law. As such, the principle of the argument is flawed.

22. In any case, there is sufficient detail in those exhibits. See, for example, E/289 at §2 and her comment on transcript D2 p.146-147 where specifics are given as to the place, and that there was more than one occasion. [Witness 5] E/27 "Correct tool…. No" duplicated apparently by an entirely different assessor, namely [Witness 3]

E/272; E/37 assistance needed with electric pumps; and [Witness 10] at E/448 §2 regarding the use of the syringe pump for two months.

23. There is some corroboration for this in the admission to charge 8a) in relation to the fetal heart tool on 20 December 2016 see [Witness 3] at 1/50 §15 and the new charge 18 in relation to the sterile delivery pack see [Witness 7].

Charge 9a

24. The Registrant correctly identifies that this evidence comes from [Witness 11], at 1/11-12 at §10 and E/15. This was not departed form in the evidence in chief where, according to counsel's note, [Witness 11] stated in examination in chief:
It was a long time ago. All I can tell you I'd witnessed it, a mother spoke to me about it and another midwife came to me about it
And in cross examination:
I directly observed this, but I can't recall how many times. Looking at this, it was more than once or twice.
When I was observing R doing these things she was doing them.

25. The charge here is of a very basic nature i.e. the difference between breastfeeding and formula. That is not a matter that requires much elaboration and is so basic as would be expected to be included in any infant feeding discussion.

26. Again, the complaint is that the evidence is vague. This is insufficient to dismiss this charge since the determinative test is not vagueness, rather that is a pre-requisite to the second limb of Galbriath, see above.

27. Additionally, and in much the same way as the charges above, all that is required is within the four corners of the charge which don't allege further detail as now said to be required by the Registrant in her submissions. No objection to the charges has been made on a point of law.

Charge 11d)

28. The Registrant here rehearses the references made to Charge 2d) but relies on the erroneous questioning about escalation and communication (perhaps through misinterpreting charge 2d) as evidence that that was the main concern.

29.

Yet [Witness 7] is clear that there were concerns with the interpretation of the CTG E/445 in a near contemporaneous email. The fact that her recollection had deteriorated in her evidence D4 56-59 (examination in chief) and D4 77-78 (cross examination) and D4 9 (panel questions).

30.

Furthermore, the Registrant's submission entirely ignores the corroborating evidence of [Witness 2]1/6 §12 and E/7 at second bullet point. While, as with [Witness 7], her memory may have deteriorated D2/90-92, 98-99, by the point of giving live evidence on one possible view the Committee could find the earlier evidence highlighting this as one of four specific concerns supplemented by a witness statement confirming this, also closer to the time, as sufficiently reliable and so the submission should be rejected.

Charge 12iv)

31. The direct evidence of this charge comes from [Witness 9] at §18 of her original statement 1/59 and §5 of the supplementary statement 1/65.

32. The Registrant's argument is that this is anonymous hearsay based on the fact that [Witness 9] didn't experience this behaviour directed towards her. There is a key factually difference between [Witness 9] not observing that behaviour herself and [Witness 9] observing the registrants lack of eye contact towards other members of staff. The latter is clearly what has been advanced in 1/65. Counsel's note of cross examination (in which she conceded that this was not something

noted specifically at E/295 and never raised it specifically with the registrant in conversation), did not depart form this, being to the effect of:
Q: R never avoided eye contact in order not to communicate?
A: I never had a problem, we had a good rapport. I did see her with other staff. I don't know the name of the person that raised it with me. No date.
33. The evidence in relation to this charge falls against a background of allegations of lack of engagement with staff about which there is no submission so evidently sufficient evidence to find proved on one view see, for example [Witness 4] §§19-22 and [Witness 8]/03 at E/295.
34. The Registrant further argues if this is anonymous hearsay (which it is not for the reasons specified above), that it should not be admitted. The time for that has passed, this evidence from [Witness 9] as with each witness was identified, confirmed, sworn to and permission granted to be admitted in addition to permission being given to ask supplemental questions.

As a procedural matter, there was no objection to its admission. Rule 31 does not provide for retrospective exclusion of the evidence, albeit perhaps not impossible.
35. The Registrant, as a secondary position to the admissibly point, then invites the Committee to ascribe weight to this evidence per NMC v. White. If the evidence is admitted, the weight to ascribe to it is a matter for a Committee to fully assess at the conclusion of the facts stage. On one possible view it is capable of preferring hearsay evidence and, as such, the submission should be rejected.

Charge 15.
36. The Registrant is correct that the evidence of this charge emanating from [Witness 11] is hearsay. Procedurally, in the same way as above, the evidence has already been admitted and the question should not, therefore, be one of admissibility, it should be one of weight a classic matter left to a "jury" having heard the whole of the factual aspects of the case.

37. The Committee is also invited to take some, albeit understandably limited, support by the actions of [Witness 11] in having received this evidence eg; she was compelled to amend her reference 2/16 and specifically mention this issue. At the time of the report, therefore, it was sufficiently compelling not simply to be remembered later but acted upon immediately and specified.

RULE 24(8) ARGUMENTS:

Charge 1.

38. The central submission is that the Registrant was prevented from completing their competencies by virtue of occupational health advice which therefore acted as a force majeure (see §21 of the Skeleton argument). This is erroneous on the following grounds:

> *a. It entirely neglects the failure of the Registrant to complete her competencies in sufficient time between 2016 and the end of 2017* [PRIVATE] *This was in excess of the usual period granted. Was in the context of additional support being offered in the tail end of 2016 to a significant extent and was beyond the usual time permitted for an ordinary rotation on the labour ward. There was simply no force majeure in this period. What there was, was serious concerns about the safety of women and babies on the labour ward arising from the Registrant's practise. That is sufficient to reject this submission.*
>
> *b. The complaint is made that the support given was flawed and, as such, pursuant to the guidance there was not a fair sample work taken. This is opposed on the basis that what should be the focus of the case is the Registrant's practise, secondary to that is the extent of support given which pursuant to the guidance is one relevant consideration akin to allegations of discrimination (not relevant in this case). The evidence in this case demonstrates genuine efforts to intervene positively in the registrant's practise in late 2016, which although not perfect were, genuine, thought through and were capable of having a positive impact in defined areas of*

concern. They did not have this effect not because they were ill-conceived, cynical or fatally flawed but because of the Registrant's lack of competence.
c. Furthermore, the Registrant's submissions amount to inviting this Panel to adopt the conclusions of a local level finding which is not permissible Enemuwe v. NMC [2013] EWHC 2081 (Admin) at §79.

Charge 13b)
39. The fact of not knowing how to use a breast pump as at 22 January 2020, 2 years and 5 months post qualification excluding [PRIVATE] *and five months and, additionally, after commencing on a specific and discrete infant feeding team is capable of demonstrating lack of competence.*
40. [Witness 4] confirmed that while general midwives could be expected to commonly have concerns, this was a piece of equipment that the registrant should have been able to use on multiple occasions previously D3/42-44, including:
Maybe more surprised that I say that she was asking at that time rather than than [sic] *previously, but other members of staff not on the infant feeding team. Umm*[sic] *often wanted clarification on how the pump would be used.*
See also the reference to "basics" like turning it on and such things "sounding silly" D3/55 and the "caveat" being that the usual midwives were not in the infant feeding team D3/56.

41. While the Registrant's submissions are that [Witness 4] found it positive she was willing to communicate, the fact of her needing the assistance is a separate issue from her ability to use it in the first place.

Charge 14:
42. In light of the circumstances of the Registrant leaving her shift on 28 April 2020 E/295 and the lack of any suggestion of any matters arising from this. It is conceded that this charge is incapable of amount to current impairment.

CONCLUSION

43. For the above reasons, it is respectfully submitted that the evidence relied upon is capable of leading to a finding of the facts being found proved and, in all except charge 14 are capable of amounting to a finding of current impairment. The application should in all respect save for Charge 14, be dismissed."

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

In respect of charge 2d, the panel determined that the first limb of the Galbraith test is not engaged. Noting that this is not a charge where no evidence has been provided. There is evidence concerning this matter from more than one source some of which is more contemporaneous to these alleged events. The panel therefore decided that there is evidence before it on which it could properly make a finding in relation to the facts and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on amendment to charge 2f

The panel invited representations on a proposed amendment to the wording of charge 2f.

The proposed amendment was to provide clarity and more accurately reflect the evidence. The proposed amendment was as follows:

2) "During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;

a. [...]
b. […]
c. […]
d. […]
e. […]
f. Were unable to change bags of I.V. fluid **<u>in the timeframe appropriate for the clinical situation”</u>**

The panel heard from submissions from Mr Hoskins who indicated that he had no objection to the proposed amendment being made.

The panel heard from Ms Shah. She submitted that she did not agree with the proposed amendment. She stated that it would be unfair to you if the amendment were to be made at a stage when the NMC has already closed its case and all of its witnesses have been released. Ms Shah submitted that she cross-examined the witnesses according to the wording of the charges as they were at the time and had the charge been worded to include ‘in the timeframe appropriate for the clinical situation’ she would have questioned the witnesses in relation to this. As such, Ms Shah submitted that it would cause injustice and prejudice to you if the amendment were made at this stage.

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

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to make the amendment of its own volition to accurately reflect the evidence.

In respect of charge 2f, the panel considered that there is some evidence in support of this charge. The panel noted that at this stage, the charge reads:

"2) During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;

[…]

f) Were unable to change bags of I.V. fluid"

The panel considered that the evidence heard was consistent with you being unable to change the bags of intravenous (IV) fluid. The NMC argued and the panel accepted that an inability to carry out a given task (in this instance changing IV fluids) would encompass being able to do so in a timely manner. The concern is clearly related to the risks associated with not being able to carry out a key task competently. The panel therefore considered that an amendment to the charge would provide greater clarity without causing unfairness in the proceedings or prejudice to the registrant as the issue of timing was explored with the relevant witness.

The panel determined that there is evidence before it on which it could properly make a finding in relation to the facts and as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In relation to charge 3e, the panel has had regard to documentation which is more contemporaneous with these events and has heard evidence from more than one witness in relation to this charge. It noted that [Witness 10]'s evidence during the hearing was that she could no longer recall what had happened, but the panel considered that [Witness 10] has also provided a witness statement in relation to this charge presented as her evidence in chief and signed as an accurate and truthful account of events which were fresh in her memory at the time of completion. The panel determined that there is evidence before it on which it could properly make a finding in relation to the facts and as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 9a, the panel noted that it has had regard to documentary evidence from [Witness 11] and has heard live evidence from her that you did not explain the difference between breastfeeding and formula milk. The panel noted that [Witness 11] alleges to have directly witnessed this having occurred and that it had also been reported to her by other members of staff. The panel decided that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In relation to charge 11d, the panel considered that it has heard evidence from [Witness 7] and [Witness 2] who were on the shift at the time and [Witness 7] was supporting you during this shift. The panel decided that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In relation to charge 12 a) iv), the panel considered that there is limited evidence relied upon by the NMC to prove this charge and much of it, if not all, is apparently hearsay evidence from others who cannot now be identified.

The NMC submitted that this issue should be dealt with as a matter of weight rather than admissibility. On your behalf, it was argued that it should be excluded or alternatively given no weight.

The panel was advised as to the clear distinction between admissibility and weight and proceeded on that basis to consider rule 31(1). Specifically, whether the evidence was relevant and if it was fair to admit it into evidence, or more properly in this instance (as it was admitted into evidence without objection) whether it was fair for the panel to continue to rely upon it. In considering the position the panel had regards to the criteria set out in Thorneycroft and the case of White.

