Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
16-17, 23, 25-27 and 31 May 2022
1, 6-9 and 13-14 June 2022
5 – 7, 12 – 13 and 21 - 22 September 2022
16 – 17, 20, 23 and 26 January 2023
5 May 2023
13-16 June 2023
10-14 July 2023
6 - 7, 30 November 2023
15 January 2024
9 –10, 12 and 18 April 2024
10 – 11 June 2024

Nursing and Midwifery Council

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	**Comfort Iyabo Momoh**	
NMC PIN:	86C0010O	
Part(s) of the register:	RM – Midwife- 05 September 1988	
Relevant location:	Lambeth, London	
Type of case:	Misconduct	
Panel members:	Michael Murphy Jude Bayly Ian Dawes	(Chair, registrant member) (Registrant member) (Lay member)
Legal Assessor:	Ian Ashford-Thom	
Hearings Coordinator:	Holly Girven (May – June 2022) Alice Byron (September 2022 – January 2023) Phil Austin (June - July 2023) Catherine Acevedo (November 2023, January 2024, April 2024, June 2024)	
Nursing and Midwifery Council:	Represented by Katie Mustard, Case Presenter	
Dr Momoh:	Present and represented by Laura Bayley, instructed by Thompsons Solicitors	

No Case to Answer:	Charge 1.1 in its entirety in relation to clinical competence only, charge 1.1.15, charge 1.2 in its entirety in relation to clinical competence only, charge 1.2.15, charge 1.3 in its entirety in relation to clinical competence only, 1.3.9, charge 1.4 in its entirety in relation to clinical competence only, charge 1.4.1, charge 1.4.2, charge 1.5.1 in relation to clinical competence only, charge 1.5.2 in relation to clinical competence only, charge 1.5.3 in relation to clinical competence on one date only, charge 1.5.4 in relation to clinical competence on one date only, charge 1.5.5 in relation to clinical competence on one date only remaining, charge 1.5.6 in relation to clinical competence on one date only remaining, charge 1.5.7 in relation to clinical competence on one date only remaining, charge 1.5.8 in relation to clinical competence only remaining, charge 1.5.9 in relation to clinical competence only remaining, charge 1.5.10 in relation to clinical competence only remaining, charge 1.6 in its entirety, charge 1.7 in its entirety, charge 2.2 in its entirety, charge, charge 2.3.2, 2.3.3, charge 2.3.5, charge 2.4.1, charge 2.4.2, charge 2.4.3, charge 3.1.2, charge 3.1.3, charge 3.1.4, charge 3.2.2, charge 3.3.2, charge 3.3.3, charge 3.3.5, charge 3.4.2, charge 3.4.3, charge 3.5.4, charge 3.6.1, charge 3.6.3, charge 3.7.2, charge 3.8.1, charge 3.8.2, charge 3.8.3, charge 3.8.4, charge 3.9.2, charge 3.9.3, charge 3.9.5, charge 3.10.1, charge 3.10.4, charge 3.11 in its entirety, charge 3.12.2, charge 3.12.3, charge 3.13.1, charge 3.13.2, charge 3.13.3, charge 3.14.2, charge 3.14.3, charge 3.14.4, charge 3.15.2, charge 3.16.1, charge 3.16.2, charge 3.16.3, charge 3.17.2, charge 3.17.4, charge 3.17.5, charge 3.18.2, charge 3.19.2, charge 3.20.2, charge 3.20.3, charge 3.23.3, charge 3.24.2, charge 3.27.3, charge 3.28.2, charge 3.28.3, charge 3.32.1, charge 3.32.2, charge 4 in its entirety, charge 5.1, charge 5.2, charge 5.6 on one date only, charge 5.7 on one date only remaining, charge 6.1, charge 6.2, charge 6.7 on one date only remaining, charge 9.6, charge 10.1, charge 10.13, charge 10.15, charge 11.1, charge 11.8, charge 12.1, charge

12.2, charge 12.10, charge 13, charge 14.1, charge 14.2, charge 14.3, charge 14.4, charge 15, charge 16, charge 18, charge 21.5, charge 21.6

Facts proved by admission: Charge 1.5 in its entirety, charge 1.9 all children apart from Child 19, charge 1.10 all children apart from Child 19. In relation to charge 3 parts of the charge were admitted but the panel decided to treat these admissions as equivocal as no admissions were made as to the stem. Charge 5 in relation to Adults 19 and 35, charge 6 in relation to Adults 19 and 35, charge 12 in relation to Adults 143 and 147, charge 17, charge 19, charge 20 admitted apart from Child 19, charge 21 admitted apart from Child 19

Facts proved: Charge 3.1.1, charge 3.2.1, charge 3.2.3, charge 3.3.1 proved, charge 3.3.4, charge 3.4.1, charge 3.5.1, charge 3.5.2 only in respect of Adult 7, charge, charge 3.5.3 only in respect of Adult 7's daughters, charge 3.6.2, charge 3.7.1, charge 3.9.1, charge 3.9.4, charge 3.10.2, charge 3.10.3, charge 3.12.1, charge 3.14.1, charge 3.15.1, charge 3.15.3 only in respect of Adult 23, charge 3.17.1, charge 3.17.3, charge 3.18.1, charge 3.19.1, charge 3.20.1, charge 3.21.2, charge 3.21.3, charge 3.21.4, charge 3.21.5, charge 3.22.2, charge 3.22.3 in respect of advice/assessment/discussion, charge 3.22.4, charge 3.23.1 in respect of advice/discussion/next steps, charge 3.23.2, charge 3.25.2 in respect of advice/discussion, charge 3.25.3, charge 3.25.5, charge 3.26.2 in respect of advice/discussion, charge 3.26.3, charge 3.27.1, charge 3.27.2, charge 3.27.4, charge 3.27.5, 3.28.4 in respect of advice/discussion, charge 3.28.5, charge 3.29.2, charge 3.29.3, charge 3.29.4, charge 3.29.5, charge 3.30.1, charge 3.30.2, charge 3.30.3, charge 3.30.4, charge 3.30.5, charge 3.31.2, charge 3.33.1, charge 3.33.4 in respect of Child 29, charge 3.33.5, charge 5.3, charge 5.4, charge 5.6, charge 5.8, charge 5.9, charge 5.10, charge 5.11, charge 5.12, charge 5.13, charge 5.14, charge 5.15, charge 6.3, charge 6.4, charge 6.6,

charge 6.8, charge 6.9, charge 6.10, charge 6.11, charge 6.12, charge 6.13, charge 6.14, charge 6.15, charge 8.1, charge 8.2, charge 8.3, charge 8.4, charge 8.5, charge 9.2, charge 9.3, charge 9.4, charge 9.5, charge 10.2, charge 10.3, charge 10.4, charge 10.5, charge 10.6, charge 10.7, charge 10.8, charge 10.9, charge 10.10, charge 10.11, charge 10.12, charge 11.2, charge 11.3, charge 11.4, charge 11.5, charge 11.6, charge 11.7, charge 12.3, charge 12.6, charge 12.7, charge 12.8, charge 12.9,

Facts not proved: Charge 1.1, charge 1.2, charge 1.3, charge 1.4, charge 1.8, charge 1.9 in relation to Child 19, charge 1.10 in relation to Child 19, charge 2.1.1, charge 2.1.2, charge 2.1.3, charge 2.1.4, charge 2.1.5, charge 2.3.1, charge 2.3.4, charge 3.5.2 in respect of Adult 7 daughters, charge 3.5.3 in respect of Adult 7, charge 3.15.3 in respect of Adult 23's children, charge 3.21.1, charge 3.22.1, charge 3.22.3 in respect of next steps, charge 3.23.1 in respect of assessment, charge 3.24.1, charge 3.24.3, 3.24.4, charge 3.24.5, charge 3.25.1, charge 3.25.2 in respect of examination/next steps, charge 3.25.4, charge 3.26.1, charge 3.26.2 in respect of examination/next steps, charge 3.26.4, charge 3.28.1, 3.28.4 in respect of examination/next steps, charge 3.29.1, charge 3.31.1, charge 3.31.3, charge 3.31.4, charge 3.31.5, charge 3.33.2, charge 3.33.3, charge 3.33.4 in respect of Child 29's mother, charge 7, charge 9.1, charge 10.14, charge 20.4, charge 21.4

Fitness to practise: Impaired

Sanction: Suspension order (6 months)

Interim order: Not imposed

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Mustard, on behalf of the NMC, to amend the wording of charges 3.21.5, 3.25.5, 3.26.3, 3.28.5 and 18.

The proposed amendment to charges 3.21.5, 3.25.5, 3.26.3 and 3.28.5 was to amend '*GP'* to the correct referrer for each patient. The proposed amendment to charge 18 was to provide clarity about what it is alleged. Ms Mustard submitted that the proposed amendments did not change the substance of the charges, and would ensure accuracy.

Following a question from the panel, Ms Mustard also applied to amend charge 3.31 to amend the date outlined in the charge.

The proposed amendments were as follows:

> '3.21.5 Did not record any follow up communication/letter with Child 16's ~~GP~~ **social worker**
>
> 3.25.5 Did not send an outcome letter to Child 21's ~~GP~~ **social services and/or the police**
>
> 3.26.3 Did not record send an outcome letter to Child 22's ~~GP~~ **social worker and/or the police**
>
> 3.28.5 Did not send an outcome letter to Child 24's ~~GP~~ **referrer**
>
> 3.31 On or around 22 ~~November~~ **September 2016** during/following your consultation with Child 27;
>
> 18. On or around ~~20 July 2017 did not refer Child 28's~~ **7 July 2017 you initially assessed Child 28 rather than refer them for**

examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.'

The panel heard from submissions from Ms Bayley, on your behalf, that whilst she did not agree that the changes did not change the substance of the charge, she did not object to the proposed amendments.

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

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

Details of charge, as originally amended

That you, whilst employed as a Specialist Female Genital Mutilation ('FGM') Midwife at Guy's & St Thomas' Hospital between 2012 & 2017;

1. Acted/practised outside the scope of your clinical competence/role, in that you:
    1.1. On one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.
    1.2. On one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.
    1.3. On one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.
    1.4. On one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule

1.5. On one or more occasion administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber, as listed in schedule 4.

1.6. On one or more occasion provided psychological/psychosexual counselling to patients, as listed in schedule 5.

1.7. On one or more occasion provided patients with sexual health counselling for dyspareunia, as listed in schedule 6.

1.8. On one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;

1.9. On one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.

1.10. On one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.

2. On one or more occasion did not, for adult patients as listed in schedule 9:

2.1. Refer adult patients to specialist counsellors

2.2. Refer adult patients for sexual health counselling

2.3. Refer adult patients for further investigation

2.4. Obtain a second opinion for adult patients during/following an FMG assessment.

3. On one or more occasion failed to maintain adequate clinical records for adult/children/patients under the age of 18, in that you:

3.1. On or around 27 October 2016 during/following your consultation with Adult 2:

3.1.1. Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.

3.1.2. Did not record information about Adult 2's background.

3.1.3. Did not record that Adult 2's anatomy change could have been due to birth trauma.

3.1.4. Did not record adequate details of the advice/assessment/discussion/next steps for Adult 2.

3.2. On or around 22 September 2016 during/following your consultation with Adult 3;

3.2.1. Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.

3.2.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 3.

3.2.3. Did not record a risk assessment for Adult 3.

3.3. On or around 21 June 2016 during/following your consultation with Adult 4;

3.3.1. Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle.

3.3.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 4

3.3.3. Did not record information about Adult 4's risk of infection/chronic pain.

3.3.4. Did not record a risk assessment for Adult 4

3.3.5. Did not record whether a swab/urine sample had been taken for Adult 4.

3.4. On or around 15 June 2017 during/following your consultation with Adult 6;

3.4.1. Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.

3.4.2. Did not record the reason for Adult 6's referral to the FGM clinic.

3.4.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 6

3.5. On or around 18 August 2016 during/following your consultation with Adult 7;

3.5.1. Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle.

3.5.2. Did not record a risk assessment of Adult 7/Adult 7's daughters.

3.5.3. Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

3.5.4. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 7

3.6. On or around 3 December 2015 during/following your consultation with Adult 8;

3.6.1. Did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle.

3.6.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8

3.6.3. Did not record/inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years.

3.7. On or around 4 June 2015 during/following your consultation with Adult 9;

3.7.1. Did not record adequate details of Adult 9's consultation in the EPR/physical patient records bundle.

3.7.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 9

3.8. On or around 19 November 2015 during/following your consultation with Adult 10;

3.8.1. Did not record adequate details of Adult 10's consultation in the EPR/physical patient records bundle.

3.8.2. Did not record whether a urine sample had been taken for Adult 10.

3.8.3. Did not record whether Adult 10 was checked for a urinary tract infection/infections.

3.8.4. Did not record adequate details of the advice provided to Adult 10

3.9. On or around 11 June 2015 during/following your consultation with Adult 12;

3.9.1. Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle.

3.9.2. Did not record whether the de-infibulation procedure was discussed with Adult 12

3.9.3. Did not record a discussion around personal hygiene with Adult 12.

3.9.4. Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

3.9.5. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 12.

3.10. On or around 6 August 2015 during/following your consultation with Adult 15;

3.10.1. Did not record adequate details of Adult 15's consultation in the EPR/physical patient records bundle.

3.10.2. Did not record a discussion about the illegality of FGM with Adult 15.

3.10.3. Did not record a risk assessment for Adult 15.

3.10.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 15.

3.11. On or around 3 November 2016 during/following your consultation with Adult 16;

3.11.1. Did not record adequate details of Adult 16's consultation in the EPR/physical patient records bundle.

3.11.2. Did not record the reasons for Adult 16's referral.

3.11.3. Did not record Adult 16's gestation period.

3.11.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 16.

3.12. On or around 22 August 2013/12 May 2016 during/following your consultation with Adult 17;

3.12.1. Did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.

3.12.2. Did not record adequate details about Adult 17's de-infibulation procedure.

3.12.3. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 17.

3.13. On or around 14 May 2015/20 August 2015/10 September 2015 during/following your consultation with Adult 19;

3.13.1. Did not record adequate details of Adult 19's consultations in the EPR/physical patient records bundle.

3.13.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 19

3.13.3. Did not record information surrounding the history of domestic abuse of Adult 19.

3.14. On or around 28 April 2016 during/following your consultation with Adult 22;

3.14.1. Did not record adequate details of Adult 22's consultation in the EPR/physical patient records bundle.

3.14.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 22.

3.14.3. Did not record the timing of the administration of Lidocaine to Adult 22.

3.14.4. Did not record the frequency of the administration of Lidocaine to Adult 22.

3.15. On or around 28 April 2016 during/following your consultation with Adult 23;

3.15.1. Did not record adequate details of Adult 23's consultation in the EPR/physical patient records bundle

3.15.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 23

3.15.3. Did not record a risk assessment for Adult 23/Adult 23's children.

3.16. On or around 20 October 2016 during/following your consultation with Adult 24;

3.16.1. Did not record adequate details of Adult 24's consultation in the EPR/physical patient records bundle

3.16.2. Did not inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment.

3.16.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 24

3.17. On or around 2 July 2015/ 9 July 2015 during/following your consultation with Adult 35;

3.17.1. Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

3.17.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 35.

3.17.3. Did not record the reason for prescribing/providing antibiotics to Adult 35.

3.17.4. Did not record the dosage of antibiotics prescribed/provided to Adult 35.

3.17.5. Did not record details surrounding Adult 35's possible allergies to antibiotics

3.18. On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 45;

3.18.1. Did not record adequate details of Adult 45's consultations in the EPR/physical patient records bundle

3.18.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 44

3.19. On or around 21 July 2016/28 July 2016 during/following your consultation with Adult 124;

3.19.1. Did not record adequate details of Adult 124's consultations in the EPR/physical patient records bundle.

3.19.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 124

3.20. On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130;

3.20.1. Did not record adequate details of Adult 130's consultations in the EPR/physical patient records bundle.

3.20.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 130

3.20.3. Did not record whether Adult 130's condition/assessment was escalated.

3.21. On or around 6 August 2015 during/following your consultation with Child 16;

3.21.1. Did not clearly record the origin of referral in Child 16's patient records.

3.21.2. Did not record any correspondence with social workers.

3.21.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 16/Child 16's mother.

3.21.4. Did not record a risk assessment for Child 16.

3.21.5. Did not record any follow up communication/letter with Child 16's Social Worker

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.1. Did not clearly record the origin of referral in Child 17's patient records.

3.22.2. Did not record a full clinical history check of Child 17.

3.22.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 17/Child 17's mother

3.22.4. Did not record a risk assessment for Child 17.

3.23. On or around 13 August 2015 during/following your consultation with Child 18;

3.23.1. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

3.23.2. Did not record a risks assessment for Child 18

3.23.3. Did not record whether a urine sample had been taken for Child 18.

3.24. On or around 11 September 2015 during/following your consultation with Child 19;

3.24.1. Did not create any official clinical healthcare records for Child 19.

3.24.2. Incorrectly stated in Child 19's GP letter dated 14 October 2015 that Child 19 was assessed on 9 September 2015.

3.24.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 19

3.24.4. Did not record a risk assessment for Child 19

3.24.5. Did not record any follow up with social care.

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.1. Did not adequately record the origin of referral in Child 21's patient records.

3.25.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 21/Child 21's mother.

3.25.3. Did not record a risk assessment for Child 21.

3.25.4. Incorrectly recorded information regarding Child 22 into Child 21's records.

3.25.5. Did not send an outcome letter to Child 21's social services and/or the police

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

3.26.1. Did not adequately record the origin of referral in Child 22's patient records.

3.26.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 22/Child 22's mother.

3.26.3. Did not record send an outcome letter to Child 22's social worker and/or the police

3.26.4. Incorrect recorded information regarding Child 21 into Child 22s records.

3.27. On or around 18 February 2016 during/following your consultation with Child 23;

3.27.1. Did not create any official clinical healthcare records for Child 23

3.27.2. Did not record a risk assessment for Child 23.

3.27.3. Did not record the social impact of FGM on Child 23.

3.27.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 23

3.27.5. Did not send an outcome letter to Child 23's GP.

3.28. On or around 26 May 2016 during/following your consultation with Child 24;

3.28.1. Did not record/consider whether the support Child 24 was receiving was optimal.

3.28.2. Did not record whether Child 24 required additional services/support.

3.28.3. Did not record which kind of support/plans were in place for Child 24.

3.28.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 24.

3.28.5. Did not send an outcome letter to Child 24's referrer

3.29. On or around 9 June 2016 during/following your consultation with Child 25;

3.29.1. Incorrectly recorded Child 25's referrer as the safeguarding team/police.

3.29.2. Did not record a risk assessment for Child 25

3.29.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 25/Child 25's mother

3.29.4. Did not record/send an outcome letter to the referrer/Children's Social Care

3.29.5. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 25's mother

3.30. On or around 9 June 2016, during/following your consultation with Child 26;

3.30.1. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 26/Child 26's mother

3.30.2. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 26's mother

3.30.3. Did not record/send an outcome letter to the referrer/Children's Social Care

3.30.4. Incorrectly informed Child 26's GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

3.30.5. Did not record a risk assessment for Child 26

3.31. On or around 22 September 2016 during/following your consultation with Child 27;

3.31.1. Did not create official healthcare records for Child 27.

3.31.2. Did not send/complete an outcome letter to/for Child 27's GP.

3.31.3. Did not record a full risk assessment for Child 27.

3.31.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 27/Child 27's mother

3.31.5. Did not record/send an outcome letter to the referrer/Children's Social Care

3.32. On or around 20 July 2017, during/following your consultation with Child 28;

3.32.1. Did not record a full risk assessment for Child 28.

3.32.2. Did not Did not record adequate details of the advice/examination/discussion/next steps provided to Child 28/Child 28's father

3.33. On or around 10 August 2017, during/following your consultation with Child 29;

3.33.1. Did not record a full risk assessment for Child 29

3.33.2. Did not record the symptoms/adverse effects suffered by Child 29.

3.33.3. Did not record the benefit of a referral to a gynaecologist for Child 29.

3.33.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 29/Child 29's mother

3.33.5. Did not record/include sufficient information/understanding surrounding the type of FGM in Child 29's GP Letter

4. Did not record the offer/confirmation of consent for FGM assessments for one or more adult patients as listed in schedule 10.

5. Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.

6. Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10;

7. Did not record the offer of a translator to Adult 10

8. Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

9. Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.

10. On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;
    a) Advice/discussion/next steps with the patient
    b) Details of assessment/examination
    c) FGM risk assessments

11. Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

12. Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle for one or more adult patients, as listed in schedule 14.

13. On or around 6 August 2015 did not refer Child 17 to a Community Paediatrician.

14. On or around 13 August 2015;
    14.1. Did not refer Child 18 to a specialist paediatric urologist.
    14.2. Did not refer Child 18 to the Consultant Lead Professor at the African Well Women Clinic (AWWC)
    14.3. Unnecessarily conducted a FGM examination/assessment of Child 18.
    14.4. Incorrectly referred Child 18 to the adult gynaecology service.

15. On or around 26 May 2016 did not refer Child 24 for psychological support

16. On or around 18 February 2016, did not refer child 23 for psychological services.

17. On or around 9 June 2016 did not refer Child 25 to a paediatric gynaecologist/specialist paediatric FGM centre/ FGM child assessment provider.

18. On or around 7 July 2017 you initially assessed Child 28 rather than refer them for examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.

