Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday, 2 January – Monday, 15 January 2024
Wednesday, 17 January & Thursday, 18 January 2024
Tuesday, 4 June- Monday, 10 June 2024

Virtual Hearing

Name of Registrant:	**Corrine Mary Dowse**
NMC PIN	02B0384S
Part(s) of the register:	Registered Midwife – RM Midwifery – 19 June 2006
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, Lay Member) Catherine Askey (Registrant Member) Georgina Foster (Lay Member)
Legal Assessor:	Oliver Wise (2 – 5, 11, 12, 15 January 2024 & 17 – 18 January 2024, 4 -10 June 2024) George Alliott (8 January 2024) Sean Hammond (9 – 10 January 2024)
Hearings Coordinator:	Khadija Patwary (2 – 8 January 2024) Angela Nkansa-Dwamena (9 – 18 January 2024, 4 - 7 June 2024) Opeyemi Lawal (10 June 2024)
Nursing and Midwifery Council:	Represented by James Lloyd, Case Presenter (2 – 15 January 2024 and 17 & 18 January 2024) Represented by Amy Taylor, Case Presenter (4 – 10 June 2024)
Mrs Dowse:	Not present and unrepresented
Facts proved:	Charge 1b (with respect to Baby 4, Baby 5 and Baby 7),

	Charge 4, Charge 5, Charge 6b (with respect to Baby 10, Baby 11, Baby 12, Patient M, Patient P, Patient Q and Patient R), Charge 7a and 7b, Charge 8, Charge 9, Charge 10, Charge 11 and Charge 12.
Facts not proved:	Charge 1a (in its entirety), Charge 1b (with respect to Baby 1, Patient B, Patient C, Baby 2, Baby 3, Baby 6, Patient D, Patient F, Patient G and Patient H), Charge 2 (with respect to Patient D, Patient G and Patient H), Charge 3, Charge 6a (in its entirety), Charge 6b (with respect to Baby 8, Baby 9, Baby 13, Baby 15, Baby 16, Baby 17, Patient J, Patient K, Patient L, Patient N and Patient O).
Fitness to practise:	Impaired
Sanction:	**Striking-off Order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Dowse was not in attendance and that the Notice of Hearing letter had been sent to Mrs Dowse's registered email address by secure email on 16 November 2023.

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

The panel accepted the advice of the legal assessor.

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

In light of all of the information available, the panel was satisfied that Mrs Dowse has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Dowse

The panel next considered whether it should proceed in the absence of Mrs Dowse. It had regard to Rule 21 and heard the submissions of Mr Lloyd who invited the panel to continue in the absence of Mrs Dowse. He submitted that Mrs Dowse had voluntarily absented herself.

Mr Lloyd referred the panel to an email from Mrs Dowse dated 19 December 2023 which stated:

> *'I will not be participating in the hearing.'*

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Mrs Dowse. In reaching this decision, the panel considered the submissions of Mr Lloyd and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. The main considerations were:

- No application for an adjournment has been made by Mrs Dowse;
- Mrs Dowse has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 10 witnesses have been scheduled to give oral evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2020 and 2022;
- Further delay may have an adverse effect on the witnesses' ability to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Dowse in proceeding in her absence. Although the evidence upon which the NMC relies on will have been sent to Mrs Dowse at her registered email address. Mrs Dowse will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf.

However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Dowse's decision to absent herself from the hearing, waive her rights to attend, and/or be represented.

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

Details of charge

That you a registered midwife:

1) Between 16 and 17 January 2020, in relation to one or more patients and/or babies listed in schedule 1:
   a) failed to provide appropriate care and/or undertake observations; and/or
   b) failed to write any or sufficient notes in their postnatal notes.

2) Between 16 and 17 January 2020 in relation to Patient D, Patient G and Patient H failed to administer medication as required.

3) Between 16 and 17 January 2020 in relation to Baby 6 failed to reapply a urine bag.

4) Between 19 and 21 February 2020 administered a steroid injection to Patient A when it was not prescribed for her.

5) Between 19 and 21 February 2020 failed to administer a steroid injection to Patient Z for whom it was prescribed.

6) Between 19 and 20 April 2020 in relation to one or more patients and/or babies listed in schedule 2:

a) failed to provide appropriate care and/or undertake observations, and/or
b) failed to write any or sufficient notes in their postnatal notes.

7) Between December 2021 and January 2022, whilst your registration was subject to an interim conditions of practice order, breached the conditions of that order in that you:
   a) Applied for a role as a midwife at Croydon Health Services and failed to provide them with a copy of the interim conditions of practice order contrary to condition 14(b) of the order.
   b) Applied for a role as a midwife at Kingston Hospital NHS Foundation Trust and failed to provide them with a copy of the interim conditions of practice order contrary to condition 14(b) of the order.

8) Your conduct at charge 7 was dishonest in that you intended those responsible for recruitment at Croydon Health Services and/or Kingston Hospital NHS Foundation Trust to believe you had no restrictions on your practice.

9) Between May and June 2021 wrote on your application form for a Band 6 midwife role at Kingston Hospital NHS Foundation Trust that your reason for leaving Surrey and Sussex Health NHS Trust/East Surrey Hospital in April 2020 was “Due to Covid 19 bank has been depleted and permanent staff are changing shifts to make sure they have enough staff for every shift.”

10) In December 2021 wrote on your application form for a Band 6 midwife role at Croydon Health Services that your reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was because “Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling.”

11) Between December 2021 and January 2022 wrote on your application form for a birth centre midwife role at Kingston Hospital NHS Foundation Trust that your reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was

because “Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling.”

12) Your conduct at charges 9, 10 and 11 was dishonest because you intended to conceal that Surrey and Sussex Health NHS Trust had stopped booking you for bank shifts due to concerns over your performance as a Bank Band 6 Midwife.

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

Schedule 1

Baby 1
Patient B
Baby 2
Baby 3
Baby 4
Patient C
Baby 5
Baby 6
Patient D
Patient F
Patient G
Patient H
Baby 7

Schedule 2

Baby 8
Baby 9
Baby 10
Baby 11
Baby 12
Baby 13
Baby 14
Baby 15
Patient J
Patient K
Patient L
Patient M
Patient N
Patient O
Baby 16
Patient P
Baby 17
Patient Q
Patient R

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

At the outset of the hearing, Mr Lloyd made a request that parts of this hearing be held in private on the basis that proper exploration of Mrs Dowse's case involves references to her personal circumstances and family matters. The application was made pursuant to Rule 19 of the Rules.

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.

Having heard that there would be references to Mrs Dowse's personal circumstances and family matters, the panel determined to hold parts of the hearing in private in order to preserve the confidential nature of those matters. The panel was satisfied that these considerations justified that course, and that this would outweigh any prejudice to the general principle of hearings being held in public.

Decision and Reasons on application to adjourn the hearing until 18 January 2024 (Day 12)

On the morning of Day 9, Mr Lloyd made an application for the hearing to adjourn until Thursday 18 January 2024 (Day 12), to hear the live evidence of Witness 9 and possibly, Witness 1. He submitted that Witness 9, who had previously been unable to give her evidence earlier in these proceedings, had indicated that the only time she would be available to give her evidence again would be on the afternoon of 18 January 2024. The NMC are still awaiting a response from Witness 1.

Mr Lloyd submitted that the NMC have carefully considered the position of both outstanding witnesses and in circumstances where both witnesses could theoretically give evidence, it would be inappropriate to make an application to adduce their witness

statements as hearsay evidence. He further submitted that both witnesses have indicated a willingness to give live evidence in the past.

Mr Lloyd submitted that if Witness 1 is unable to give live evidence on that day, then the NMC will make a further application to adjourn the hearing. Mr Lloyd submitted that the NMC has carefully considered the implications of this application and its impact on timetabling for the remainder of the hearing, including the likelihood for a lengthy adjournment period.

The panel carefully considered this application and decided to accede to the NMC's application to adjourn the hearing until 18 January 2024 to hear the live evidence of Witness 9 and possibly, Witness 1.

Decision and Reasons on application to adjourn the hearing until a later date

The panel heard a further application to adjourn the hearing to a date to be fixed because Witness 1 was not available due to personal reasons.

The panel acceded to this application.

Decision and reasons on service of Notice of Hearing

The hearing resumed on Tuesday 4 June 2024. The panel was informed at the start of this hearing that Mrs Dowse was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 29 April 2024.

Ms Taylor, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including

instructions on how to join and, amongst other things, information about Mrs Dowse's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Dowse has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Dowse

The panel next considered whether it should proceed in the absence of Mrs Dowse. It had regard to Rule 21 and heard the submissions of Ms Taylor who invited the panel to continue in the absence of Mrs Dowse.

Ms Taylor submitted that Mrs Dowse has voluntarily absented herself as she has been made aware of the dates of this hearing in the Notice of Hearing. She further submitted that Mrs Dowse has not made an application for an adjournment and there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Ms Taylor reminded the panel that Mrs Dowse did not attend the first part of this hearing in January 2024, and she had informed the NMC via email on 19 December 2023 that she would not be attending the hearing. She submitted that there is some injustice to a registrant when a panel decides to proceed in their absence but, Mrs Dowse's has voluntarily absented herself. Ms Taylor further submitted that any injustice is mitigated to an extent as the panel has before it, communication from Mrs Dowse stating that she has decided to not attend.

Ms Taylor submitted that there is a strong public interest in the expeditious review of this case and she invited the panel to exercise its discretion to hear this case in Mrs Dowse's absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Mrs Dowse. In reaching this decision, the panel considered the submissions of Ms Taylor and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *GMC v Adeogba* and had regard to the overall interests of justice and fairness to all parties.