Having found the evidence is clearly relevant the panel went onto consider the issue of fairness. The panel concluded that there remains an absence of clarity concerning whether the evidence provided by Witness 9 results from her own first-hand observations or is reliant entirely upon the accounts of other unidentified parties. It is not possible to separate her account as being independent evidence of the alleged facts. It cannot therefore be said with confidence that there is evidence beyond the anonymous hearsay accounts to substantiate this allegation. This evidence is contentious as you deny this charge. As the identities of other relevant witnesses are unknown there is no way for the panel to establish whether there may be any risk of fabrication or otherwise (beyond the absence of any such suggestion in respect of Witness 9) - a factor that clearly and seriously impacts upon your ability to challenge it by for example exploring what may have prompted the accusation in terms of motivation or factual circumstances, and little opportunity to counter it beyond mere denial. The panel noted that in isolation this is not the most serious of regulatory concerns a registrant may face, but nonetheless your fitness to practise is being called into question based on this and other concerns which could therefore have potentially serious consequences if the matter were to be found proved. The reasons for the nonattendance of the witness(es) and any consideration about what reasonable steps had (or could have) been taken to secure their attendance is plain from the fact that their identities remain unknown, and no record appears to have been taken at the time. In all of these circumstances the panel find that it would not be fair to rely on this evidence

Having excluded the hearsay evidence, the panel considered the remaining evidence provided by Witness 9. She stated:

> *"When the registrant did not want to communicate with a member of staff, they would avoid making eye contact."*

In a supplementary statement Witness 9 provided the following clarification:

> *"I mention that the Registrant would avoid eye contact with other members of staff. This is a general observation of the Registrant based on my interactions with her. I am unable to recall specific times when I witnessed first-hand the Registrant avoiding eye contact with other members of staff, but this was a general observation shared by other members of the team."*

The panel therefore considered that the evidence in support of this
charge is wholly ambiguous and therefore of a tenuous character and was of the view that, taking account of all the evidence before it, that no properly directed panel could find the facts of charge 12 a) iv) proved and therefore decided that there is no case to answer in respect of this charge.

The panel noted that as set out in the submissions of both Ms Shah and Mr Hoskins, they refer to charge 15 but the wording of the charge and submissions in fact relate to charge 16. The panel noted that the evidence relied upon by the NMC for charge 16 is that of hearsay evidence and therefore it considered the factors as set out in Thorneycroft. The panel determined that the evidence was not sole or decisive but is denied by you. The panel did not have any evidence to suggest there was any reason to fabricate the evidence. However, it noted that the panel was not aware of who the person who made the initial report of the incident was and therefore could not determine for certain any reason for fabrication. The panel noted that the NMC was not aware of who the original complainant was and therefore considered that it could not determine whether there is good reason for their non-attendance at this hearing and noted that the NMC could not take steps to secure their attendance as they do not know who the person is.

The panel noted that the evidence relied upon by the NMC for charge 16 is anonymous hearsay evidence that was initially admitted unchallenged but latterly disputed and therefore considered the factors as set out in Thorneycroft and the guidance provided in White.

As with charge 12 a) iv) above the NMC submitted that this issue should be dealt with as a matter of weight rather than admissibility. On your behalf, it was again argued that it should be excluded or alternatively given no weight.

The panel was advised as to the clear distinction between admissibility and weight and proceeded on that basis to consider rule 31(1). Specifically, whether the evidence was relevant and if it was fair to admit it into evidence, or more properly in this instance (as it was admitted into evidence without objection) whether it was fair for the panel to continue to rely upon it. In considering the position the panel had regards to the criteria set out in Thorneycroft and the case of White.

Having found the evidence is clearly relevant the panel went onto consider the issue of fairness. The panel concluded that whilst there is other general evidence on this point the hearsay evidence is decisive on the issue of timing and the nature of the conduct alleged. This evidence is contentious as you deny this charge. As the identities of other relevant witnesses are unknown there is no way for the panel to establish whether there may be any risk of fabrication or otherwise – a factor that clearly and seriously impacts upon your ability to challenge it by for example exploring what may have prompted the accusation in terms of motivation or factual circumstances, and little opportunity to counter it beyond mere denial. The panel noted that in isolation this is not the most serious of regulatory concerns a registrant may face, but nonetheless your fitness to practise is being called into question based on this and other concerns which could therefore have potentially serious consequences if the matter were to be found proved. The reasons for the nonattendance of the witness(es) and any consideration about what reasonable steps had (or could have) been taken to secure their attendance is plain from the fact that their identities remain unknown, and no record appears to have been taken at the time. In all of these circumstances the panel find that it would not be fair to rely on this evidence.

The panel therefore concluded that without this evidence there is no evidence on which a properly directed panel could find this charge proved in accordance with the first limb of

Galbraith. The panel decided to accede to the application for no case to answer in respect of charge 16.

In relation to charge 1, the panel had information before it which indicated the period of time which you had available to you to complete the competencies. The panel also had regard to information indicating the periods during which you had taken a leave of absence from work due to sickness. The panel decided that a properly directed panel could find impairment on this charge and, as such, it was not prepared, to accede to an application of no case to answer. What view the panel ultimately takes of this charge in terms of impairment remains to be determined at the conclusion of the impairment stage of this case.

In relation to charge 13b, the panel noted that you made an admission to the factual allegation as set out in charge 13b but dispute that it amounts to a lack of competence. The panel noted that this charge relates to a lack of knowledge on how to operate a breast pump and to consider whether or not your actions amount to a lack of competence, it would need to take into account the context that you were at the time employed in as a midwife in the infant feeding team and any associated risks and impact on the mothers and babies being cared for in not knowing how to manage the breast pump. The panel decided that a properly directed panel could find impairment on this charge and, as such, it was not prepared, to accede to an application of no case to answer. What view the panel ultimately takes of this charge in terms of impairment remains to be determined at the conclusion of the impairment stage of this case.

In relation to charge 14, the panel has heard evidence that you did leave your shift but that this was in line with the agreement and authorisation from a senior member of staff. The panel noted that it is also conceded by the NMC that this charge is not capable of amounting to current impairment and therefore, whilst you have already made factual admissions to the charge, the panel determined that there is no case to answer in respect of this charge amounting to impairment.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Shah, who informed the panel that you made admissions to charges 1, 2a, 2b, 2c, 2e, 3a, 3b, 3c, 3d, 4a, 4b, 4c, 5, 6a, 6b, 7a, 7b, 7c, 8a, 8b, 10, 11a, 11b, 11c, 11d, 11d(i), 12b(i), 12b(ii), 12b(iii), 12b(iv), 13(b), 14, 15a, 15b(i), 15b(ii), 17, 18a, 18b, and 18c.

The panel therefore finds charges 1, 2a, 2b, 2c, 2e, 3a, 3b, 3c, 3d, 4a, 4b, 4c, 5, 6a, 6b, 7a, 7b, 7c, 8a, 8b, 10, 11a, 11b, 11c, 11d, 11d(i), 12b(i), 12b(ii), 12b(iii), 12b(iv), 13(b), 14, 15a, 15b(i), 15b(ii), 17, 18a, 18b, and 18c proved, by way of your admissions.

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

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

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

- Witness 1: Rotational Midwife, Postnatal Transitional Care Ward, Wexham Park Hospital

- Witness 2: Labour Ward Coordinator, Wexham Park Hospital (at the time of concerns)

- Wtiness 3: Head of Midwifery, Frimley Health NHS Foundation Trust
- Witness 4: Band 7 Infant Feeding Lead Midwife at Wexham Park Hospital.
- Witness 5: Band 6 Midwife, Postnatal Ward, Wexham Park Hospital
- Witness 6: Intrapartum Matron, Wexham Park Hospital
- Witness 7: Clinical Skills Facilitator, Wexham Park Hospital (At the time of concerns)
- Witness 8: Inpatients Matron, Wexham Park Hospital
- Witness 9: Consultant Psychiatrist
- Witness 10: Band 6 Midwife, Postnatal Ward, Wexham Park Hospital
- Witness 11: Band 6 Midwife, Postnatal Ward, Wexham Park Hospital

- Witness 12: Director of Midwifery Ward, Wexham Park Hospital

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered all the oral and documentary evidence provided by both the NMC and you.

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

Charge 2d

2) During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;

d. Were unable to escalate concerns to senior staff members

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence as well as the oral evidence.

The panel had regard to the near contemporaneous local statement provided by Witness 10 to Witness 6 in which she stated: *"Rachel does not seem to escalate to senior staff when there is any deviation from normal".*

The panel also had regard to the written statement of Witness 6 in which she stated:

> "[Witness 10] *was concerned that the Registrant was unable to escalate their concerns to senior staff members when any situation deviated from normal."*

It also took into account that after having worked with you and attempting to complete an assessment of your practice, Witness 3 emailed Witness 6 highlighting her concerns. She stated that one of the themes of concern with your competence and safe practice was: "*4) Uncertainty with independent ability to escalate effectively if incorrect care plan made"*

The panel also had regard to the mid assessment which was completed by Witness 5 in which she stated: *"Above findings reached in discussion between* [Witness 5 & Witness 10]*. Both feel that Rachel lacks insight and unaware of when care deviates from normal/need to escalate."*

The panel considered that the documentary evidence which supports this charge is all near contemporaneous documentation produced by a group of more experienced midwives who were selected by Witness 6 to support, monitor and observe your practice.

The panel noted that these midwives were informed at the outset that the purpose of their involvement was to observe your practice and support you in your transition to becoming an autonomous midwife. The panel noted that the comments documented from these witnesses about your ability to escalate concerns to senior staff members were not based on a reflection after a period of time but based on observations at the time. Further, it noted that these comments relate to observations undertaken by more than one midwife working with you on different shifts and that each of them independently came to the same conclusions.

Based on the evidence before it, the panel determined that, on the balance of probabilities, it is more likely than not that you were unable to escalate concerns to senior staff members. It therefore finds this charge proved.

Charge 2f

2) During one-to-one supervised shifts commencing on 12 October 2016, on one or more occasion;

f. Were unable to change bags of I.V. fluid in the timeframe appropriate for the clinical situation

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence as well as the oral evidence.

It had regard to the near contemporaneous local statement provided by Witness 10 to Witness 6 in which she stated: *"[Rachel] did not seem able to change a bag of fluids as well-this has improved subsequently"*.

The panel also had regard to the written statement of Witness 6 in which she stated:

> "[Witness 10] *was also concerned that the Registrant was having problems operating the electronic intravenous pumps on the Labour Ward and changing bags of I.V. fluid. These are very simple skills that the registrant should have been able to do, particularly as they had been in the role for 2 months by this point"*

The identified cluster skill of *"In the course of their professional midwifery practice, supply and administer medicinal products safely and in a timely manner, including controlled drugs"* included "*skills needed to administer safely via various means, eg, oral, topical, by infusion, injection, syringe driver and pumps*" was not yet achieved when you met with Witness 3 in December 2016.

The panel had regard to the near contemporaneous statement of Witness 5 dated 1 January 2017 in which she stated in respect of her clinical skills, *"Rachel still has difficulty in mastering some basic midwifery skills. […] There are some procedures Rachel is able*

to competently do eventually, but extremely slowly. For example catheterisation, drawing up IV drugs."

During her evidence, when Witness 5 was asked by the panel whether speed was of the essence when I.V. fluid bags needed to be changed, she responded:

> *"…yes, it can do if you're in a situation where a woman's collapsed if she's haemorrhaging or, […] blood pressure suddenly drops, […] and there's a concern over the baby's heart rate and you need to give the woman some fluid quickly to help correct the baby's heart rate and or if you are going to theatre and an emergency situation for a category one caesarean. […] Those kind of things you need to be able to put up fluid quickly."*

When Witness 5's evidence was cross-examined by Ms Shah, she stated:

> *"it was more the speed that she was able to do then.*
> *[…]*
> *it would take a lot longer than what I would expect from another newly qualified midwife."*

The panel took into account your evidence. It had regard to your written statement in which you denied being unable to change the bags of I.V. fluid. You stated:

> *"40. It is not clear to me from the NMC evidence as to whether this relates to a specific occasion, or what aspect of changing a bag of I.V. fluid I was unable to do.*
> *41. Changing bags of I.V. fluid on a drip stand has always been one of the tasks that I have always been competent at since my days as a support worker, student midwife as well as a qualified midwife.*
> *42. This concern has never been raised with me as a qualified midwife, and it was not noted as one of my training/development needs."*

The panel considered that, on the basis of the evidence before it, being able to change bags of I.V. fluid implies that the person carrying out the change would be able to do so in an appropriate time frame. The panel has found that the NMC's evidence has been consistent in that it clearly indicates that you were unable to change bags of I.V. fluid with a level of speed commensurate to the clinical situation. The panel concluded that, on the balance of probabilities, it is more likely than not, you were unable to change bags of I.V. fluid in the timeframe appropriate for the clinical situation. It therefore finds this charge proved.