19. On or around 10 August 2017 did not refer Child 29's examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider

20. Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

21. Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

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

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

1. Adult 1 on or around 18 May 2017
2. Adult 2 on or around 27 October 2016
3. Adult 3 on or around 22 September 2016
4. Adult 4 on or around 21 April 2016
5. Adult 5 on or around 19 June 2014
6. Adult 6 on or around 15 June 2017
7. Adult 7 on or around 18 August 2016
8. Adult 8 on or around 3 December 2015
9. Adult 9 on or around 4 June 2015
10. Adult 10 on or around 19 November 2015

11. Adult 11 on or around 20 December 2012
12. Adult 12 on or around 11 June 2016
13. Adult 13 on or around 22 May 2014
14. Adult 15 on or around 6 August 2015
15. Adult 17 on or around 22 August 2013/12 May 2016
16. Adult 18 on or around 6 September 2012/30 October 2014
17. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
18. Adult 20 on or around 8 January 2015
19. Adult 21 on or around 6 December 2012/28 March 2013
20. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
21. Adult 23 on or around 28 April 2016
22. Adult 24 on or around 20 October 2016
23. Adult 28 on or around 25 April 2013
24. Adult 29 on or around 3 January 2013
25. Adult 30 on or around 13 March 2013
26. Adult 31 on or around 18 July 2013/18 August 2013
27. Adult 32 on or around 28 August 2014
28. Adult 33 on or around 7 November 2014
29. Adult 34 on or around 12 March 2015
30. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
31. Adult 36 on or around 3 January 2013
32. Adult 37 on or around 13/27 November 2014
33. Adult 38 on or around 12 May 2016
34. Adult 40 on or around 15 May 2014/2015
35. Adult 41 on or around 3 August 2017
36. Adult 42 on or around 12 June 2014
37. Adult 43 on or around 8/14 August 2014
38. Adult 44 on or around 5/12 December 2013
39. Adult 45 on or around 6 March 2014/15 May 2014/3 July 2014
40. Adult 46 on or around 17 July 2014
41. Adult 47 on or around 11 December 2014

42. Adult 48 on or around 24 July 2014
43. Adult 49 on or around 18 July 2013
44. Adult 50 on or around 8 August 2013
45. Adult 51 on or around 27 November 2014/11 December 2014
46. Adult 52 on or around 4 December 2014
47. Adult 53 on or around 18 July 2013
48. Adult 54 on or around 3 January 2013
49. Adult 55 on or around 3 July 2014
50. Adult 56 on or around 29 May 2014
51. Adult 57 on or around 20 December 2012
52. Adult 58 on or around 11 September 2014
53. Adult 59 on or around 14 November 2013
54. Adult 60 on or around 8 January 2015
55. Adult 61 on or around 9 December 2013
56. Adult 62 on or around 2/30 January 2014/27 February 2014
57. Adult 63 on or around 20 November 2014
58. Adult 64 on or around 28 March 2013
59. Adult 67 on or around 15 January 2015
60. Adult 68 on or around 17 July 2014
61. Adult 69 on or around 15 October 2015
62. Adult 70 on or around 11 September 2014
63. Adult 71 on or around 1 October 2015/3 December 2015
64. Adult 72 on or around 12 September 2013/10 October 2013
65. Adult 73 on or around 1/8 October 2015
66. Adult 74 on or around 3 October 2013
67. Adult 75 on or around 16/30 April 2015
68. Adult 76 on or around 20 November 2014
69. Adult 77 on or around 21 August 2014
70. Adult 78 on or around 10 October 2013
71. Adult 79 on or around 1 October 2015
72. Adult 80 on or around 10/17 September 2015

73. Adult 81 on or around 12 September 2013
74. Adult 82 on or around 15 May 2014
75. Adult 83 on or around 7 November 2013
76. Adult 84 on or around 27 June 2013
77. Adult 85 on or around 26 September 2013
78. Adult 86 on or around 25 April 2013
79. Adult 87 on or around 13 February 2014
80. Adult 88 on or around 2 May 2013
81. Adult 89 on or around 8 October 2015
82. Adult 90 on or around 20 September 2012
83. Adult 91 on or around 7 November 2013
84. Adult 92 on or around 15 August 2013
85. Adult 93 on or around 21 February 2013
86. Adult 94 on or around 28 February 2013
87. Adult 95 on or around 26 June 2012/19 July 2012
88. Adult 96 on or around 27 December 2012/3 January 2013
89. Adult 97 on or around 21 June 2012
90. Adult 98 on or around 19 July 2012
91. Adult 99 on or around 7/12 June 2012
92. Adult 100 on or around 8 March 2012
93. Adult 101 on or around 21 June 2012
94. Adult 102 on or around 16 February 2012
95. Adult 103 on or around 2 February 2012
96. Adult 104 on or around 23 February 2012
97. Adult 105 on or around 16 February 2012
98. Adult 106 on or around 24 May 2012
99. Adult 107 on or around 10 May 2012
100. Adult 108 on or around 29 March 2012
101. Adult 109 on or around 14 May 2015
102. Adult 110 on or around 4 August 2011
103. Adult 112 on or around 1 November 2012

104. Adult 113 on or around 19 July 2012

105. Adult 114 on or around 8 March 2012/21 June 2012

106. Adult 115 on or around 3 May 2012

107. Adult 116 on or around 5 July 2012

108. Adult 117 on or around 21 June 2012

109. Adult 118 on or around 24 May 2012

110. Adult 120 on or around 28 April 2016

111. Adult 121 on or around 9 June 2016

112. Adult 122 on or around 26 May 2016/ 9 June 2016/21 June 2016

113. Adult 123 on or around 30 June 2016

114. Adult 124 on or around 21 July 2016

115. Adult 125 on or around 18 February 2016

116. Adult 126 on or around 26 June 2016/25 August 2018

117. Adult 127 on or around 18 August 2016

118. Adult 128 on or around 20 October 2016

119. Adult 129 on or around 18 August 2016/10 November 2016

120. Adult 130 on or around 10/24 November 2016

121. Adult 131 on or around 10/24 November 2016

122. Adult 132 on or around 8 December 2016

123. Adult 134 on or around 5 January 2017

124. Adult 135 on or around 10 August 2017

125. Adult 136 on or around 16 August 2017

126. Adult 137 on or around 12 May 2014

127. Adult 138 on or around 29 June 2017

128. Adult 139 on or around 8 March 2018

129. Adult 140 on or around 30 April 2015

130. Adult 141 on or around 4 August 2016

131. Adult 142 on or around 16 March 2017

132. Adult 143 on or around 12 March 2013

133. Adult 144 on or around 23 July 2015

134. Adult 145 on or around 24 November 2016

135. Adult 146 on or around 7 January 2016

136. Adult 147 on or around 9 December 2016

137. Adult 148 on or around 24 May 2012

138. Adult 149 on or around 5 October 2017

139. Adult 152 on or around 15 November 2013- no clinical notes

140. Adult 153 on or around 20 December 2012 no clinical notes

141. Adult 154 on or around 25 May 2017

142. Adult 155 on or around 18 February 2016

143. Adult 156 on or around 24 January 2013

144. Adult 157 on or around 29 May 2014/ 19 June 2014/ 3 July 2014

145. Adult 158 on or around 7 November 2013

146. Adult 159 on or around 13 February 2014

147. Adult 160 on or around 17 September 2015

148. Adult 161 on or around 18 February 2016

149. Adult 162 on or around 25 August 2016

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

1. Adult 1 on or around 18 May 2017
2. Adult 9 on or around 4 June 2015
3. Adult 12 on or around 11 June 2015
4. Adult 16 on or around 3 November 2016
5. Adult 17 on or around 22 August 2013
6. Adult 19 on or around 20 August 2015
7. Adult 22 on or around 16 April 2015
8. Adult 26 on or around 13 July 2017
9. Adult 31 on or around 18 July 2013/18 August 2013
10. Adult 41 on or around 3 August 2017
11. Adult 44 on or around 5 December 2013
12. Adult 69 on or around 15 October 2015
13. Adult 71 on or around 1 October 2015

14. Adult 73 on or around 1 October 2015
15. Adult 75 on or around 16 April 2015
16. Adult 79 on or around 1 October 2015
17. Adult 80 on or around 10 September 2015
18. Adult 89 on or around 8 October 2015
19. Adult 120 on or around 28 April 2016
20. Adult 121 on or around 9 June 2016
21. Adult 122 between 26 May 2016 & 21 June 2016
22. Adult 123 on or around 30 June 2016
23. Adult 124 on or around 21 July 2016
24. Adult 125 on or around 18 February 2016
25. Adult 126 between 25 June 2016 & 25 August 2016
26. Adult 127 on or around 18 August 2016
27. Adult 128 on or around 20 October 2016
28. Adult 129 between 18 August 2016 & 10 November 2016
29. Adult 132 on or around 8 December 2016
30. Adult 134 on or around 5 January 2017
31. Adult 135 on or around 10 August 2017
32. Adult 138 on or around 29 June 2017
33. Adult 139 on or around 8 March 2018
34. Adult 141 on or around 4 August 2016
35. Adult 142 on or around 16 March 2017
36. Adult 144 on or around 23 July 2015
37. Adult 145 on or around 24 November 2016
38. Adult 146 on or around 7 January 2016
39. Adult 147 on or around 9 December 2016
40. Adult 149 on or around 5 October 2017
41. Adult 154 on or around 25 May 2017
42. Adult 155 on or around 18 February 2016
43. Adult 160 on or around 17 September 2015
44. Adult 161 on or around 18 February 2016

45. Adult 162 on or around 25 August 2016
46. Adult 163 on or around 12 January 2017

Schedule 3. Did not obtain second opinion during de-infibulation

1. Adult 2 on or around 27 October 2016
2. Adult 4 on or around 21 June 2016
3. Adult 8 on or around 3 December 2015
4. Adult 14 on or around 20 December 2013
5. Adult 17 on or around 22 August 2013
6. Adult 18 on or around 30 October 2014
7. Adult 19 on or around 20 August 2015
8. Adult 35 on or around 2 July 2015
9. Adult 44 on or around 5 December 2013
10. Adult 130 on or around 24 November 2016

Schedule 4: Administered medication without a prescription

1. Adult 1 on or around 18 May 2017
2. Adult 9 on or around 4 June 2015
3. Adult 11 on or around 20 December 2012
4. Adult 12 on or around 11 June 2016
5. Adult 13 on or around 22 May 2014
6. Adult 14 on or around 27 December 2013
7. Adult 15 on or around 6 August 2015
8. Adult 18 on or around 6 September 2012/30 October 2014
9. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
10. Adult 20 on or around 8 January 2015
11. Adult 21 on or around 6 December 2012/28 March 2013
12. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
13. Adult 26 on or around 6/13 July 2017

14. Adult 27 on or around 1 November 2012
15. Adult 28 on or around 25 April 2013
16. Adult 29 on or around 3 January 2013
17. Adult 30 on or around 13 March 2013
18. Adult 31 on or around 18 July 2013/18 August 2013
19. Adult 33 on or around 7 November 2014
20. Adult 34 on or around 12 March 2015
21. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
22. Adult 37 on or around 13/27 November 2014
23. Adult 40 on or around 15 May 2014/2015
24. Adult 41 on or around 3 August 2017
25. Adult 43 on or around 8/14 August 2014
26. Adult 44 on or around 5/12 December 2013
27. Adult 45 on or around 6 March 2014/15 May 2014/3 July 2014
28. Adult 46 on or around 17 July 2014
29. Adult 47 on or around 11 December 2014
30. Adult 48 on or around 24 July 2014
31. Adult 49 on or around 18 July 2013
32. Adult 50 on or around 8 August 2013
33. Adult 51 on or around 27 November 2014/11 December 2014
34. Adult 52 on or around 4 December 2014
35. Adult 53 on or around 18 July 2013
36. Adult 54 on or around 3 January 2013
37. Adult 55 on or around 3 July 2014
38. Adult 56 on or around 29 May 2014
39. Adult 57 on or around 20 December 2012
40. Adult 58 on or around 11 September 2014
41. Adult 60 on or around 8 January 2015
42. Adult 61 on or around 9 December 2013
43. Adult 62 on or around 2/30 January 2014/27 February 2014
44. Adult 63 on or around 20 November 2014

45. Adult 64 on or around 28 March 2013
46. Adult 66 on or around 11 June 2015
47. Adult 67 on or around 15 January 2015
48. Adult 68 on or around 17 July 2014
49. Adult 69 on or around 15 October 2015
50. Adult 70 on or around 11 September 2014
51. Adult 71 on or around 1 October 2015/3 December 2015
52. Adult 72 on or around 12 September 2013/10 October 2013
53. Adult 73 on or around 1/8 October 2015
54. Adult 74 on or around 3 October 2013
55. Adult 75 on or around 16/30 April 2015
56. Adult 76 on or around 20 November 2014
57. Adult 77 on or around 21 August 2014
58. Adult 78 on or around 10 October 2013
59. Adult 79 on or around 1 October 2015
60. Adult 80 on or around 10/17 September 2015
61. Adult 81 on or around 12 September 2013
62. Adult 82 on or around 15 May 2014
63. Adult 83 on or around 7 November 2013
64. Adult 84 on or around 27 June 2013
65. Adult 86 on or around 25 April 2013
66. Adult 87 on or around 13 February 2014
67. Adult 88 on or around 2 May 2013
68. Adult 89 on or around 8 October 2015
69. Adult 90 on or around 20 September 2012
70. Adult 93 on or around 21 February 2013
71. Adult 94 on or around 28 February 2013
72. Adult 95 on or around 26 June 2012/19 July 2012
73. Adult 96 on or around 27 December 2012/3 January 2013
74. Adult 97 on or around 21 June 2012
75. Adult 98 on or around 19 July 2012

76. Adult 99 on or around 7/12 June 2012
77. Adult 100 on or around 8 March 2012
78. Adult 101 on or around 21 June 2012
79. Adult 102 on or around 16 February 2012
80. Adult 103 on or around 2 February 2012
81. Adult 104 on or around 23 February 2012
82. Adult 105 on or around 16 February 2012
83. Adult 106 on or around 24 May 2012
84. Adult 107 on or around 10 May 2012
85. Adult 108 on or around 29 March 2012
86. Adult 109 on or around 14 May 2015
87. Adult 110 on or around 4 August 2011
88. Adult 111 on or around 16 February 2012
89. Adult 112 on or around 1 November 2012
90. Adult 113 on or around 19 July 2012
91. Adult 114 on or around 8 March 2012/21 June 2012
92. Adult 115 on or around 3 May 2012
93. Adult 116 on or around 5 July 2012
94. Adult 117 on or around 21 June 2012
95. Adult 118 on or around 24 May 2012
96. Adult 120 on or around 28 April 2016
97. Adult 121 on or around 9 June 2016
98. Adult 122 on or around 26 May 2016/ 9 June 2016/21 June 2016
99. Adult 123 on or around 30 June 2016
100. Adult 124 on or around 21 July 2016
101. Adult 125 on or around 18 February 2016
102. Adult 126 on or around 26 June 2016/25 August 2018
103. Adult 127 on or around 18 August 2016
104. Adult 128 on or around 20 October 2016
105. Adult 129 on or around 18 August 2016/10 November 2016
106. Adult 130 on or around 10/24 November 2016

107. Adult 132 on or around 8 December 2016
108. Adult 134 on or around 5 January 2017
109. Adult 135 on or around 10 August 2017
110. Adult 136 on or around 16 August 2017
111. Adult 138 on or around 29 June 2017
112. Adult 141 on or around 4 August 2016
113. Adult 142 on or around 16 March 2017
114. Adult 143 on or around 12 March 2013
115. Adult 144 on or around 23 July 2015
116. Adult 145 on or around 24 November 2016
117. Adult 146 on or around 7 January 2016
118. Adult 147 on or around 9 December 2016
119. Adult 148 on or around 24 May 2012
120. Adult 149 on or around 5 October 2017
121. Adult 150 on or around 22 September 2016
122. Adult 151 on or around 18 February 2016
123. Adult 152 on or around 15 November 2013- no clinical notes
124. Adult 153 on or around 20 December 2012 no clinical notes
125. Adult 154 on or around 25 May 2017
126. Adult 155 on or around 18 February 2016
127. Adult 156 on or around 24 January 2013
128. Adult 157 on or around 29 May 2014/ 19 June 2014/ 3 July 2014
129. Adult 158 on or around 7 November 2013
130. Adult 159 on or around 13 February 2014
131. Adult 160 on or around 17 September 2015
132. Adult 161 on or around 18 February 2016
133. Adult 162 on or around 25 August 2016

Schedule 5. Provided psychological/psychosexual counselling

1. Adult 2 on or around 27 October 2016

2. Adult 3 on or around 22 September 2016
3. Adult 7 on or around 18 August 2016
4. Adult 15 on or around 6 August 2015
5. Adult 23 on or around 28 April 2016

Schedule 6; Provided sexual health counselling

1. Adult 3 on or around 22 September 2016
2. Adult 7 on or around 18 August 201
3. Adult 19 between May & September 2015

Schedule 7: Undertook smear test without training/competency

1. Adult 6 on or around 15 June 2017
2. Adult 8 on or around 3 December 2015
3. Adult 13 on or around 22 May 2014
4. Adult 32 on or around 28 April 2014

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

1. Child 1 on or around 17 September 2012
2. Child 2 on or around 1 November 2012
3. Child 3 on or around 20 December 2012
4. Child 4 on or around 3 January 2013
5. Child 5 on or around 3 January 2013
6. Child 6 on or around 25 January 2013
7. Child 7 on or around 19 April 2013
8. Child 8 on or around 6 June 2013
9. Child 10 on or around 25 July 2013

10. Child 11 on or around 26 July 2013
11. Child 12 on or around 12 September 2013
12. Child 13 on or around 12 September 2013
13. Child 14 on or around 30 January 2014
14. Child 15 on or around 16 October 2014
15. Child 16 on or around 6 August 2015
16. Child 17 on or around 6 August 2015
17. Child 18 on or around 13 August 2015
18. Child 19 on or around 11 September 2015
19. Child 21 on or around 22 October 2015
20. Child 22 on or around 22 October 2015
21. Child 23 on or around 18 February 2016
22. Child 24 on or around 26 May 2016
23. Child 25 on or around 9 June 2016
24. Child 26 on or around 9 June 2016
25. Child 27 on or around 22 November 2016
26. Child 28 on or around 20 July 2017
27. Child 29 on or around 10 August 2017

Schedule 9: Failed to refer/investigate

1. Adult 1 on or around 18 May 2017
2. Adult 2 on or around 27 October 2016
3. Adult 3 on or around 22 September 2016
4. Adult 4 on or around 21 April 2016
5. Adult 5 on or around 19 June 2014
6. Adult 6 on or around 15 June 2017
7. Adult 7 on or around 18 August 2016
8. Adult 8 on or around 3 December 2015
9. Adult 9 on or around 4 June 2015
10. Adult 10 on or around 19 November 2015

11. Adult 11 on or around 20 December 2012
12. Adult 14 on or around 20 December 2013
13. Adult 15 on or around 6 August 2015
14. Adult 17 on or around 22 August 2013/12 May 2016
15. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
16. Adult 23 on or around 28 April 2016
17. Adult 30 on or around 13 March 2013
18. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
19. Adult 36 on or around 3 January 2013
20. Adult 37 on or around 13/27 November 2014
21. Adult 51 on or around 27 November 2014/11 December 2014
22. Adult 56 on or around 29 May 2014.
23. Adult 59 on or around 14 November 2013
24. Adult 71 on or around 1 October 2015/3 December 2015
25. Adult 80 on or around 10/19 September 2015
26. Adult 124 on or around 28 July 2016

Schedule 10: Failed to record the offer of consent for examination/de-infibulation

Failed to record the offer of a chaperone for examination/de-infibulation.

1. Adult 1 on or around 18 May 2017
2. Adult 2 on or around 27 October 2016
3. Adult 8 on or around 3 December 2015
4. Adult 9 on or around 4 June 2015
5. Adult 12 on or around 11 June 2016
6. Adult 14 on or around 20 December 2013
7. Adult 13 on or around 22 May 2014
8. Adult 16 on or around 2 November 2016
9. Adult 18 on or around 6 September 2012/30 October 2014
10. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

11. Adult 20 on or around 8 January 2015
12. Adult 21 on or around 6 December 2012/28 March 2013
13. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
14. Adult 26 on or around 6 July 2017 & 13 July 2017
15. Adult 27 on or around 1 November 2012
16. Adult 28 on or around 25 April 2013
17. Adult 29 on or around 3 January 2013
18. Adult 31 on or around 18 July 2013/18 August 2013
19. Adult 33 on or around 7 November 2014
20. Adult 34 on or around 12 March 2015
21. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
22. Adult 37 on or around 13/27 November 2014
23. Adult 40 on or around 15 May 2014/2015
24. Adult 41 on or around 3 August 2017
25. Adult 43 on or around 8/14 August 2014
26. Adult 44 on or around 5/12 December 2013
27. Adult 45 on or around 6 March 2014/15 May 2014/3 July 2014
28. Adult 46 on or around 17 July 2014
29. Adult 47 on or around 11 December 2014
30. Adult 48 on or around 24 July 2014
31. Adult 49 on or around 18 July 2013
32. Adult 50 on or around 8 August 2013
33. Adult 51 on or around 27 November 2014/11 December 2014
34. Adult 52 on or around 4 December 2014
35. Adult 54 on or around 3 January 2013
36. Adult 55 on or around 3 July 2014
37. Adult 56 on or around 29 May 2014
38. Adult 57 on or around 20 December 2012
39. Adult 58 on or around 11 September 2014
40. Adult 60 on or around 8 January 2015
41. Adult 61 on or around 9 December 2013

42. Adult 62 on or around 2/30 January 2014/27 February 2014
43. Adult 63 on or around 20 November 2014
44. Adult 64 on or around 28 March 2013
45. Adult 66 on or around 11 June 2015
46. Adult 67 on or around 15 January 2015
47. Adult 68 on or around 17 July 2014
48. Adult 69 on or around 15 October 2015
49. Adult 70 on or around 11 September 2014
50. Adult 71 on or around 1 October 2015/3 December 2015
51. Adult 72 on or around 12 September 2013/10 October 2013
52. Adult 73 on or around 1/8 October 2015
53. Adult 74 on or around 3 October 2013
54. Adult 75 on or around 16/30 April 2015
55. Adult 76 on or around 20 November 2014
56. Adult 77 on or around 21 August 2014
57. Adult 78 on or around 10 October 2013
58. Adult 79 on or around 1 October 2015
59. Adult 80 on or around 10/17 September 2015
60. Adult 81 on or around 12 September 2013
61. Adult 82 on or around 15 May 2014
62. Adult 83 on or around 7 November 2013
63. Adult 84 on or around 27 June 2013
64. Adult 86 on or around 25 April 2013
65. Adult 87 on or around 13 February 2014
66. Adult 88 on or around 2 May 2013
67. Adult 89 on or around 8 October 2015
68. Adult 90 on or around 20 September 2012
69. Adult 93 on or around 21 February 2013
70. Adult 94 on or around 28 February 2013
71. Adult 95 on or around 26 June 2012/19 July 2012
72. Adult 96 on or around 27 December 2012/3 January 2013