The panel had regard to its previous decision in relation to proceeding in the absence of Mrs Dowse and determined that the same reasons were applicable.

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

Decision and reasons on application to amend the charge

At the outset of the hearing, Ms Taylor made an application pursuant to Rule 28 of the Rules to amend Schedule 2, which is referred to in Charge 6.

The proposed amendment was to remove the inclusion of Baby 14 in Schedule 2. Ms Taylor submitted that there are no concerns in relation to Baby 14, which is supported by the documentary evidence of Witness 4.

Ms Taylor submitted that this amendment could be made without injustice to Mrs Dowse however, the panel will have regard to the merits of this case and the fairness of these proceedings.

Original Charge and Schedule

That you, a registered midwife:

6) Between 19 and 20 April 2020 in relation to one or more patients and/or babies listed in schedule 2:

a) failed to provide appropriate care and/or undertake observations, and/or

b) failed to write any or sufficient notes in their postnatal notes

Schedule 2

Baby 8
Baby 9
Baby 10
Baby 11
Baby 12
Baby 13
Baby 14
Baby 15
Patient J
Patient K
Patient L
Patient M
Patient N
Patient O
Baby 16
Patient P
Baby 17
Patient Q
Patient R

Proposed Amendment

That you, a registered midwife:

6) Between 19 and 20 April 2020 in relation to one or more patients and/or babies listed in schedule 2:

a) failed to provide appropriate care and/or undertake observations, and/or

b) failed to write any or sufficient notes in their postnatal notes

Schedule 2

Baby 8
Baby 9
Baby 10
Baby 11
Baby 12
Baby 13
~~Baby 14~~
Baby 15
Patient J
Patient K
Patient L
Patient M
Patient N
Patient O
Baby 16
Patient P
Baby 17
Patient Q
Patient R

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Dowse 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, for accuracy and completeness.

Background

The NMC received a referral from Surrey & Sussex Healthcare NHS Trust (the Trust) on 24 June 2020, in relation to Mrs Dowse's performance as a Band 6 Registered Midwife working on the bank.

In this referral, concerns were raised by different registered midwives who worked on shifts with Mrs Dowse on antenatal and postnatal wards at the Trust. The allegations arose between the dates of 17 January 2020 and 19 April 2020,

and predominantly relate to the standard of care that Mrs Dowse delivered to patients. The alleged concerns raised are as follows:

- Poor and absent documentation;
- Missed baby oxygen saturation measurements and feeding histories;
- Missed baby and mother observations;
- Missed analgesia;
- A wrong patient drug error, where steroids were given to a diabetic patient that did not require steroids; and
- Patients not receiving appropriate CTG monitoring.

There is also a second referral from Kingston Hospital NHS Foundation Trust (Kingston Hospital) dated 24 January 2022. Mrs Dowse allegedly applied for a role as a midwife at the Trust's Birth Centre and did not declare that she was under an interim conditions of practice order and did not comply specifically with condition 14, which states:

'14. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.

b) Any employers you apply to for work (at the time of application).

c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.'

Mrs Dowse allegedly did not provide Kingston Hospital with a copy of the interim conditions of practice order in accordance with the interim order.

It is also alleged that Mrs Dowse received a job offer from Croydon Health Services (CHS), which was subsequently rescinded. Mrs Dowse allegedly did not inform CHS in her application, her interview or subsequent communication regarding when she could start the job that she was the subject of an interim conditions of practice order. It is further alleged that she did not supply a copy of the order to CHS.

Decision and reasons on facts

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 Lloyd and Ms Taylor, on behalf of the NMC.

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

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: Maternity Matron at Surrey and Sussex Hospital (the Hospital) at the time of the allegations.
- Witness 2: Registered Midwife at the Hospital at the time of the allegations.
- Witness 3: Clinical Lead Midwife at the Hospital at the time of the allegations.
- Witness 4: Maternity Matron at the Hospital at the time of the allegations.
- Witness 5: Registered Midwife at the Hospital at the time of the allegations.

- Witness 6: Lead Professional Development Midwife at Kingston Hospital at the time of the allegations.
- Witness 7: Lead Professional Development Midwife at CHS at the time of the allegations.
- Witness 8: Birth Centre and Better Births Lead Midwife at Kingston Hospital at the time of the allegations.
- Witness 9: Registered Midwife at the Hospital at the time of the allegations.
- Witness 10: Senior Investigator at the NMC.

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

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

Charges 1a and 1b

1) Between 16 and 17 January 2020, in relation to one or more patients and/or babies listed in schedule 1:

   a) failed to provide appropriate care and/or undertake observations; and/or

b) failed to write any or sufficient notes in their postnatal notes.

Charge 1a is found NOT proved in relation to all the patients and babies listed in Schedule 1.

Charge 1b is found proved in relation to Baby 4, Baby 5 and Baby 7.

Charge 1b is found NOT proved with respect to Baby 1, Patient B, Patient C, Baby 2, Baby 3, Baby 6, Patient D, Patient F, Patient G and Patient H.

In reaching this decision, the panel took into account the documentary evidence of Witness 4, which included her NMC witness statements, her local witness statement and the handheld postnatal notes for the patients/babies referred to below. The panel also took into account the oral and documentary evidence of Witness 9.

Baby 1

With respect to Baby 1, the panel had regard to the written statement of Witness 4 dated 24 March 2022, in which she stated:

> *'…I attach the postnatal notes of the baby of from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries from the midwife and therefore no evidence the midwife attended this baby. There no indication of the baby's wellbeing [sic]. The baby had a history of respiratory distress (grunting) and therefore the baby should have been regularly observed…'*

The panel noted that Witness 4 had set out in her witness statement what a midwife would be expected to document in the postnatal notes:

> *'Proper procedure would mean that the notes should include evidence of multiple entries by the midwife responsible for care every few hours. Example entries include: Care taken over by Named Midwife, History – day 0 EMCS, last*

breastfed at (time), history of grunting. Baby has good colour and tone, no signs of respiratory distress. Plan of care – monitor for signs of respiratory distress, regular feeding support. Baby feeding well. Currently settled in cot, no signs of respiratory distress. No concerns overnight. I would expect this to be documented in the long written notes, time date in the left column and print, sign and designation in the right column.'

The panel acknowledged that during an informal meeting between Witness 4, Mrs Dowse and another Ward Manager, Mrs Dowse had expressed that the night of 16 January 2020 was busy, and she found the workload challenging:

'We then discussed the night of the 16.01.20 and Corrine reported a high level of activity including a complex social case and multiple day 0 caesarean section patients. Corrine reported she has a preference for antenatal and intrapartum care and reported finding the workload, due to the number of patients, on Burstow challenging.'

The panel had sight of Baby 1's postnatal notes and there were no entries made on the night shift of 16 January 2020 by any member of staff. The panel considered that Witness 4 had outlined in her witness statement what would be the 'gold-standard' for recordkeeping. However, the panel considered the evidence which suggested that the night shift of 16 January 2020 was busy and was of the view that this level of recordkeeping may not have been realistic in this context.

The panel acknowledged that other than Witness 4's witness statement, it had no evidence to suggest that Baby 1 was in fact Mrs Dowse's patient. Witness 4 had undertaken a review of Mrs Dowse's notes on 17 January 2020, following the night shift in question. Baby 1's postnatal notes had not been identified as one of Mrs Dowse's patients, nor had there been any concerns raised at the time. The panel considered that Witness 4's review of the postnatal notes was contemporaneous and took place shortly after the initial concern were raised; therefore it would have accurately reflected the situation at the time.

The panel was of the view that it was difficult to ascertain whether Baby 1 was Mrs Dowse's patient, to whom she would have had a duty of care given the context of a busy and chaotic shift.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Baby 1's postnatal notes.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Baby 1.

Patient B

In relation to Patient B, the panel noted that Witness 4 had stated the following in her witness statement:

> *'…I attach the postnatal notes of Patient B from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is only one entry from the midwife but is not signed for or printed so it is unclear which midwife had written in the notes.'*

The panel had regard to Patient B's postnatal notes. There were seven entries made on the night shift of 16 January 2020. However, none of these entries were made by Mrs Dowse. The panel considered that this may suggest that Patient B was cared for by another member of staff. In addition, the panel noted that only one entry had been made by a midwife, but this entry was unsigned, so it is unclear which midwife had written the notes. This is supported by Witness 4's statement in her written witness statement.

Again, the panel was of the view that it was difficult to ascertain whether Patient B was Mrs Dowse's patient, to whom she would have had a duty of care.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient B's postnatal notes.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Patient B.

Baby 2 and Patient H

The panel noted that Witness 9 had stated in her witness statement dated 17 November 2022, the following:

> *'I had taken over care of in the morning on 17 January. Baby 2 was at risk of low blood sugar and required breastfeeding support. My entry on the notes was at 0730, to state that Baby 2 still required feeding support overnight. I am unsure if Baby 2 was on observations, however there was an entry overnight about supporting the baby with feeding and checking blood sugars. (Unsure of signature – may have been Corinne). When I checked Baby 2 all was well and there was nothing concerning.'*

Witness 4 had also stated:

> *'…I attach the postnatal notes of from 15 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because the baby is at risk of hypoglycaemia - low blood sugar and has a history of poor feeding. The baby required breastfeeding support…*
>
> *Entry by Midwife at 19.30 indicating feeding, an entry for supplementation at an unknown time not completed appropriately. No indication of infant feeding support or rational for supplementing. A BM (blood sugar) was performed but limited detail about feeding support provided throughout the night. BM's are not indicated for poor feeding, a full feeding assessment and observing a feed is required prior to conducting a BM. This does not appear to be documented…'*

In relation to Patient H, the mother of Baby 2, Witness 4 stated:

> *'… I attach the postnatal notes of from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is*

only one entry from the midwife regarding IV antibiotics. Maternal observations were also missed on two occasions.'