Charge 3e

3) Were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in the following areas;

e. Use of medical equipment

This charge is found proved.

In reaching this decision, the panel took into account the notes taken by Witness 3 of the local meeting which took place on 11 October 2016. Witness 3 states:

> *"Rachel is not confident in practice with knowing when or why to use a sonic aid or CTG for accessing fetal wellbeing:- low risk women on CTG and small for gestational age with static growth sonic aid."*

The panel had regard to the mid-point assessment form completed by Witness 5 which under clinical skill read: '*Racheal*[sic] *can select to best tool for the job and understand why; for example – CTG or FSE'*. In response to this field, for each of the following criteria's '*consistently', 'independently', 'skilfully' and 'safely'*, Witness 5 had assessed you as not being able to do so.

The panel had regard to the document entitled '*Rachel's programme whilst having plus 1 named mentor support on labour ward*'. On 10 December 2016 in the section which read '*Correct tool, location, skill, documentation, speed and communication for the situation; is selected with understanding of why those decisions were made'* it was not signed that you had achieved these criteria.

The panel also had regard to the email from Witness 3 to Witness 6 which stated:

> *"Theme of issues with competency and safe practice:-*
> *Primarily the confidence with Rachel to practice independently by not requiring support or prompting to:-*
> *1) […]*
> *2) Choosing the correct tool for care need (high or low risk, MAC or LW,)"*

The panel noted that there is supporting evidence from your earlier admissions in relation to your proficiency in the use of catheters, delivery packs, sterile gloves, syringe pumps and fetal heart monitoring equipment.

Based on the evidence before it, the panel concluded that, it is more likely than not that you were unable to demonstrate proficiency in/complete your programme whilst having plus 1 named mentor support on the Labour Ward between 12 October 2016 and 28 December 2016, in respect of your use of medical equipment. It therefore finds this charge proved.

Charge 9a and 9b

9) On unknown dates, whilst providing care to one or more new mothers;
 a) Did not explain the difference between breastfeeding and formula milk.
 b) Did not explain that formula milk is heavier and could inhibit a new-born's ability to want to feed from the breast.

These charges are found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 11.

The panel had regard to the Witness 11's witness statement to the NMC in which she stated:

> *"I had also had a chance to observe how the Registrant communicated with patients and how they discussed and helped the new mothers with their breastfeeding. Typically new mothers are quite tired and if the new-born infants does not latch easily to their breasts they may ask for a formula milk instead. If this occurs it is our responsibility as a Midwife to explain to the patient why the new-born infant may be acting in this way, and explain to differences between breast milk and formula milk. One of the issues with formula milk is that it is heavier than breast milk and if given to a new-born whose mother wants to breast feed it can inhibit babies natural response as baby is fuller longer and may not want to feed from the breast so easily. I observed that the Registrant did not explain any of this to patients and tended to just give the new mothers a formula. This goes against the work and ethics of the midwives. The Registrant seemed quite detached during her talks with the patients. I was concerned that the Registrant did not appear to be functioning as a qualified midwife should be."*

During her oral evidence, Witness 11 acknowledged that this occurred a long time ago but maintained that she had witnessed and observed that you had given formula to women who wanted to breastfeed. During cross examination she maintained that she had observed this but could not recall the number of times, she stated that it would have been once or twice.

The panel considered the evidence of Witness 4. In her witness statement she stated:

"Often after the Registrant had conversations with patients I felt that I had to check with the mothers that they knew what to do. I did not trust the Registrant to provide patients with all of the necessary information in feeding.

[…]

On paper, the Registrant could meet the standards of what we needed on Ward 22 from a Midwife. […]. There was however a large deficit between this and the everyday practise of a Midwife. The Registrant struggled to multi-task, assess risk, and meet the needs of the mothers and babies. The Registrant did not seem to meet the emotional requirements of patients and offer confident, knowledgeable support that was evidenced based and indicative of an Infant Feeding Midwife."

The panel had regard to Witness 11's email to Witness 6 dated 15 September 2020 in which she stated:

"I have spoken with four women Rachel has cared for and they have all been very positive towards her. She is providing the care she is documenting. […] However, when it comes to breast feeding support I feel Rachel is too keen to suggest giving formula top ups and as she has been with as she has been with the BF team for such a long time this suggests that Rachel is not retaining or abiding by the national guidance."

The panel considered the evidence of Witness 4. It noted that she is not the key person who speaks to this charge but that her evidence has been consistent with other evidence in support of this charge. Overall, the panel found Witness 4's documentary and oral evidence to be fair and balanced and it noted that she gives positive feedback about any improvements about your practice where relevant. The panel therefore found that Witness 4's evidence to be reliable and credible.

The panel found that Witness 11's oral evidence was consistent with her documentary evidence which provides a significant level of detail. The panel concluded that, on the

balance of probabilities, it is more likely than not that whilst providing care to one or more new mothers, you did not explain the difference between breastfeeding and formula milk and did not explain that formula milk is heavier and could inhibit a new-born's ability to want to feed from the breast. The panel therefore finds these charges proved.

Charge 11d (ii)

11) On 16 September 2019 whilst providing midwifery care to Patient X;
d) were unable to demonstrate proficiency in;
ii) CTG interpretation/Change of care plan

This charge is found proved.

In reaching this decision, the panel took into account the near contemporaneous email from Witness 7 to Witness 6 dated 18 September 2019. The email is dated 2 days after the incident is alleged to have occurred. In the email, Witness 7 stated:

> *"Reduced variability present on CTG – there were concerns in regards to the trace, Oxytocin was stopped while the patient was having an epidural. Rachel wanted to recommence the Oxytocin drip and asked me at which rate should have been recommenced.*
>
> *Having concerns with the trace I was expecting Rachel to at least explain to the patient and relatives the reason why before re-commencing the drip it was better to inform the obstetric team and midwife in charge. I just felt that the midwifery aspect was missing. I would expect any midwife to recognise when a trace is suspicious at the time and to escalate."*

The panel also had regard to the email from Witness 2 to Witness 6 dated 12 November 2019 in which she stated:

"I am escalating a concern [to] you about a midwife, Rachel Muchoki, who was working on Labour Ward on the 16th September.

Main Concerns:

- *[…]*
- *CTG [Interpretation]/changing plan of care"*

The panel considered that there have been detailed accounts by Witness 2 and Witness 7 about their concerns about you not being able to demonstrate proficiency in CTG interpretation/Change of care plan. Further, the panel noted that the evidence from Witness 2 and Witness 7 was consistent with each other.

The panel noted that you did not have a clear recollection of this and when asked about this during your evidence you would refer back to the period before the epidural and at no point made any comment about the changing of the plan of care.

On the basis of the evidence before it, the panel concluded that, it is more likely than not that you were unable to demonstrate proficiency in CTG interpretation/Change of care plan. The panel therefore finds this charge proved.

Charge 12a (i) and (iii)

12) Between October 2019 and April 2020, whilst working on the Infant Feeding Team,

a) Did not communicate with colleagues/management adequately, in that you, on one or more occasion;

i) Did not approach your line manager to discuss care plans.

ii) […]

iii) Did not discuss or request feedback

These charges are found proved.

In reaching this decision, the panel took into account the documentary and oral evidence from Witness 4.

In her witness statement, Witness 4 states:

> *“Communication plays a large role in Midwifery, and the Registrant's communication skills were very limited. We often deal with a wide range of the population on Ward 22 and I do not think that the Registrant was able to read the different situations and people very well, and the Registrant frequently failed to meet the needs of the patients. [...]. There was no communication from the Registrant regarding feedback and they did not engage well with how they were doing.”*

During her oral evidence, Witness 4 explained that there were instances when women were referred to her, that you had seen previously, but that you did not communicate to Witness 4 what the patient care plans were as she would have expected.

The panel had regard to the local statement from Witness 4 dated 22 April 2020 in which she stated:

> *“Regarding her role as a band 5/6 midwife in our team I would suggest that she has unfortunately not met the requirement of a midwife over the past 6 months. Rachel does not communicate effectively with her team members, colleagues and sometimes women in her care. It is not that she is rude in her communication it is more a significant lack of communication. Rachel doesn't come to me on shift to discuss cases or plans of care and staff have fed back that she doesn't work as part of the team, appearing distant and disengaged.”*

The panel noted the meeting minutes from 28 April 2020 between Witness 8, Witness 4 and Rachel "*The concerns raised with Rachel were that Rachel rarely gives feedback on the feeding care plan for the women to the woman nor to the ward staff / feeding*".

The panel also had regard to the local update from Witness 4 dated 27 May 2020 in which she stated:

> *"Following the cancelation of the Rachel's previous meeting scheduled for May 5th Rachel and I have met today to review how things were going.*
>
> *Since our meeting between* [Witness 8], *Rachel and myself on April 28th I have noted that Rachel has made a clear effort to improve her communication within the team and on the postnatal ward. Rachel interacts more as part of the team socially and has come to me with care plans or asking for a 'senior review' for mothers and babies she has been concerned about. I have commended Rachel for her efforts."*

The panel considered that the update in May 2020 demonstrates that Witness 4 was providing a fair and balanced review based on what she observed of your practice and acknowledged any improvements she could see. The panel therefore found that her evidence was reliable and that she was a credible witness.

The panel determined that, on the basis of the evidence before it, it is more likely than not that between October 2019 and April 2020 you did not communicate with colleagues or management adequately, in that you, did not approach your line manager to discuss care plans and did not discuss or request feedback on one or more occasions. The panel therefore finds these charges proved,

Charge 12a (ii)

12) Between October 2019 and April 2020, whilst working on the Infant Feeding Team,
   a) Did not communicate with colleagues/management adequately, in that you, on one or more occasion;
   ii) Did not work as part of the team.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

During her evidence, when cross-examined, she indicated that allegation arose from general concerns from other members of staff about your communication within the team.

The panel had regard to the local statement from Witness 4 dated 22 April 2020 in which she stated:

> *"We first and foremost wanted to ensure that Rachel was well and felt supported and happy at work as a number of staff had mentioned that she was not interacting as part of a team and seemed despondent."*

The panel noted that Witness 4's evidence does not suggest that she herself witnessed you not having worked as part of the team and therefore the limited evidence in support of this charge is that of anonymous hearsay evidence.

The panel noted that this evidence is relevant to the charge and is the sole and decisive evidence in support of the charge.

The panel went on to consider the issue of fairness. The panel considered that there is an absence of information relating to the unidentified parties who reported these concerns including details about the specific instances where they say you did not act as part of a team. The panel noted that you deny this charge and as the members of staff concerned are unidentifiable there is no way for the panel to establish whether there may be any risk of fabrication or otherwise. Further, the panel noted that there is no way for the anonymous hearsay to be properly challenged. The panel noted that in isolation this is not the most serious of regulatory concerns a registrant may face, but nonetheless your fitness to practise is being called into question based on this and other concerns which could therefore have potentially serious consequences if the matter were to be found proved. The reasons for the nonattendance of the witness(es) and any

consideration about what reasonable steps had (or could have) been taken to secure their attendance is plain from the fact that their identities remain unknown, and no record appears to have been taken at the time. In all of these circumstances the panel find that it would not be fair to rely on the anonymous hearsay evidence.

The panel concluded that the NMC has not discharged its burden of proof in respect of this charge. It therefore concluded that this charge is found not proved.

Charge 13a

13) Around 22 January 2020;

a) Provided formula milk to a new mother without attempting to teach/support breastfeeding.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it which included the email from Witness 4 to Witness 8 dated 22 January 2020. In this email, Witness 4 stated:

"[…] We then asked Rachel to read and comment on the Friends and Family test where a patient had noted she felt Rachel was 'uninterested and uninformed'. Rachel feels these comments might be due to her needing to see another woman from community whereby Rachel was pulled away but given breastfeeding help by Rachel. However Rachel says the lady asked her for formula milk. This does conflict with what the mother and other staff members have stated.