73. Adult 97 on or around 21 June 2012
74. Adult 98 on or around 19 July 2012
75. Adult 99 on or around 7/12 June 2012
76. Adult 100 on or around 8 March 2012
77. Adult 101 on or around 21 June 2012
78. Adult 102 on or around 16 February 2012
79. Adult 103 on or around 2 February 2012
80. Adult 104 on or around 23 February 2012
81. Adult 105 on or around 16 February 2012
82. Adult 106 on or around 24 May 2012
83. Adult 107 on or around 10 May 2012
84. Adult 108 on or around 29 March 2012
85. Adult 109 on or around 14 May 2015
86. Adult 110 on or around 4 August 2011
87. Adult 111 on or around 16 February 2012
88. Adult 112 on or around 1 November 2012
89. Adult 113 on or around 19 July 2012
90. Adult 114 on or around 8 March 2012/21 June 2012
91. Adult 115 on or around 3 May 2012
92. Adult 116 on or around 5 July 2012
93. Adult 117 on or around 21 June 2012
94. Adult 118 on or around 24 May 2012
95. Adult 120 on or around 28 April 2016
96. Adult 121 on or around 9 June 2016
97. Adult 122 on or around 26 May 2016/ 9 June 2016/21 June 2016
98. Adult 123 on or around 30 June 2016
99. Adult 124 on or around 21 July 2016
100. Adult 125 on or around 18 February 2016
101. Adult 126 on or around 26 June 2016/25 August 2018
102. Adult 127 on or around 18 August 2016
103. Adult 128 on or around 20 October 2016

104. Adult 129 on or around 18 August 2016/10 November 2016
105. Adult 130 on or around 10/24 November 2016
106. Adult 132 on or around 8 December 2016
107. Adult 134 on or around 5 January 2017
108. Adult 135 on or around 10 August 2017
109. Adult 136 on or around 16 August 2017
110. Adult 138 on or around 29 June 2017
111. Adult 139 on or around 8 March 2018
112. Adult 140 on or around 30 April 2015
113. Adult 141 on or around 4 August 2016
114. Adult 142 on or around 16 March 2017
115. Adult 143 on or around 12 March 2013
116. Adult 144 on or around 23 July 2015
117. Adult 145 on or around 24 November 2016
118. Adult 146 on or around 7 January 2016
119. Adult 147 on or around 9 December 2016
120. Adult 148 on or around 24 May 2012
121. Adult 149 on or around 5 October 2017
122. Adult 150 on or around 22 September 2016
123. Adult 151 on or around 18 February 2016
124. Adult 152 on or around 15 November 2013
125. Adult 153 on or around 20 December 2012
126. Adult 154 on or around 25 May 2017
127. Adult 155 on or around 18 February 2016
128. Adult 156 on or around 24 January 2013
129. Adult 157 on or around 29 May 2014/ 19 June 2014/ 3 July 2014
130. Adult 158 on or around 7 November 2013
131. Adult 159 on or around 13 February 2014
132. Adult 160 on or around 17 September 2015
133. Adult 161 on or around 18 February 2016
134. Adult 162 on or around 25 August 2016

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

1. Adult 1 on or around 18 May 2017
2. Adult 2 on or around 27 October 2016
3. Adult 3 on or around 22 September 2016
4. Adult 4 on or around 21 April 2016
5. Adult 5 on or around 19 June 2014
6. Adult 6 on or around 15 June 2017
7. Adult 7 on or around 18 August 2016
8. Adult 9 on or around 4 June 2015
9. Adult 11 on or around 20 December 2012
10. Adult 14 on or around 20 December 2014
11. Adult 20 on or around 8 January 2015
12. Adult 21 on or around 6 December 2012/28 March 2013
13. Adult 23 on or around 28 April 2016
14. Adult 24 on or around 20 October 2016
15. Adult 27 on or around 1 November 2012
16. Adult 28 on or around 25 April 2013
17. Adult 29 on or around 3 January 2013
18. Adult 30 on or around 13 March 2013
19. Adult 31 on or around 18 July 2013/18 August 2013
20. Adult 32 on or around 28 August 2014
21. Adult 33 on or around 7 November 2014
22. Adult 37 on or around 13/27 November 2014
23. Adult 38 on or around 12 May 2016
24. Adult 42 on or around 12 June 2014
25. Adult 46 on or around 17 July 2014
26. Adult 47 on or around 11 December 2014
27. Adult 48 on or around 24 July 2014
28. Adult 51 on or around 27 November 2014/11 December 2014
29. Adult 54 on or around 3 January 2013

30. Adult 56 on or around 29 May 2014
31. Adult 58 11 September 2014
32. Adult 59 on or around 14 No ember 2013
33. Adult 60 on or around 8 January 2015
34. Adult 62 on or around 2/30 January 2014/27 February 2014
35. Adult 64 on or around 28 March 2013
36. Adult 71 on or around 1 October 2015/3 December 2015
37. Adult 74 on or around 3 October 2013
38. Adult 75 on or around 16/30 April 2015
39. Adult 76 on or around 20 November 2014
40. Adult 77 on or around 21 August 2014
41. Adult 78 on or around 10 October 2013
42. Adult 79 on or around 1 October 2015
43. Adult 81 on or around 12 September 2013
44. Adult 84 on or around 27 June 2013
45. Adult 86 on or around 25 April 2013
46. Adult 87 on or around 13 February 2014
47. Adult 88 on or around 2 May 2013
48. Adult 89 on or around 8 October 2015
49. Adult 90 on or around 20 September 2012
50. Adult 91 on or around 7 November 2013
51. Adult 92 on or around 15 August 2013
52. Adult 93 on or around 21 February 2013
53. Adult 94 on or around 21 February 2013
54. Adult 98 on or around 19 July 2012
55. Adult 99 on or around 7/21 June 2012
56. Adult 100 on or around 8 March 2012
57. Adult 101 on or around 21 June 2012
58. Adult 102 on or around 16 February 2012
59. Adult 103 on or around 2 February 2012
60. Adult 104 on or around 23 February 2012

61. Adult 105 on or around 16 February 2012
62. Adult 106 on or around 24 May 2012
63. Adult 107 on or around 10 May 2012
64. Adult 109 on or around 14 May 2015
65. Adult 112 on or around 1 November 2012
66. Adult 113 on or around 19 July 2012
67. Adult 114 on or around 21 June 2012
68. Adult 115 on or around 3 May 2012
69. Adult 116 on or around 5 July 2012
70. Adult 117 on or around 21 June 2012
71. Adult 118 on or around 24 May 2012
72. Adult 126 on or 25 August 2018
73. Adult 127 on or around 18 August 2016
74. Adult 128 20 October 2016
75. Adult 129 on or around 10 November 2016
76. Adult 130 24 November 2016
77. Adult 131 on or around 10 November 2016
78. Adult 132 on or around 8 December 2016
79. Adult 133 on or around 22 December 2016
80. Adult 134 on or around 5 January 2017
81. Adult 136 on or around 10 August 2017
82. Adult 138 on or around 29 June 2017
83. Adult 139 on or around 8 March 2018
84. Adult 141 on or around 4 August 2016
85. Adult 149 on or around 5 October 2017
86. Adult 158 on or around 7 November 2013

Schedule 12: Did not record adequate details of the appointment/consultation.

1. Adult 1 on or around 18 May 2017
2. Adult 5 on or around 19 June 201
3. Adult 11 on or around 20 December 2012

4. Adult 13 on or around 22 May 2014
5. Adult 14 on or around 20 December 2013/27 February 2014
6. Adult 16 on or around 3 November 2016
7. Adult 18 on or around 6 September 2012
8. Adult 20 on or around 8 January 2015
9. Adult 21 on or around 6 December 2012/28 March 2013
10. Adult 25 on or around 3 July 2014
11. Adult 26 on or around 6/13 July 2017
12. Adult 27 on or around 1 November 2012
13. Adult 28 on or around 25 April 2013
14. Adult 29 on or around 3 January 2013
15. Adult 30 on or around 13 March 2013
16. Adult 31 on or around 18 July 2013/18 August 2013
17. Adult 32 on or around 28 August 2014
18. Adult 33 on or around 7 November 2014
19. Adult 36 on or around 3 January 2013
20. Adult 37 on or around 13/27 November 2014
21. Adult 38 on or around 12 May 2016
22. Adult 40 on or around 15 May 2014
23. Adult 41 on or around 3 August 2017
24. Adult 42 on or around 12 June 2014
25. Adult 43 on or around 8/14 August 2014
26. Adult 45 on or around 6 March 2014/15 May 2014/3 July 2014
27. Adult 46 on or around 17 July 2014
28. Adult 47 on or around 11 December 2014
29. Adult 48 on or around 24 July 2014
30. Adult 49 on or around 18 July 2013
31. Adult 50 on or around 8 August 2013
32. Adult 51 on or around 27 November 2014/11 December 2014
33. Adult 52 on or around 4 December 2014
34. Adult 53 on or around 18 July 2013

35. Adult 54 on or around 3 January 2013
36. Adult 55 on or around 3 July 2014
37. Adult 56 on or around 29 May 2014
38. Adult 57 on or around 20 December 2012
39. Adult 58 on or around 11 September 2014
40. Adult 59 on or around 14 November 2013
41. Adult 60 on or around 8 January 2015
42. Adult 61 on or around 9 December 2013
43. Adult 62 on or around 2/30 January 2014/27 February 2014
44. Adult 63 on or around 20 November 2014
45. Adult 64 on or around 28 March 2013
46. Adult 66 on or around 11 June 2015
47. Adult 67 on or around 15 January 2015
48. Adult 68 on or around 17 July 2014
49. Adult 69 on or around 15 October 2015
50. Adult 70 on or around 11 September 2014
51. Adult 71 on or around 1 October 2015/3 December 2015
52. Adult 72 on or around 12 September 2013/10 October 2013
53. Adult 73 on or around 1/8 October 2015
54. Adult 74 on or around 3 October 2013
55. Adult 75 on or around 16/30 April 2015
56. Adult 76 on or around 20 November 2014
57. Adult 77 on or around 21 August 2014
58. Adult 78 on or around 10 October 2013
59. Adult 79 on or around 1 October 2015
60. Adult 80 on or around 10/17 September 2015
61. Adult 81 on or around 12 September 2013
62. Adult 82 on or around 15 May 2014
63. Adult 83 on or around 7 November 2013
64. Adult 84 on or around 27 June 2013
65. Adult 85 on or around 26 September 2013

66. Adult 86 on or around 25 April 2013
67. Adult 87 on or around 13 February 2014
68. Adult 88 on or around 2 May 2013
69. Adult 89 on or around 8 October 2015
70. Adult 90 on or around 20 September 2012
71. Adult 91 on or around 7 November 2013
72. Adult 92 on or around 15 August 2013
73. Adult 94 on or around 28 February 2013
74. Adult 95 on or around 26 June 2012/19 July 2012
75. Adult 96 on or around 27 December 2012/3 January 2013
76. Adult 97 on or around 21 June 2012
77. Adult 98 on or around 19 July 2012
78. Adult 99 on or around 7/12 June 2012
79. Adult 100 on or around 8 March 2012
80. Adult 101 on or around 21 June 2012
81. Adult 102 on or around 16 February 2012
82. Adult 103 on or around 2 February 2012
83. Adult 104 on or around 23 February 2012
84. Adult 105 on or around 16 February 2012
85. Adult 106 on or around 24 May 2012
86. Adult 107 on or around 10 May 2012
87. Adult 108 on or around 29 March 2012
88. Adult 109 on or around 14 May 2015
89. Adult 110 on or around 4 August 2011
90. Adult 111 on or around 16 February 2012
91. Adult 112 on or around 1 November 2012
92. Adult 113 on or around 19 July 2012
93. Adult 114 on or around 8 March 2012/21 June 2012
94. Adult 115 on or around 3 May 2012
95. Adult 116 on or around 5 July 2012
96. Adult 117 on or around 21 June 2012

97. Adult 118 on or around 24 May 2012
98. Adult 120 on or around 28 April 2014
99. Adult 121 on or around 9 June 2016
100. Adult 122 on or around 9/21/26 May 2016
101. Adult 123 on or around 30 June 2016
102. Adult 125 on or around 18 February 2016
103. Adult 126 on or around 26 June 2016/25 August 2018
104. Adult 127 on or around 18 August 2016
105. Adult 128 on or around 20 October 2016
106. Adult 129 on or around 18 August 2016/10 November 2016
107. Adult 131 on or around 4/10 November 2016
108. Adult 132 on or around 8 December 2016
109. Adult 133 on or around 22 December 2016
110. Adult 134 on or around 5 January 2017
111. Adult 135 on or around 10 August 2017
112. Adult 136 on or around 16 August 2017
113. Adult 137 on or around 12 May 2014
114. Adult 138 on or around 29 June 2017
115. Adult 139 on or around 8 March 2018
116. Adult 140 on or around 30 April 2015
117. Adult 141 on or around 4 August 2016
118. Adult 142 on or around 16 March 2017
119. Adult 143 on or around 12 March 2013
120. Adult 144 on or around 23 July 2015
121. Adult 145 on or around 24 November 2016
122. Adult 146 on or around 7 January 2016
123. Adult 147 on or around 9 December 2016
124. Adult 148 on or around 24 May 2012
125. Adult 149 on or around 5 October 2017
126. Adult 150 on or around 22 September 2016
127. Adult 151 on or around 18 February 2016

128. Adult 152 on or around 15 November 2013
129. Adult 153 on or around 20 December 2012
130. Adult 154 on or around 25 May 2017
131. Adult 155 on or around 18 February 2016
132. Adult 156 on or around 24 January 2013
133. Adult 157 on or around 29 May 2014/ 19 June 2014/ 3 July 2014
134. Adult 158 on or around 7 November 2013
135. Adult 159 on or around 13 February 2014
136. Adult 160 on or around 17 September 2015
137. Adult 161 on or around 18 February 2016
138. Adult 162 on or around 25 August 2016
139. Adult 163 on or around 12 January 2017

Schedule 13: Did not clearly record the reason/origin of referral

1. Adult 11 on or around 20 December 2012
2. Adult 28 on or around 25 April 2013
3. Adult 32 on or around 28 April 2014
4. Adult 33 on or around 7 November 2014
5. Adult 46 on or around 17 July 2014
6. Adult 47 on or around 11 December 2014
7. Adult 50 on or around 8 August 2013
8. Adult 51 on or around 27 November 2014/11 December 2014
9. Adult 58 on or around 11 September 2014
10. Adult 59 on or around 14 November 2013
11. Adult 63 on or around 20 November 2014
12. Adult 75 on or around 16 April 2015
13. Adult 77 on or around 21 August 2014
14. Adult 86 on or around 25 April 2013
15. Adult 87 on or around 13 February 2014
16. Adult 100 on or around 8 March 2012
17. Adult 105 on or around 16 February 2012

18. Adult 107 on or around 10 May 2012
19. Adult 108 on or around 29 March 2013
20. Adult 110 on or around 4 August 2011
21. Adult 111 on or around 16 February 2012
22. Adult 112 on or around 1 November 2012
23. Adult 113 on or around 19 July 2012
24. Adult 115 on or around 3 May 2012
25. Adult 117 on or around 21 June 2012
26. Adult 125 on or around 18 February 2016
27. Adult 131 on or around 3/10 November 2016
28. Adult 139 on or around 8 March 2018
29. Adult 152 on or around 15 November 2013
30. Adult 158 on or around 7 November 2013
31. Adult 160 on or around 17 September 2015

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record (“EPR”) /physical patient records bundles

1. Adult 30 on or around 13 March 2014
2. Adult 38 on or around 12 May 2016
3. Adult 131 on or around 10/11 November 2016
4. Adult 142 on or around 16 March 2017
5. Adult 143 on or around 12 March 2013
6. Adult 144 on or around 23 July 2015
7. Adult 145 on or around 24 November 2016
8. Adult 146 on or around 7 January 2016
9. Adult 147 on or around 9 December 2016
10. Adult 150 on or around 22 September 2016
11. Adult 151 on or around 18 February 2016
12. Adult 152 on or around 15 November 2013
13. Adult 153 on or around 20 December 2012
14. Adult 154 on or around 25 May 2017

15. Adult 155 on or around 18 February 2016
16. Adult 156 on or around 24 January 2013
17. Adult 157 on or around 29 May 2014/19 June 2014/3 July 2014
18. Adult 158 on or around 7 November 2013
19. Adult 159 on or around 13 February 2014
20. Adult 160 on or around 17 September 2015
21. Adult 161 on or around 18 February 2016
22. Adult 162 on or around 25 August 2016
23. Adult 163 on or around 12 January 2017

Decision and reasons on application to exclude opinion evidence

The panel heard an application made by Ms Bayley to exclude opinion evidence of three NMC witnesses in relation to your scope of practice. She submitted that this amounted to non-expert opinion evidence, and the witnesses are neither impartial nor have the required expertise of your skills, knowledge and experience. She submitted that the witnesses' opinion on the scope of practice of a midwife is irrelevant and has no basis in fact, and cannot be afforded any weight by the panel.

Ms Bayley submitted that a practitioner's scope of practice is not defined by the NMC, or by law, but by the competencies, experience and expertise of the individual practitioner. She submitted that the evidence relates to the '*ultimate issue'* in charge 1, and so should flow from the expert's field of expertise. She submitted that the panel should find the evidence inadmissible.

Ms Mustard submitted that the evidence should not be excluded. She stated that the witnesses did not work directly with you and so are independent. She submitted that the witnesses are highly qualified and experienced, which gives them the ability to comment on your scope of practice. She further submitted that they are able to comment on the

local policies, which is relevant. Ms Mustard stated that underlying evidence from other investigations can be provided to the panel with no prejudice to you.

Ms Mustard submitted that the evidence should not be excluded, and invited the panel to attach the appropriate weight to the evidence once they have heard live evidence from the witnesses which will be tested by questioning.

The panel accepted the advice of the legal assessor.

The panel considered that the witnesses are due to give live evidence and will be able to be questioned both by your representative and the panel to test their evidence. The panel determined that the evidence is likely to be relevant due to the witnesses' roles and experience. The panel was satisfied that the evidence, however expressed, consists predominantly of statements of fact. The panel determined that it was fair and proportionate to not exclude the evidence, and to attach the appropriate weight to the evidence.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Mustard under Rule 31 to allow the hearsay testimony of Ms 5 into evidence. She submitted that the format of the evidence may affect the weight attached to it, but should not affect its admissibility. She submitted that the hearsay evidence is relevant to the issues, but it is not the sole or decisive evidence of any of the charges, rather it is corroborative evidence.

Ms Mustard informed the panel that Ms 5 was not approached by the NMC to provide a statement as it was considered unnecessary and disproportionate in an already large investigation when the evidence of what you were permitted/able to do in your role (and your knowledge of the same) could be found elsewhere. She submitted that admitting the evidence would not be unfair as there are other safeguards in place to ensure there is no prejudice to you.

Ms Bayley submitted that the evidence should not be admitted. She submitted that the evidence is multiple hearsay as it relates to what Ms 5 told someone who is also not a witness. She stated that there is no way to corroborate the evidence and no means to test the evidence, and submitted that as a result there is no fair way to admit the evidence. She submitted that it is not clear why the NMC have not spoken to Ms 5 and that if the NMC wish to rely on her evidence, it should call her to give evidence during this hearing. She submitted that the prejudicial effect of admitting the hearsay evidence outweighs any probative value.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered that it has not been provided with a statement from Ms 5, and that the NMC have not made any efforts to contact her. The panel determined that the hearsay evidence is relevant, and that it will not be possible for the hearsay evidence to be tested. The panel considered that the evidence is multiple hearsay. The panel determined that whilst the evidence is not the sole or decisive evidence in relation to a charge, it would be unfair to admit the evidence as it will not be possible to test the evidence. The panel determined that it was unreasonable to admit the evidence when the NMC has not made any attempts to contact Ms 5.

In these circumstances the panel refused the application.

Decision and reasons on application for the panel to not sit on 24 May 2022

Ms Bayley informed the panel that she is instructed in a part-heard matter that is due to be heard on 24 May 2022 and applied for the panel to not sit on that date. She stated that the other matter was unavoidable.

Ms Mustard did not make any objection to the application.

The panel accepted the advice of the legal assessor.

The panel accepted that Ms Bayley has another matter that she cannot rearrange. The panel considered that not sitting on 24 May 2022 would cause minimal delay to the hearing. The panel therefore determined to not sit on 24 May 2022.

Decision and reasons on application to adjourn the hearing

On 17 May 2022, the panel heard an application from Ms Mustard to adjourn the hearing until 23 May 2022. Following questions from the panel relating to the charges and schedule of charges, Ms Mustard stated that the NMC intends to redraft the schedule of charges to provide specimen examples. She submitted that this will give the panel clarity of what charges and examples the NMC wish the panel to make a decision on, but stated that it is not the NMC's case that the specimens that will be provided are exhaustive of the issues.

Ms Mustard invited the panel to adjourn the hearing until 23 May 2022 to allow sufficient time for the NMC to complete this task, ensuring fairness to you and the NMC. She submitted that once this has been completed, it should streamline the rest of the hearing.

Ms Bayley did not object to the application to adjourn. She submitted that it is in the interests of fairness for the schedules to be amended.

The panel accepted the advice of the legal assessor.

The panel allowed the application to adjourn the hearing until 23 May 2022. The panel determined that it was in the interests of fairness to allow the NMC time to amend the schedules of charge. The panel directed that the hearing should resume on 23 May 2022.

Decision and reasons on application to amend the charge

Following a question from the panel, Ms Mustard made an application to amend the wording of charges 2.4, 3.26.3 and 3.26.4.

The proposed amendments were to correct typographical errors and to provide clarity. Ms Mustard submitted that the proposed amendments would ensure consistency between charges and ensure accuracy.

The proposed amendments were as follows:

> '2.4 Obtain a second opinion for adult patients during/following an ~~FMG~~ **FGM** assessment.
>
> 3.26.3 Did not ~~record~~ send an outcome letter to Child 22's social worker and/or the police
>
> 3.26.4 ~~Incorrect~~ **Incorrectly** recorded information regarding Child 21 into Child 22s records.'