The panel had sight of Baby 2's and Patient H's postnatal notes. In Baby 2's notes, there were three entries made by Mrs Dowse outlining feeding observations and support given as well as a documented blood glucose test result throughout the night shift of 16 January 2020. With regard to Patient H, the panel noted that there were three entries over the course of the night shift, two of which were made by Mrs Dowse recording maternal observations undertaken at 20:30 hours and medication being administered at 22:00 hours. The panel also noted that on Patient H's prescription chart, Mrs Dowse had signed her initials indicated that she had administers Ibuprofen at 22:00, which is consistent with her long-hand documentation.

The panel considered the above evidence and determined that Mrs Dowse had provided appropriate care, undertaken appropriate observations and her documentation was sufficient with respect to Baby 2 and Patient H. The panel noted that it had limited evidence before it to suggest what 'sufficient' notes were. The panel acknowledged that although Witness 4 had outlined what would be expected as good practice, the panel weighed this against the context of a busy and chaotic work environment and determined that Mrs Dowse's documentation was sufficient in these circumstances.

In light of this, the panel was satisfied that Mrs Dowse had provided appropriate care, undertaken observations and/or written sufficient notes in Baby 2 and Patient H's postnatal notes.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Baby 2 and Patient H.

Baby 3 and Patient D

Witness 9 had stated in her witness statement that:

'I note that Baby 3 was on observations noted down on the NEWS observation chart as Meconium and GBS(Group B Streptococcus – which is a bacteria found in the vagina which can pass to baby and cause infection). Baby 3 would have been considered high risk and required two hourly observations over 12 hours….

…I could see that observations for Baby 3 were only ticked at hour one and hour 2. The rest of the chart for observations was bank [sic] from hour 4-24 when observations should have been performed every two hours…

…Corinne would have been responsible for the observations as the baby was born at 18:22 on 16 January according to the chart and observations should be undertaken for 12 hours.'

The panel had regard to the NEWS Observation Chart for Baby 3 and noted that observations documented were consistent with Witness 9's account.

This was further supported by Witness 4's account:

'…I attach the postnatal notes of Baby 3 from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is a lack of documentation, missed observations and oxygen saturations.

… No observations were taken after 20:30. The risk of not completing observations is that they healthcare professional would not be able to identify early signs of infection and escalate as required to commence management of suspected infection.'

However, the panel also had regard to Witness 4's statement in relation to Patient D, the mother of Baby 3:

'I attach the postnatal notes of Patient D from 17 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because the patient had been on the ward since 00:00 following her recent LSCS. From the documentation, the midwife did not indicate handover of care, now responsible for the patient. The woman has entries from the healthcare assistant

till 06:00 and no indication she was seen by a midwife. The midwife's only entry has very limited information 'analgesia given as per drug chart' and does not indicate lochia, pain, nausea, or patient wellbeing.'

The panel also had regard to Patient D's postnatal notes.There were entries made by other members of staff documenting the care that was provided throughout the course of the shift as well as an entry from Mrs Dowse in relation to the administration of medication. The panel referred to Patient D's prescription chart which indicated that Paracetamol, Dihydrocodeine and Lactulose had been administered to Patient D by Mrs Dowse, which supported her long-hand documentation.

The panel considered the above evidence and determined that Mrs Dowse had provided appropriate care, undertaken appropriate observations and her documentation was sufficient with respect to Baby 3 and Patient D. The panel noted that other members of staff had made entries in Patient D's notes indicated that care had been provided. The panel was of the view that it would be considered normal practice for members of the midwifery team, which would include midwives and support staff, to work collaboratively and document the care they provide to each patient. The panel considered that if there were any concerns with Patient D or Baby 3, this would be escalated to the midwife responsible, Mrs Dowse. The panel determined that although Patient D and Baby 3 were under the care of Mrs Dowse, there was no reason why care could not be provided by the wider maternity team and fed back to Mrs Dowse.

In light of this, the panel was satisfied that appropriate care had been provided to Patient D and Baby 3 and sufficient notes had been written in their postnatal notes.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Baby 3 and Patient D.

Baby 4

Witness 4 stated in her witness statement that:

'… I attach the postnatal notes of from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries in the notes….

This patient was requiring feeding support due difficulty attaching to the breast and requiring expressed breast milk via a syringe. I would have expected to see documented at the start of the shift… There is no documentation from the night shift on the 16 January (last entry 12:30 on day shift and next entry at 07:30 on 17 January)…

I would have expected to see further 2-3 entries of wellbeing assessments on baby throughout the night with a particular focus on feeding…

The midwife who took over during the day created a feed plan due to poor feeding which involved bottle feeding formula and jaundice was noted. This indicates that feeding support overnight was an essential element of this baby's care and there is no evidence of this being done.'

During her oral evidence, the panel heard from Witness 9 who stated that she had received a verbal handover from Mrs Dowse with regards to Baby 4. She told the panel that there was nothing remarkable about the handover as there were no concerns highlighted at that point about the baby's feeding or wellbeing. Witness 9 could not recall the level of Baby 4's jaundice or what the serum bilirubin (SBR) test result was.

The panel had regard to Baby 4's postnatal notes and it noted that no entries were made between 12:30 hours on 16 January 2020 and 07:30 hours on 17 January 2020.

During her oral evidence in relation to the handover she received from Mrs Dowse in respect of Baby 4, Witness 9 made no reference to any concerns in care overnight and only commented that in general, she felt that the documentation was 'light'.

The panel considered the above and determined that there was no evidence to suggest that Mrs Dowse had written sufficient notes with regard to Baby 4. Often, the absence of

notes referring to a nurse's or midwife's care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse's part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

Accordingly, the panel found Charge 1b proved with respect to Baby 4 but not proved with respect to Charge 1a.

Patient C

When considering this charge, the panel noted that there were no maternal postnatal notes adduced in relation to Patient C. The panel noted that Patient C was the mother of Baby 4 and during her oral evidence in relation to the handover she received from Mrs Dowse, Witness 9 made no reference to Patient C and only commented that in general, she felt that the documentation was 'light'.

Further, the panel acknowledged that Patient C did not form part of Witness 4's review on 17 January 2020.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient C's postnatal notes.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Patient C.

Baby 5

In her witness statement, Witness 4 outlined:

> *'I attach the postnatal notes of Baby 5 from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries in the notes completed by the midwife responsible for care…*

This baby received regular support from health care assistant … at 20.00, 21.30 and 23.00 regarding feeding support…

I would have expected to see an entry at the start of the night shift written by the responsible midwife of the baby's care, Corrine…

Due to the healthcare assistant helping the mother, I would have expected to see further 1 entry of wellbeing assessments on baby towards the later half of the night, by the responsible midwife or delegated to a healthcare assistant) as it appears the baby was not seen between 2300 and 07.30 (8.5 hours).'

The panel had regard to Baby 5's postnatal notes and noted that on the document before it, there were three entries made by the Healthcare Assistant identified by Witness 4 on the night shift of 16 January 2020, but there were no entries made by Mrs Dowse throughout the course of that shift.

The panel considered the above and determined that there was no evidence to suggest that Mrs Dowse had written sufficient notes with regard to Baby 5. Often, the absence of notes referring to a nurse's or midwife's care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse's part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

Accordingly, the panel found Charge 1b proved with respect to Baby 5 but not proved with respect to Charge 1a.

Baby 6

The panel had regard to Witness 4's written statement:

'I attach the postnatal notes of Baby 6 from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because observations of the baby were missed…

The baby required 4 hourly withdrawal observations… The observations were charted at 17.30 so Corrine would have needed to complete at 21.30, 01.30 and 05.30. Corrine completed 1 set at 04.00 indicating 2 sets of observations were not completed.

I would have expected to see ongoing documentation from the responsible midwife of 1-2 further occasions to assess the wellbeing of the baby, any concerns regarding the mother caring for baby and any support with feeding.'

The panel had sight of Baby 6's postnatal notes and noted that Mrs Dowse had made two entries in Baby 6's notes at 19:15 hours and 23:00 hours. In addition to this, Mrs Dowse had also recorded observations on Baby 6's NAS chart at 04:00 as described by Witness 4. The panel noted that Witness 4 had also acknowledged that Mrs Dowse had made entries in Baby 6's notes:

'Corrine did document at the start of the shift that Corrine took over care. No history or care plan was documented however Corrine noted no concerns at present…

A further entry by Corrine at 23.00'

The panel considered that although Witness 4 had outlined what she would expect to be 'sufficient' notes, the panel had no other evidence for it to determine whether Mrs Dowse's entries were enough to qualify as sufficient.

In light of this, the panel was satisfied that there was evidence that Mrs Dowse had provided appropriate care and had written sufficient notes to support this.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Baby 6.

Patient F

In her written statement, Witness 4 stated:

> *'… I attach the postnatal notes of Patient F from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is one entry from the midwife of analgesia given at 07:00. This indicated that there is no evidence the midwife attended this patient for the first 12 hours of her shift to check in on the mother's wellbeing.*
>
> *… Medication was given by the midwife at 22:00 so was seen at least once prior to 07:00 but no evidence of maternal wellbeing.'*

The panel had regard to Patient F's prescription chart in which Mrs Dowse had signed her initials at 22:00 hours indicating she had administered Paracetamol, Ibuprofen and Dihydrocodeine to Patient F, which was consistent with Witness 4's findings. In addition, the panel had sight of Mrs Dowse's long-hand documentation in Patient F's postnatal notes in which Mrs Dowse had made an entry at 07:00 on 17 January 2020, detailing that Patient F had been self-caring overnight.