I have offered Rachel further breastfeeding training if she feels like she would benefit from this but Rachel suggest the only thing she feels unconfident about is using a breast pump […]"

The panel had regard to the local statement from Witness 4 dated 22 April 2020 in which she reiterated the comments as above.

The panel had regard to Witness 4’s witness statement which stated:

> *“On 22 January 2020 I held a meeting with the Registrant and Witness 11 regarding concerns that had been raised to me about the Registrant. The concerns were initially raised to me after I had a friends and family feedback card handed to me. It was Person 2, a MSW, that handed the card to me, although I cannot remember when this was. A friends and family feedback card is a feedback form that is completed by women when they are being discharged or moved to another area of the Hospital. The feedback enables us to gather an idea of the level of care and support that they had been given.”*

The panel noted that it has heard during evidence from Witness 11 that she had witnessed you giving formula milk to new mothers without offering breastfeeding support.

The panel had regard to your witness statement in which you indicated that you deny this allegation. You explained:

> *“153. On this occasion I recall I offered the woman breastfeeding support.*
> *154. On this occasion as the mother was reluctant to engage, I found it difficult to understand what her choices were as she was not open with me.”*

When asked about this incident at a local level during a capability hearing on 17 September 2020, you responded: “*I have not had any women request for formula”*

During your oral evidence, when cross-examined, you stated that at no stage where you asked by the woman for formula milk which contradicts what Witness 4 reports that you told her. In your evidence you explained that the interaction between you and the new mother and family was difficult. The panel noted that your evidence in relation to this

charge has been inconsistent and unclear as to whether or not you were asked for formula milk or not.

However, the panel considered that this allegation arises from an unknown patient having handed a feedback card to Person 2 who handed the card to Witness 4. It considered that there has been information from you that the communication between you and the family of this patient was difficult. The panel took into account that there is a lack of information about the details of the patient, the intent behind the report by the patient and any relationship issues that arose during the interaction. The panel had no way to explore these matters and whilst it had information before it of similar behaviours by you, it did not have sufficient evidence that was specific to this incident.

The panel considered that there is a lot of surrounding circumstantial evidence that is capable of suggesting propensity in relation to this charge and that your evidence about what happened is inconsistent. However, it noted that propensity can only support a charge but cannot prove it. The panel noted that there is clear evidence from you and from the NMC's witnesses that you provided formula milk to the mother but there is insufficient direct evidence which speaks to this incident on this specific date that you did so without having attempting to teach or support breastfeeding. The panel therefore concluded that the NMC has not discharged its burden of proof in respect of this allegation and finds the charge not proved.

Charge 15c (i)

15) On 11 September 2020

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

i) Failed to pull/press the emergency call bell.

This charge is found proved.

In reaching this decision, the panel had regard to the Trust's investigation report dated 30 October 2020 in which Witness 8 reports;

> *"I reminded Rachel that the mother had called Rachel asking for help, saying her baby was blue, I asked Rachel can you recollect what you did? Rachel responded saying initially the baby was blue but on reading the notes of the meeting asked for this to be changed to say the baby was not blue. […] When I said to Rachel "you left the room"? Rachel responded saying "to look for a midwife to get a history. Rachel's RCM representative then asked Rachel if she got help from the midwife outside of the room, Rachels response was that the baby was struggling to breath[sic] and she left to get a stethoscope and a thermometer.*
> *[…]*
> *When I asked Rachel why did she not press the emergency bell Rachel responded that the baby was pink, (See Appendix 3). This response contradicts her statement the "baby was struggling to breath[sic]*
> *My concern is that when faced with a potential emergency as in this case where the mother had told Rachel that her baby was blue, my expectation from Rachel would have been is to shout for help and or activate the emergency call bell"*

The panel found that Trust investigation report was the most contemporaneous record of your account of the incident. It noted that within the report it is recorded that you have provided a varying account of whether the baby appeared blue or not. The report informs the panel that you initially described the baby as appearing blue and upon reflection of the notes asked for this to be changed. Further, the report goes onto inform the panel that you believed the baby was struggling to breathe but this does not accord with your later account that the baby appeared pink.

The panel considered that whilst Witness 1's description of the baby was consistent with your later suggestion that the baby was pink, this was some time after the initial report. The panel was of the view that your initial responses to these events and subsequent responses during earlier stages of these proceedings are more likely accurately to reflect

what happened and should therefore be afforded greater weight. The panel is of the view that it is more likely than not that the baby was blue and/or having breathing difficulties as you initially reported.

The panel concluded that it was more likely than not that Baby C appeared to be blue and/or was having breathing difficulties based on your comments outlined in the Trust investigation report.

The panel considered whether there would be a duty on you to have pressed the emergency call bell on being informed or noting that the baby was appearing blue or having breathing difficulties.

The panel heard evidence from Witnesses 1, 8 and 11 who all confirmed that if there were concerns about the baby's breathing or if the baby was appearing blue, the emergency call bell should have been pressed and assistance would need to be called for.

The panel had regard to the consultant psychiatrist report dated 22 February 2022 which addressed the interview with you that took place on 3 December 2021. The report states:

> *"Miss Muchoki stated, in regard to her alleged failure to manage and act on a deteriorating baby, that she now understands she should have pressed the emergency bell instead of carrying out her own further investigations or leaving the site to seek additional equipment. She also recognises that she should have accessed and reviewed the patient's and the baby's notes.*
> […]
> *With regard to the baby's skin colour change, she said that she has thought it 'not that bad', however the baby was vomiting and she now recognises that she should have pressed the emergency button."*

During your evidence, you were presented with a statement by you which was produced in preparation for an NMC interim order hearing in November 2020. In the statement you said:

> *"On reflection, with regard to the incident where it is said that I failed to manage and act upon a deteriorating baby, I understand now that it would have been more appropriate if I had pressed the emergency call bell for assistance, instead of trying to do further observations on my own, or leaving the mother and baby to seek additional observational equipment."*

You responded to this statement and explained that your reasons for the comments above were because you had hoped that if you had said the right thing the regulatory concerns would not have gone any further. However, the panel concluded that the evidence before it suggests that there was a need for the emergency call bell to be pressed and that in writing the statement above, you recognised that there was a requirement to do so. In addition, the panel found that the comments in the statement above is broadly consistent with the comments by you recorded in the Trust's investigation report and the consultant psychiatrist report.

On the basis of all the evidence before it, the panel concluded that it is more likely than not that you failed to pull/press the emergency call bell after noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing. It therefore finds this charge proved.

Charge 15c (ii), (iii), (iv) and 15d

15) On 11 September 2020

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

ii) Did not assess Baby C's breathing.

iii) Did not assess Baby C’s airways.

iv) Did not assess Baby C’s circulation.

d) When asked by Colleague Y if you had taken any action regarding Baby C colour/breathing difficulties, you responded using words to the effect ‘Nothing it is your lady’.

These charges are found proved.

In reaching this decision, the panel took into account your evidence during which you stated that you had observed the baby as being pink in colour and felt warm to touch. You stated that you had monitored the baby’s respiration rate but there has been no documentary evidence which supported this. You explained that you counted the respirations using your mobile phone and that you concluded the respiration rate of the baby was normal. You said that you put the baby in the neutral position on the bed to assess for any blockages in the airway.

This evidence, however, was not consistent with your earliest account of these events when you did not mention any of these steps, which led the panel to have some doubts about the accuracy of this version of events.

The panel had regard to the written statement by Witness 1 in which she stated:

> *“The Ward had accepted a baby that had been moved from the Special Care Unit who had breathing difficulties when they were born… The mother of the baby, Patient B was very anxious about the health of the baby. I was the allocated Midwife to Patient B and the baby…*
> *At approximately 01:30pm I prepared the baby for phototherapy. Phototherapy is used when babies are jaundiced….*

At this point I conducted a full examination of the baby and had no concerns Patient B's partners expressed that he was anxious and I reassured him by instructing them to shout for us or ring the call bell if she had any concerns…
At approximately 02:30pm… The Registrant approached me and asked me "Are you looking after Side room 3?" I replied yes and that is when the registrant informed me that Patient B had told the registrant that her baby was not breathing properly and that they were worried about the baby's colour/ the significance of the baby being 'blue' is that they are not taking in adequate amounts of oxygen. There was no sense of urgency in the Registrant and so I asked what the Registrant had done to the baby. The Registrant replied "Nothing, it is your lady".

During her oral evidence, Witness 1 maintained that there was no sense of urgency in the manner in which you approached her during this incident and that you did not tell her that you had conducted any observations on the baby.

The panel had regard to the minutes of the meeting with Witness 8 dated 21 October 2020 in which you stated:

> *"Can I clarify that baby was not blue […] I called [Witness 6] we went into together. They did temp and resps I was assisting got the sats ocimeter to connect for baby. Put in neutral position."* When asked whether you had left the room, you stated *"to look for the midwife".*

The panel noted that the most contemporaneous record of a discussion with you about this incident informs the panel that you left the room and after returning into the room with Witness 1 the baby's temperature and respirations were assessed by her and another staff member. This corresponded with Witness 1's account of the incident that you had not conducted any of the assessments as set out in the charge and when asked by her what you had done, your response was "Nothing, it is your lady".

During her oral evidence, Witness 1 maintained that you used the words “Nothing, it is your lady.” She explained that *“those words are the words that actually prompted me to get up and and* [sic] *respond because I thought nothing had been done with the patient.”* The panel noted that Witness 1 provides a clear account of her recollection of what was said and includes detail about her response to the words.

The panel considered that whilst your evidence is that you conducted the observations, you did not inform Witness 1 that you had conducted any observations either at the time when you first spoke to her or when she rushed away to Baby C. The panel found that this does not sit easily with your later account of events.

The panel concluded that, based on the evidence before it, on the balance of probabilities, it is more likely than not that you did not assess Baby C’s breathing, airways and circulation. Further, the panel found that when asked by Colleague Y if you had taken any action regarding Baby C colour/breathing difficulties, it is more likely than not that you responded using words to the effect ‘Nothing it is your lady’. The panel therefore finds these charges proved.

Charge 15c (v)

15) On 11 September 2020

c) After noting/being informed that Baby C was looking ‘blue’ in colour/having difficulty breathing, did not adequately escalate Baby C’s condition, in that you;

v) Did not move Baby C to the resuscitaire.

This charge is found proved.

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

"When I arrived at Side Room 3 the baby was pink and kicking and screaming which is an indicator that the baby was fine. As Patient B was anxious I took the baby to the Resuscitaire Room to reassure her."

During her evidence, Witness 1 explained that if there had not been the anxiety from Patient B, she would still have taken the action that she did. She stated:

"I would still take the baby to the resuscitaire because of the history that had been given just to ensure that the oxygen levels were at the correct requirement that the baby was OK to do a full examination."

In your statement, you stated:

"I assessed baby and there were no concerns at present or indication for resuscitation. I wanted to do observation on baby to reassure the mother. Therefore, I left the room, advising the mother I was going to get Thermometer and stethoscope to do a full set or observation and reassure as well as patient notes. As I was working to the nursing station I saw Witness 1, and asked her if she was looking after baby C inside room 3. I spoke to Witness 1 regarding, concerns mother of Baby C had raised about her baby. I did not say to Witness 1 I observed baby being blue or that I observed baby having breathing difficulties. I was trying to convey to Witness 1 what the mother reported to me and told Witness 1 what I had done. However, as soon as Witness 1 heard baby blue and breathing difficulties, she ran to Side room 3 and may not have heard everything I said. She did not ring the emergency bell after she went to the room. She decided to take baby to the resuscitaire and instructed me to tell Person 1 to come to the rescuscitaire."

The panel noted that it has already determined that, on the balance of probabilities, Baby C appeared blue and/or presented with breathing difficulties.