Ms Bayley did not make any objections to the application.

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

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

Decision and reasons on application to amend the schedules of charge

When the hearing resumed on 23 May 2022, Ms Mustard made an application to amend the schedules of charge. She stated that the schedules had been redrafted in line with the panel's request for clarity as to which aspects of the schedules the NMC intends to rely on. She submitted the number of examples in the schedule has been greatly reduced.

The proposed amended schedules were as follows:

> 'Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.
>
> 1. Adult 2 on or around 27 October 2016
> 2. Adult 3 on or around 22 September 2016
> 3. Adult 4 on or around 21 April 2016
> 4. Adult 6 on or around 15 June 2017
> 5. Adult 7 on or around 18 August 2016
> 6. Adult 8 on or around 3 December 2015
> 7. Adult 9 on or around 4 June 2015
> 8. Adult 12 on or around 11 June 2016
> 9. Adult 15 on or around 6 August 2015
> 10. Adult 17 on or around 22 August 2013/12 May 2016
> 11. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
> 12. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
> 13. Adult 23 on or around 28 April 2016
> 14. Adult 24 on or around 20 October 2016
> 15. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
> 16. Adult 89 on or around 8 October 2015
> 17. Adult 109 on or around 14 May 2015
> 18. Adult 124 on or around 21 July 2016

19. Adult 130 on or around 10/24 November 2016
20. Adult 134 on or around 5 January 2017

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

1. Adult 9 on or around 4 June 2015
2. Adult 12 on or around 11 June 2015
3. Adult 17 on or around 22 August 2013
4. Adult 19 on or around 20 August 2015
5. Adult 22 on or around 16 April 2015
6. Adult 41 on or around 3 August 2017
7. Adult 73 on or around 1 October 2015
8. Adult 123 on or around 30 June 2016
9. Adult 135 on or around 10 August 2017
10. Adult 146 on or around 7 January 2016

Schedule 3. Did not obtain second opinion during de-infibulation

1. Adult 14 on or around 20 December 2013
2. Adult 17 on or around 22 August 2013
3. Adult 19 on or around 20 August 2015
4. Adult 35 on or around 2 July 2015
5. Adult 130 on or around 24 November 2016

Schedule 4: Administered medication without a prescription

1. Adult 9 on or around 4 June 2015
2. Adult 12 on or around 11 June 2016
3. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
4. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

5. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
6. Adult 43 on or around 8/14 August 2014
7. Adult 44 on or around 5/12 December 2013
8. Adult 123 on or around 30 June 2016
9. Adult 124 on or around 21 July 2016
10. Adult 138 on or around 29 June 2017

Schedule 5. Provided psychological/psychosexual counselling

1. Adult 2 on or around 27 October 2016
2. Adult 3 on or around 22 September 2016

Schedule 6: Provided sexual health counselling

1. Adult 3 on or around 22 September 2016
2. Adult 19 between May & September 2015

Schedule 7: Undertook smear test without training/competency

1. Adult 8 on or around 3 December 2015
2. Adult 32 on or around 28 April 2014

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

1. Child 16 on or around 6 August 2015
2. Child 17 on or around 6 August 2015
3. Child 18 on or around 13 August 2015
4. Child 19 on or around 11 September 2015

5. Child 21 on or around 22 October 2015
6. Child 22 on or around 22 October 2015
7. Child 23 on or around 18 February 2016
8. Child 24 on or around 26 May 2016
9. Child 25 on or around 9 June 2016
10. Child 26 on or around 9 June 2016
11. Child 27 on or around 22 November 2016
12. Child 28 on or around 20 July 2017
13. Child 29 on or around 10 August 2017

Schedule 9: Failed to refer/investigate

Charge 2.1

1. Adult 2 on or around 27 October 2016
2. Adult 7 on or around 18 August 2016
3. Adult 15 on or around 6 August 2015
4. Adult 23 on or around 28 April 2016
5. Adult 36 on or around 3 January 2013

Charge 2.2

1. Adult 2 on or around 27 October 2016
2. Adult 7 on or around 18 August 2016
3. Adult 15 on or around 6 August 2015
4. Adult 23 on or around 28 April 2016
5. Adult 36 on or around 3 January 2013

Charge 2.3

1. Adult 4 on or around 21 April 2016
2. Adult 10 on or around 19 November 2015
3. Adult 17 on or around 22 August 2013/12 May 2016
4. Adult 56 on or around 29 May 2014.

5. Adult 124 on or around 28 July 2016

Charge 2.4

1. Adult 2 on or around 27 October 2016
2. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
3. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

Schedule 10: Failed to record the offer of consent for examination/de-infibulation

Failed to record the offer of a chaperone for examination/de-infibulation.

1. Adult 2 on or around 27 October 2016
2. Adult 8 on or around 3 December 2015
3. Adult 9 on or around 4 June 2015
4. Adult 12 on or around 11 June 2016
5. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
6. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
7. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
8. Adult 44 on or around 5/12 December 2013
9. Adult 69 on or around 15 October 2015
10. Adult 74 on or around 3 October 2013
11. Adult 124 on or around 21 July 2016
12. Adult 130 on or around 10/24 November 2016
13. Adult 138 on or around 29 June 2017
14. Adult 143 on or around 12 March 2013
15. Adult 154 on or around 25 May 2017

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

Charge 8

1. Adult 2 on or around 27 October 2016
2. Adult 6 on or around 15 June 2017
3. Adult 7 on or around 18 August 2016
4. Adult 9 on or around 4 June 2015
5. Adult 23 on or around 28 April 2016
6. Adult 24 on or around 20 October 2016

Charge 9

1. Adult 3 on or around 22 September 2016
2. Adult 4 on or around 21 April 2016
3. Adult 7 on or around 18 August 2016
4. Adult 23 on or around 28 April 2016
5. Adult 30 on or around 13 March 2013
6. Adult 98 on or around 19 July 2012

Schedule 12: Did not record adequate details of the appointment/consultation.

1. Adult 25 on or around 3 July 2014
2. Adult 26 on or around 6/13 July 2017
3. Adult 30 on or around 13 March 2013
4. Adult 38 on or around 12 May 2016
5. Adult 41 on or around 3 August 2017
6. Adult 48 on or around 24 July 2014
7. Adult 54 on or around 3 January 2013
8. Adult 59 on or around 14 November 2013
9. Adult 80 on or around 10/17 September 2015

10. Adult 90 on or around 20 September 2012
11. Adult 118 on or around 24 May 2012
12. Adult 128 on or around 20 October 2016
13. Adult 136 on or around 16 August 2017
14. Adult 150 on or around 22 September 2016
15. Adult 162 on or around 25 August 2016

Schedule 13: Did not clearly record the reason/origin of referral

1. Adult 11 on or around 20 December 2012
2. Adult 28 on or around 25 April 2013
3. Adult 46 on or around 17 July 2014
4. Adult 50 on or around 8 August 2013
5. Adult 86 on or around 25 April 2013
6. Adult 131 on or around 3/10 November 2016
7. Adult 158 on or around 7 November 2013
8. Adult 160 on or around 17 September 2015

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundles

1. Adult 30 on or around 13 March 2014
2. Adult 38 on or around 12 May 2016
3. Adult 142 on or around 16 March 2017
4. Adult 143 on or around 12 March 2013
5. Adult 147 on or around 9 December 2016
6. Adult 153 on or around 20 December 2012
7. Adult 156 on or around 24 January 2013
8. Adult 159 on or around 13 February 2014
9. Adult 161 on or around 18 February 2016
10. Adult 162 on or around 25 August 2016'

Ms Bayley did not make any objections to the application. She submitted that the changes make the schedules more manageable and provides clarity of the case against you.
The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that the amendments, as applied for, are in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. The panel noted that the amended schedules provide clarity as to the charges and allegations against you.

Panel direction for further evidence

The panel of its own volition made a direction under Rule 22(5) for further evidence. The panel determined that it required evidence from Ms 4 and Ms 5. The panel determined that their evidence should be relevant to the charges, and could provide relevant context of your practice. The panel noted that the witnesses due to give evidence at this hearing did not work directly with you, and determined that it would be relevant to hear from those who supervised, managed and worked alongside you.

The panel invited Ms Mustard and Ms Bayley to make any comments in relation to the direction of the panel.

Ms Mustard informed the panel that the NMC has tried to contact both Ms 4 and Ms 5 to obtain witness statements and potential availability to give evidence. She stated that prior to the hearing, it had been considered that it was not necessary to obtain evidence from either Ms 4 or Ms 5.

Ms Bayley stated that she had no objections to the direction, and submitted that it was important the panel hear evidence from Ms 4 and Ms 5.

The panel accepted the advice of the legal assessor, which included that Rule 22(5) states:

> *'The Committee may of its own motion require a person to attend the hearing to give evidence, or to produce relevant documents.'*

The panel directed that the NMC should make efforts to contact Ms 4 and Ms 5 to give witness statements and to attend the hearing. The panel also directed that the witnesses should be asked to produce any documents relevant to their evidence, such as supervisory records/reports/appraisals and Vulnerable Persons Assurance Committee (VPAC) minutes.

Decision and reasons on application to amend the charge

During the course of witness evidence, it became apparent that the date outlined in charge 3.14 did not reflect the date outlined in Adult 22's record. Ms Mustard and Ms Bayley confirmed they had no objections to the charge being amended to correct the date.

The proposed amendment were as follows:

> '3.14 On or around ~~28 April 2016~~ **16 April 2015** during/following your consultation with Adult 22;'

The panel accepted the advice of the legal assessor and had regard to Rule 28.
The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure accuracy.

Details of charges, as finalised

That you, whilst employed as a Specialist Female Genital Mutilation ('FGM') Midwife at Guy's & St Thomas' Hospital between 2012 & 2017;

1. Acted/practised outside the scope of your clinical competence/role, in that you:
    1.1. On one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.
    1.2. On one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.
    1.3. On one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.
    1.4. On one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule
    1.5. On one or more occasion administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber, as listed in schedule 4.
    1.6. On one or more occasion provided psychological/psychosexual counselling to patients, as listed in schedule 5.
    1.7. On one or more occasion provided patients with sexual health counselling for dyspareunia, as listed in schedule 6.
    1.8. On one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;
    1.9. On one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.
    1.10. On one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.

2. On one or more occasion did not, for adult patients as listed in schedule 9:
    2.1. Refer adult patients to specialist counsellors
    2.2. Refer adult patients for sexual health counselling
    2.3. Refer adult patients for further investigation
    2.4. Obtain a second opinion for adult patients during/following an FGM assessment.

3. On one or more occasion failed to maintain adequate clinical records for adult/children/patients under the age of 18, in that you:

3.1. On or around 27 October 2016 during/following your consultation with Adult 2:

3.1.1. Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.

3.1.2. Did not record information about Adult 2's background.

3.1.3. Did not record that Adult 2's anatomy change could have been due to birth trauma.

3.1.4. Did not record adequate details of the advice/assessment/discussion/next steps for Adult 2.

3.2. On or around 22 September 2016 during/following your consultation with Adult 3;

3.2.1. Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.

3.2.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 3.

3.2.3. Did not record a risk assessment for Adult 3.

3.3. On or around 21 June 2016 during/following your consultation with Adult 4;

3.3.1. Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle.

3.3.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 4

3.3.3. Did not record information about Adult 4's risk of infection/chronic pain.

3.3.4. Did not record a risk assessment for Adult 4

3.3.5. Did not record whether a swab/urine sample had been taken for Adult 4.

3.4. On or around 15 June 2017 during/following your consultation with Adult 6;

3.4.1. Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.

3.4.2. Did not record the reason for Adult 6's referral to the FGM clinic.

3.4.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 6

3.5. On or around 18 August 2016 during/following your consultation with Adult 7;

3.5.1. Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle.

3.5.2. Did not record a risk assessment of Adult 7/Adult 7's daughters.

3.5.3. Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

3.5.4. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 7

3.6. On or around 3 December 2015 during/following your consultation with Adult 8;

3.6.1. Did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle.

3.6.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8

3.6.3. Did not record/inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years.

3.7. On or around 4 June 2015 during/following your consultation with Adult 9;

3.7.1. Did not record adequate details of Adult 9's consultation in the EPR/physical patient records bundle.

3.7.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 9

3.8. On or around 19 November 2015 during/following your consultation with Adult 10;

3.8.1. Did not record adequate details of Adult 10's consultation in the EPR/physical patient records bundle.

3.8.2. Did not record whether a urine sample had been taken for Adult 10.

3.8.3. Did not record whether Adult 10 was checked for a urinary tract infection/infections.

3.8.4. Did not record adequate details of the advice provided to Adult 10

3.9. On or around 11 June 2015 during/following your consultation with Adult 12;

3.9.1. Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle.

3.9.2. Did not record whether the de-infibulation procedure was discussed with Adult 12

3.9.3. Did not record a discussion around personal hygiene with Adult 12.

3.9.4. Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

3.9.5. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 12.

3.10. On or around 6 August 2015 during/following your consultation with Adult 15;

3.10.1. Did not record adequate details of Adult 15's consultation in the EPR/physical patient records bundle.

3.10.2. Did not record a discussion about the illegality of FGM with Adult 15.

3.10.3. Did not record a risk assessment for Adult 15.

3.10.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 15.

3.11. On or around 3 November 2016 during/following your consultation with Adult 16;

3.11.1. Did not record adequate details of Adult 16's consultation in the EPR/physical patient records bundle.

3.11.2. Did not record the reasons for Adult 16's referral.

3.11.3. Did not record Adult 16's gestation period.

3.11.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 16.

3.12. On or around 22 August 2013/12 May 2016 during/following your consultation with Adult 17;

3.12.1. Did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.

3.12.2. Did not record adequate details about Adult 17's de-infibulation procedure.

3.12.3. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 17.

3.13. On or around 14 May 2015/20 August 2015/10 September 2015 during/following your consultation with Adult 19;

3.13.1. Did not record adequate details of Adult 19's consultations in the EPR/physical patient records bundle.

3.13.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 19

3.13.3. Did not record information surrounding the history of domestic abuse of Adult 19.

3.14. On or around 16 April 2015 during/following your consultation with Adult 22;

3.14.1. Did not record adequate details of Adult 22's consultation in the EPR/physical patient records bundle.

3.14.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 22.

3.14.3. Did not record the timing of the administration of Lidocaine to Adult 22.

3.14.4. Did not record the frequency of the administration of Lidocaine to Adult 22.

3.15. On or around 28 April 2016 during/following your consultation with Adult 23;

3.15.1. Did not record adequate details of Adult 23's consultation in the EPR/physical patient records bundle

3.15.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 23

3.15.3. Did not record a risk assessment for Adult 23/Adult 23's children.

3.16. On or around 20 October 2016 during/following your consultation with Adult 24;

3.16.1. Did not record adequate details of Adult 24's consultation in the EPR/physical patient records bundle

3.16.2. Did not inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment.

3.16.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 24

3.17. On or around 2 July 2015/ 9 July 2015 during/following your consultation with Adult 35;

3.17.1. Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

3.17.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 35.

3.17.3. Did not record the reason for prescribing/providing antibiotics to Adult 35.

3.17.4. Did not record the dosage of antibiotics prescribed/provided to Adult 35.

3.17.5. Did not record details surrounding Adult 35's possible allergies to antibiotics

3.18. On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 45;

3.18.1. Did not record adequate details of Adult 45's consultations in the EPR/physical patient records bundle

3.18.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 44

3.19. On or around 21 July 2016/28 July 2016 during/following your consultation with Adult 124;

3.19.1. Did not record adequate details of Adult 124’s consultations in the EPR/physical patient records bundle.

3.19.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 124

3.20. On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130;

3.20.1. Did not record adequate details of Adult 130’s consultations in the EPR/physical patient records bundle.

3.20.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 130

3.20.3. Did not record whether Adult 130’s condition/assessment was escalated.

3.21. On or around 6 August 2015 during/following your consultation with Child 16;

3.21.1. Did not clearly record the origin of referral in Child 16’s patient records.

3.21.2. Did not record any correspondence with social workers.

3.21.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 16/Child 16’s mother.

3.21.4. Did not record a risk assessment for Child 16.

3.21.5. Did not record any follow up communication/letter with Child 16’s Social Worker

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.1. Did not clearly record the origin of referral in Child 17’s patient records.

3.22.2. Did not record a full clinical history check of Child 17.

3.22.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 17/Child 17's mother

3.22.4. Did not record a risk assessment for Child 17.

3.23. On or around 13 August 2015 during/following your consultation with Child 18;

3.23.1. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

3.23.2. Did not record a risks assessment for Child 18

3.23.3. Did not record whether a urine sample had been taken for Child 18.

3.24. On or around 11 September 2015 during/following your consultation with Child 19;

3.24.1. Did not create any official clinical healthcare records for Child 19.

3.24.2. Incorrectly stated in Child 19's GP letter dated 14 October 2015 that Child 19 was assessed on 9 September 2015.

3.24.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 19

3.24.4. Did not record a risk assessment for Child 19

3.24.5. Did not record any follow up with social care.

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.1. Did not adequately record the origin of referral in Child 21's patient records.

3.25.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 21/Child 21's mother.

3.25.3. Did not record a risk assessment for Child 21.

3.25.4. Incorrectly recorded information regarding Child 22 into Child 21's records.

3.25.5. Did not send an outcome letter to Child 21's social services and/or the police

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

3.26.1. Did not adequately record the origin of referral in Child 22's patient records.

3.26.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 22/Child 22's mother.

3.26.3. Did not send an outcome letter to Child 22's social worker and/or the police

3.26.4. Incorrectly recorded information regarding Child 21 into Child 22s records.

3.27. On or around 18 February 2016 during/following your consultation with Child 23;

3.27.1. Did not create any official clinical healthcare records for Child 23

3.27.2. Did not record a risk assessment for Child 23.

3.27.3. Did not record the social impact of FGM on Child 23.

3.27.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 23

3.27.5. Did not send an outcome letter to Child 23's GP.

3.28. On or around 26 May 2016 during/following your consultation with Child 24;

3.28.1. Did not record/consider whether the support Child 24 was receiving was optimal.

3.28.2. Did not record whether Child 24 required additional services/support.

3.28.3. Did not record which kind of support/plans were in place for Child 24.

3.28.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 24.

3.28.5. Did not send an outcome letter to Child 24's referrer

3.29. On or around 9 June 2016 during/following your consultation with Child 25;

3.29.1. Incorrectly recorded Child 25's referrer as the safeguarding team/police.

3.29.2. Did not record a risk assessment for Child 25

3.29.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 25/Child 25's mother

3.29.4. Did not record/send an outcome letter to the referrer/Children's Social Care

3.29.5. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 25's mother

3.30. On or around 9 June 2016, during/following your consultation with Child 26;

3.30.1. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 26/Child 26's mother

3.30.2. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 26's mother

3.30.3. Did not record/send an outcome letter to the referrer/Children's Social Care

3.30.4. Incorrectly informed Child 26's GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

3.30.5. Did not record a risk assessment for Child 26

3.31. On or around 22 September 2016 during/following your consultation with Child 27;

3.31.1. Did not create official healthcare records for Child 27.

3.31.2. Did not send/complete an outcome letter to/for Child 27's GP.

3.31.3. Did not record a full risk assessment for Child 27.

3.31.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 27/Child 27's mother

3.31.5. Did not record/send an outcome letter to the referrer/Children's Social Care

3.32. On or around 20 July 2017, during/following your consultation with Child 28;

3.32.1. Did not record a full risk assessment for Child 28.

3.32.2. Did not Did not record adequate details of the advice/examination/discussion/next steps provided to Child 28/Child 28's father

3.33. On or around 10 August 2017, during/following your consultation with Child 29;

3.33.1. Did not record a full risk assessment for Child 29

3.33.2. Did not record the symptoms/adverse effects suffered by Child 29.

3.33.3. Did not record the benefit of a referral to a gynaecologist for Child 29.

3.33.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 29/Child 29's mother

3.33.5. Did not record/include sufficient information/understanding surrounding the type of FGM in Child 29's GP Letter

4. Did not record the offer/confirmation of consent for FGM assessments for one or more adult patients as listed in schedule 10.

5. Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.

6. Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10;

7. Did not record the offer of a translator to Adult 10

8. Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

9. Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.

10. On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;
    d) Advice/discussion/next steps with the patient
    e) Details of assessment/examination
    f) FGM risk assessments

11. Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

12. Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle for one or more adult patients, as listed in schedule 14.

13. On or around 6 August 2015 did not refer Child 17 to a Community Paediatrician.

14. On or around 13 August 2015;
    14.1. Did not refer Child 18 to a specialist paediatric urologist.
    14.2. Did not refer Child 18 to the Consultant Lead Professor at the African Well Women Clinic (AWWC)
    14.3. Unnecessarily conducted a FGM examination/assessment of Child 18.
    14.4. Incorrectly referred Child 18 to the adult gynaecology service.

15. On or around 26 May 2016 did not refer Child 24 for psychological support

16. On or around 18 February 2016, did not refer child 23 for psychological services.

17. On or around 9 June 2016 did not refer Child 25 to a paediatric gynaecologist/specialist paediatric FGM centre/ FGM child assessment provider.

18. On or around 7 July 2017 you initially assessed Child 28 rather than refer them for examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.