The panel considered that a self-caring patient would not require a significant amount of midwifery care input. However, there was evidence to suggest that Mrs Dowse had attended to Patient F during the night shift of 16 January 2020 by way of administering medications.

In light of this, the panel was satisfied that there was evidence that Mrs Dowse had written sufficient notes and provided appropriate care to Patient F.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Patient F.

Patient G

Witness 4 stated in her witness statement that:

> *'… I attach the postnatal notes of Patient G from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because only two entries are noted, both regarding medication only. No indication of patient wellbeing or needs of the patient.'*

The panel had regard to Patient G's postnatal notes in which Mrs Dowse had made two entries at 22:00 hours and 06:00 hours outlining the administration of various medications. This was supported by Patient G's prescription chart in which Mrs Dowse had signed her initials in the corresponding boxes for prescribed analgesia and IV antibiotics.

In light of this, the panel was satisfied that there was evidence that Mrs Dowse had provided appropriate care and had written sufficient notes to support this.

Accordingly, the panel found Charges 1a and 1b not proved with respect to Patient G.

Baby 7

In her witness statement, Witness 4 had stated that:

> *'I have noted in my review on notes from 17 January 2020. Baby 7's oxygen saturations were not completed and there was no documentation of a feed for the baby which is particularly concerning as this baby had blood sugar monitoring due to risk factors of hypoglycaemia (low blood sugar).'*

The panel noted that it did not have Baby 7's postnatal notes before it as explained by Witness 4:

> *'The postnatal notes for Patient I [mother of Baby 7] and Baby 7 are not present as they have to be sent into the hospital from community once the mother and*

baby are discharged from midwifery care. I am therefore unable to provide further evidence on the care provided by Corrine.'

The panel noted that Witness 4 had identified that there was a lack of documentation in relation to O_2 saturation readings, blood sugar monitoring and feeding support. The panel considered that Witness 4's review of Mrs Dowse's notes was contemporaneous and took place shortly after the end of the night shift and that Witness 4 would have had the notes before her to come to this conclusion.

In light of this and Witness 4's explanation for the absence of Baby 7's postnatal notes, the panel determined that it was more likely than not that Mrs Dowse had not written sufficient notes.

Often, the absence of notes referring to a nurse's or midwife's care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse's part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

Accordingly, the panel found Charge 1b proved with respect to Baby 7 but not proved with respect to Charge 1a.

Charge 2)

2) Between 16 and 17 January 2020 in relation to Patient D, Patient G and Patient H failed to administer medication as required.

This charge is found NOT proved in its entirety.

In reaching this decision, the panel took into account the documentary evidence of Witness 4 including her NMC witness statements and the postnatal notes of the patient referred to below.

Patient D

In relation to Patient D, the panel considered the written witness statements of Witness 4, in which she stated:

> *'… I attach the postnatal notes of from 17 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because the patient had been on the ward since 00:00 following her recent LSCS.*
>
> *These notes also included medication records. These records were not completed appropriately because medications were missed (dihydrocoedine [sic] and paracetamol). If this was prior to handover, Corrine should have reviewed the drug chart and offered at 00:00 when admitted to the ward. The ibuprofen at 06:00 was missed. Paracetamol and dihyrocoedine [sic] was given at 06:00.*
>
> *…Medication (Paracetamol, Dihydrocodeine and Lactulose) for patient was prescribed to be administered at 22:00 on 16th January. It is unclear what time this patient arrived on the ward and the time Corrine took over the responsibility of care.*
>
> *…On the drug chart, the medication that was due at 22:00 should have been administered and signed for but the chart is left blank, indicating that it was not given or not documented to be given. The following dose for Paracetamol and Dihydrocodeine was given at 06:00 by Corrine and initialled appropriately on the drug chart. Ibuprofen was due at 06:00 and the drug chart does not indicate that the medication was given as there is a blank space.'*

The panel had regard to Patient D's prescription chart and postnatal notes. It noted that Mrs Dowse had made an entry at 06:00 hours stating that analgesia had been given. This was consistent with Witness 4's account.

This was further supported by Patient D's prescription chart, where Mrs Dowse had signed to indicate that Paracetamol, Dihydrocodeine and Lactulose had been administered to Patient D.

The panel considered the above evidence and concluded that the medications administered to Patient D by Mrs Dowse were medications that were meant to be given to Patient D as and when she required it (PRN medications). In light of this, the panel was satisfied that there was sufficient evidence to support the fact that Mrs Dowse had administered the medications to Patient D at the time she required it.

Accordingly, the panel found Charge 2 not proved with respect to Patient D.

Patient G

With regard to Patient G, the panel considered the written witness statements of Witness 4, in which she stated:

> *'… I attach the postnatal notes of Patient G from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because only two entries are noted, both regarding medication only.*
>
> *… These records were not completed appropriately because the entry for oral antibiotics is missed at 22:00.*
>
> *… Antibiotics (Cefalexin and Metronidazole oral tablets) were prescribed for 22:00 and the drug chart is left blank for the box indicating 22:00 on the 16th January. This indicates that these medications were not given or documented to be given.'*

The panel had regard to Patient G's prescription chart and postnatal notes. It noted that Mrs Dowse had made an entry at 22:00 hours on 16 January 2020 and 06:00 hours on 17 January 2024 stating that analgesia had been given at both times, but Lactulose had been omitted at 06:00 hours as Patient G had loose stools. The panel noted that although she had not documented in the long-hand notes, Mrs Dowse had signed her

initials to indicate that she had administered the Cefalexin and Metronidazole tablets later at 06:00 hours on 17 January 2020.

The panel considered the above evidence and concluded that although the medications were given at a later time by Mrs Dowse, it was satisfied that there was sufficient evidence to support the fact that Mrs Dowse had administered the medications to Patient G during the night shift of 16 January 2020.

Accordingly, the panel found Charge 2 not proved with respect to Patient G.

Patient H

In relation to Patient H, the panel considered the written witness statements of Witness 4, in which she stated:

> *'… I attach the postnatal notes of Patient H from 16 January 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is only one entry from the midwife regarding IV antibiotics…*
>
> *…These records were completed appropriately because IV antibiotics that were due at 06:00 were not given but the midwife who took over noted it in her care plan to give the IV antibiotics instead.*
>
> *… In the long written notes, Corrine documents IV antibiotics were administered at 22:00. The midwife who took over care on the morning on 17.01.20 at 07:30 documents that IV Abx (indicating intravenous antibiotics) was planned to be given during her shift as they were due at 06:00. This indicated that Corrine did not administer the IV antibiotics due at 06:00...'*

The panel had regard to Patient H's prescription chart and postnatal notes. It noted that Mrs Dowse had made an entry at 22:00 hours stating that analgesia and IV antibiotics had been administered to Patient H at that time. The panel noted that there were no other entries made by Mrs Dowse.

The panel noted that the prescription chart before it did not include the prescriptions for the IV antibiotics therefore it could not determine whether Mrs Dowse had signed for 06:00 hours dose. However, the panel acknowledged that Mrs Dowse had administered Ibuprofen to Patient H at 22:00 hours as detailed in her long-hand documentation.

The panel considered the above evidence and concluded that there was evidence to suggest that Mrs Dowse had administered the Ibuprofen to Patient H during the night shift of 16 January 2020.

Furthermore, in light of the absence of the prescriptions for the IV antibiotics, the panel was not satisfied that Mrs Dowse had failed to administer them to Patient H at 06:00 hours as alleged by Witness 4.

Accordingly, the panel found Charge 2 not proved with respect to Patient H.

Charge 3)

> 3) Between 16 and 17 January 2020 in relation to Baby 6 failed to reapply a urine bag.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 4, which included her witness statement and the postnatal notes for Baby 6 and its mother, Patient E.

The panel noted that in her witness statement, Witness 4 stated:

> *'…I attach the postnatal notes of Baby 6 from 16 January 2020 onwards. This was one of Corrine's patients.*

A further entry by Corrine at 23.00 noted the mother took off the baby's urine bag. There is no evidence that Corrine reapplied a urine bag. It was part of the care plan that a urine sample for toxicology was collected from the baby due to a history of mother's substance misuse and complex social history. The midwife on the next day shift at 09.00 attached the urine bag which Corrine should have attached in the night.'

The panel had regard to Baby 6's postnatal notes which confirmed Witness 4's account that at 23:00 hours, Baby 6's urine bag was removed by Patient E (mother). However, the panel also had regard to the postnatal notes of Patient E in which Mrs Dowse had written a lengthy entry at 04:00 hours in relation to Baby 6's urine bag. Mrs Dowse had outlined that Patient E was upset that staff were trying to obtain a urine sample from her baby, despite consent previously being obtained. Mrs Dowse further noted that Patient E felt that she was being looked down on and she did not want staff to apply a new bag to Baby 6 for another urine test. The panel noted that Mrs Dowse had recorded at 05:00 hours that Patient E was happy for staff to reapply the bag and proceed with the urine testing later in the shift but not at that time.

The panel considered the above evidence and concluded that it was appropriate for Mrs Dowse not to reapply the urine bag to Baby 6 as its mother had withdrawn consent. The panel considered that Patient E had responsibility for Baby 6 and if Mrs Dowse had proceeded to apply the urine bag in the absence of Patient E's consent, this would have been deemed as assault on Baby 6.

In light of the above, the panel determined that Mrs Dowse could not be considered to 'fail to reapply' the urine bag on Baby 6.

Accordingly, the panel found Charge 3 not proved.

Charges 4 and 5

4) Between 19 and 21 February 2020 administered a steroid injection to Patient A when it was not prescribed for her.