The panel determined that, on the basis of the evidence before it, after being informed of Baby C's presentation by the parents, you did not take the baby to the resuscitaire. Your evidence is that Witness 1 took the baby to the resuscitaire, and you had no concerns at the time and did not see any indication for resuscitation.

Based on the evidence before it, the panel finds this charge proved.

Charge 15c (vi) and (vii)

15) On 11 September 2020

c) After noting/being informed that Baby C was looking 'blue' in colour/having difficulty breathing, did not adequately escalate Baby C's condition, in that you;

vi) Went to look for Colleague Y/the Midwife in charge of Baby C

vii) Went to look for a stethoscope/thermometer

These charges are found proved.

In reaching this decision, the panel took into account all of the documentary evidence.

In your statement, you stated:

"I assessed baby and there were no concerns at present or indication for resuscitation. I wanted to do observation on baby to reassure the mother. Therefore, I left the room, advising the mother I was going to get Thermometer and stethoscope to do a full set or observation and reassure as well as patient notes. As I was working to the nursing station I saw Witness 1, and asked her if she was looking after baby C inside room 3. I spoke to Witness 1 regarding, concerns mother of Baby C had raised about her baby. I did not say to Witness 1 I observed baby being blue or that I observed baby having breathing difficulties. I was trying to convey to Witness 1 what the mother reported to me and told Witness 1 what I had

done. However, as soon as Witness 1 heard baby blue and breathing difficulties, she ran to Side room 3 and may not have heard everything I said. She did not ring the emergency bell after she went to the room. She decided to take baby to the resuscitaire and instructed me to tell Person 1 to come to the resuscitaire."

The panel had regard to the local statement by Witness 1 dated 30 October 2020 which stated:

"Rachel Muchoki approached me after searching the ward to find me to inform me that Patient B and her partner were worried about their babies' colour and that he wasn't breathing properly. i asked Rachel what she had done and where the baby was. Rachel didn't look concerned, nor did she find me or any other member of staff in urgency. She replied and said that she hadn't done anything as I was the midwife looking after the baby, so she decided it was best to try and find me to deal with the emergency myself."

The panel had regard to the Trust's investigation report dated 30 October 2020 in which Witness 8 reports;

"Rachel described how she left the side room where the baby was with his mother to go and look for midwife Witness 1, […], who was caring for the TCU babies that day. This account is similar to the account RM Witness 1 has given in her statement […]
When I said to Rachel "you left the room"? Rachel responded saying "to look for a midwife to get a history. Rachel's RCM representative then asked Rachel if she got help from the midwife outside of the room, Rachels response was that the baby was struggling to breath[sic] and she left to get a stethoscope and a thermometer."

On the basis of the evidence before it, the panel concluded that you did leave the room to find Witness 1 to obtain a patient history which you stated in your most contemporaneous account. This corresponds with Witness 1's evidence.

The panel further noted that your account at a local investigation interview was that you left the room to get a stethoscope and a thermometer and in your statement to the NMC you reiterated this.

The panel therefore finds these charges proved.

Charge 15e

15) On 11 September 2020
e) Did not know how to use a SATS monitor.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it which included the written statement of Witness 11 in which she stated:

> *"The emergency alarm had been pulled by Witness 1 and a new-born infant had been taken to the Resuscitaire machine. When I arrived at the Resuscitaire, Witness 1 and another midwife whom I cannot remember were already there and were performing an examination of the infant. The Registrant was standing to one side of the Rescuscitaire machine and I asked them if they were okay. The Registrant just looked at me and it said yes. I cannot remember who, but someone asked the Registrant to perform a task and I think this may have been to put a SATS monitor on the infant. A SATS monitor measures the oxygen levels and this was needed because the new born infant was allegedly blue, indicating a lack of oxygen It appeared at this point that the Registrant did not know how to use the SATS monitor and they were unable to support Witness 1 who was examining the new-born infant.*

As a qualified Midwife the Registrant should have been able to put the SATS monitor on. If a new-born infant has an episode, then it is important that the Midwifery team are able to determine the infant's oxygen saturation levels. If the oxygen saturation levels are not in a normal range then this may give some indication why the infant is having an episode and enables the examining Midwife to act on it. The baby recovered and no harm was done."

The panel had regard to the local statement by Witness 11 in which she stated:

"Also on 11/09/20 the emergency bell was sounded and a baby rushed to resuscitaire.
RM Muchoki ran to the room but instead of offering help I observed her standing and watching. When asked to assist she did not appear to understand what was being asked of her."

During her oral evidence, Witness 11 stated that there was nothing unusual about the SATs machine and that when asked to use the SATs monitor you froze in response, stood very still and stared. She stated that as you were stood by the SATs monitor you were asked to put it on and when asked you just stood there as if you were caught in the moment and did not know what to do. She stated that you were asked a couple of times until someone else had put the SATs monitor on. She clarified that it could not have been the case that you did not hear this request being made as the alarm bell was not going off, the room was quiet and everything was in control.

This evidence was consistent with Witness 1's local statement in which she stated:

"I took him to the Resusitaire where I was joined by my colleague Person 1. We could see that the baby looked visually well, pink, active and had a normal heart rate, breathing rate and saturations. Rachel stood behind myself and Person 1 without supporting or helping with the situation. The baby was very quickly returned to the parents and they were reassured at that time."

In your statement you denied this allegation and stated:

> *"191. I recall I attached a Term SATs monitor Baby C which was on the resuscitator, and it was not picking up SATS. I recall initially using a baby Term SATS probe but during observation on the resuscitator, Witness 1 reported baby was Pre-term. I recall requesting a Maternity support worker to get a Pre-term SAT's probe and I was able to pick up SATs which were normal 98%"*

The panel had regard to the oral evidence of Witness 11 that the pre-term SATS probes were kept on the resuscitaire, and the stock on the resuscitaire was checked daily. Witness 11 told the panel that the spare stock of preterm SATS probes were kept in a cupboard in the room where the resuscitaire was situated.

In oral evidence you told the panel that the MSW that you asked to get a preterm SATS probe left the room and came back with one.

The panel noted that there is more than one account of this incident informing it that you froze and did not assist. The panel further noted the inconsistency of your account that the MSW left the room to obtain the preterm SATS probe when a senior midwife who has significant experience of working on the ward told the panel that they are stored in the room that you were in.

The panel considered all the evidence before it and concluded that, on the balance of probabilities, it is more likely than not that you did not know how to use a SATs monitor.

The panel therefore finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amounted to a lack of competence and/or by reason of a [PRIVATE] in regard to charges 10-15 and 17, if so, whether your fitness to practise is currently impaired by reason of the lack of competence and/or by reason of a [PRIVATE]. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence and/or [PRIVATE]. Secondly, only if the facts found proved amount to a lack of competence and/or [PRIVATE], the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or [PRIVATE].

Submissions on lack of competence and [PRIVATE]

The NMC has defined a lack of competence as:

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

Mr Hoskins provided written submissions which included the legal position to the panel in which he stated:

‘*4. As indicated during submissions and following legal advice at the submission of no case to answer stage it is submitted that the following directions of law apply in this case:*

a. That there is no burden placed on either party at this stage, it is a matter of the professional judgment of the Committee.

b. One of the allegations of impairment is by virtue of lack of competence pursuant to Article 22(1)(a)(ii) of the 2001 Order. The central question is whether there was "an unacceptably low standard of professional performance, judged on a fair sample of [her] work, which could put patients at risk" per Calhaem v. GMC [2007] EWHC 2606 (Admin) and R(obo Remedy UK Ltd) v. GMC [2010] EWHC 1245. One relevant consideration to the issue of lack of competence specifically mentioned in the guidance is whether there exists "a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation".

c. [PRIVATE]

The NMC has also produced guidance on the role of [PRIVATE] *in a potential finding of impairment (Reference FTP-2d).*
That provides in relevant part:

i. [PRIVATE]*"*
ii. [PRIVATE]

d. The relevant "test" for current impairment whether looked at through the lens of lack of competence or [PRIVATE] *was outlined in CHRE v. NMC and Grant [2011] 3 EWHC 927 (Admin), previously provided to the Committee. So too is the citation and guidance from Meadow about the approach of taking account of actions in the past in order to form a view of Ms Muchoki's*

fitness to practise today. The only gloss on the case of Grant (a misconduct case) when applied to allegations of impairment by reason of [PRIVATE] *comes from the NMC's published guidance.* [PRIVATE]

<u>Submissions</u>

A) Charges amount to lack of competence:

5. Was the sample of the Registrant's work a fair sample?

a. It is submitted that this concept can be usefully separated into two aspects: first, the motivation of those providing support and, second, the adequacy of the structure and thoroughness of the support offered. Each of these should be applied to the specific context of the Registrant's practise between 1 September 2016 and 17 September 2020 (i.e. throughout her time at Wexham Hospital within the Frimley Trust) and in the context of a Band 5/6 midwife. On this banding point, it is submitted that there is little distinction save that the Registrant evidently never obtained the Band 6 role at Wexham following the Agenda for Change, as all midwives were required to work to. Whether or not the standards of a Band 5 were met, notwithstanding her employment at this level, is a matter for to which the witnesses to each period speak.

b. In terms of the motivation of those working with the Registrant (i.e. the NMC's witnesses), the submissions made at facts stage are renewed. This is not a case of victimisation or discrimination really being alleged. That which has been somewhat mutedly pointed to by the Registrant (some communication difficulties with [Witness 10] *and a lack of real support from* [Witness 4] *who sat in the office on her phone) should be rejected as inconsistent with what was raised at the time, and uncorroborated.*

c. In terms of the adequacy of the support provided, two preliminary points emerge: first, the standard that the Committee should be looking at is

adequacy not perfection; second, when assessing the individual minutiae of each episode of support, or each charge the lack of competence allegation is made across all of the charges, as such the Committee 4 should not lose sight of the more general and overarching view that could on the evidence be taken.

i. Looking at the support in the preliminary period, from September/October 2016 to the end of December 2016 it is conceded there were some imperfections. [Witness 3] *failed to send the correct competency tool to* [Witness 5] *and* [Witness 10] *via email (albeit she gave evidence that she would have expected the Registrant to play a role in this); at the end of the period she herself provided evidence that a single mentor may have been better in the particular circumstances to improve communication E/279 and D2/137-139; and by the time of the provision of plans, learning and competency tools each period of six weeks had had some time elapsed. However, the Committee should not lose sight of the fact that this episode of care provided a fair opportunity for improvement, described as "extraordinary" by* [Witness 6] *[W/78 at §20]: (i) it was relatively long given that a majority of students would be expected to be working independently within a few weeks and this period of about 10-12 weeks on top of the September 2016 time is significantly more than this; (ii) it was entirely supernumerary and so was a real opportunity to observe and grow; (iii) it was with good quality mentors and, albeit not perfect that there was more than one personality, this guarded against the potential for individual personality differences or clashes, and each of* [Witness 5], [Witness 10] *and* [Witness 2] *were evidently qualified and well situated to learn from; (iv) it was structured in two episodes of bespoke intervention around clear goals as opposed to, for example, a high pressure single moment assessment style test situation; (v) there was different sorts of intervention and observation such as academic study and training, mentoring, practical provision of*