19. On or around 10 August 2017 did not refer Child 29's examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider

20. Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

21. Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

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

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

1. Adult 2 on or around 27 October 2016
2. Adult 3 on or around 22 September 2016
3. Adult 4 on or around 21 April 2016

4. Adult 6 on or around 15 June 2017
5. Adult 7 on or around 18 August 2016
6. Adult 8 on or around 3 December 2015
7. Adult 9 on or around 4 June 2015
8. Adult 12 on or around 11 June 2016
9. Adult 15 on or around 6 August 2015
10. Adult 17 on or around 22 August 2013/12 May 2016
11. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
12. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
13. Adult 23 on or around 28 April 2016
14. Adult 24 on or around 20 October 2016
15. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
16. Adult 89 on or around 8 October 2015
17. Adult 109 on or around 14 May 2015
18. Adult 124 on or around 21 July 2016
19. Adult 130 on or around 10/24 November 2016
20. Adult 134 on or around 5 January 2017

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

1. Adult 9 on or around 4 June 2015
2. Adult 12 on or around 11 June 2015
3. Adult 17 on or around 22 August 2013
4. Adult 19 on or around 20 August 2015
5. Adult 22 on or around 16 April 2015
6. Adult 41 on or around 3 August 2017
7. Adult 73 on or around 1 October 2015
8. Adult 123 on or around 30 June 2016
9. Adult 135 on or around 10 August 2017
10. Adult 146 on or around 7 January 2016

Schedule 3. Did not obtain second opinion during de-infibulation

1. Adult 14 on or around 20 December 2013
2. Adult 17 on or around 22 August 2013
3. Adult 19 on or around 20 August 2015
4. Adult 35 on or around 2 July 2015
5. Adult 130 on or around 24 November 2016

Schedule 4: Administered medication without a prescription

1. Adult 9 on or around 4 June 2015
2. Adult 12 on or around 11 June 2016
3. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
4. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
5. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
6. Adult 43 on or around 8/14 August 2014
7. Adult 44 on or around 5/12 December 2013
8. Adult 123 on or around 30 June 2016
9. Adult 124 on or around 21 July 2016
10. Adult 138 on or around 29 June 2017

Schedule 5. Provided psychological/psychosexual counselling

1. Adult 2 on or around 27 October 2016
2. Adult 3 on or around 22 September 2016

Schedule 6: Provided sexual health counselling

1. Adult 3 on or around 22 September 2016

2. Adult 19 between May & September 2015

Schedule 7: Undertook smear test without training/competency

1. Adult 8 on or around 3 December 2015
2. Adult 32 on or around 28 April 2014

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

1. Child 16 on or around 6 August 2015
2. Child 17 on or around 6 August 2015
3. Child 18 on or around 13 August 2015
4. Child 19 on or around 11 September 2015
5. Child 21 on or around 22 October 2015
6. Child 22 on or around 22 October 2015
7. Child 23 on or around 18 February 2016
8. Child 24 on or around 26 May 2016
9. Child 25 on or around 9 June 2016
10. Child 26 on or around 9 June 2016
11. Child 27 on or around 22 November 2016
12. Child 28 on or around 20 July 2017
13. Child 29 on or around 10 August 2017

Schedule 9: Failed to refer/investigate

Charge 2.1

1. Adult 2 on or around 27 October 2016
2. Adult 7 on or around 18 August 2016

3. Adult 15 on or around 6 August 2015
4. Adult 23 on or around 28 April 2016
5. Adult 36 on or around 3 January 2013

Charge 2.2

1. Adult 2 on or around 27 October 2016
2. Adult 7 on or around 18 August 2016
3. Adult 15 on or around 6 August 2015
4. Adult 23 on or around 28 April 2016
5. Adult 36 on or around 3 January 2013

Charge 2.3

1. Adult 4 on or around 21 April 2016
2. Adult 10 on or around 19 November 2015
3. Adult 17 on or around 22 August 2013/12 May 2016
4. Adult 56 on or around 29 May 2014.
5. Adult 124 on or around 28 July 2016

Charge 2.4

1. Adult 2 on or around 27 October 2016
2. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015
3. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

Schedule 10: Failed to record the offer of consent for examination/de-infibulation
Failed to record the offer of a chaperone for examination/de-infibulation.

1. Adult 2 on or around 27 October 2016
2. Adult 8 on or around 3 December 2015
3. Adult 9 on or around 4 June 2015
4. Adult 12 on or around 11 June 2016
5. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

6. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
7. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
8. Adult 44 on or around 5/12 December 2013
9. Adult 69 on or around 15 October 2015
10. Adult 74 on or around 3 October 2013
11. Adult 124 on or around 21 July 2016
12. Adult 130 on or around 10/24 November 2016
13. Adult 138 on or around 29 June 2017
14. Adult 143 on or around 12 March 2013
15. Adult 154 on or around 25 May 2017

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

Charge 8

1. Adult 2 on or around 27 October 2016
2. Adult 6 on or around 15 June 2017
3. Adult 7 on or around 18 August 2016
4. Adult 9 on or around 4 June 2015
5. Adult 23 on or around 28 April 2016
6. Adult 24 on or around 20 October 2016

Charge 9

1. Adult 3 on or around 22 September 2016
2. Adult 4 on or around 21 April 2016
3. Adult 7 on or around 18 August 2016
4. Adult 23 on or around 28 April 2016
5. Adult 30 on or around 13 March 2013
6. Adult 98 on or around 19 July 2012

Schedule 12: Did not record adequate details of the appointment/consultation.

1. Adult 25 on or around 3 July 2014
2. Adult 26 on or around 6/13 July 2017
3. Adult 30 on or around 13 March 2013
4. Adult 38 on or around 12 May 2016
5. Adult 41 on or around 3 August 2017
6. Adult 48 on or around 24 July 2014
7. Adult 54 on or around 3 January 2013
8. Adult 59 on or around 14 November 2013
9. Adult 80 on or around 10/17 September 2015
10. Adult 90 on or around 20 September 2012
11. Adult 118 on or around 24 May 2012
12. Adult 128 on or around 20 October 2016
13. Adult 136 on or around 16 August 2017
14. Adult 150 on or around 22 September 2016
15. Adult 162 on or around 25 August 2016

Schedule 13: Did not clearly record the reason/origin of referral

1. Adult 11 on or around 20 December 2012
2. Adult 28 on or around 25 April 2013
3. Adult 46 on or around 17 July 2014
4. Adult 50 on or around 8 August 2013
5. Adult 86 on or around 25 April 2013
6. Adult 131 on or around 3/10 November 2016
7. Adult 158 on or around 7 November 2013
8. Adult 160 on or around 17 September 2015

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record (“EPR”) /physical patient records bundles

1. Adult 30 on or around 13 March 2014
2. Adult 38 on or around 12 May 2016
3. Adult 142 on or around 16 March 2017
4. Adult 143 on or around 12 March 2013
5. Adult 147 on or around 9 December 2016
6. Adult 153 on or around 20 December 2012
7. Adult 156 on or around 24 January 2013
8. Adult 159 on or around 13 February 2014
9. Adult 161 on or around 18 February 2016
10. Adult 162 on or around 25 August 2016

Application for Adjournment on 5 September 2022

At the outset of the first day of the resuming hearing on 5 September 2022, Ms Bayley made an application for an adjournment of this hearing until the following day to allow Ms Bayley and you to properly consider and take instructions from you on the bundle of documents which was served by the NMC on 31 August 2022.

Ms Mustard accepted that the new material was served on you late in the day and acknowledged that Ms Bayley would likely require some time to consider this and take instructions before proceeding to hear the evidence of Ms 4. However, Ms Mustard said that this request should be balanced with the requirement to make progress in this matter. She reminded the panel that Ms 4 was warned and on standby for 5, 6 and 7 September 2022, after which she has limited availability. Ms Mustard said that it may be necessary to secure further dates for Ms 4 to reattend if her evidence is not concluded by 7 September 2022. In light of this Ms Mustard said that she did not wish to lose any of the time which Ms 4 is available, however she said that this application is a matter for the panel.

The panel accepted the advice of the Legal Assessor, which included reference to Rule 32, which deals with postponement and adjournments.

The panel granted Ms Bayley's application and adjourned the hearing, to recommence at 09:30 on 6 September 2022. The panel bore in mind that this adjournment may be inconvenient to Ms 4, but would not result in any injustice to either party. It determined that in the interests of fairness, it is appropriate to allow Ms Bayley the time to read the new bundle of information and take instructions from you before commencing with the oral evidence of Ms 4.

Decision to Postpone the Oral Evidence of Ms 5 until January 2023

Prior to receiving the evidence of Ms 5, Ms Bayley expressed concerns about non-consecutive days in which the oral evidence of this witness was due to be received. Due to Ms 5's professional commitments and the unexpected cancellation of a sitting day in which the panel was due to commence her evidence, Ms 5 is only available to give evidence for three half days in the agreed dates for this hearing during this, and the subsequent listing, being 22 September 2022, 28 September 2022 and 13 October 2022. Ms Bayley said that this lack of availability, although understandable, is disappointing as Ms 5 is the only witness who has worked alongside you and can speak to your practice as a midwife, the allegations before the panel and your competence. Ms Bayley said that it is likely that little progress will be made in the three half-day periods scheduled as she intends to take Ms 5 through the extensive documentary records before the panel.

Ms Bayley further stated that Ms 5's NMC witness statement lacks detail, and it is likely that most of her evidence will come out in the course of cross-examination. She suggested that it would a good use of the time which the NMC has secured in Ms 5's diary to take a further and more detailed witness statement, and to hear her evidence over a period of several days in a block together on the resuming dates scheduled for this hearing, in January 2023.

Ms Mustard accepted that the dates and gaps between the days in which Ms 5 is due to give evidence is far from ideal, however she submitted that it would be best to make use of the time which the NMC has secured in Ms 5's diary in order to make some progress in this case.

The panel accepted the advice of the Legal Assessor.

The panel bore in mind that it has a duty to ensure fairness to both you and the NMC. It concluded that the evidence of Ms 5 would be extremely fractured were the panel to commence with her evidence as scheduled on 22 September 2022. It bore in mind that hearing a witness under such circumstances may hinder their ability to give their best evidence, and could result in a potential lack of continuity in their evidence.

The panel considered Ms Bayley's suggestion that a further statement be taken from Ms 5. However, the panel considered that the NMC has sufficiently complied with the panel's direction to secure a witness statement from Ms 5, so a further statement will not be required. Any aspects of her evidence which require further elucidation can be explored with her in her oral evidence.

The panel considered Ms 5 to be an extremely relevant and key witness. She established the service, where you worked, in 1997 and is considered as the lead clinician. She is the only witness who is able to provide first hand evidence of how this service ran, she is also the only witness who can provide first-hand evidence of your clinical abilities.

In all the circumstances, the panel directed that inquiries be made for Ms 5's attendance to give evidence at the hearing during the listed period in January 2023 for a block period of five days, or, where this may not be possible, for a period of five days with as few breaks between the days as possible in order to allow Ms 5 to give her best evidence in the most coherent fashion.

On 22 September 2022, Ms 5 attended the hearing and the importance of her evidence was underlined to her by Ms Mustard and Ms Bayley, who shared the charges against you with this witness. At the conclusion of these meetings, Ms 5 provided availability for three full days and two half-days between 16 and 20 January 2023.

The panel met with Ms 5 and thanked her for her attendance at the hearing today and underlined the importance of her evidence. The panel shared with her its concerns that a further day may be required to conclude her evidence. In light of this, the panel requested that Ms 5 consider whether further availability could be secured on the week commencing 23 January 2023. Having heard Ms 5's concerns about her availability and commitments to her various employers, the panel directed that the NMC send correspondence to these employers which outlines the requirement for Ms 5 to attend the hearing in the listed period between 16 and 27 January 2023, and the importance of her evidence to this hearing.

Agreement to Include Evidence Previously Excluded as Hearsay

On 16 January 2023, Ms Mustard said that it had been agreed that the sections of the evidence bundle previously excluded as the hearsay evidence of Ms 5 could be properly taken into account by the panel in its deliberations. She said that it is now open to the panel to consider these matters because Ms 5 has attended the hearing to give evidence and can now be cross-examined and questioned on such matters.

Ms Bayley agreed that it is now open to the panel to consider this evidence.

The panel accepted the advice of the legal assessor.

The panel determined to include the evidence of Ms 5 which was previously excluded as hearsay.

Background

You were first registered as a nurse on 3 March 1986. On 5 September 1988, you also qualified as a midwife. The NMC was established on 1 April 2001, having previously been the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC). By April 2001, your nursing registration had lapsed, and you were on the NMC register solely as a midwife.

You were registered as a nurse on the NMC register on 1 April 2004, which again lapsed on 12 March 2007. Your midwifery registration lapsed on 1 April 2010. On 8 April 2010, both your nursing and midwifery registrations became effective. Your nursing registration lapsed for the final time on 1 April 2013. Your midwifery registration lapsed on 1 March 2013 but was reinstated on 3 April 2013.

You commenced employment at Guys and St Thomas's NHS Foundation Trust (the Trust) in 1997. You remained employed there until your retirement on 31 August 2017. You were employed as a specialist Female Genital Mutilation (FGM) midwife working within the Trust's FGM clinic. You set up the African Well Women Clinic (AWWC) at the Trust. You have published articles and spoken in the UK and abroad about FGM.

On 8 August 2017, the NMC received a referral from a consultant obstetrician at University College London Hospitals (UCLH). Following this referral, the Trust conducted internal reviews of your caseload and commissioned an external review by the Royal College of Paediatrics and Child Health (RCPCH) into your practice. The reviews identified concerns surrounding your practice.

Your engagement with the Trust's investigation was minimal. You were not interviewed as part of the service review by the RCPCH or the investigating team at the Trust.

The regulatory concerns cover three separate areas; that you acted outside your professional competencies, that you failed to appropriately refer patients onto other medical or health care professionals and failures in record keeping.

In relation to the first regulatory concern, it is alleged that you assessed and examined non-pregnant children without the appropriate paediatric training or qualification. It is also alleged that you assessed and treated non-pregnant women, when you were not a registered nurse. It is further alleged that you administered prescription only medication, other than in situations that were within the midwifery exemptions, when you were not a non-medical prescriber. You do not deny that you treated the patients but deny that this was outside of your competencies.

The second regulatory concern is linked to the first in that it is alleged that you should have referred the patients to someone who could treat them within the scope of their competence. The concern relates to failing to seek a second opinion in complex cases, failing to appropriately refer patients for psychosexual/sexual health counselling and support, failing to redirect/refer children to a paediatrician or child specialist, failing to refer for urological/gynaecological review and failing to refer to a registered nurse.

The final regulatory concern relates to alleged failures to keep adequate records. These relate to not recording information in the correct documents/format, not recording information accurately/fully, not recording consent, not recording the presence/offer of a chaperone, not recording the use of an interpreter/translator, not completing/sending GP summary letters or other outcome letters or sending these letters with incomplete or inaccurate information, and not recording or communicating safeguarding steps.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Bayley that there is no case to answer in respect of charges 1.1.1; 1.1.2; 1.1.3; 1.1.4; 1.1.5; 1.1.6; 1.1.7; 1.1.8; 1.1.9; 1.1.10; 1.1.11; 1.1.12; 1.1.13; 1.1.14; 1.1.15; 1.1.16; 1.1.17; 1.1.18; 1.1.19; 1.1.20; 1.2.1; 1.2.2; 1.2.3; 1.2.4; 1.2.5; 1.2.5; 1.2.6; 1.2.7; 1.2.8; 1.2.9; 1.2.10; 1.2.11; 1.2.12; 1.2.13; 1.2.14; 1.2.15; 1.2.16; 1.2.17; 1.2.18; 1.2.19; 1.2.20; 1.3.1; 1.3.2; 1.3.3; 1.3.4; 1.3.5; 1.3.6; 1.3.7; 1.3.8; 1.3.9; 1.3.10; 1.4.1; 1.4.2; 1.4.3; 1.4.4; 1.4.5; 1.5.1; 1.5.2; 1.5.3; 1.5.4; 1.5.5; 1.5.6; 1.5.7; 1.5.8; 1.5.9; 1.5.10; 1.6.1; 1.6.2; 1.7.1; 1.7.2; 1.8.1; 1.8.2; 1.9.7; 1.9.11; 1.9.12; 1.9.13; 1.10.5; 1.10.6; 1.10.7; 1.10.12; 1.10.13; 2.1.1; 2.1.2; 2.1.3; 2.1.4; 2.1.5; 2.2.1; 2.2.2; 2.2.3; 2.2.4; 2.2.5; 2.3.1; 2.3.2; 2.3.3; 2.3.4; 2.3.5; 2.4.1; 2.4.2; 2.4.3; 3.1.1; 3.1.2; 3.1.3; 3.1.4; 3.2.1; 3.2.2; 3.2.3; 3.3.1; 3.3.2; 3.3.3; 3.3.4; 3.3.5; 3.4.1; 3.4.2; 3.4.3; 3.5.1; 3.5.2; 3.5.3; 3.5.4; 3.6.1; 3.6.2; 3.6.3; 3.7.1; 3.7.2; 3.8.1; 3.8.2; 3.8.3; 3.8.4; 3.9.1; 3.9.2; 3.9.3; 3.9.4; 3.9.5; 3.10.1; 3.10.2; 3.10.3; 3.10.4; 3.11.1; 3.11.2; 3.11.3; 3.11.4; 3.12.1; 3.12.2; 3.12.3; 3.13.1; 1.13.2; 3.13.3; 3.14.1; 3.14.2; 3.14.3; 3.14.4; 3.15.1; 3.15.2; 3.15.3; 3.16.1; 3.16.2; 3.16.3; 3.17.1; 3.17.2; 3.17.3; 3.17.4; 3.17.5; 3.18.1; 3.18.2; 3.19.1; 3.19.2; 3.20.1; 3.20.2; 3.20.3; 3.21.1; 3.22.1; 3.23.1; 3.23.3; 3.24.2; 3.25.1; 3.26.1; 3.27.1; 3.27.3; 3.27.5; 3.28.2; 3.28.3; 3.29.2; 3.30.4; 3.30.5; 3.32.1; 3.32.2; 3.33.1; 4.1; 4.2; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8; 4.9; 4.10; 4.11; 4.12; 4.13; 4.14; 4.15; 5.1; 5.2; 5.3; 5.4; 5.5 (in relation to the stem of charge 5 only); 5.6; 5.7; 5.8; 5.9. 5.10; 5.11; 5.12; 5.13; 5.14; 5.15; 6.1; 6.2; 6.3; 6.4; 6.5 (in relation to the stem of charge 6 only); 6.6; 6.7; 6.8; 6.9; 6.10; 6.11; 6.12; 6.13; 6.14; 6.15 (in relation to the stem of charge 6 only); 7; 8.1; 8.2; 8.3; 8.4; 8.5; 8.6; 9.1; 9.2; 9.3; 9.4; 9.5; 9.6; 10.1; 10.2; 10.3; 10.4; 10.5; 10.6; 10.7; 10.8; 10.9; 10.10; 10.11; 10.12; 10.13; 10.14; 10.15; 11.1; 11.2; 11.3; 11.4; 11.5; 11.6; 11.7; 11.8; 12.1; 12.2; 12.3; 12.4; 12.5; 12.6; 12.7; 12.8; 12.9; 12.10; 13; 14.1; 14.2; 14.4; 15; 16; 18; 20.7; 20.12; 21.5; 21.6; 21.7; 21.12.

This application was made under Rule 24(7).

<u>Ms Bayley's Written Submissions of No Case to Answer</u>

1. *The Nursing and Midwifery Council ("NMC") brings this case and the burden of proof rests with the NMC at all times. Mrs Momoh is not required to prove anything.*

2. *At the close of the NMC's case, it is submitted that the NMC has failed to discharge the persuasive burden and that there is no case for Mrs Momoh to answer in relation to a number of the charges, as follows [highlighted in bold]:*

   "That you, whilst employed as a Specialist Female Genital Mutilation ('FGM') Midwife at Guy's & St Thomas 'Hospital between 2012 & 2017;

   1. Acted/practised outside the scope of your clinical competence/role, in that you:

   1.1. On one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.

   Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

   1. Adult 2 on or around 27 October 2016

   2. Adult 3 on or around 22 September 2016

   3. Adult 4 on or around 21 April 2016

   4. Adult 6 on or around 15 June 2017

   5. Adult 7 on or around 18 August 2016

   6. Adult 8 on or around 3 December 2015

   7. Adult 9 on or around 4 June 2015

   8. Adult 12 on or around 11 June 2016

   9. Adult 15 on or around 6 August 2015

   10. Adult 17 on or around 22 August 2013/12 May 2016

   11. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

   12. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

   13. Adult 23 on or around 28 April 2016

14. Adult 24 on or around 20 October 2016

15. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

[…] this patient was seen by [Witness 5] on 16 July 2015. This woman came for deinfibulation so that she could "try for a baby" (medical notes recently disclosed). This patient is therefore at the clinic for preconception advice and treatment

16. Adult 89 on or around 8 October 2015

[…] diary only. Pre-conceptual care: "newly married" recorded in audit

17. Adult 109 on or around 14 May 2015

[…] diary only. Pre-conceptual care: "newly married" recorded in audit

18. Adult 124 on or around 21 July 2016

19. Adult 130 on or around 10/24 November 2016

20. Adult 134 on or around 5 January 2017

[…] no blue notes. Pre-conceptual care: "recently married, not been able to have sexual intercourse" recorded in audit

1.2. On one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

1. Adult 2 on or around 27 October 2016

2. Adult 3 on or around 22 September 2016

3. Adult 4 on or around 21 April 2016

4. Adult 6 on or around 15 June 2017

5. Adult 7 on or around 18 August 2016

(patient not examined or assessed, [Witness 3]) […] - diary only. Diary states "not assessed"

6. Adult 8 on or around 3 December 2015

[…] - patient not assessed, smear only

7. Adult 9 on or around 4 June 2015

8. Adult 12 on or around 11 June 2016

9. Adult 15 on or around 6 August 2015

10. Adult 17 on or around 22 August 2013/12 May 2016

11. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

12. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

13. Adult 23 on or around 28 April 2016

14. Adult 24 on or around 20 October 2016

15. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

[…] this patient was seen by [Witness 5] on 16 July 2015. This woman came for deinfibulation so that she could "try for a baby" (medical notes recently disclosed). This patient is therefore at the clinic for preconception advice and treatment

16. Adult 89 on or around 8 October 2015

[…] diary only. Pre-conceptual care: "newly married" recorded in audit

17. Adult 109 on or around 14 May 2015

[…] diary only. Pre-conceptual care: "newly married" recorded in audit

18. Adult 124 on or around 21 July 2016

19. Adult 130 on or around 10/24 November 2016

20. Adult 134 on or around 5 January 2017

[…] no blue notes. Pre-conceptual care: "recently married, not been able to have sexual intercourse" recorded in audit

1.3. On one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

1. Adult 9 on or around 4 June 2015

2. Adult 12 on or around 11 June 2015

3. Adult 17 on or around 22 August 2013

4. Adult 19 on or around 20 August 2015

5. Adult 22 on or around 16 April 2015

6. Adult 41 on or around 3 August 2017

7. Adult 73 on or around 1 October 2015

8. Adult 123 on or around 30 June 2016

9. Adult 135 on or around 10 August 2017

[…] no blue notes. No evidence it was Comfort who saw this patient. The audit records "done by [Ms 6]". [Witness 3] gave evidence that this patient was seen by [Ms 6] […]

10. Adult 146 on or around 7 January 2016

[…] diary only, no notes available to auditors. Potentially pre-conceptual care

1.4. On one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule 3.

Schedule 3. Did not obtain second opinion during de-infibulation

1. Adult 14 on or around 20 December 2013

[…] - diaries only (No evidence that there were complications requiring a second opinion, [Witness 5]. […])

2. Adult 17 on or around 22 August 2013

[…] - diaries only (No evidence that there were complications during the procedure, […])

3. Adult 19 on or around 20 August 2015

[…] - diaries only (No evidence there were complications during the procedure) Records provided January 2023

4. Adult 35 on or around 2 July 2015

[…] this patient was seen by [Witness 5] on 16 July 2015 - medical notes - second opinion obtained

5. Adult 130 on or around 24 November 2016

[…] diaries only ([…])

1.5. On one or more occasion administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber, as listed in schedule 4.

Schedule 4: Administered medication without a prescription

1. Adult 9 on or around 4 June 2015

[…] no blue notes

2. Adult 12 on or around 11 June 2016

[…] no blue notes (In relation to antibiotics, the cannot be a presumption that Comfort prescribed. The notes state "antibiotics prescribed" - prima facie, there was a prescription, […])

3. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

4. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

[…] - no blue notes

5. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

[…] (see also recently disclosed notes. Cannot be inferred from "antibiotics given" in medical notes that no prescription was obtained)

6. Adult 43 on or around 8/14 August 2014

[…] diaries only. Audit suggests woman was seen on 14 August 2014 by [Witness 5]. The woman had a de-infibulation procedure on 14 August 2014. It is reasonable to infer that the procedure was undertaken by [Witness 5] (perhaps under general anaesthetic if she has noted "not suitable for LA as to [sic] tense"). Not possible to make any finding without the clinical records.