5) Between 19 and 21 February 2020 failed to administer a steroid injection to Patient Z for whom it was prescribed.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 1 and the oral and documentary evidence of Witness 5.

In relation to Patient A, the panel noted that in her witness statement, Witness 1 had expressed:

> *'Corrine had administered steroids to a diabetic patient mother, who was also the wrong patient. The patient would have required a combination of insulin and sugar. The effects could have been catastrophic as she had given the wrong patient a steroid injection. The patient's name was Patient A…She was an antenatal patient.*
>
> *… In regard to the diabetic patient she told me that she had given the steroid injection to the mother upon her verbal order. However, Corrine still shouldn't have given the injection without cross checking the prescription chart for name, of the patient, Date of Birth i.e. right drug right patient.'*

The panel noted that Witness 5 had also stated in relation to Patient Z that:

> *'… I then asked Corrine if she could administer the medication to the patient. I do not remember why, maybe due to the competing demands at that time…*
>
> *Later on I returned to the triage section and back to the patient so that I could discharge her. During this time, I gave her the information about returning for her second steroid injection in either the next 12 or 24 hours, I cannot recall exactly. But the patient said she had not received the first injection at all. This was confusing because Corrine was supposed to have administered it to the patient.*

I went back to the antenatal ward to ask Corrine why she had not given the injection to the patient. But Corrine said she had administered it. By this point, I realised that she obviously given the medication to the wrong patient or maybe not administered it at all. I went back to the treatment room and saw that the patient's drug chart was still sat on the side where the medication had been prepared but the medication was gone. Which confirmed my suspicions that it had been administered to the wrong person.

I brought out a new medication and I asked Corrine to check with me again. I then administered the medication to the right patient. Once the medication was administered, we both signed the patient's drug chart.'

During her oral evidence, Witness 5 recounted a similar version of events.

The panel had regard to the Datix Incident Form dated 21 February 2020, completed by Witness 9. The panel noted that the Datix Form had outlined that Patient A had reported being given a steroid injection, despite there being no documentation with regards to this or any indication for its administration.

The panel noted that within her undated local statement in relation to this incident, Mrs Dowse had stated that she had been transferred to another ward that she was not familiar working in. She stated that this working environment was busy and chaotic. She accepted that she had become confused when Witness 5 had asked her to administer steroids to a patient. She explained that she thought Witness 5 had asked her to administer the injection to Patient A who was in Bed D but did not realise that the injection was actually for Patient Z in Triage D.

The panel considered the above evidence and determined that Mrs Dowse had administered the steroid injection to Patient A when it was not prescribed for her. In light of this, the panel concluded that Mrs Dowse had failed to administer the injection to Patient Z, for whom it was intended and prescribed.

Accordingly, the panel found Charges 4 and 5 proved.

Charges 6a and 6b

6) Between 19 and 20 April 2020 in relation to one or more patients and/or babies listed in schedule 2:

a) failed to provide appropriate care and/or undertake observations, and/or

b) failed to write any or sufficient notes in their postnatal notes

Charge 6a was found NOT proved with respect to all babies and patients in Schedule 2.

Charge 6b was found proved with respect to Baby 10, Baby 11, Baby 12, Patient M, Patient P, Patient Q and Patient R.

Charge 6b was found NOT proved with respect to Baby 8, Baby 9, Baby 13, Baby 15, Baby 16, Baby 17, Patient J, Patient K, Patient L, Patient N and Patient O.

In reaching this decision, the panel took into account the documentary evidence provided by Witness 4. The panel also considered the relevant mother and baby pairs collectively.

Baby 8 and Patient J

In her witness statement, Witness 4 stated the following:

> *'…I attach the postnatal notes of Baby 8 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there was no documentation by the midwife.'*

Witness 4 made a similar statement in relation to Patient J, the mother of Baby 8.

The panel had regard to Baby 8's and Patient J's postnatal notes and noted that there were no entries made by any member of staff for the night shift of 19 April 2020. Other than Witness 4's witness statement, there was no further evidence to suggest that Baby 8 or Patient J were the responsibility of Mrs Dowse. Witness 4 had undertaken another review of Mrs Dowse's notes on 20 April 2020, following the night shift in question. Baby 8's postnatal notes had not been highlighted as a point of concern, but Patient J had been referred to as having no documentation in the patient notes. The panel was unable to determine whether Patient J or Baby 8 were actually in the care of Mrs Dowse during the night shift of 19 April 2020.

The panel considered the above evidence and determined that there was insufficient evidence to satisfy it that Baby 8 and Patient J were Mrs Dowse's patients, to whom she would have had a duty of care.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient J and Baby 8's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 8 and Patient J.

Baby 9 and Patient L

The panel had regard to Witness 4's written statement in which she stated:

> *'…I attach the postnatal notes of Baby 9 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is only one entry regarding observations, and no indication of feeding and wellbeing. However, baby observations four hourly were accurately recorded.'*

Similarly with Patient L, Witness 4 stated:

‘I attach the postnatal notes of Patient L from 19 April 2020 onwards. This was one of Corrine’s patients. I would have concerns about these notes because there is no entry from midwife, no indication of wellbeing assessments or individualised care provided through night shift.’

However, the panel had regard to the postnatal notes of Baby 9 and Patient L. It noted that at 21:30 hours, Mrs Dowse had made an entry stating observations had been undertaken on Baby 9 with consent and no concerns had been identified, this was supported by an entry on Baby 9’s NEWS chart. Similarly, the panel noted that an entry had been made at 20:00 hours in Patient L’s notes by another member of staff.

The panel considered the above evidence and it determined that there was evidence enabling it to conclude that care had been provided to Baby 9 and Patient L by Mrs Dowse.

The panel noted that in Witness 4’s review of Mrs Dowse’s notes on 20 April 2020, Baby 9’s postnatal notes had not been highlighted as a point of concern, but Patient L had been referred to as having no documentation in the patient notes.

Often, the absence of notes referring to a nurse’s or midwife’s care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse’s part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient L and Baby 9’s postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 9 and Patient L.

Baby 10 and Patient P

In relation to this charge the panel considered the witness statement of Witness 4:

> *'… I attach the postnatal notes of Baby 10 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries in notes by any member of staff and four hourly observations were not completed overnight….*
>
> *… I attach the postnatal notes of Patient P from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries or evidence of care provided.*
>
> *…I would have expected to see further 1-2 entries of wellbeing assessments on mother throughout the night. This may include if she feels well, her bleeding, pain, emotional wellbeing and/ or any concerns.'*

The panel had sight of the postnatal notes for Baby 10 and Patient P. In Baby 10's postnatal notes, no entries had been made by any member of staff between 19:00 hours on 19 April 2020 and 08:45 hours on 20 April 2020 and no observations had been carried out since 19:00 hours. Similarly, no entries had been made in Patient P's postnatal notes between 16:40 hours on 19 April 2020 and 08:45 hours on 20 April 2020.

The panel also had regard to Witness 4's contemporaneous review of patient notes and Patient P had been identified as having missed documentation of baby observations for Baby 10.

Often, the absence of notes referring to a nurse's or midwife's care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse's part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

The panel considered the above evidence and determined that there was no evidence to suggest that Mrs Dowse had written sufficient notes.

Accordingly, the panel found Charge 6b proved with respect to Baby 10 and Patient P, but not Charge 6a.

Baby 11 and Patient Q

With respect to Baby 11 and Patient Q, the panel had regard to Witness 4's witness statement:

> *'… I attach the postnatal notes of Baby 11 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because no entries in notes by any member of staff during the night shift.*
>
> *.. I attach the postnatal notes of Patient Q from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries or evidence of care provided.*
>
> *I would have expected to see further 3-4 entries of wellbeing assessments on mother throughout the night with a particular focus on the presentation, potential causes (distended abdomen, abnormal bleeding) and management of serve [sic] abdominal pain. Any ongoing concerns overnight regarding abdominal pain should be escalated to the on call doctor however it is not clear if further doctors reviews were indicated overnight as there is no evidence the midwife reviewed and observed the patient.'*

The panel had sight of the postnatal notes for Baby 11 and Patient Q. In both sets of notes, no entries had been made by the midwife responsible for the course of the night shift. The panel had regard to Witness 4's contemporaneous review of patient notes and noted that Patient Q had been identified by Witness 4 as one of Mrs Dowse's patients

whose notes lacked documentation. In light of this, the panel was satisfied that it was more likely than not that Patient Q and Baby 11 were Mrs Dowse's patients, to whom she had a duty of care.

Often, the absence of notes referring to a nurse's or midwife's care of a patient will lead to the inference that such care has not taken place. The panel concluded that this inference should not be drawn. This is because there is no general evidence of a lack of care on Mrs Dowse's part either from other midwives or from patients, and there is evidence of shortcomings in relation to documentation of care.

The panel considered the above evidence and determined that there was no evidence to suggest that Mrs Dowse had written sufficient notes.

Accordingly, the panel found Charge 6b proved with respect to Baby 11 and Patient Q, but not proved with respect to Charge 6a.

Baby 12 and Patient R

In relation to Baby 12 and Patient R, the panel considered the witness statement of Witness 4:

> *'…I attach the postnatal notes of Baby 12 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because no entries in notes by any member of staff during the night shift.*
>
> *…I attach the postnatal notes of Patient R from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries or evidence of care provided.*
>
> *I would have expected to see further 1-2 entries of wellbeing assessments on mother throughout the night. This may include if she feels well, her bleeding,*

pain, emotional wellbeing and/ or any concerns. Mother's post birth are at risk of heavy bleeding, feeling faint, experiencing pain, difficulty passing urine, developing infection or feeling unwell.'