SOM mentor, on-shift supervision, management oversight; (vi) the programmes were put in place with full consultation and communication with the Registrant, who herself had a role to play not just as passive receiver of support but as an active learner. Those working with her provided her with feedback at the time and more generally across the progress of the two learning tools. In light of the above, while [Witness 12] *ultimately concluded that not everything that could be done had been done and decided to continue the Registrant's support and elongate timescales further, the question for the Committee is; was this support given adequate and in good faith? It is submitted that it was.*

ii. The period from February 2017 to March 2018 (the conclusion of the first competency procedures and the Registrant's [PRIVATE]*) was one in which the timescales for completion of the competencies were extended, further supernumerary time given (and ultimately lifted [E/175]) and oversight by management provided to assess progress [E/1750176].*

iii. From around August 2019 until the summer of 2020, following her return from an [PRIVATE] *the Registrant was allocated first to the general ward 22 postnatal and shortly afterwards to a more limited and discrete practise area, the infant feeding team, to allow her practise to be more manageable and accommodate her needs (eg starting later,* [PRIVATE]*). She was working with a clear appraiser,* [Witness 4]*. She was occupying a position outside the numbers albeit not supernumerary [W/25 §8]. There was a focus on increasing her confidence and a supportive attitude demonstrated. Her work was audited. She had practical skills reviews. Meetings were convened to discuss concerns (not found proved by this Committee) and the Registrant's account in response considered [W/26 §12].*

iv. Following the capability procedure held in the summer of 2020 until the end of the charge period there were efforts to afford the possibility of the Registrant achieving competence (not merely the completion of her preceptorship competencies), she was redeployed in the wider postnatal ward 22 and efforts were being made ([PRIVATE]*) to place her back on the labour ward. She was provided with a structured 4-week capability plan from June - July 2020 E/68 by which "Rachel was aware of plan to work on ward 22, goals set, method of assessment and expectations. Time frame confirmed and agreed" and this was signed by the Registrant.*

*6**. Was the standard of practise unacceptably low?***

a. It is submitted the facts found proved comprising Charges 1-8 and 18 so far as they relate to the period September-December 2016 demonstrate repeated and wide ranging failures on matters which connote an unacceptably low standard of professional practise, as highlighted by [Witness 2]*"..[I]t is apparent that there are significant gaps in Rachel's knowledge base, both theoretically and clinically… I cannot be confident she learns from these instances or that a change in practise would be evident next time" [E/5],* [Witness 5] *"Overall I would have serious concerns about Rachel's ability to practise as a midwife autonomously. She has a clear lack of insight into the above issues, even after discussion and verbal feedback, and I do not feel that there has been any significant improvement over the course of our working together" [E/38] and* [Witness 10] *"Overall I find that Rachel makes the same mistakes over time even though I have gone through procedures with her" [E/448] and* [Witness 3] *"…she was not practising midwifery care at a level required of a qualified midwife" [W/50 at §15].*

b. The period from February 2017 to March 2018 had some evident positive improvement but on her own account the Registrant has still not completed her suturing competency (part of Charge 1) and waterbirth competencies on labour ward (Charge 2c was previously about this aspect of care and not by this point remediated). Furthermore, what was achieved had to be facilitated through the granting of substantial additional beyond that already granted [E/175-6].

c. From her return to work in April 2019 until June 2020, the Registrant was unable to demonstrate adequate clinical practise in the wider post-natal ward setting -see charge 11- and, from around October 2019, was unable to achieve full competence as part of the infant feeding team (charges 12 and 13b, the latter of which should be put in the context not of general midwives' experience of the use of the pump, but this Registrant who by January 2020 some four months after starting specific infant feeding practise, was still requiring support in the use of this equipment). Although academic study and audits in the initial part of this period demonstrated improvement, [Witness 4] *formed the view in a relatively short period of time that she remained lacking in the wider field of midwifery "The Registrant could give care in a task specific manner, but they did not follow this up or develop any broader sense of Midwifery practise. In my opinion the Registrant was not meeting the requirement of a Band 6 Midwife at this time and could only give limited support which was more representative of a Band 2 MSW" [W/28 at §17]. The Committee may have some particular concern regarding the effect on competence of charges 12a) i) and iii) because it submitted that this sort of behaviour strikes at the heart of the building blocks of improved practise. Similarly,* [Witness 8] *indicates at W/59 §19 "The Registrant was on the Ward 22 rota as a Midwife, working to the same level as a Band 2 MCA".*

d. From June 2020 until September 2020, the Registrant returned to more varied practise on Ward 22. In a relatively short period of time (when one

accounts for her substantial periods away from work – letter of 19 August 2020 indicating that [PRIVATE]*…") E/204. She demonstrated specific failures in information governance, ensjuring* [sic] *continuity of care and the handling of Baby B (charge 15). More generally, she failed to complete the four-week capability assessment (charge 17) E/68, the standard of this was at a level of student midwife E/31 at 27.*

e. Aside from the observations of the Registrant's standards of midwifery practise within the trust, the NMC code provides an objective basis for identifying the unacceptably low standard. It is submitted that the breaches in the standard of care identified by the above charges also constitutes a breach of the NMC code, predominantly paragraphs 13, 19 and 20, but the corollary effect of these breaches is that the care provided was not effective and the charges also disclose breaches of paragraphs 6, 7, 8 and 16 of the Code.

7. Did these deficiencies put patients at risk?

a. There is clear evidence of risk to patients arising from the individual instances and the evidence of the NMC witnesses coupled with the self-evident risk to mothers and babies of harm. Albeit there is only limited evidence of actual harm within the charges, this is because of the safeguards put in place (supernumerary and closely supervised working, very specific work in the infant feeding team). The overriding impression given by the NMC witnesses is practise without supervision would result in harm to patients.

b. In addition to the above, the Registrant in her reflection statement [§25-27] concedes that there was risk to patients in her actions. This was confirmed in her examination in chief when Ms Shah took her through the charges individually. The risk of patient harm arising from these charges does no, therefore, appear to be disputed.

8. Registrant's admissions:

a. In response to Ms Shah's questions the Registrant has agreed that at the time of charges 1-9 and 18 she lacked competence. She also conceded that charges 11-13, 15 and 17 were in part potentially explained by a lack of competence.

B) Charges amounting to* [PRIVATE]*:

9. What is the link* [PRIVATE] *and charges 11- 13, 15 and 17?

a. [PRIVATE]

i. [PRIVATE]

ii. [PRIVATE]*".*

b. [PRIVATE]*:*

i. [PRIVATE]*;*

ii. [PRIVATE]

iii. [PRIVATE]

iv. [PRIVATE]

10. Were there risks to patients?

a. [PRIVATE]

b. [PRIVATE]

c. [PRIVATE]

d. There is further, an inherent risk, arising from the breach of the NMC code in respect of [PRIVATE] *arising from Paragraph 20.9 of the code, and through this specific breaches of paragraphs 16, 17 and 19.*

11. The Registrant's concession:

a. [PRIVATE]

Ms Shah submitted that she is in agreement with the legal framework Mr Hoskins has set out in respect of considering whether the charges found proved amount to a lack of competence.

Ms Shah submitted that you have accepted charges 1 – 9 and 18 and that you did demonstrate a lack of competence at the time of when the conduct occurred. She submitted that your admissions can be taken into account by the panel.

Ms Shah submitted that she did not seek to address the panel at all in respect of the first part of the decision making which is whether or not the charges amount to a lack of competence or [PRIVATE]. She informed the panel that she would be restricting her submissions to the issue of current impairment only.

Submissions on impairment

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

Mr Hoskins provided written submissions to the panel in which he stated:

> *'**CURRENT IMPARIMENT:***
> *12. The Committee will again look at the separate paths to impairment, namely by reason of lack of competence and/or* [PRIVATE]*. There is no definition of current impairment beyond the question of whether the Registrant is free to practise without restriction.*

13. In light of the above, it is submitted that the past limbs of the first three aspects of the Grant test for impairment has been satisfied, namely: past risk of unwarranted patient harm; past bringing the profession into disrepute; and past breach of fundamental tenets of the profession (notably practise to a competent standard).

14. It is submitted given the wide range of failings and lack of competence there is a stand-alone public confidence need to make a current impairment finding per paragraph 74 of Grant. In accordance with the NMC's guidance on the public confidence finding on [PRIVATE]

15. The Committee may well think that fertile areas to examine the future limb of the Grant test is to examine both remediation and insight through the lenses of, first, lack of competence and, secondly, [PRIVATE].

A) Remediation of the lack of competence:

16. By the conclusion of her time at Wexham Hospital the Registrant had not completed her competencies and was never signed off as a fully competent midwife. Moreover, her standard of practise as outlined above was evidently not at the standard nor as wide ranging as a newly qualified Band 5/6 midwife. Evidently these failures are remediable, in that midwives can learn and develop to full practise. Perhaps the real issue for this aspect of impairment is whether the is sufficient evidence of whether the identified concern has been fully remedied. The NMC say that it has not.

17. Since that time, the Registrant has, until October 2023 worked outside the profession as a YMCA support worker. Since October 2023, the Registrant has obtained employment at Hillingdon Hospital as a Booking Midwife, which is part of the Community Midwifery Team specialising in antenatal care. Whilst laudable that

the Registrant has remained dedicated and has rejoined the profession, the extent of remediation demonstrated by this recent role is compromised by:

a. The work being done currently does not tackle head-on the same areas as arise from the charges given the role is so very different, a matter apparently accepted by the Registrant in her evidence in chief (see labouring women, water birth, limited reading 11 of CTG), exclusively ante-natal practise in a community setting. This is, therefore, a relatively limited or specialised practise as was the infant feeding team. Given the question of impairment concerns unrestricted in the profession as a whole, the Committee may rightly feel that at b.est this evidence will only display partial remediation see for example the Job Description R/12-13;
b. It is still relatively early days in employment from October 2023 to present, having only passed her probation on 30 May 2024;
c. The Committee have only limited evidence form persons who supervise the Registrant see R/6 at Part 6, Appraiser [Person 3] *as at 14 May 2024; and R/45 two very short references from* [Person 4] *which emphasises she "does not participate in the Community On call rota" and the areas she addresses relate to skills such as communication with patients, time management and prioritising work and so do not deal in detail with the full areas of lack of competence previously. In addition, the Committee has not had the benefit of hearing their evidence nor having additional questions about the Registrant's practise answered;*
d. The evidence of completion of courses is of limited utility given that the central issue in this case was not qualification it was the application of knowledge to specific real-life cases. As such, the myriad certificates produced by the Registrant should not be regarded as determinative on the issue of remediation.
e. The Registrant is still the subject of workplace adjustments, which although identified by this employer in the context of candour from the Registrant do not demonstrate unrestricted practise.

B) Insight into lack of competence:

> *18. The evidence that the Committee has heard is that, historically, the Registrant would not recognise her shortcomings nor would remedy problems pointed out to her previously. Moreover, of specific concern, is the suggestion that the registrant would be able to 'talk the talk' and come across as a competent and knowledgeable midwife but then fail to apply the knowledge in a real word environment, causing concerns about shortcoming being identified in a timely fashion in the future. Evidently, there was a failure to recognise that she lacked competence at the time. She has since accepted that she was not competent looking back. What the Registrant has failed to demonstrate is why this committee should accept this evidence or whether it is another example of her "talking the talk" but not applying this in practise.*

***C)* [PRIVATE]**

***D)* [PRIVATE]**

Ms Shah submitted that the panel will have in mind the guidance given in the case of *Grant*. She submitted that *Grant* is not entirely relevant as that case relates to one of misconduct. However, she submitted that what is relevant from the case of *Grant,* is that it sets out that the panel out to consider whether the registrants actions put patients at a risk of harm.

Ms Shah submitted that the panel has heard from the evidence that there has been no incident of actual harm. However, she accepted that the panel would need to consider whether there was a risk of harm to patients.

Ms Shah submitted that you have identified and acknowledged that the charges allege a lack of competence and that they involve [PRIVATE] related matters which all had the

potential to put patients at a risk of harm. However, she submitted that, in cases of lack of competence and indeed [PRIVATE], the risk of harm is less of a determinative factor.

Ms Shah submitted that what the panel really ought to be considering is whether there has been adequate remediation and whether there has been adequate insight. She submitted that, in respect of [PRIVATE], the panel have had the benefit of a written report and hearing oral evidence from an expert witness, Witness 9 [PRIVATE] and had the benefit of a written report from Dr 2 [PRIVATE]. She submitted that Dr 2's report reflects how things were in February 2022 and the evidence of current impairment is best heard from Witness 9 who gave evidence to this panel during the course of these proceedings as it was based on an updated assessment of you.

Ms Shah submitted that the expert evidence that this panel has had the benefit of, should bear the most weight in the panel's considerations of current impairment. She submitted that Witness 9 was very firm and repeatedly made it very clear that, according to him, you do not pose a present a risk to members of the public as of the date that he gave evidence.