7. Adult 44 on or around 5/12 December 2013

[…] no blue notes

8. Adult 123 on or around 30 June 2016

[…] diary only

9. Adult 124 on or around 21 July 2016

[…] diary and outcome letters

10. Adult 138 on or around 29 June 2017

[…] no blue notes

1.6. On one or more occasion provided psychological/psychosexual counselling to patients, as listed in schedule 5.

Schedule 5. Provided psychological/psychosexual counselling

1. Adult 2 on or around 27 October 2016

[…] diary only - no evidence Comfort provided

2. Adult 3 on or around 22 September 2016

[…] - diary only - no evidence Comfort provided. Outcome letters read "referral made to other agencies for support"

1.7. On one or more occasion provided patients with sexual health counselling for dyspareunia, as listed in schedule 6.

Schedule 6: Provided sexual health counselling

(No clear evidence of what sexual health counselling is)

1. Adult 3 on or around 22 September 2016

[…] - diary only - nothing to suggest Comfort provided sexual health counselling

2. Adult 19 between May & September 2015

[…] - diaries only - Records provided January 2023

([…] - referred appropriately - no evidence Comfort provided sexual health counselling. See also medical records)

1.8. On one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;

Schedule 7: Undertook smear test without training/competency

1. Adult 8 on or around 3 December 2015

[...] ([…], no evidence about when the quality assurance programme was introduced or that Comfort was not competent to take smears. The test

was ordered by [Ms 7], who may have been present. Result returned, indicating smear was successful)

2. Adult 32 on or around 28 April 2014

[…] no documentation at all ([…]. No evidence provided on what the necessary training/competencies were at these times)

1.9. On one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

(There is no evidence that Comfort treated any children)

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

1. Child 16 on or around 6 August 2015

2. Child 17 on or around 6 August 2015

3. Child 18 on or around 13 August 2015

4. Child 19 on or around 11 September 2015

5. Child 21 on or around 22 October 2015

6. Child 22 on or around 22 October 2015

7. Child 23 on or around 18 February 2016

[…] aged 16 years

8. Child 24 on or around 26 May 2016

9. Child 25 on or around 9 June 2016

10. Child 26 on or around 9 June 2016

11. Child 27 on or around 22 November 2016

12. Child 28 on or around 20 July 2017

(not referred to CM - PICU)

13. Child 29 on or around 10 August 2017

[…] patient was 17 years old, and turned 18 in 2017 […]

1.10. On one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

1. Child 16 on or around 6 August 2015

2. Child 17 on or around 6 August 2015

3. Child 18 on or around 13 August 2015

4. Child 19 on or around 11 September 2015

5. Child 21 on or around 22 October 2015

[…] child seen by [Dr 8]

6. Child 22 on or around 22 October 2015

[…] child seen by [Dr 8]

7. Child 23 on or around 18 February 2016

[…] aged 16 years

8. Child 24 on or around 26 May 2016

9. Child 25 on or around 9 June 2016

10. Child 26 on or around 9 June 2016

11. Child 27 on or around 22 November 2016

12. Child 28 on or around 20 July 2017

(PICU)

13. Child 29 on or around 10 August 2017

[…] patient was 17 years old, and turned 18 in 2017 […]

2. On one or more occasion did not, for adult patients as listed in schedule 9

2.1. Refer adult patients to specialist counsellors

Schedule 9: Failed to refer/investigate

Charge 2.1

1. Adult 2 on or around 27 October 2016

[...] diary entry only - cannot infer from note in diary "sexual problems" that this patient required such a referral

2. Adult 7 on or around 18 August 2016

([…] [Witness 3] not able to say if onward referral) […] - diary only

3. Adult 15 on or around 6 August 2015

[…] ([…], it was unclear whether referral was made or not. Diary note says "she will need psychosexual")

4. Adult 23 on or around 28 April 2016

[…] diary only

5. Adult 36 on or around 3 January 2013

[…] diary only. This woman was referred by sexual health services. No outcome letter or notes are provided. The diaries indicate "will benefit from psychosexual counsellor". Does this appear in the outcome letter? Discussed with [Witness 3] […]. It would be acceptable for Comfort to recommend a referral for psychosexual counselling within the outcome letter

2.2. Refer adult patients for sexual health counselling

Charge 2.2

(No evidence presented to outline what sexual health counselling is)

1. Adult 2 on or around 27 October 2016

[…] diary only - no evidence patient required sexual health counselling

2. Adult 7 on or around 18 August 2016

(Referral came from sexual and reproductive health practitioner, […] - diary only

3. Adult 15 on or around 6 August 2015

[…] ([…], [Witness 3], indicated required psychosexual counselling, not sexual health counselling)

4. Adult 23 on or around 28 April 2016

[…] diary only ([…] - "it wasn't clear"). Diary and audit suggests this woman required a referral for psychosexual counselling, not sexual health counselling

5. Adult 36 on or around 3 January 2013

[…] diary only ([…]- this woman was referred from sexual health services - onward referral to psychosexual counselling discussed. No evidence required sexual health counselling referral)

2.3. Refer adult patients for further investigation

Charge 2.3

1. Adult 4 on or around 21 April 2016

[…] - diary only

2. Adult 10 on or around 19 November 2015

[…] - audit records "referred back to GP ✓ ", as indicated in notes

3. Adult 17 on or around 22 August 2013/12 May 2016

[…] - diaries only ([…], cyst not present at examination, no requirement for further investigation)

4. Adult 56 on or around 29 May 2014

[…] diary only […] Audit states "unclear", insufficient. Diary notes "needs referral to gynae clinic". There was an outcome letter but it is not provided

5. Adult 124 on or around 28 July 2016

[…] diaries only (No evidence any referral was indicated). This woman had several follow up appointments and outcome letters were sent to her GP

2.4. Obtain a second opinion for adult patients during/following an FGM assessment.

Charge 2.4

1. Adult 2 on or around 27 October 2016

[…] diary only - no evidence required a second opinion

2. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

[…] - diaries only - Records provided January 2023

(No evidence of necessity to seek second opinion, FGM noted by [Ms 9] and [Dr 10] in 2011)

3. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

[…] (This patient was referred to [Witness 5] and seen by her on 16 July 2015, see medical records)

3. On one or more occasion failed to maintain adequate clinical records for adult/children/patients under the age of 18, in that you:

(What is "adequate" for an FGM appointment?)

3.1. On or around 27 October 2016 during/following your consultation with Adult 2

[…] diary only

3.1.1. Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.

(Not provided for consideration)

3.1.2. Did not record information about Adult 2's background.

(Notwithstanding the above, there is information about patient history in diary)

3.1.3. Did not record that Adult 2's anatomy change could have been due to birth trauma.

(No evidence this was required)

3.1.4. Did not record adequate details of the advice/assessment/discussion/next steps for Adult 2.

[…] duplicitous with charge 3.1.1

3.2. On or around 22 September 2016 during/following your consultation with Adult 3;

[…] - diary only

3.2.1. Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.

(We do not have the physical patient records - outcome letter mentions domestic violence)

3.2.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 3.

[…] duplicitous with charge 3.2.1

3.2.3. Did not record a risk assessment for Adult 3

(No evidence Adult 3 required a risk assessment or that it should be recorded, [Witness 5])

3.3. On or around 21 June 2016 during/following your consultation with Adult 4;

[…] - diary only

3.3.1. Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle.

(No records available for this woman)

3.3.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 4

(Duplicitous with charge 3.3.1)

3.3.3. Did not record information about Adult 4's risk of infection/chronic pain.

(No evidence of chronic pain – […] - potentially duplicitous with charge 3.3.1)

3.3.4. Did not record a risk assessment for Adult 4

3.3.5. Did not record whether a swab/urine sample had been taken for Adult 4.

(If no swab/urine sample taken, no obligation to record - potentially duplicitous with charge 3.3.1)

3.4. On or around 15 June 2017 during/following your consultation with Adult 6;

[…] no blue notes

3.4.1. Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.

3.4.2. Did not record the reason for Adult 6's referral to the FGM clinic.

[…] good practice only - potentially duplicitous with charge 3.4.1

3.4.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 6

(Duplicitous with charge 3.4.1)

3.5. On or around 18 August 2016 during/following your consultation with Adult 7;

[…] - diary only

3.5.1. Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle.

([…] [Witness 3] not able to comment on adequacy of notes "without the notes in front of me" - no records provided for consideration. Audit silent on consent and chaperone)

3.5.2. Did not record a risk assessment of Adult 7/Adult 7's daughters.

(Cannot recall if there was a risk assessment, […]. Risk assessment not required for woman. Risk assessments for children would not be on Adult 7's records. Children's records not considered in the review)

3.5.3. Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

([…], [Witness 3] not able to say whether there were risk assessments or not. The daughters notes were not looked at – […])

3.5.4. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 7

(Duplicitous with 3.5.1)

3.6. On or around 3 December 2015 during/following your consultation with Adult 8;

[…] no blue notes

3.6.1. Did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle.

(No evidence of what else is required for smear test)

3.6.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8

(Duplicitous with charge 3.6.1)

3.6.3. Did not record/inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years.

[…]. This would not be done by Comfort, but would automatically be sent to the patient directly. Comfort could not have told Adult 8 to repeat the smear in 3 years, because the results were awaited. This information would have been communicated directly to Adult 8 with her results. Outcome letter indicates that GP was aware smear had been taken

3.7. On or around 4 June 2015 during/following your consultation with Adult 9;

[…] no blue notes

3.7.1. Did not record adequate details of Adult 9's consultation in the EPR/physical patient records bundle.

3.7.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 9

([…] - duplicitous with charge 3.7.1)

3.8. On or around 19 November 2015 during/following your consultation with Adult 10;

[…] no blue notes

3.8.1. Did not record adequate details of Adult 10's consultation in the EPR/physical patient records bundle.

([…]) records relatively detailed

3.8.2. Did not record whether a urine sample had been taken for Adult 10.

([…]) good practice only. Woman referred back to GP to assess whether antibiotics required

3.8.3. Did not record whether Adult 10 was checked for a urinary tract infection/infections.

([…]) good practice only. Woman was referred back to GP to assess whether antibiotics required

3.8.4. Did not record adequate details of the advice provided to Adult 10

([…]) duplicitous with charge 3.8.1

3.9. On or around 11 June 2015 during/following your consultation with Adult 12;

[…] - this seems to be diaries only as further details are recorded in the audit

3.9.1. Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle.

([Witness 3] "I can only go from what… has recorded on here")

3.9.2. Did not record whether the de-infibulation procedure was discussed with Adult 12

([…])

3.9.3. Did not record a discussion around personal hygiene with Adult 12.

([…] "personal hygiene advised")

3.9.4. Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

(No requirement)

3.9.5. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 12.

([…]) Duplicitous with charge 3.9.1

3.10. On or around 6 August 2015 during/following your consultation with Adult 15;

[…] - no blue notes

3.10.1. Did not record adequate details of Adult 15's consultation in the EPR/physical patient records bundle.

([…], "I can only go with hat [sic] … has put on the audit form")

3.10.2. Did not record a discussion about the illegality of FGM with Adult 15.

("All issues relating to FGM discussed with Adult 15, well understood" […])

3.10.3. Did not record a risk assessment for Adult 15.

([…])

3.10.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 15.

Duplicitous with charge 3.10.1

3.11. On or around 3 November 2016 during/following your consultation with Adult 16;

[…] - no documentation provided at all

3.11.1. Did not record adequate details of Adult 16's consultation in the EPR/physical patient records bundle.

([…], "potentially that is adequate". […] not able to comment on adequacy)

3.11.2. Did not record the reasons for Adult 16's referral.

(Letter indicates this was a midwife referral for antenatal deinfibulation […] - NB this was missed by the audit)

3.11.3. Did not record Adult 16's gestation period.

("Not clear" recorded in audit - not clear what that means)

3.11.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 16.

Duplicitous with charge 3.11.1

3.12. On or around 22 August 2013/12 May 2016 during/following your consultation with Adult 17;

[…] - diaries only

3.12.1. Did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.

3.12.2. Did not record adequate details about Adult 17's de-infibulation procedure.

3.12.3. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 17.

Duplicitous with charge 3.12.1

3.13. On or around 14 May 2015/20 August 2015/10 September 2015 during/following your consultation with Adult 19;

[…] - diaries only (No evidence there were complications during the procedure) Records provided January 2023

3.13.1. Did not record adequate details of Adult 19's consultations in the EPR/physical patient records bundle.

(See medical records, […])

3.13.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 19

(Duplicitous with charge 3.13.1)

3.13.3. Did not record information surrounding the history of domestic abuse of Adult 19.

(Duplicitous with charge 3.13.3. No evidence history of DV should be recorded)

3.14. On or around 16 April 2015 during/following your consultation with Adult 22;

[…] - no blue notes

3.14.1. Did not record adequate details of Adult 22's consultation in the EPR/physical patient records bundle.

([…], [Witness 3 did] not recall this case) outcome letters not disclosed, no blue notes

3.14.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 22.

Duplicitous with charge 3.14.1

3.14.3. Did not record the timing of the administration of Lidocaine to Adult 22.

(Not required, [Witness 5]. Not alleged in relation to any other patient)

3.14.4. Did not record the frequency of the administration of Lidocaine to Adult 22.

(No evidence this was required. Not alleged against any other patient)

3.15. On or around 28 April 2016 during/following your consultation with Adult 23;

[…] diary only

3.15.1. Did not record adequate details of Adult 23's consultation in the EPR/physical patient records bundle

No records provided

3.15.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 23

Duplicitous with charge 3.15.1

3.15.3. Did not record a risk assessment for Adult 23/Adult 23's children.

(Daughter's notes not called for – [...]. The GP would have been expected to risk assess as well, given information recorded about referral)

3.16. On or around 20 October 2016 during/following your consultation with Adult 24;

[…] - diary only

3.16.1. Did not record adequate details of Adult 24's consultation in the EPR/physical patient records bundle

([…] [Witness 3] cannot recall adequacy - lots of information in audit tends to suggest notes were detailed)

3.16.2. Did not inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment.

([…] [Witness 3] it was not for Comfort to inform the GP, she is unlikely to have been aware)

3.16.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 24

Duplicitous with charge 3.16.1

3.17. On or around 2 July 2015/ 9 July 2015 during/following your consultation with Adult 35;

[…] and recently disclosed medical notes

3.17.1. Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

(This appears to be a patient seen by [Witness 5] on 16 July - notes available are adequate. […])

3.17.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 35.

Duplicitous with charge 3.17.1

3.17.3. Did not record the reason for prescribing/providing antibiotics to Adult 35.

Duplicitous with charge 3.17.1

3.17.4. Did not record the dosage of antibiotics prescribed/provided to Adult 35.

Duplicitous with charge 3.17.1

3.17.5. Did not record details surrounding Adult 35's possible allergies to antibiotics

(No evidence Adult 35 had allergies or that Comfort was obliged to record the patient's lack of allergy to antibiotics – […], also duplicitous with charge 3.17.1)

3.18. On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 44;

[…] no blue notes (No evidence of poor documentation, […])

3.18.1. Did not record adequate details of Adult 44's consultations in the EPR/physical patient records bundle

3.18.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 44

(Duplicitous with charge 3.18.1)

3.19. On or around 21 July 2016/28 July 2016 during/following your consultation with Adult 124;

[…] diaries only

3.19.1. Did not record adequate details of Adult 124's consultations in the EPR/physical patient records bundle.

([…] [Witness 3] cannot comment on adequacy)

3.19.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 124

(Duplicitous with 3.19.1)

3.20. On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130;

[…] diaries only

3.20.1. Did not record adequate details of Adult 130's consultations in the EPR/physical patient records bundle.

3.20.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 130

(Duplicitous with 3.20.1 – […] [Witness 3] cannot be sure this was not a patient of [Witness 5])

3.20.3. Did not record whether Adult 130's condition/assessment was escalated.

(No evidence this patient needed to be escalated - this is a judgment that could only be made by examining the patient)

3.21. On or around 6 August 2015 during/following your consultation with Child 16;

3.21.1. Did not clearly record the origin of referral in Child 16's patient records.

[…] blue notes record "referred to the AWWC by her GP/social worker re: FGM"

3.21.2. Did not record any correspondence with social workers.

3.21.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 16/Child 16's mother.

3.21.4. Did not record a risk assessment for Child 16.

3.21.5. Did not record any follow up communication/letter with Child 16's Social Worker

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.1. Did not clearly record the origin of referral in Child 17's patient records.

[…] blue notes record "GP/social worker referred"

3.22.2. Did not record a full clinical history check of Child 17.

3.22.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 17/Child 17's mother

3.22.4. Did not record a risk assessment for Child 17.

3.23. On or around 13 August 2015 during/following your consultation with Child 18;

3.23.1. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

[…] blue notes contain detail about referral, background, assessment and advice

3.23.2. Did not record a risks [sic] assessment for Child 18

3.23.3. Did not record whether a urine sample had been taken for Child 18.

No evidence to suggest a urine sample was taken. No requirement to record

3.24. On or around 11 September 2015 during/following your consultation with Child 19;

3.24.1. Did not create any official clinical healthcare records for Child 19.

3.24.2. Incorrectly stated in Child 19's GP letter dated 14 October 2015 that Child 19 was assessed on 9 September 2015.

[…] the outcome letter clinic date is recorded as 11 September 2015. The letter contains an obvious typo and this could not amount to misconduct

3.24.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 19

3.24.4. Did not record a risk assessment for Child 19

3.24.5. Did not record any follow up with social care.

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.1. Did not adequately record the origin of referral in Child 21's patient records.

[…] blue notes indicate referral was from "social services/police"

3.25.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 21/Child 21's mother.

3.25.3. Did not record a risk assessment for Child 21.

3.25.4. Incorrectly recorded information regarding Child 22 into Child 21's records.

3.25.5. Did not send an outcome letter to Child 21's social services and/or the police

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

3.26.1. Did not adequately record the origin of referral in Child 22's patient records.

[...] blue notes indicate referral was from "social services/police"

3.26.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 22/Child 22's mother.

3.26.3. Did not send an outcome letter to Child 22's social worker and/or the police

3.26.4. Incorrectly recorded information regarding Child 21 into Child 22s records.

3.27. On or around 18 February 2016 during/following your consultation with Child 23;

3.27.1. Did not create any official clinical healthcare records for Child 23

[…] aged 16 years. Only diary page available to auditors. Audit notes "not available" which is then scribbled out

3.27.2. Did not record a risk assessment for Child 23.

***3.27.3. Did not record the social impact of FGM on Child 23**.*

No evidence this was required. Duplicitous with 3.27.4

3.27.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 23

3.27.5. Did not send an outcome letter to Child 23's GP.

Outcome letter appears in the records "via email". Email not searched for the purposes of the audit.

3.28. On or around 26 May 2016 during/following your consultation with Child 24;

3.28.1. Did not record/consider whether the support Child 24 was receiving was optimal.

3.28.2. Did not record whether Child 24 required additional services/support.

Duplicitous with charge 3.28.1

3.28.3. Did not record which kind of support/plans were in place for Child 24

[…] blue notes record "receiving some support/counselling" Duplicitous with charge 3.28.4

3.28.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 24.