The panel had sight of the postnatal notes for Baby 12 and Patient R. In both sets of notes, no entries had been made by the midwife responsible for the course of the night shift. The panel had regard to Witness 4's contemporaneous review of patient notes. Patient R had been identified by Witness 4 as one of Mrs Dowse's patients whose notes lacked documentation. In light of this, the panel was satisfied that Patient R and Baby 12 were Mrs Dowse's patients, to whom she had a duty of care.

The panel considered the above evidence and determined that there was no evidence to suggest that Mrs Dowse had written sufficient notes.

Accordingly, the panel found Charge 6b proved with respect to Baby 12 and Patient R, but not proved in relation to Charge 6a as explained in relation to other patients and babies.

Baby 13

The panel considered the witness statement of Witness 4:

'… I attach the postnatal notes of Baby 13 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because no entries in notes by any member of staff during the night shift.

Proper procedure would mean that the notes should include "Care taken over by X, History X, Plan X wellbeing assessment, feeding support, regular entries throughout night of wellbeing" I would expect this to be documented in the long written notes, time date in the left column and print, sign and designation in the right column.'

The panel had sight of the postnatal notes for Baby 13. Between 16:05 hours on 19 April 2020 and 09:10 on 20 April 2020, there were no entries made by the midwife responsible for the course of the night shift. However, the panel had regard to Witness 4's contemporaneous review of patient notes. Baby 13 was not identified in those notes as one of Mrs Dowse's patients, suggesting that this baby may not have been allocated to her.

Consequently, the panel could not be satisfied that Mrs Dowse was in breach of any duty to provide appropriate care to Baby 13.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 13.

Baby 15

The panel considered the witness statement of Witness 4:

> *'… I attach the postnatal notes of Baby 15 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is only one entry from midwife regarding saturations and poor feeding. There was no feeding support given after 23:40 and this baby was not effectively feeding so should have been given more support.'*

The panel had sight of the postnatal notes for Baby 15. It noted that two entries had been made by two different members of staff at 22:00 hours and 23:40 hours documenting care such as O_2 saturation readings, feeding support and a nappy change. The panel had regard to Witness 4's contemporaneous review of patient notes and noted that Baby 15 had not been identified as one of Mrs Dowse's patients, suggesting that this baby may not have been allocated to her.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Baby 15's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 15.

Patient K

The panel considered the written statement of Witness 4:

> *'… I attach the postnatal notes of Patient K from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because no entries from midwife responsible for care. Midwife [REDACTED] did take handover at 23.30, (potentially because Corrine was unavailable at that time) and documented appropriately. Then there is no further documentation from midwives for the remaining shift.'*

The panel had regard to Patient K's postnatal notes. It noted that an entry was recorded in the patient notes at 23:30 hours Patient K was transferred to the postnatal ward and her care taken over by another midwife. Additionally, there were three other entries made by other members of the maternity team at 02:30 hours, 03:10 hours and 04:30 hours outlining the care provided to Patient K; however there was no documentation to suggest that Patient K was subsequently transferred to the care of Mrs Dowse. Furthermore, Patient K had not been identified in Witness 4's notes review as one of Mrs Dowse's patients. The panel concluded that in the absence of a handover of care, it was unlikely that Mrs Dowse was responsible for the care of Patient K.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient K's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Patient K.

Patient M

In considering this charge in relation to Patient M, the panel had regard to Witness 4's witness statement:

'…I attach the postnatal notes of Patient M from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there is only 1 entry of care at 21:00.

This patient birthed her baby a few hours prior to arriving on the postnatal ward and being in Corrine's care. Corrine documented admission and orientation, bladder details and baby's feed history. It is signed, printed and designation on the right. This is a good example of documentation.

I would have expected to see further 2-3 entries of wellbeing assessments on mother throughout the night and evidence of support for a first-time mother to ensure the wellbeing of mother.'

The panel had regard to Patient M's postnatal notes, and it noted that Mrs Dowse had made an entry at 21:00 hours on 19 April 2020, which was consistent with Witness 4's account. The panel was satisfied that there was sufficient evidence to suggest that Mrs Dowse was the midwife responsible for Patient M's care. This was further supported by Witness 4's note review which identified Patient M as one of Mrs Dowse's patients.

The panel considered the above evidence and determined that Mrs Dowse's single entry at 21:00 hours was not sufficient documentation for the period of a 12 hours shift. However, for the reasons given above in relation to other patients and babies, the panel was not satisfied that Mrs Dowse had failed to provide appropriate care to Patient M.

Accordingly, the panel found Charge 6b proved with respect to Patient M, but not proved in relation to Charge 6a.

Patient N

The panel considered the witness statement of Witness 4:

'…I attach the postnatal notes of Patient N from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries or evidence of care provided.

I would have expected to see further 1-2 entries of wellbeing assessments on mother throughout the night. This may include if she feels well, her bleeding, pain, emotional wellbeing and/ or any concerns.'

The panel had regard to Patient N's postnatal notes, and it noted the episodes of care for Patient N between 18:00 hours on 18 April 2020 to 08:30 hours on 20 April 2020. The panel noted that documentation indicated that Patient N's baby was admitted on the Special Care Baby Unit (SCBU) and Patient N was spending most of her time away from the postnatal ward visiting SCBU. Furthermore, the panel noted that Patient N was self-caring and expected to be discharged to community care on 20 April 2020.

The panel considered the above evidence and concluded that Patient N was a self-caring patient who would not have received care as she was not present on the ward throughout the shift. The panel was of the view that in these circumstances, it would not be expected of Mrs Dowse to write extensive documentation in Patient N's notes considering Patient N required minimal care and was absent from the ward for much of the shift.

In light of this, the panel was satisfied, on the balance of probabilities, that Mrs Dowse did not fail to provide appropriate care, undertake observations or fail to write any or sufficient notes in Patient N's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Patient N.

Patient O

In considering this charge in relation to Patient O, the panel took into account the written statement of Witness 4:

'… I attach the postnatal notes of Patient O from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries or evidence of care provided.

I would have expected to see further 1-2 entries of wellbeing assessments on mother throughout the night. This may include if she feels well, her bleeding, pain, emotional wellbeing and/ or any concerns.'

The panel had regard to Patient O's postnatal notes, and it noted the episodes of care for Patient O up to 08:00 hours on 20 April 2020. It had been recorded that Patient O was a self-caring patient who did not require extensive midwifery input. Also, the panel had limited evidence before it to suggest that Patient O was in fact Mrs Dowse's patient other than Witness 4's comment in her witness statement.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Patient O's postnatal notes.
Accordingly, the panel found Charges 6a and 6b not proved with respect to Patient O.

Baby 16

In relation to Baby 16, the panel considered the statement of Witness 4:

'… I attach the postnatal notes of Baby 16 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries in the notes.

This patient was having 3 hourly BM's (blood sugar blood tests) and 4 hourly observations due to risk of developing low blood sugar.

I would have expected to see further 2-3 entries of wellbeing assessments on baby throughout the night with a particular focus on feeding history and support due to the risk factors for developing low blood sugar. 2 further blood sugars and

observations were taken during the night however it is not clear which member of staff completed these observations as there is no signature on the NEWs chart.'

The panel had regard to Baby 16's postnatal notes. There appeared to be five entries for 19 April 2020 however, the panel was unable to decipher which entries corresponded with the night shift as the times had been obscured during the photocopying process. Furthermore, the panel had limited evidence before it to suggest that Baby 16 was in fact Mrs Dowse's patient other than Witness 4's comment in her witness statement as Baby 16 had not been identified as a case for concern in Witness 4's review of the notes.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Baby 16's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 16.

Baby 17

With regards to Baby 17, the panel considered the written statement of Witness 4:

'… I attach the postnatal notes of Baby 17 from 19 April 2020 onwards. This was one of Corrine's patients. I would have concerns about these notes because there are no entries in the notes completed by the midwife responsible for care following the admission entry.

This baby was admitted to the ward by a midwifery colleague [REDACTED] at 23.30 possibly due to Corrine being unavailable at the time of admission. [REDACTED] showed good documentation on admission. There is 1 further entry by a healthcare assistant indicating baby was not breastfeeding well and requiring support.

I would have expected to see ongoing documentation from the responsible midwife of 1-2 further occasions to assess the wellbeing of the baby and any support with feeding.'

The panel had regard to Baby 17's postnatal notes. Another midwife had taken over the care of Baby 17 at 23:30 hours and had recorded an entry to this effect. In addition to this, it noted that there were two other entries made by other members of the maternity team at 02:30 hours and 07:10 hours, outlining the care provided to Baby 17, but there were no other entries to suggest that care had subsequently been transferred to Mrs Dowse. Furthermore, Baby 17 had not been identified in Witness 4's notes review as one of Mrs Dowse's patients. The panel concluded that in the absence of a written record of a handover of care, it was unlikely that Mrs Dowse was responsible for the care of Baby 17.

In light of this, the panel could not be satisfied, on the balance of probabilities, that Mrs Dowse had failed to provide appropriate care, undertake observations or failed to write any or sufficient notes in Baby 17's postnatal notes.

Accordingly, the panel found Charges 6a and 6b not proved with respect to Baby 17.

Charges 7a and 7b

7) Between December 2021 and January 2022, whilst your registration was subject to an interim conditions of practice order, breached the conditions of that order in that you:

a) Applied for a role as a midwife at Croydon Health Services and failed to provide them with a copy of the interim conditions of practice order contrary to condition 14(b) of the order.

b) Applied for a role as a midwife at Kingston Hospital NHS Foundation Trust and failed to provide them with a copy of the interim conditions of practice order contrary to condition 14(b) of the order.

These charges are found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 7 and Witness 8 and the oral and documentary evidence of Witness 10.