Ms Shah submitted that he confirmed [PRIVATE]. [PRIVATE]

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

Ms Shah submitted that reasonable adjustments are not forced adjustments that carry the weight of regulatory conditions. She submitted that reasonable adjustments are put in place by an employer in order to assist a registrant. She submitted that it was not Witness 9's view that these were required to keep you from being a risk to members of public going forward, but that they were a bonus to ensure that you flourished in the workplace.

Ms Shah submitted that if the panel were to disregard the evidence of Witness 9 on the level of risk that you present, the level of stability that you have demonstrated, and the level of insight you have shown, the panel will need to explain the reasons for this very clearly, although of course they are allowed to disregard the evidence of an expert. Ms Shah submitted that the panel would need to explain very clearly why they have sought to depart from the opinion of an expert that has given evidence in proceedings.

Ms Shah submitted that, on the one hand, the panel could take the view that the competencies that are outstanding, the concerns that are apparent from a lack of competence, could only ever be remediated if you returned to the same working environment, returned to the labour ward and antenatal ward and demonstrated to the panel that you can do what you were previously unable to.

Ms Shah submitted that this is not the right way of looking at a current impairment. She invited the panel to consider what level of insight has been demonstrated, and what level of effort has been made to remediate. She submitted that the panel has before it training documentation that demonstrates you have gone back to address some of the concerns that were raised.

Ms Shah submitted that in relation to the GDPR charge, this was a serious incident and that you have demonstrated an understanding of the gravity of that seriousness. She submitted that at the time, you were working in an unusual situation compared to your usual work in that, you have not sought to blame anybody else for what you accept was your failure.

Ms Shah submitted that you have undertaken training in respect of security and data protection and are currently working as a community midwife since October 2023 and have had no concerns reported about you.

Ms Shah invited the panel to find that concerns have now been remediated on account of you demonstrating full insight and being able to demonstrate remediation of the principles that underlie what that concern was.

Ms Shah submitted that the panel has had no evidence of repetition of conduct, which demonstrates the registrant has learnt about the underlying principles which led to that conduct. She submitted that you have acknowledged that you would not feel that you were competent to go into the labour ward again and deal with waterbirths without asking for supervision. In those circumstances, she submitted that the panel could find that this is a registrant who has insight into the sorts of area of practice that she is competent in.

Ms Shah submitted that when considering whether you are a registrant who requires restrictions on your practice, it should take into account that you have been practising since October 2023 with no concerns raised about your practice.

Ms Shah submitted that you not only demonstrate full insight into both of the routes to impairment, but it also acknowledge the limitations you have in areas of your practice. For those reasons, she invited the panel to find that you are not currently impaired.

Ms Shah submitted that impairment on public interest grounds is probably less relevant to cases [PRIVATE], and she submitted is also less relevant to cases of a lack of competence. She submitted that public interest is about dealing with misconduct.

Ms Shah submitted that the public interest component should be considered in respect of the standard of a well-informed member of the public. She submitted that a well-informed

member of the public, knowing what the expert witness has had to say, would not expect for finding of impairment to be made.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Calhaem v General Medical Council [2007] EWHC 2606 (Admin) which was referenced in the later case R (on the application of Remedy UK Ltd) v GMC [2010] EWHC 1245* for competence and *Brocklebank v GMC [2003] UKPC 57* for health.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") (Published 29 January 2015 and effective from 31 March 2015) in respect of charges of 1- 10 and 18. In respect of charges 11 – 15 and 17, the panel had regard to the 2018 Code updated to reflect the regulation of nursing associates on 10 October 2018 in making its decision.

In respect of charges 1-10 and 18, the following sections of the Code were engaged:

> *'1.2 make sure you deliver the fundamentals of care effectively*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> *6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services, and*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice.*

7 Communicate clearly

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.4 work with colleagues to evaluate the quality of your work and that of the team

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

10 Keep clear and accurate records relevant to your practice

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

13.1 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

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

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

In respect of charges 11 -15 and 17, the following sections of the Code were engaged:

'1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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

5 Respect people's right to privacy and confidentiality

5.1 respect a person's right to privacy in all aspects of their care

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

7 Communicate clearly

8.2 maintain effective communication with colleagues

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

10.5 take all steps to make sure that records are kept securely

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

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

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

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 you should be judged by the standards of the reasonable average band 5/6 registered midwife and not by any higher or more demanding standard.

The panel noted that you received extensive and re-evaluated support from the Trust and colleagues during the period of time that you were working at the Trust. It determined that the Trust gave you fair opportunity over a protracted period of time by assisting you to demonstrate your competency. The panel noted your assertions during your evidence that at times you lacked support, however there was insufficient evidence that you raised these concerns at the time. Further, the panel heard evidence from witnesses who had worked with you in particular Witness 4 who spoke to occasions when you had improved in your work and spoke positively. The panel concluded that you had received support during the time of these concerns.

The panel considered the NMC's guidance on *Lack of competence* (Reference: FTP-2b, last updated 14/04/2021), in which it states *'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk.'*

The panel determined that the evidence before it was a fair sample of work over a prolonged period of time, which identified repeated clinical failings, CPD failings and patient care failings. There was documentation from competency programmes and a preceptorship extension. It was identified that the skills expected of a midwife who had just completed training were not evident during the period of time that you were working at the Trust. You were assessed based on the essential skills clusters expected of a registered midwife at the time of entry onto the NMC register.

The panel considered the charges found proved individually and collectively to determine whether your behaviour was of an unacceptably low standard of professional performance which could put patients at risk. The panel determined your actions did put patients at risk of harm and, you were not signed off as competent in fundamental areas of practice as a midwife. It also noted that you worked on a supernumerary basis for a prolonged period of time as you were unable to practise safely unsupervised. Despite your midwifery training being extended for a year, your preceptorship period and support while working in a supernumerary capacity, you still did not reach sufficient competence. The panel considered that your lack of competence included basic and fundamental skills of a midwife such as CTG monitoring, management of oxytocin infusions, principles of infection control, use of medical equipment, handling babies, and not recognising an emergency situation when a baby turned blue and failing to act appropriately in the circumstances.

The panel identified themes of ongoing failings in your practice from October 2016 continuing till September 2020.

The panel therefore determined that given the extensive support given by the Trust to support you in achieving your preceptorship programme and to demonstrate your competency, you were unable to demonstrate that your practise met the standards required of a registered midwife.

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

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment on lack of competence

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

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

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

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

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

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

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

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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 found that limbs (a), (b) and (c) were engaged. Limb (d) did not apply in this case.

The panel found that patients were put at unwarranted risk of harm and could have been caused physical and emotional harm as a result of your lack of competence. Your lack of competence gave rise to breaches of fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute.

The panel considered that the concerns are remediable. It noted that you have provided a reflective statement which demonstrated your knowledge of midwifery, however it found that this was not reflected in your clinical skills. You also acknowledged that some of the charges found proved did amount to lack of competence. The panel noted that your reflection was very limited and did not fully address the impact your actions had on patients, your colleagues and the midwifery profession.

The panel considered that you had completed some training and provided evidence of this. However, you were unable to demonstrate your application of this training in your clinical practice. There was a lack of evidence before the panel that demonstrated you have completed the competencies for a midwife or working in a pressurised environment. There was evidence before the panel that you had theoretical aptitude but had difficulties implementing your knowledge in practical clinical circumstances. The Panel had regard to the statement of Witness 4:

> ‘*On paper, the Registrant could meet the standards of what we needed on Ward 22 from a Midwife…they had audited well during the UNICEF BFI audit and in conversations about skills they did very well. There was however a large deficit between this and the everyday practise of a midwife. The Registrant struggled to multi-task assess risk and meet the needs of the mothers and babies. The registrant did not seem to meet the emotional requirements of patients and offer confident knowledgeable support there was evidence based and indicative of an infant feeding midwife. The Registrant’s capability ended when tasks were no longer specific*’.

The panel noted that you are currently working as a booking midwife and working in post-natal clinics. You told the panel that you aspire to work in a case loading team within the

community and the panel recalled you also stated this to your manager as early as 2017. There is little before the panel that shows you have made an improvement in fundamental areas of midwifery practice or how you would manage a normal birth or a water birth. The panel was of the view that you need to demonstrate competency in the full role of a midwife and not just in a specific and limited area of practice. The panel had sight of a testimonial provided by your current line manager dated 27 March 2024, which described your current role:

> *'Rachel Muchoki is an employee of mine and I have known her since the commencement of her employment on 02/10/2023. Rachel has been employed at the Trust as a Booking Midwife and therefore does not attend to women/birthing persons in labour and does not participate in the Community on call rota. She has always been polite and professional and she was open and honest at her interview about an NMC investigation that was on-going.'*

The panel had limited evidence that you have strengthened your practice as you are yet to pass your midwifery competencies. The panel is of the view that there is a risk of repetition of the facts found proved. It therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a well-informed member of the public would be concerned that a midwife who despite significant support from the Trust over a four year period had not been deemed competent was allowed to practice unrestricted. It therefore finds impairment on the grounds of public interest.

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

Decision and reasons on impairment for [PRIVATE]

The panel was aware that in order to find your fitness to practise impaired by reason of your [PRIVATE], it must first establish whether you have a [PRIVATE] that goes to the issue of your fitness to practise. If it does not, then there can be no subsequent finding of impairment of fitness to practise. If it does, the panel should go on to consider whether by reason of that[PRIVATE] your fitness to practise is impaired.

In coming to its decision, the panel had regard to Rule 31(5) and the Fitness to Practise Library, updated on 27 February 2024, which states:

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

The panel considered whether your [PRIVATE] affected your practice as a midwife in respect of charges 10-15 and 17 which were found proved.

The panel noted there were adjustments to your work role from April 2019 in order to manage your [PRIVATE]. This included being moved to a role within the Infant Feeding Team which was created for you to allow you to work in a lower stress environment where you would not have to work long shifts. By 2020 you still had two outstanding competencies on your preceptorship programme; water births and suturing both of which would need to be completed on a labour ward. The recommendation [PRIVATE] in May

2020 was that you should still be restricted to non-ward work. In August 2020 [PRIVATE] confirmed that you would only be fit to work on the infant feeding unit and postnatal ward.

The panel had regard to the statement of Witness 6:

> *'The impact that the Registrants* [PRIVATE] *had on the preceptorship was that they were not able to work on the labour ward in order to achieve the outstanding competencies. This made it impossible to complete the preceptorship.* [PRIVATE]'

The panel considered the expert UKIM report from Witness 9 who conducted a [PRIVATE] assessment of you, on behalf of the NMC. Witness 9 completed the report on 16 February 2024.

Witness 9 stated the following:

> '[PRIVATE]'

The panel also considered the report from Dr 2,

> '[PRIVATE] .'

The panel determined therefore in relation to charges 10-15 and 17 your fitness to practise was impaired by reason of your [PRIVATE].

[PRIVATE].

The panel considered the more recent evidence it had received in respect of your [PRIVATE].

[PRIVATE].

The panel understand that there are roles in midwifery that are more limited in their scope of practice, but at any point in time you could take another role. The panel considered your current impairment in relation to the full role of a registered midwife and what would be expected of them within this role.

You indicated that you aspire to work as a case loading midwife. [PRIVATE] .

[PRIVATE]

The panel noted that in oral evidence you indicated the steps that you currently take to manage your [PRIVATE] in your current role, but since the incidents relating to the charges found proved occurred you have not worked on a labour ward or demonstrated your capabilities as a midwife. Despite your current level of insight, the panel are unable to ascertain how you would recognise and manage [PRIVATE in a typical midwifery environment such as a birth environment or during on calls, as this has not been tested. [PRIVATE].

[PRIVATE]. Therefore, the panel determined that your fitness to practice is currently impaired by reason of your [PRIVATE].

This finding is made to protect the public from harm which might be caused by you practising without restriction in any role within midwifery [PRIVATE], which would involve a breach of a fundamental tenet of the profession and result in you bringing the midwifery profession into disrepute, albeit that this could be involuntary on your part.