3.28.5. Did not send an outcome letter to Child 24's referrer

3.29. On or around 9 June 2016 during/following your consultation with Child 25;

3.29.1. Incorrectly recorded Child 25's referrer as the safeguarding team/police.

Referral came from Southwark Social Services, unclear that this was incorrect

3.29.2. Did not record a risk assessment for Child 25

[…] ([…], [Witness 1] no requirement for risk assessment)

3.29.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 25/Child 25's mother

3.29.4. Did not record/send an outcome letter to the referrer/Children's Social Care

3.29.5. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 25's mother

3.30. On or around 9 June 2016, during/following your consultation with Child 26;

3.30.1. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 26/Child 26's mother

3.30.2. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 26's mother

3.30.3. Did not record/send an outcome letter to the referrer/Children's Social Care

3.30.4. Incorrectly informed Child 26's GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

[…] No evidence letter sent

3.30.5. Did not record a risk assessment for Child 26

([…], [Witness 1] no requirement for risk assessment)

3.31. On or around 22 September 2016 during/following your consultation with Child 27;

3.31.1. Did not create official healthcare records for Child 27.

3.31.2. Did not send/complete an outcome letter to/for Child 27's GP.

3.31.3. Did not record a full risk assessment for Child 27.

3.31.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 27/Child 27's mother

3.31.5. Did not record/send an outcome letter to the referrer/Children's Social Care

3.32. On or around 20 July 2017, during/following your consultation with Child 28;

[…] (There was no consultation with Child 28)

3.32.1. Did not record a full risk assessment for Child 28.

(This child was in PICU – […] [Witness 1], risk assessment not necessary)

3.32.2. Did not Did not record adequate details of the advice/examination/discussion/next steps provided to Child 28/Child 28's father

(PICU - the referral letter to UCLH was not picked up in the audit, which was demonstrably flawed in relation to this child. […]

3.33. On or around 10 August 2017, during/following your consultation with Child 29;

3.33.1. Did not record a full risk assessment for Child 29

[…] 17 year old child already has a social worker allocated and police informed

3.33.2. Did not record the symptoms/adverse effects suffered by Child 29.

3.33.3. Did not record the benefit of a referral to a gynaecologist for Child 29.

3.33.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 29/Child 29's mother

3.33.5. Did not record/include sufficient information/understanding surrounding the type of FGM in Child 29's GP Letter

4. Did not record the offer/confirmation of consent for FGM assessments for one or more adult patients as listed in schedule 10.

It is not clear that an FGM assessment would require consent or involve any examination. If this charge relates to examination, it is duplicitous with charge 5.

Schedule 10: Failed to record the offer of consent for examination/de- infibulation

1. Adult 2 on or around 27 October 2016

[…] diary only - good practice only for adults

2. Adult 8 on or around 3 December 2015

[...] (smear only - no examination)

3. Adult 9 on or around 4 June 2015

[…]

4. Adult 12 on or around 11 June 2016

[…] the audit is silent on whether consent was recorded

5. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015 - *of note that neither did [Dr 10].*

6. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

[…] no blue notes

7. Adult 35 on or around *2/9**/16/ July 2015**/ 6 August 2015*

[…] - see also recently disclosed notes - this patient was seen by [Witness 5] on 16 July 2015

8. Adult 44 on or around 5/12 December 2013

[…] diary only - audit silent on whether consent recorded

9. Adult 69 on or around 15 October 2015

[…] no blue notes

10. Adult 74 on or around 3 October 2013

[…] - diaries only

11. Adult 124 on or around 21 July 2016

[…] diaries only

12. Adult 130 on or around 10/24 November 2016

[…] diaries only

13. Adult 138 on or around 29 June 2017

[…] no blue notes

14. Adult 143 on or around 12 March 2013

[…] diary only, blue notes were not available to the auditors. Audit undertaken on the basis of the diary page alone

15. Adult 154 on or around 25 May 2017

[…] diary only, notes not available to auditors. Audit undertaken on the basis of the diary page alone. Audit notes there was an outcome letter on EPR

5. Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.

Schedule 10: Failed to record the offer of consent for examination/de- infibulation

1. Adult 2 on or around 27 October 2016

[…] diary only - good practice only for adult patients. For this patient, the audit is silent on consent

2. Adult 8 on or around 3 December 2015

[...] smear only, no FGM examination/de-infibulation procedure carried out

3. Adult 9 on or around 4 June 2015

[…]

4. Adult 12 on or around 11 June 2016

[…] the audit is silent on whether consent was recorded

5. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

6. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

[…] diary only

***7. Adult 35 on or around** 2/9**/16/ July 2015/** 6 August 2015*

[…] - see also recently disclosed notes - this patient was seen by [Witness 5] on 16 July 2015

8. Adult 44 on or around 5/12 December 2013

[…] diary only - audit silent on whether consent recorded

9. Adult 69 on or around 15 October 2015

[…] no blue notes

10. Adult 74 on or around 3 October 2013

[…] - diaries only

11. Adult 124 on or around 21 July 2016

[…] diaries only

12. Adult 130 on or around 10/24 November 2016

[…] diaries only

13. Adult 138 on or around 29 June 2017

[…] no blue notes

14. Adult 143 on or around 12 March 2013

[…] diary only, blue notes were not available to the auditors. Audit undertaken on the basis of the diary page alone

15. Adult 154 on or around 25 May 2017

6. Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10;

Schedule 10:

1. Adult 2 on or around 27 October 2016

[…] diary only - good practice only for adult patients. For this patient, the audit is silent on whether chaperone was recorded

2. Adult 8 on or around 3 December 2015

[...] - smear only - no FGM examination/de-infibulation procedure carried out

3. Adult 9 on or around 4 June 2015

[…]

4. Adult 12 on or around 11 June 2016

[…] the audit is silent on whether details of a chaperone were recorded

5. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015

6. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

***7. Adult 35 on or around** 2/9/**16/ July 2015/** 6 August 2015*

[…] see also recently disclosed notes (16 July 2015 saw [Witness 5])

8. Adult 44 on or around 5/12 December 2013

[…] diary only - audit silent on whether chaperone recorded

9. Adult 69 on or around 15 October 2015

[…] no blue notes

10. Adult 74 on or around 3 October 2013

[…] - diaries only

11. Adult 124 on or around 21 July 2016

[…] diaries only

12. Adult 130 on or around 10/24 November 2016

[…] diaries only

13. Adult 138 on or around 29 June 2017

[…] no blue notes

14. Adult 143 on or around 12 March 2013

[…] diary only, blue notes were not available to the auditors. Audit undertaken on the basis of the diary page alone

15. Adult 154 on or around 25 May 2017

7. Did not record the offer of a translator to Adult 10

[…] notes indicate woman's daughter translated

8. Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

(No checks made with GPs to ask if outcome letter received - no evidence letters not sent, only not recorded)

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

Charge 8

1. Adult 2 on or around 27 October 2016

[…] diary only - no evidence failed to send outcome letter/follow up

2. Adult 6 on or around 15 June 2017

[…] - audit notes "seen in gynae clinic" on 18 July 2017. Audit also appears to indicate a letter was on EPR dated 28 June 2017 - this has not been provided

3. Adult 7 on or around 18 August 2016

[…] - diary only

4. Adult 9 on or around 4 June 2015

[...] recorded GP details

5. Adult 23 on or around 28 April 2016

[…] diary only […]

6. Adult 24 on or around 20 October 2016

[...] diary only ([…], [Witness 3], no recollection if there was a note, no evidence follow up with the MDT was required)

9. Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.

(There is no evidence of who the MDT might be)

Charge 9

1. Adult 3 on or around 22 September 2016

[…] - diary only - no evidence follow up with MDT required

2. Adult 4 on or around 21 April 2016

[…] - diary only - no evidence follow up with MDT required

3. Adult 7 on or around 18 August 2016

[…] - not obtained children's files and not clear who the MDT is that Comfort should have followed up with. Already under sexual health team) […] - diary only

4. Adult 23 on or around 28 April 2016

[…] diary only ([…] - nothing to suggest follow up with the MDT required)

5. Adult 30 on or around 13 March 2013

[…] diary only (No evidence this patient required follow up with the MDT, transcript, […])

6. Adult 98 on or around 19 July 2012

[…] (No evidence follow up with MDT required, […])

10. On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;

a) Advice/discussion/next steps with the patient

b) Details of assessment/examination

c) FGM risk assessments

FGM risk assessments not required to be undertaken where a woman already has FGM ([Witness 5])

Schedule 12: Did not record adequate details of the appointment/consultation.

1. Adult 25 on or around 3 July 2014

[...] diary only ([…], comprehensive letter to GP, cannot say whether adequate records, blue notes, or not)

2. Adult 26 on or around 6/13 July 2017

[…] diaries only ([…], cannot comment on standard of notes)

3. Adult 30 on or around 13 March 2013

[…] diary only

4. Adult 38 on or around 12 May 2016

[…] diary only

5. Adult 41 on or around 3 August 2017

[…] no blue notes […]

6. Adult 48 on or around 24 July 2014

[…] diary only

7. Adult 54 on or around 3 January 2013

[…] diary only […]

8. Adult 59 on or around 14 November 2013

[…] diary only […]

9. Adult 80 on or around 10/17 September 2015

[…] no blue notes […]

10. Adult 90 on or around 20 September 2012

[…] diary only […]

11. Adult 118 on or around 24 May 2012

[…] blue notes […]

12. Adult 128 on or around 20 October 2016

[…] diary only

13. Adult 136 on or around 16 August 2017

[…] no blue notes. No evidence it was Comfort who saw this patient. The audit records "done by [Ms 6]". [Witness 3] gave evidence that this patient was potentially seen by [Ms 6] ([…]). This was the same day as the consultation for Adult 135, recorded as "done by [Ms 6]" in the audit. The allegation includes the wrong date. It should read "10 August 2017"

14. Adult 150 on or around 22 September 2016

[…] diary only (This pregnant woman was seen in the ante-natal maternity clinic, likely notes written in maternity notes, […], not obtained for audit or NMC investigation). Audit notes outcome letter was on EPR

15. Adult 162 on or around 25 August 2016

[…] (Duplicitous with charge 12) diaries only, blue notes not available to auditors. The audit notes an outcome letter was seen […]

11. Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

Schedule 13: Did not clearly record the reason/origin of referral

1. Adult 11 on or around 20 December 2012

[…] - diary only […]. Diary indicates "Ref. Self". This is clearly a self-referral

2. Adult 28 on or around 25 April 2013

[…] diary only. This appears to be a self-referral. Clinical notes and outcome letters not provided.

3. Adult 46 on or around 17 July 2014

[…] diary only. Diary states referred by [Dr 11] and the audit suggests an email address is provided. The audit also states that the reason for referral is "Re: FGM III". Suggests the auditors may have seen a referral letter in the file

4. Adult 50 on or around 8 August 2013

[…] diary only

5. Adult 86 on or around 25 April 2013

[…] diary only. Diary struck through, indicating this woman was not referred by anyone, ie a self-referral

6. Adult 131 on or around 3/10 November 2016

[…] diaries only. This was potentially a patient of [Witness 5]. As with patient 130, this woman was referred to a clinic on 24 November 2016. There is nothing to suggest this woman attended an appointment on 3 November 2016. No clinical notes were "found" for this patient, though

an outcome letter appears on EPR. The audit was based therefore on the diary alone. This is not the clinical record for adult 131

7. ***Adult 158 on or around 7 November 2013***

[…] diary only, blue notes not available to auditors. In the diary, there is a line through "ref by" which would indicate this was a self-referral (as this patient was not referred by anyone)

8. Adult 160 on or around 17 September 2015

[…] blue notes not available to auditors. In the diary/pro-forma, it states this woman was first seen on 10 September 2015. It can be expected that the referral details would be included within the notes of the first appointment, rather than the second. There is an outcome letter for this patient (though not disclosed).

12. Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle for one or more adult patients, as listed in schedule 14.

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundles

2. Adult 30 on or around 13 March 2014

[…] diary only (Duplicitous with charge 10)

2. Adult 38 on or around 12 May 2016

[…] diary only (Duplicitous with charge 10)

3. Adult 142 on or around 16 March 2017

[…] (This patient was a maternity patient of Lewisham and Greenwich. It is acceptable if Comfort wrote in her maternity notes. Notes not obtained as part of the audit or investigation. Blue notes were not available for the audit (reasons unknown) therefore audit undertaken on what basis?)

4. Adult 143 on or around 12 March 2013

[…] dairy only, notes not available to auditors [sic]

5. Adult 147 on or around 9 December 2016

[…] diary only, notes not available to auditors

6. Adult 153 on or around 20 December 2012

[…] diary only, notes not available to auditors. Audit notes outcome letter on EPR

7. Adult 156 on or around 24 January 2013

[…] diary only, blue notes not available to auditors. Audit notes "EPR nothing" however the diary page indicates "EPR ✓" (top left hand corner). Of note, the diary page indicates "got married last week" - potentially this patient's name changed on her clinical records/EPR

8. Adult 159 on or around 13 February 2014

[...] diary only, blue notes not available to auditors. Of note, the diary page indicates "just got married" - potentially this patient's name changed on her clinical records/EPR

9. Adult 161 on or around 18 February 2016

[...] diaries only, blue notes not available to auditors. There are two audits for this woman. This woman was seen and treated by [Witness 5] on 7 July 2016. The audit notes an outcome letter was seen

10. Adult 162 on or around 25 August 2016

[…] (Duplicitous with charge 10) diaries only, blue notes not available to auditors. The audit notes an outcome letter was seen

13. On or around 6 August 2015 did not refer Child 17 to a Community Paediatrician.

[…] not clear that a referral to the community paediatrician was required. Letter […] indicates this child was already under the community paediatrician and had multiple referrals to the Evelina bladder clinic.

14. On or around 13 August 2015;

14.1. Did not refer Child 18 to a specialist paediatric urologist.

[…] blue notes and outcome letter state "will need further investigation and support"

14.2. Did not refer Child 18 to the Consultant Lead Professor at the African Well Women Clinic (AWWC)

14.3. Unnecessarily conducted a FGM examination/assessment of Child 18.

14.4. Incorrectly referred Child 18 to the adult gynaecology service.

Charge 14.2 and 14.4 seem to be charging both scenarios. The outcome letter does not indicate that any referrals were made. Without the full notes, it is not possible to see if further referral letters were on this patient's file, or further appointments were attended

15. On or around 26 May 2016 did not refer Child 24 for psychological support

Duplicitous with charge 3.28.1

***16. On or around 18 February 2016, did not refer child 23 for psychological services**.*

[…] aged 16 years, not clear the referral was required

17. On or around 9 June 2016 did not refer Child 25 to a paediatric gynaecologist/specialist paediatric FGM centre/ FGM child assessment provider.

18. On or around 7 July 2017 you initially assessed Child 28 rather than refer them for examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.

(Duplicitous with 1.10)

19. On or around 10 August 2017 did not refer Child 29's examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider

20. Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

Schedule 8:

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

1. Child 16 on or around 6 August 2015

2. Child 17 on or around 6 August 2015

3. Child 18 on or around 13 August 2015

4. Child 19 on or around 11 September 2015

5. Child 21 on or around 22 October 2015

6. Child 22 on or around 22 October 2015

7. Child 23 on or around 18 February 2016

[…] aged 16 years. Only diary page available to auditors

8. Child 24 on or around 26 May 2016

9. Child 25 on or around 9 June 2016

10. Child 26 on or around 9 June 2016

11. Child 27 on or around 22 November 2016

12. Child 28 on or around 20 July 2017

(PICU)

13. Child 29 on or around 10 August 2017

21. Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

Schedule 8:

1. Child 16 on or around 6 August 2015

2. Child 17 on or around 6 August 2015

3. Child 18 on or around 13 August 2015

4. Child 19 on or around 11 September 2015

5. Child 21 on or around 22 October 2015

[…] child seen by [Dr 8] and mother present

6. Child 22 on or around 22 October 2015

[…] child seen by [Dr 8] and mother present

7. Child 23 on or around 18 February 2016

[…] aged 16 years. Only diary page available to auditors

8. Child 24 on or around 26 May 2016

9. Child 25 on or around 9 June 2016

10. Child 26 on or around 9 June 2016

11. Child 27 on or around 22 November 2016

12. Child 28 on or around 20 July 2017

(PICU)

13. Child 29 on or around 10 August 2017"

Legal Framework

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

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

4. *In accordance with the principles set out in the criminal case of R v Galbraith [1981] 1 W.L.R. 1039, when considering whether there is a case to answer, the Panel should first determine whether there is any evidence upon which a Panel could properly find the charges proved. Where there is none, the Panel should find no case to answer. Where there is some evidence presented, the Panel should consider the nature and strength of that evidence and decide whether it*

can properly be relied upon to find the facts proved. Evidence which is inherently weak and vague, or inconsistent with the remaining evidence in the case, ought not be relied upon.

5. *Application is made that no reasonable panel, properly directed could find the above charges proved. This is a legal application related to the sufficiency of the evidence in this case. The panel must decide whether the allegation could be made out, not whether it would be made out, on the balance of probabilities, taking the NMC case at its highest. The panel is reminded of the principle in the case of Shippey [1988] Crim LR 767 that "'taking a prosecution case at its highest' did not mean picking out the plums and leaving the duff behind".*

6. *The standard of proof the NMC must meet is the balance of probabilities. Application is made that the evidence presented is insufficient to meet that standard. The balance of probabilities requires the panel to consider all the evidence in the case and decide where the balance of the evidence lies in relation to each charge. There is no evidential burden upon Mrs Momoh to prove that these charges are false.*

7. *In the case of Re H (Minors) [1996] AC 563 at 586, Lord Nicholls explained that the balance of probabilities standard is a flexible test:*

    "The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability... Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation. Although the result is much the same, this does not

mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established."

8. To quote from Lord Hoffman, in Secretary of State for the Home Department v Rehman [2001] UKHL 47:

   "It would need more cogent evidence to satisfy [a judge] that the creature seen walking in Regent's Park was more likely *than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian."*

9. *R (Dutta) v GMC [2020] EWHC 1974 (Admin) is an important reminder to tribunals about the proper approach to the assessment of evidence and factual findings. The High Court found that, when assessing evidence, a panel should begin with a consideration of the objective facts, as shown by contemporaneous documents. It was suggested that the best approach is to base factual findings on inferences drawn from documentary evidence and known or probable facts. Contemporary documents are always of the utmost importance. This is particularly relevant when the witnesses have given oral evidence concerning events occurring at least four and a half years ago. The witness evidence can be tested against those known or probable facts. The documentary evidence can be tested against the oral testimony of witnesses.*

10. *Dutta also highlights that it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based in that recollection provides any reliable guide to the truth. The demeanour of a witness is not a reliable pointer to his or her honesty. It is an*

error of principle to ask "do we believe him/her?" before considering the documents. Particular regard should be had to the witnesses' motives and to the overall probabilities. Credibility can be supported by internal or external consistency of witness evidence.

11. *Where the NMC charges a failure, the NMC is obliged to prove that there exists a duty AND an unreasonable failure on the part of the Registrant to fulfil that duty (Daly v NMC [2018] CSIH 51).*

12. *Mrs Momoh is of good character before her regulator. The case of Wisson v Health Professions Council [2013] EWHC 1036 (Admin) (paragraphs 41-44), cited with approval in Sawati v GMC [2022] EWHC 283 (Admin), confirms the principles to be applied. First, good character can go to credibility – how reasonable it is to believe or disbelieve what an individual says. Second, it can go to propensity – the probability that they have misconducted themselves. It may be considered less likely that an erstwhile blameless person has seriously misconducted themselves if they have never done so before. Mrs Momoh is a midwife with an unblemished record before her regulator. The panel will recall that she joined the NMC Register in 1986 and has had no previous or subsequent referrals.*

13. *The NMC produces guidance on "no case to answer" applications, as well as taking account of context.*

Submissions

14. *The panel has insufficient evidence that it could reasonably conclude that Comfort Momoh:*
    a. *Was not competent to accept referrals for and/or treat non-pregnant women;*
    b. *Did not make onward referrals to other specialists;*

c. *Had cause to seek a second opinion in relation to any patient during the deinfibulation procedure and/or that any patient suffered from complications during those procedures;*
d. *Provided psychosexual counselling to patients;*
e. *Provided sexual health counselling to patients (to a degree that it was outside of her scope of competence);*
f. *Was required to undertake a risk assessment for women who had already undergone to FGM;*
g. *Was required to undertake a risk assessment for children already within safeguarding/social services;*
h. *Did not have the correct training/competency to conduct smear tests; and/or*
i. *Kept inadequately detailed records for her patients.*

Audits

15. *The NMC investigation appears to have been limited to adopting the Guys and St Thomas' ("GSST") adults' and children's audits, with no independent inquiry being made. As such, the NMC case is subject to the limitations of the audits. There are a number of demonstrable failings in the audits. These were discussed with [Witness 3] […]. Her evidence continued […]:*

"Q. Was there any agreement between you, [Ms 12] and [Ms 13] about how it would be reflected in the audit ie you told us sometimes there's a difference between where they were available, but they were empty or not written in or where they just simply were not available and might have gone missing. Was there some sort of standardised way you would record the difference between those two things?

A. I can't recall that explicitly, to be honest. I think we agreed that we would write whether they were available or not. As you can see, with the passage of time and we perhaps have written it slightly differently, so it's difficult now to decipher with 100% accuracy whether they weren't available or whether they weren't available for reason that they were

somewhere else or they couldn't be found or there was just nothing written in them. It's difficult to say for 100%."

16. *Comfort's emails were not searched as part of the GSST or NMC investigations […]:*

    "Q. Right. Next is Adult 6, so we can skip across to page 170, please, this is the new audit form.

    [Witness 3]. Yes.

    Q. The new audit form has a specific list of concerns that have been identified, and also it has got "email search" written there.

    [Witness 3]. Yes.

    Q. So there must have been some sort of conversation about emails.

    [Witness 3]. I think there was some notion that perhaps we were missing some information, that there had been additional records and patient information that we could glean from emails, potentially that onward referral, that outcome through email processes. I am not saying that – I would say that was good practice, but I think we wanted to give every opportunity to search all avenues to try and identify where there may have been some record of care indicated, but it was not something that was easy to do because the search term was a patient name, a hospital number, were we certain that either or, and I do not know whether you have ever done a search via an email, one search can take up to an hour to complete so it was unwieldy, so we did not pursue that."

17. *The evidence suggests that records were stored on various different systems: Badgernet, WinDip, EPR, PIMS, diaries, pro-forma clinic notes, clinical (blue and/or brown) notes and handheld maternity notes.*

18. *The EPR system was not intuitive or easy to search. [Witness 3] was not confident that things may have been missed […]:*

    "Q. With EPR, I know you said there are different layers and it is not a

particularly intuitive system, are you satisfied that the search you did on EPR for an onward referral was thorough, or did you search at all, and, if so, was that a thorough search?

A. At the time I thought it was, I did have some, as I say, help from colleagues that were more experienced with it, so I am not sure if there was something else."