Witness 7 who was the Lead Professional Development Midwife at Croydon Health Services (CHS) at the time of the allegations stated:

> *'Our recruitment adviser…conducted her usual checks for Corrine and highlighted to us that Corrine had restrictions on her practise. She searched Corrine's PIN and found conditions on her midwifery practise which we were unaware of. I had not seen any conditions of practise declared on her application form either. I spoke to my line manager at the time,… and informed of Corrine's restrictions. One of the conditions was that she had to declare her restrictions to us as a prospective employer which she failed to do.*
>
> *… Corrine told me she had been very transparent with everything and had mentioned it on her application form. I told her I had screen the application form and hadn't seen that she had declared the restrictions on her practise. I also told her that she didn't mention anything to me during her interview, and she requested if she could send me all the paperwork regarding her restrictions.'*

The panel had sight of Mrs Dowse's TRAC Jobs application form for CHS and her Interview Assessment Form. It noted that Mrs Dowse had not recorded that she had restrictions on her practice and there was no note that she had informed CHS of this at the interview or provide a copy of the conditions in accordance with Condition 14b.

Similarly, the panel noted that Witness 8, the Birth Centre and Better Births Lead Midwife at Kingston Hospital at the time of the allegations, had stated:

'Corrine had not written much information of her application form, but what she had stated came across to me as though she had a lot of experience so I had selected her.

We looked Corrine up on the register to check her NMC status. We found that she had an Interim Conditions of Practise Order (ICPO) placed on her practice by the NMC. One of the conditions mentioned was that she had to declare her restrictions on her practise at the point of applying for a midwifery role. However, Corrine had failed to declare the conditions on her practise on the application form.

There is a section, called Under Membership of Professional Bodies on the application form on TRAC. In the section which states other, Corrine had the chance to declare her conditions of practice… I produce a screenshot of the professional registration section on TRAC as …This shows the free text box labelled, any other restrictions on practice, where Corrine could have her Conditions of Practice Order.'

The panel had regard to Mrs Dowse's TRAC jobs application form for Kingston Hospital and a screenshot of the area Witness 8 identified where Mrs Dowse could have disclosed her restrictions. It noted that although Mrs Dowse may have recorded that she had restrictions on her practice, she failed to provide a copy of the conditions in accordance with Condition 14b.

The panel also had regard to Condition 14b of Mrs Dowse's interim conditions of practice order, which stated the following:

'14. You must immediately give a copy of these conditions to:
a) …
b) Any employers you apply to for work (at the time of application).
c) …'

The panel noted from the determination that Mrs Dowse was in attendance at the hearing when this order was imposed on 8 March 2021, and that the decision letter had

been sent to her the following day. This was supported by the written determination from that hearing and an email containing the decision letter dated 9 March 2021.

The panel considered the above evidence and determined that Mrs Dowse was aware that there were restrictions on her practice and that she would need to disclose this to employers at the time of application. In light of this, the panel concluded that Mrs Dowse had failed to provide a copy of her restrictions to Croydon Health Services and Kingston Hospital NHS Foundation.

Accordingly, the panel found Charges 7a and 7b proved.

Charge 8)

> 8) Your conduct at charge 7 was dishonest in that you intended those responsible for recruitment at Croydon Health Services and/or Kingston Hospital NHS Foundation Trust to believe you had no restrictions on your practice.

This charge is found proved.

The panel first considered its previous findings with respect of Charge 7 and the witness evidence of Witness 7, Witness 8 and Witness 10.

Having established this, the panel went on to consider whether Mrs Dowse's actions in Charge 7 were dishonest. It had regard to the test set out in *Ivey v Genting Casinos* [2017] UKSC 67 which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel also had regard to the NMC guidance entitled *'Making decisions on dishonesty charges' (reference DMA-8)* dated 27 February 2024. Within this guidance, Fitness to Practise Committee (FtPC) panels are advised to decide whether the conduct indeed took place and if so, what was the registrant's state of mind at the time. Panels are reminded to consider the following:

- *'What were the background facts or circumstances and what did the nurse, midwife or nursing associate know or believe at the time?*
- *Were the nurse, midwife or nursing associate's actions dishonest?*
- *Is there evidence of an alternative explanation? Is the alternative more likely?'*

In reviewing the evidence, the panel considered the evidence of Witness 7, Witness 8 and Witness 10. It found that Mrs Dowse was aware of the outcome of her interim order hearing as she had attended that hearing and had been sent the decision letter with the outcome and conditions enclosed. The panel concluded that Mrs Dowse had failed to disclose and provide a copy of her conditions, despite it being clearly outlined in Condition 14b. In the panel's view, she was trying to mislead CHS and Kingston Hospital into believing that there were no restrictions on her practice.

In light of the above evidence, the panel concluded that Mrs Dowse's conduct would be considered dishonest by the standards of ordinary decent people.

The panel therefore found Charge 8 proved.

Charge 9)

> 9) Between May and June 2021 wrote on your application form for a Band 6 midwife role at Kingston Hospital NHS Foundation Trust that your reason for leaving Surrey and Sussex Health NHS Trust/East Surrey Hospital in April 2020 was "Due to Covid 19 bank has been depleted and permanent staff are changing shifts to make sure they have enough staff for every shift."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 6.

In her written statement dated 12 April 2023, Witness 6 stated:

‘Corrine would have applied for the Band 6 midwife role at Kingston hospital though NHS jobs site.

Whilst screening this application form, I noticed the applicant had put down continuous service since 2006, however, there were a lot of gaps in the different jobs the applicant was employed at.’

The panel had sight of Mrs Dowse’s TRAC jobs application form for Kingston Hospital and it noted that under ‘Reason for leaving (if applicable)’, Mrs Dowse had put:

“Due to Covid 19 bank has been depleted and permanent staff are changing shifts to make sure they have enough staff for every shift.”

In light of the above evidence, the panel determined that Mrs Dowse had stated that her reason for leaving Surrey and Sussex Health NHS Trust/East Surrey Hospital in April 2020 was “Due to Covid 19 bank has been depleted and permanent staff are changing shifts to make sure they have enough staff for every shift.”

The panel therefore found Charge 9 proved.

Charge 10)

10) In December 2021 wrote on your application form for a Band 6 midwife role at Croydon Health Services that your reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was because “Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling.”

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 7.

In her written statement dated 31 March 2023, Witness 7 stated:

> *'Whilst screening the form, we did wonder why she had worked at various Trusts and left working for them in a short while. I had also wondered why she had not been working at the time for a long period.'*

The panel had sight of Mrs Dowse's TRAC jobs application form for CHS and it noted that under 'Reason for leaving (if applicable)', Mrs Dowse had put:

> *"Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling."*

In light of the above evidence, the panel determined that Mrs Dowse had stated that her reason for reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was because "Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling."

The panel therefore found Charge 10 proved.

Charge 11)

> 11) Between December 2021 and January 2022 wrote on your application form for a birth centre midwife role at Kingston Hospital NHS Foundation Trust that your reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was because "Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 8.

In her written statement dated 16 November 2022, Witness 8 stated:

'When I was shortlisting through Corrine's application form, I saw that she had worked for Surrey and Sussex Health NHS Trust (SASH) from August 2019- April 2020. Her reasons for leaving was stated as "severely reduced taking bank shifts due to home schooling her children and Covid -19".

The panel had sight of Mrs Dowse's TRAC jobs application form for Kingston Hospital and it noted that under 'Reason for leaving (if applicable)', Mrs Dowse had put:

"Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling."

In light of the above evidence, the panel determined that Mrs Dowse had stated that her reason for reason for leaving Surrey and Sussex Health NHS Trust in April 2020 was because "Bank shifts were severely reduced to Covid 19. Decided to stay at home to look after children and help with home schooling."

The panel therefore found Charge 11 proved.

Charge 12)

12) Your conduct at charges 9, 10 and 11 was dishonest because you intended to conceal that Surrey and Sussex Health NHS Trust had stopped booking you for bank shifts due to concerns over your performance as a Bank Band 6 Midwife.

This charge is found proved.

In reaching this decision, the panel first considered its previous findings with respect of Charges 9, 10 and 11. It also took into account the witness evidence of Witness 6, Witness 7, Witness 8 and Witness 10 and the test as set out in *Ivey v Genting* and NMC guidance (*reference DMA-8*).

In reviewing the evidence, the panel considered the evidence of Witness 6, Witness 7 and Witness 8. It found that Mrs Dowse knew that the reason why Surrey and Sussex

Health NHS Trust had stopped booking her for bank shifts was due to concerns over her performance as midwife. The panel noted that Mrs Dowse had sought to provide a number of alternate explanations as to why there were gaps in her employment, and this was likely an attempt to conceal the fact that her previous employer had raised concerns about her performance.

In light of the above evidence, the panel concluded that Mrs Dowse intended to mislead a prospective future employer. The panel decided that her conduct would be considered dishonest by the standards of ordinary decent people.

The panel therefore found Charge 12 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Dowse's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 therefore exercised its own professional judgement.

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

Submissions on misconduct

Ms Taylor referred the panel to NMC guidance (*reference FTP-2a*) and the case of Roylance v General Medical Council (No. 2) [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. *The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.*'

Ms Taylor submitted that Mrs Dowse has breached the terms of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2018) (the Code), namely Sections 1 (1.2 and 1.4), 10 (10.1) and 20 (20.1 and 20.2). She submitted that Mrs Dowse has breached a number of provisions of the Code, and while it is acknowledged that not every breach of the Code amounts to misconduct, Ms Taylor submitted that the failings in this case do amount to a serious departure from the standards and behaviour expected of a registered midwife and do amount to misconduct.