The panel was of the view that a woman shortly before, during and after birth is particularly vulnerable and requires the utmost care, attention and professionalism. Further, the panel’s findings that [PRIVATE] in a typical midwifery work environment are such that a well-informed member of the public would be shocked if you were allowed to practise unrestricted. A finding of impairment in the public interest is necessary to uphold proper professional standards and public confidence in the profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired because of your lack of competence and by reason of your [PRIVATE].

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Mr Hoskins informed the panel that the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months if it found your fitness to practise currently impaired.

Mr Hoskins submitted that there were aggravating and mitigating features the panel are to consider. In respect of the aggravating features, he submitted:

- Your actions placed vulnerable mothers and babies at significant risk of harm
- In relation to your lack of competence there is limited insight and limited remediation
- In relation to your lack of competence – your reflection on the matters found proved was somewhat mechanistic and did not assist the panel further in assessing your current impairment
- [PRIVATE]

- There was a clear pattern of your lack of competence over a prolonged period of time during 2016 – 2020 when you had a significant and varied level of support, but were still unable to demonstrate safe and effective practice.

Mr Hoskins submitted that the concerns raised deal with wide-ranging and fundamental aspects of midwifery care, and this amounts to a very serious lack of competence in this case. He further stated that your case goes to the heart of the function of the NMC, to protect the public.

Mr Hoskins drew the panel's attention to the email from your solicitors to the NMC (dated 5 December 2024), which concerned a record keeping matter and he submitted that this indicated that there has not been a prolonged period of safe and effective practice.

In respect of mitigating features, Mr Hoskins submitted:

- You accepted some of the concerns at an early stage
- You have engaged with the NMC
- There are no previous regulatory findings against you

Mr Hoskins submitted that taking no further action order and a caution order would not be appropriate in this case as there are serious wide-ranging concerns. These orders would only be appropriate if there was no risk to patients. In your case, vulnerable mothers and babies were put at significant risk of harm.

Mr Hoskins submitted that there are areas of concern identified that could be remediated with a conditions of practice order. However, in this case you were unable to practice as a newly qualified midwife despite extensive support and there is still no significant change eight years on. Mr Hoskins submitted that any conditions imposed would be tantamount to you starting your training over again as there are a broad range of midwifery concerns that need to be addressed.

Mr Hoskins submitted that a suspension order would be the most appropriate in the circumstances. He said the incidents were not isolated and there was a significant risk of repetition. Mr Hoskins referred to the panel's decision in which it found that you are unable to relate your academic knowledge to your practical clinical skills and that this indicated a relevant behaviour. Mr Hoskins concluded his submissions by stating that your lack of competence is at the higher end of seriousness which requires your temporary removal from the register in order to protect the public and the reputation of the midwifery profession.

Mr Hoskins submitted that as this case relates to both lack of competence and [PRIVATE], a striking-off order is not available to the panel.

Ms Shah submitted that a conditions of practice order would be appropriate in the circumstances.

She reminded the panel of its findings at impairment that some of the concerns are remediable and that the panel should remember this when making their decision.

Ms Shah submitted, that you are committed to the midwifery profession and patient safety. You informed the NMC that you are subject to an investigation at work because of a Datix issue. Ms Shah submitted that this demonstrates you can be trusted to comply with conditions and are deeply committed to the midwifery profession as you have cooperated with your regulator in every way.

Ms Shah submitted that you have a number of [PRIVATE] and that you are currently working with a Trust who have been supportive. The Trust are aware of your history and have risk assessed you. She said the Trust have taken the appropriate action. Ms Shah submitted that the panel may wish to restrict your practice to your current employer and for the employer to decide what type of practice you can do.

Ms Shah informed the panel that you have a manager who is supportive and that you are working within the workplace without stress.

Ms Shah suggested to the panel some conditions that may be applicable, restricting your practice to your current employer and developing a Personal Development Plan (PDP) with your line manager to create a timeline to address the concerns. Ms Shah further submitted that the concerns are remediable and that having a PDP plan will allow you to demonstrate your competence. Ms Shah further suggested direct supervision when working in certain midwifery roles until you are deemed competent by a registered midwife of Band 6 or above and a requirement to remain registered. [PRIVATE].

Ms Shah submitted that you have good insight [PRIVATE].

Ms Shah submitted that a suspension order would be disproportionate, as there are conditions that exist that can allow you to continue to practice. There is work available at the Trust in a non-clinical role which is available to you. She further stated that a suspension order would not allow you to address the concerns raised by the panel.

Ms Shah submitted the following mitigating features:

- Your admission to some of the charges
- Your continued engagement during the protracted period of time of these proceedings
- You have been open and honest with the regulator by providing the up to date information
- You are a midwife with limited experience
- [PRIVATE]

Ms Shah invited the panel to allow you to continue to practice and to put your new found insight into practice to address the clinical concerns. She further submitted that you can then retrain and provide a further panel with evidence that you can practice safely.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- You pose a real and significant risk of harm to patients in multiple areas of midwifery practice
- You have demonstrated limited insight into the effect that your actions or omissions may have potentially had on mothers and babies, and the consequences of this.
- There is a lack of remediation with little evidence of further training in many areas of concern.
- [PRIVATE]
- There is insufficient evidence that you have ever been competent to practice safely, effectively and autonomously as a qualified midwife as you did not complete your preceptorship programme over a period of four years.
- There were wide-ranging failings in key clinical skills of a midwife, even following extensive support to achieve your competencies.

The panel also took into account the following mitigating features:

- [PRIVATE] .
- You made early admissions to some of the charges
- [PRIVATE]

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel took into account the SG, in particular the non-exhaustive guidance on when a conditions of practice order may be appropriate which includes the following:

- *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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed*

The panel is mindful that any conditions imposed must be proportionate, measurable and workable and considered that arguably it might have been possible to formulate conditions of practice in this case. However, when the panel considered the contents of your submissions (dated 11 December 2024) it found your reflective piece was still lacking in understanding of the impact of your actions on mothers and babies and the potential risks to their safety focusing instead on litigation and reputational consequences.

Further the panel noted that despite its findings of facts on 3 July 2024, there is limited recognition or insight by you into the scope of the true deficiencies in your clinical practice. Specifically, that you did not complete your preceptorship programme and that significant time has passed since you last undertook key midwifery clinical skills which were the subject of charges found proved. Despite the significant passage of time a broad range of competency issues remain in respect of many fundamental aspects of safe practice as a midwife. Whilst the panel does not suggest this amounts to general incompetence it nonetheless suggests an array of competency concerns that could not be workably addressed by conditions of practice.

The panel also considered the evidence offered from you in relation to strengthening your practice (within the same documents) and found the training to be mainly mandatory training with little training targeted specifically at the concerns raised by the charges found proved. In consideration of the references and testimonials you provided, the panel could only place limited weight on these as they did not speak directly to the concerns raised nor attest in any substantial way to your clinical practice.

The panel understand the difficulties posed by strengthening practise given the scope of your recent and current roles but believe a far more proactive response was required on your part, both to demonstrate the requisite level of insight and to begin addressing these concerns such as for example undertaking Royal College of Midwives online courses, requesting to observe or shadow other midwives performing clinical roles or asking colleagues for their advice on how best to perform certain procedures and reflecting on the advice that they gave.

The panel considered the scope of the competency concerns demonstrated by the charges found proved and your own admissions, and that you still have limited insight into the significance of the charges, your own competency and the broader impact this could have in terms of emotional and physical risks to patients and others. This presents a barrier to you addressing these matters safely even with conditions. Moreover, the evidence and history of the case suggests that despite the passage of time and the support afforded very limited progress has been made towards strengthening your practise. Therefore, the panel determined that the conditions necessary (as submitted by Mr Hoskins on behalf of the NMC) would be tantamount to retraining and thus would be unworkable, would not provide adequate protection for the public, nor satisfy the public interest.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel noted that you lack insight into your current skill level and also lack insight into the potential harm that may have been caused by your actions or omissions to vulnerable mothers and their babies. Your reflection did not adequately address the potential impact of your lack of competency on mothers, babies and colleagues or recognise the potential seriousness of the consequences of this. Therefore, the panel could not be satisfied that you fully appreciated the risk that your lack of competence and/or your [PRIVATE] may have had on others. Without this insight your lack of competence and to a lesser extent

your [PRIVATE] would present a real risk of repetition with a consequent risk to patient safety.

The panel therefore accepted the submissions of Mr Hoskins that the incidents were not isolated and there was a significant risk of repetition. The panel reminded itself of its previous decision in which it found that you are unable to relate your academic knowledge to your practical clinical skills and the panel agreed with Mr Hoskins submission that this indicated a relevant behaviour. In the panel's view this behaviour is relevant to the risk you continue to present to patients. The panel's findings show a repeated pattern of issues suggesting you have had difficulties over a lengthy period, in implementing theoretical learning and building the necessary practical clinical skills to carry out the role of a midwife safely, despite considerable support and close supervision.

The panel did not consider strike-off as this was not available to the panel.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months with a review was necessary in this case to mark the seriousness and wide-ranging extent of your lack of competence and a significant risk of [PRIVATE] when working in a typical midwifery work environment. This length of the suspension order would give you the opportunity for continued engagement with the regulatory process, to fully reflect on the charges found

proved and take actions to remediate your practice whilst managing and maintaining your [PRIVATE].

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

Any future panel reviewing this case would be assisted by:

- A fully developed reflection which demonstrates your insight into your abilities and clinical skills as a midwife, and the impact of your actions or omissions on women, their babies, colleagues and the wider midwifery profession.
- Evidence of professional development, including documentary evidence of completion of courses which address themes in the charges found proved.
- A plan on how you intend to demonstrate your competence in a typical midwifery work environment.
- [PRIVATE].

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Hoskins. He submitted that an interim order is necessary to protect the public and otherwise also in the wider public interest.

He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period of 28 days and any appeal if made.

The panel also took into account the submissions made by Ms Shah. She submitted that an interim order is not necessary in your case. She informed the panel that whilst you are currently employed as Band 6 midwife you are currently restricted by your employer undertaking non-clinical duties whilst there is an ongoing investigation which has the effect of protecting the public. Ms Shah submitted that there is therefore no need for a further restriction until the substantive suspension order takes place in 28 days.

Ms Shah submitted that if an interim suspension order is imposed it would have a severe impact on your finances and a subsequent impact on your personal family life. Ms Shah highlighted [PRIVATE]. Ms Shah submitted that you would need time to make alternative arrangements for work and an interim suspension order would be disproportionate.

Ms Shah invited the panel to consider its decision carefully as this is not a *“rubber stamping exercise”*, just because the panel made a substantive suspension order it does not mean that you will need to be immediately restricted with an interim order.

The panel accepted the advice of the legal assessor.

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 wide-ranging 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 had regard to Mr Hoskins and Ms Shah’s submissions. It has also carefully considered the impact that an interim order would have on you.

The panel considered whether an interim conditions of practice order would be proportionate and workable. The panel determined, that given the seriousness and the wide-ranging extent of your lack of competence and a [PRIVATE] typical midwifery work environment, and for the reasons set out in its decision, that it was necessary to protect the public for there to be interim restrictions on your clinical practice.

The panel noted that Ms Shah in her submissions stated you are currently temporarily restricted to non-clinical duties within the Trust. However, the panel had limited information from the Trust about the circumstances of your restriction including their risk assessment or how long the restriction in your role would last and therefore could not rely on this restriction to protect the public for the duration of the appeals process.

The panel considered imposing a conditions of practice order. However, the panel was of the view that to adequately protect the public and to meet the public interest concerns of this case your practice would need to be restricted to non-clinical duties. The panel

determined that restricting you to non-clinical duties for the duration of the appeals process would be tantamount to suspension and therefore unworkable.

The panel was cognisant of the financial impact upon you as outlined by Ms Shah and whilst there was no intention to be punitive, the risks outlined outweighed the impact on you and therefore the panel determined that an interim suspension order was necessary to protect the public and otherwise in the public interest.

Therefore, the panel made an interim suspension order for a period of 18 months. If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.