Ms Taylor submitted that the midwifery profession as a whole is built on caring and providing for people who are at their most vulnerable and the care provided by Mrs Dowse was contrary to that. She submitted that Mrs Dowse administered a steroid injection to the wrong patient, failed to administer it to the patient it was prescribed for and also failed to write any or sufficient notes for several patients and babies. Ms Taylor submitted that those taking over care following Mrs Dowse's shift, understandably, would have relied on her notes to ensure that they could provide adequate care to those patients. It was in reviewing the notes of Mrs Dowse's patients for that purpose that these concerns came to light and were escalated.

Ms Taylor submitted that patients and the public expect to be able to trust midwives. She reminded the panel of its finding in relation to Mrs Dowse's failure to provide a copy of her interim conditions of practise order when applying for jobs and the alternate explanations she gave for leaving her previous employer, which was dishonest as she knew the reason why she was not offered further bank shifts by the Trust was due to concerns over her performance. Ms Taylor submitted that these were a serious departure from the standards and behaviour expected of a registered midwife. Failure to

uphold the standards of the midwifery profession could seriously undermine public trust and confidence and could make the public reluctant to access healthcare services.

Ms Taylor submitted that this case raises fundamental questions about Mrs Dowse's ability to uphold the standards and values in the Code. She submitted that the professional misconduct in this case is serious, and she invited the panel to find that the facts proved amount to misconduct.

Submissions on impairment

Ms Taylor the addressed the panel on impairment. She referred to NMC guidance (DMA-1) which sets out that a panel when considering if a midwife is impaired, should consider the following question:

> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

In relation to the test set out in Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin), Ms Taylor submitted that all the limbs are engaged in this case. She submitted that Mrs Dowse has in the past, acted and or is it liable to act in the future so as to put a patient or patients at unwarranted risk of harm. In relation to Charges 4 and 5, harm was caused to a diabetic patient who had a steroid injection wrongly administered. Witness 1 had explained that there was a risk of harm to the patient as her blood glucose levels could have increased and there was a risk of stillbirth. Witness 1 also referred to this incident as a 'near miss incident'.

Ms Taylor submitted that Mrs Dowse has in the past brought and/or is liable in the future to bring the midwifery profession into disrepute. She submitted that members of the public would be concerned to hear that such incidents had occurred, especially in light of the support provided to Mrs Dowse by way assistance and a medication competency assessment. She further submitted that Mrs Dowse has in the past breached the fundamental tenets of the midwifery profession as there are a number of breaches of

the Code. Finally, Ms Taylor submitted that Mrs Dowse has in the past, acted dishonestly as outlined in the panel's decisions in Charges 8 and 12.

Regarding a current risk of unwarranted harm, Ms Taylor submitted that there are significant concerns that Mrs Dowse's conduct could be repeated in the future. Despite concerns being raised following the night shifts in January and February 2020, the medication competency training in March 2020 and the subsequent issues regarding the care provided in April of 2020, Mrs Dowse has shown no insight.

Ms Taylor reminded the panel that Mrs Dowse initially engaged with the local and NMC investigations but subsequently decided to not engage. She submitted that the panel has the benefit of Mrs Dowse's bundle, which contains her statement with respect to the shift on 20 February 2020. However, there is no information before the panel to suggest there has been any meaningful or developed insight, remorse or strengthened practice which addresses the specific concerns that have been raised. Ms Taylor submitted that Mrs Dowse remains a risk to the health, safety and wellbeing of patients and the public therefore, a finding of impairment is required on that basis.

Ms Taylor submitted that in accordance with the facts found proved, a finding of impairment is required to uphold professional standards and conduct given the number of issues in relation to Mrs Dowse's insufficient documentation. There is no evidence that Mrs Dowse appreciates that this type of behaviour is capable of undermining the public confidence in the profession. She submitted that in the absence of a current finding of impairment, the public confidence would be undermined in the midwifery profession. Ms Taylor invited the panel to find Mrs Dowse's fitness to practise impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance*, Grant and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

> *'**10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
>
> *To achieve this, you must:*
>
> > ***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> ***20 Uphold the reputation of your profession at all times***
>
> *To achieve this, you must:*
>
> > ***20.1** keep to and uphold the standards and values set out in the Code*
> >
> > ***20.2** act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.*
>
> ***23 Cooperate with all investigations and audits***
>
> *To achieve this, you must:*
>
> > ***23.3** tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved were serious and did amount to serious misconduct. The panel considered that Mrs Dowse's failure to write sufficient notes for a number of patients and babies, failure to administer

a steroid injection to the correct patient, failure to provide a copy of her interim conditions of practice order to prospective employers and her dishonesty were serious departures from the standards that could be properly expected of a midwife. Mrs Dowse's actions put vulnerable patients at an unwarranted risk of harm and would undermine public confidence in the midwifery profession. The panel was of the view that Mrs Dowse's failures related to fundamental components of a registered midwife's role and her actions did fall seriously short of the conduct and standards expected of a midwife and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

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

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

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

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

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

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

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

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

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

The panel concluded that all limbs of the *Grant* test are engaged in this case. The panel found that patients and babies were put at risk as a result of Mrs Dowse's misconduct. The panel was also of the view that Mrs Dowse's misconduct had breached the

fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the midwifery profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel was aware that this is a forward-looking exercise, and accordingly it went on to consider whether Mrs Dowse's misconduct was remediable and whether Mrs Dowse had strengthened her practice.

The panel had regard to the case of *Cohen* and considered whether the misconduct identified was capable of remediation. The panel were concerned about the deception inherent in Mrs Dowse's dishonesty. Not only had she failed to provide a copy of her interim conditions of practice order as required of her in accordance with Condition 14b, but she had also attempted to conceal the fact that the Trust were no longer booking her for shifts due to issues with her performance by providing alternate explanations for the gaps in her employment history on three separate occasions. The panel was of the view that Mrs Dowse's dishonesty would be difficult to remediate. The panel determined that Mrs Dowse's misconduct was serious and that it had no evidence before it of strengthened practice or remediation.

The panel went on to consider whether Mrs Dowse remained liable to act in a way that would put patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future.

The panel considered that upon finding out that her job offer had been rescinded due to her failure to provide a copy of her interim conditions of practice order, Mrs Dowse sought to plead with the employer for the job and subsequently offer to provide a copy, putting her own interests above the safety of patients and the public.

Regarding insight, the panel considered that there was no evidence before it, such as an up-to-date reflective piece, to demonstrate Mrs Dowse's insight or attempts to strengthen her practice. The panel had regard to Mrs Dowse's reflective statement in relation to the steroid injection incident on 20 February 2020. It considered that Mrs Dowse showed limited insight into the incident and focused mainly on why she had administered the injection to the wrong patient, as opposed to reflecting on the impact of

her actions on the patients, her colleagues and the reputation of the midwifery profession. The panel noted that Mrs Dowse had not provided a reflection in relation to the other incidents.

In light of this, the panel concluded that there was a risk to the public and there was a high likelihood of this conduct being repeated. The panel noted that Mrs Dowse has not engaged with the NMC, since her correspondence in December 2023, and there have been no indications of further insight or any remediation. The panel was of the view that due to her lack of insight and recognition of the seriousness of her actions, there was a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. A well-informed member of the public and other members of the midwifery profession would find Mrs Dowse's dishonesty in relation to withholding information about her interim conditions of practice order and concealing the reason for leaving the Trust as deplorable.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Dowse off the register. The effect of this order is that the NMC register will show that Mrs Dowse has been struck-off the register.

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

Submissions on sanction

Ms Taylor informed the panel that the NMC had advised Mrs Dowse that it would seek the imposition of a striking-off order if it found Mrs Dowse's fitness to practise currently impaired.

Ms Taylor referred the panel to the NMC guidance SAN-1 and outlined aggravating factors arising in this case.

Aggravating features

- Lack of insight into failings;
- A pattern of misconduct over a period of time and this is not a one-off case, and there are wide ranging concerns; and
- The conduct put patients at risk of suffering harm.

Ms Taylor submitted that it is for the professional judgement the panel to outline any mitigating features, if any.

Ms Taylor submitted that Ms Dowse's actions were too serious for a conditions of practice order, given that these concerns are about an absence of general level of competence and a lack of progress after a subsequent competency assessment.

It was also submitted that it is too serious for a suspension order as Mrs Dowse's actions were not a single instance of misconduct and there is evidence of repetition both clinically and of dishonesty. She further submitted that without any insight there is a risk

of repetition leading to a risk of safety to patients and the public. So therefore, Mrs Dowse's conduct is incompatible with her remaining on the register. Ms Taylor invited the panel to impose a striking-off order for these reasons.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings;
- A pattern of misconduct over a period of time and this is not a one-off case, and there are wide ranging concerns;
- The conduct put patients at risk of suffering harm;
- Concerns regarding general nursing practice in particular, record keeping;
- Job applications completed inaccurately; and
- Direct dishonesty in that Mrs Dowse repeated on more than one occasions false reasons for leaving her previous trust.

The panel found that there were no mitigating features in this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Dowse's practice would not be appropriate in the circumstances.

The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Dowse's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Dowse's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct of dishonesty identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Dowse's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel decided that the serious

breach of the fundamental tenets of the profession evidenced by Mrs Dowse's actions is fundamentally incompatible with Mrs Dowse remaining on the register.

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

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

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

Mrs Dowse's actions were significant departures from the standards expected of a registered midwife and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Dowse's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Dowse in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Dowse's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Taylor. She submitted that the substantive order would not come into effect for 28 days and an interim suspension order is appropriate to cover the appeal period, on the grounds of public protection and public interest. She asked for an 18 month order.

The panel heard 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 facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.