19. *The Trust had no access to the handheld maternity notes from outside GSST (eg. Adult 142 […]). They were not requested as part of the audit, or the NMC investigation. No inquiries were made of GPs, referrers or patients to check whether outcome letters were sent. No inquiries were made with professionals known to have links to the FGM clinic to ask about whether they had received onward referrals for any patients.*

20. *In some cases, the audit was simply incorrect and missed information. For example, in relation to Adult 41, the audit initially recorded "no outcome letter", but one was found on further search […].*

21. *In relation to Adult 115, the audit missed that these were [Witness 5]'s notes.*

22. *In relation to Adult 17, the audit recorded "no diary page found", but diary pages are in the bundle […].*

23. *In relation to Adult 3, the audit records "no letter to GP" [...], but GP letters appear in the exhibits […].*

24. *In relation to Adult 16, no documentation is provided at all (not even diaries). The audit records "not clear who made referral", but [Witness 3]'s GP letter records that this was a referral from a midwife for antenatal deinfibulation.*

25. *In relation to Adult 142, the audit records "no documentation on diary page", but we have the diary page, with information recorded […]. Further information was found on the Lewisham and Greenwich EPR system.*

26. *In relation to Adults 135 and 136, both seen on 10 August 2017, the evidence suggests that it was [Ms 6] who saw these patients.*

27. *Not all notes requested were sent to the auditors […]:*

    "Q. You also said yesterday that obviously we are looking at a large volume of notes, I think you said that not all the patient notes were available, or they might have been elsewhere in the hospital, or people had requested them from you. Do you know how many you were not able to obtain?

    [Witness 3]. I cannot remember to be honest."

    "Sometimes there would be a, you know, on a previous lady there would be no clinical notes; there would be a system of re-requesting certain notes if they didn't come to us first time because some of the woman would have been receiving care in other departments and have other appointments, so there was a sort of, like, tracking of the notes as well. Then there would be a looking on, like, the previous, WinDIP, a WinDIP search, because the pregnancy notes once they're complete they get scanned and stored in the WinDIP system and you can sort of, like, look for notes there. You know, there's layers of lots of chasing of notes but in this case there's nothing to suggest that we did an extra search for trying to find out what happened on the 10th October and we only have the diary page here, so I can't say any more than that with certainty."

28. *In relation to Adults 131, 142, 143, 146, 153, 154, 156, 159, 160, 161 and 162 the notes were unavailable to the audit. The audit therefore appears to be based upon Comfort's diary notes alone in relation to those women. In some cases the audit sheet notes that an outcome letter was on EPR, though they*

have not been provided to us. These audits are not an accurate reflection of what was recorded in the clinical notes. The reasons the notes were not available are not clear, but it is known that some records requested by the audit were not provided (as discussed above). It is also noted that a number of these women were recently married, therefore may have had different names or contact details by the time of the audits.

29. *No documentation is available in the NMC exhibits for Adults 16, 32, 159.*

30. *In relation to Adult 12, the audit indicates that the FGM clinic proforma notes are "diaries" and that there were also blue notes. This tends to suggest that the proforma notes […] were not clinical outpatient, or "blue notes" and that blue notes were also completed for patients with proforma notes. None have been provided for Adult 12.*

31. *The proforma notes also appear in the exhibits for Adult 19 […], as well as the clinical outpatient notes which were recently disclosed. The same situation arises in relation to Adult 35 […]. It can fairly be assumed therefore that the proforma FGM clinic notes are not the clinical blue notes, but are more akin to the diary entires, not forming part of the formal hospital outpatient clinic notes.*

32. *This was confirmed by [Witness 1] […], who stated:*

    > *"1365 is a local form that was used by Ms Momoh in the latter part, this is slightly separate to diary entries. Up until 2015 it was diaries that were used to record information. From 2015 onwards this new form has started to appear in loose sheets in a folder held by Ms Momoh and the department which was recording some of the clinical information. This information on 1365 does not make its way into an official healthcare record. So this form 1365 is a variation on the local system that Ms Momoh had in place for recording activity in the department, but in this example, 1366, the information was recorded in official records on 1366"*

33. *It is of concern that the NMC has not requested notes for each of the patients, in circumstances where you are being asked to make judgments about their content and adequacy. There is insufficient evidence for there to be a case to answer in relation to the vast majority of the record keeping allegations.*

34. *Clinical notes are available for Adults 19, 35, 118 only. Some, selected, clinical records are available for the child patients.*

35. *Where the only documentation available is the diary pages, there can be no assurance that the appointments were not part of the joint clinics held with [Witness 5]. We know that the joint clinics ran approximately every eight weeks. We know that the audit did not acknowledge that the deinfibulation of patient 115 was conducted by [Witness 5]. The panel can have no confidence that other deinfibulations charged were not conducted by [Witness 5]. This is of particular relevance to Adults 130, 131 who were given appointment dates two weeks after their assessment with Comfort […]. This suggests there may have been a joint clinic on 24 November 2016.*

36. *Of deep concern, following the panel requests for the notes for Adults 19 and 35, these notes further demonstrate flaws in the audit process. In relation to Adult 19, the audit questions whether this patient had really undergone FGM. This was, in large part, due to the fact that this patient had been seen by [Ms 9] in 2011, who, it was said, had not diagnosed FGM. This assertion is demonstrably wrong, as the notes make clear. This case highlights the dangers of the panel being asked to merely rely upon the GSST audit in relation to the entire case against Comfort. The panel can have no confidence that other records or entries were not missed by the audit, or were not available to the auditors at the time.*

37. *This is not said to be critical of the audits. They were not conducted for the purpose of these fitness to practice proceedings. But it clearly demonstrates that the NMC has undertaken little or no investigatory work before bringing several hundred charges against Comfort Momoh. The inadequacy of the investigation calls into question the fairness of the entire proceedings. The panel is invited to find no case to answer in relation to all charges based solely on the evidence of the audits and/or dairy pages, on the basis that you can have little or no confidence that they provide a true reflection of Comfort's notes.*

Scope of Practice

38. *The evidence that Comfort was working outside of the scope of her practice, in seeing non-pregnant women, came from the non-expert opinion evidence from various NMC witnesses. Their opinions regarding what falls within or without a midwife's scope of practice is irrelevant and beyond the witnesses' area of expertise. Scope is a regulatory matter. Their evidence should be afforded little or no weight in this regard.*

39. *No definition of "scope of practice" appears within the papers. This is because, in reality, a practitioner's scope of practice is not defined by the NMC, or by law, but by the competencies, experience and expertise of the individual practitioner, as set out in the NMC guidance […]. The formal definition of a midwife, adopted by the International Confederation of Midwives (ICM), the International Federation of Gynaecologists and Obstetricians (FIGO) and the WHO reads as follows […], emphasis added]:*

    > *"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.*

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. <u>This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance</u> and the execution of emergency measures in the absence of medical help. <u>She has an important task in health counselling and education, not only for the women, but also within the family and the community</u>. <u>The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care</u>. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

40. *Midwives need to have the regulatory authority to perform, without undue restriction, the functions that may be necessary to treat the conditions they encounter as primary caregivers. This includes care of women pre-conception. Comfort's expertise, including her previous experience in nursing, enabled her to competently see and treat women and, in some cases girls, who had undergone FGM.*

41. *The 2015 Department of Health ("DoH") guidance, "Commissioning services to support women and girls with female genital mutilation", acknowledges […] "Currently many FGM services are based within or linked to maternity services, with some services being delivered through community settings, within GP Practices." There is nothing within the guidance, or the RCOG Greentop Guideline No.53 […], or the Multi-agency statutory guidance on female genital mutilation […] to suggest that FGM midwives should not see non-pregnant women.*

42. *The GGST clinical guidance […] states, in relation to non-pregnant women "Women should be seen by [Witness 5] and Comfort Momoh, MBE for*

assessment and counselling at the one stop clinic". The 2016 GSST FGM Clinical Guidance document […] includes: "Women should be referred to The African Well Woman's Clinic." The same guidance includes the following "Roles and Responsibilities" […]:

> *"All health professionals must be aware of the issues around FGM, and be able to recognise when girls or women may be at risk of FGM <u>or have already had FGM performed on them</u>. All health professionals are required to work with other agencies to protect girls and women who may be at risk to ensure that the victims receive the response and support they need. Staff need to address any safeguarding concerns that are identified.*
>
> *...*
>
> *<u>Specialist FGM Midwife is responsible for providing training to the multi disciplinary team; running the FGM clinic; counselling victims; identifying the type of FGM; performing de- infibulation (reversal) and documenting management plans for victims of FGM.</u>"*

43. *The job description provided by GSTT to the NMC includes […]:*

> *"Job summary:*
>
> *The FGM specialist midwife will be responsible for clinical care for women and girls referred through Women's Services who have undergone Female Genital Mutilation (FGM), as well as raising awareness of FGM in practicing communities."*

44. *The NMC Guidance, Practising as a Midwife in the UK includes […]:*

> *"...*
>
> *The role of the midwife is to provide skilled, knowledgeable, respectful, and compassionate care for all women, newborn infants and their families. Midwives work across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum, and the early weeks of newborn infants' life. This includes women's future reproductive health, well-being,*

and decisions and in promoting very early child development and the parents' transition to parenthood. Midwives respect and enable the human rights of women and children, and their priority is to ensure that care always focuses on the needs, views, preferences, and decisions of the woman and the needs of the newborn infant.

...

Scope of practice

The term 'scope of practice' is frequently used in relation to professions such as midwifery, but UK health professionals tend not to be regulated with reference to a specified 'scope of practice'. <u>A midwife's 'scope of practice' might be taken to mean 'the range of things that the midwife has the skills, knowledge and proficiency to do' and it should not be confused with 'protected function' which means 'something that only midwives can legally do'</u> (see above).

The standards of proficiency and the Code are important factors in thinking about scope of practice. <u>A midwife's scope of practice may change depending on the nature of their roles and the learning they have undertaken. The Code requires midwives not to practise outside of their skills, knowledge or competence</u>. It is important that providers of maternity services are mindful of this professional duty when they deploy midwives..."

45. *The above NMC guidance sits in marked contrast with the thrust of this case, which relates, in large part, to Comfort's "scope of practice". Within pre-existing guidance, there is nothing to suggest that midwives' practice is confined to treating pregnant women. On the contrary, a midwife's role is to provide care to all women, from pre-conception to post-partum. The NMC guidance specifically includes the treatment of future reproductive health. FGM can and does impact upon a woman's ability to conceive and give birth. As such, treatment for FGM falls well within the scope of a specialist FGM midwife's practice.*

46. *Further guidance can be found in* *<u>Midwifery 2020, Delivering Expectations,</u>* *Department of Health, 9 September 2010 […]:*

"Expanding the role of the midwife

By engaging in lifelong learning, midwives will continue to develop and update their practice, <u>to think innovatively as leaders and to contribute to system design and service delivery</u>. All midwives are autonomous practitioners and in addition to their core role, <u>some midwives will progress to roles which require specialist knowledge and skills, and possibly to advanced practice roles where midwifery education, practice and research are integrated effectively</u>.

Specialist and advanced practice

There are important distinctions between 'specialist' and 'advanced' midwifery roles (Figure 1).

Specialist midwifery practice will normally be particular to a specific context, be it a client group, a skill set or an organisational concept. For example, some midwives may work in areas which require them, for some or part of their role, to develop specialist knowledge or skill sets such as a midwife with a specialist focus on teenage pregnancy. Such roles are likely to be underpinned by additional education and development appropriate to the role. It is possible for 'specialist' practice to be demonstrated at a number of different levels.

Advanced practice is, however, benchmarked by a particular level of practice and some midwives may progress in their careers to take on advanced level roles. These roles are characterised by high levels of clinical skill, competence and autonomous decision making when discharging the responsibilities of that role and, in common with other roles at this level, will normally be underpinned by masters level education, robust supervision and competence assessment.

<u>Such roles may be developed, where appropriate in response to the needs of women, across both generalist and specialist areas of midwifery</u>

practice. Thus, some midwives who specialise may be advanced practitioners; however, not all advanced practitioners will be specialists. This recognises that the developmental pathway towards advanced level practice may be different for individual practitioners, with some following an 'advanced specialist' route through focus on high-level skills and decision making within a particular client group or clinical context, while others will develop a portfolio that reflects high- level assessment, decision making and autonomous practice across a greater breadth of practice (advanced generalist).

Importantly, for both specialist practice and advanced level practice to support strong governance, role consistency and the safe and effective care of women and children, these roles should be subject to clear role expectations, good employment practice and appropriate educational underpinning. Post-holders in these roles remain accountable, as registered midwives, for their competence across their wider scope of practice. Midwives in such roles would maintain a clinical portfolio which identifies their progress along the career continuum, demonstrates their on-going competence and maintains their clinical credibility within the profession."

47. *Again, the above guidance makes clear that advanced specialist practitioners require robust supervision, clear role expectation and support, which the Trust accepts was absent in Comfort's case.*

48. *In any event, it was, or ought to have been known, that Comfort was seeing non-pregnant woman as a matter of routine. This was never questioned. Indeed it was part of her role, as set out in the numerous job descriptions. This case represents the only time in her career that Comfort's competence to see non-pregnant women has ever come into question. The panel is invited to find no case to answer in relation to these allegations.*

Referrals/outcome letters

49. *In a number of charges, the NMC alleges that Comfort "did not refer" or "did not send" an outcome letter. This is not a conclusion that the panel could properly draw from the GSST audits. Absent any inquiry having been made of the patients, their GPs, specialists to whom the clinic referred or Comfort's emails, the NMC cannot demonstrate that these things were not done.*

50. *Where referral to external agencies were done by email or telephone, these would not necessarily be captured within the EPR or GSST system. This may amount to poor record keeping, but is not evidence that referrals were not made. Email searches were considered by GSST to be overly complex and therefore not undertaken in any meaningful way as part of the audits. The NMC cannot demonstrate, on the limited "investigation" undertaken, purely for the purposes of the GSST audits, that referrals were not made, only that they were not recorded.*

51. *For example, Adult 3, the notes stated that a referral was made to onward agencies. The starting point ought to be that this indicates the [sic] Comfort, an experienced professional without complaint having been raised against her before, made the onward referral. The audit could not find a referral letter in the notes, but that cannot amount to a factual finding that the referral was not made, without any investigation to establish the same. Follow up appointments within GSST appear not to have been considered as part of the audit.*

52. *No inquiry has been made of the patients, their GPs, specialists to whom the AWWC referred or, importantly, of Comfort's email account, to check whether these things had in fact been actioned.*

53. *It is a fallacy and an oversimplification of the matter, to suggest that "if something is not recorded, it wasn't done". Such an assertion has no basis in law or fact. The lack of a referral or outcome letter on the patient's file is not*

evidence that such a letter was not sent, or referral not made. The burden is on the NMC to prove that referrals were not made or outcome letters were not sent. This cannot be simply inferred by the lack of a copy of the relevant letter in the notes.

54. *It is not in dispute that outcome letters and referral letters ought to be in the notes. It may have been an oversight on Comfort's part that such documentation was not placed into patients' files. It may be that such documentation was misplaced or lost, as we know happened on occasion at GSST. It may be that the auditors simply missed the relevant documentation. It is not evidence that letters were not sent, or that referrals were not completed. The panel is reminded that it is the NMC's case that Comfort's record keeping was inadequate, something she accepted, in part, as indicated at the outset of these proceedings.*

55. *In the case of Miller & Another v The Health Service Commissioner for England [2018] EWCA Civ 144, Sir Ernest Ryder, Senior President found the following in relation to that oft recounted mantra [at para 59, emphasis added]:*

    "It is also conceded that the ombudsman's evidence from one of her most experienced Directors, Mr Kellett, contained an unfortunate use of language when he said " if it is not written down it didn't happen unless there is other corroborating evidence ". I do not accept that this was an erroneous use of language: it reflected the practice of and language used by officials in the documents to which this court was taken ie unless the doctor had noted something in the clinical records, poor practice is assumed. <u>Aside from reinforcing an impression of pre-determination, that is an inappropriate way to conduct an investigation</u>: it merely engenders defensive note taking by doctors rather than clinical good practice. It is important to look for corroborating contemporaneous notes and also for evidence of good recording and safeguarding practices but it is also important to listen to what a professional says."

56. *The old mantra serves as a good reminder to practitioners to keep detailed notes and documentation, however the absence of records does not amount to proof that something was not done, only that it was not recorded.*

Second opinion for complications

57. *Comfort is an experienced and highly regarded FGM specialist. [Witness 5], the only witness who has any experience of working with Comfort, gave evidence that she trusted Comfort's judgment. A paper review, years after the event, amounts to mere speculation about the requirement for Comfort to obtain a second opinion for her patients. Evidence from witnesses who have no experience working with FGM survivors ought to be given little or no weight in this respect.*

Provided psychosexual/sexual health counselling to patients;

58. *It is not clear what "sexual health counselling" is. In any event, there is no evidence that Comfort provided any such treatment to patients. Comfort was knowledgeable in complications surrounding FGM and would therefore be qualified to provide some advice, or make appropriate onward referrals.*

Risk Assessments

59. *It is clear that there is no requirement for Comfort to complete a formal risk assessment for FGM where her patients presented having undergone FGM. They are not "at risk" of FGM. For midwifery patients, we have clear evidence that any such risk assessment would be undertaken at the booking in appointment. There is no evidence that risk assessments were required for children who were already under the care of social services or local safeguarding teams.*

Smear tests

60. The NMC have provided no evidence that Comfort is not competent to undertake smear tests. The tests do not appear to have been unsuccessful, indicating that they were carried out to a satisfactory standard.

Record Keeping

61. Comfort will accept, and has always accepted, that her record keeping was, at times, lacking. However, the standards created from the audit are not based on any knowledge from FGM specialist clinics, but from theoretical standards, drawn from policy. It is difficult to distinguish between "adequate", "good practice" and "best practice". You are being invited to adopt the subjective judgment demonstrated by the auditors, rather than making your own judgments based on the records.

62. The evidence appears to agree that, at the relevant times, EPR was in the process of being rolled out. It was not relied upon by practitioners necessarily to see details of previous contact, other than outcome letters. Clinical information was still captured in the paper notes. EPR was not being routinely used at the time to capture information from appointments. It would appear therefore that Comfort was not obliged to capture details of patient appointments on EPR.

Conclusion

63. The NMC has not produced any, or any sufficient evidence such that a reasonable panel, properly advised, could find the specified outstanding factual charges proved. The panel is invited to find no case to answer in relation to the charges, in accordance with Rule 24(7).

Ms Bayley's Supplementary Oral Submissions on No Case to Answer

Ms Bayley said that a submission of no case to answer has been made in respect of the charges which there is no evidence, the allegations are completely wrong, or the evidence

before the panel is so tenuous, vague or inconsistent with other evidence in the case that no panel reasonably advised could properly find them proved.

Ms Bayley invited the panel to remind itself that the burden of proving the allegations lies with the NMC. She said that this is particularly important when considering allegations which relate to you practising outside of your scope of practice. She said that these charges suggest that you do not have the qualifications, competency, skills, knowledge and experience to carry out your practice as charged in charge 1. However, she said that in this case there is little or no evidence of what your skills, knowledge, experience and expertise is. She said it is not the right approach for the panel to wait to hear your evidence before making a decision about whether you have such competencies and experience, and the correct and fair approach is for the panel to have before it sufficient evidence that it can find the allegations proved on the basis of the evidence which the NMC has called. She said that the NMC has not called any evidence which goes to your training, competencies, skills or knowledge, although it has produced evidence about the skills or qualifications needed to undertake the activities which form the basis of the charges. She said that the burden falls on the NMC to prove that you are not competent, and not for you to prove that you are.

Ms Bayley addressed the panel on the allegations relating to non-pregnant women. She said that if the case is that a practitioner must have a nursing registration or nursing qualification to treat non-pregnant women, the NMC ought to make it plain. She said that, in this case, there has never been any input or definitive answer from the NMC as to what the scope of a midwife's practice is. Ms Bayley referred the panel to a list of specialist clinics for FGM patients, and noted that the services advertise as being available to non-pregnant women, with some services stating that they are available to children. She said that FGM specialist midwives also work within these services.

Ms Bayley highlighted that the panel has not received evidence from any FGM specialist midwives. She said that it has not heard about how other clinics are ran, including how records are kept. She said that the record keeping allegations are based upon

hypothetical, theoretical standards derived from various policies and documents, some of which may or may not be relevant, alongside the individual auditor's own standards of record keeping, which are not comparable to other specialist FGM clinics.

Ms Bayley said that, on the basis of the NMC's evidence, it is clear that this matter has not been investigated. She said that the panel has conducted more investigation in the course of the hearing than the NMC had done previously. She reminded the panel that neither Witness 4 nor Witness 5 had been contacted by the NMC at the outset of this case. She submitted that nobody who you have worked with, or who has actual working knowledge of the clinic has been spoken to by the NMC. She said that the fact that the NMC has not spoken to other FGM specialist midwives has left the panel with a *"gaping hole"* about scope in relation to Charge 1.

Ms Bayley said that if it is the case that FGM midwives ought not to treat non-pregnant women, this may have an impact on the status of FGM care in this country. She said that there is evidence before the panel that FGM specialist midwives treat non-pregnant women, therefore if they ought not to do so services will be cut for a large number of vulnerable women. Ms Bayley said that she did not know if this should form part of the panel's consideration, however it emphasises the scale of the neglect on the part of the NMC in its investigation, to the point that it could be said to be irresponsible.

In respect of the issue of scope of practice, Ms Bayley said that this is matter which the panel has been tasked with deciding, although one would think it ought to be for a regulator. She said that, if it is the case that you required an ongoing nursing registration to see non-pregnant women, the NMC need to produce guidance or a witness to speak to this, which it has not. She said that the evidence currently before the panel is from nurses and Witness 5, who gave their opinion on whether you should have been treating non-pregnant women, which is not of particular relevance. Ms Bayley said that the best evidence before the panel in respect of scope of practice is the NMC literature entitled *"Practising as a Midwife in the UK: An Overview of Midwifery Regulation".* She said that, although many witnesses have said that midwives treat pregnant women and nurses

everyone else, in reality a midwife is a protected title and function which allows a midwife to attend to a woman in labour, but does not limit them to that function. Ms Bayley submitted that there are a variety of roles which exist within nursing and midwifery which are non-standard, therefore scope of practice has to be wide enough to fit a plethora of different careers which nurses and midwives have built over many years to become specialist. She referred the panel to the NMC's definition of scope of practice:

> *"The term 'scope of practice' is frequently used in relation to professionals such as midwifery, but UK health professionals tend not to be regulated with reference to a specified scope of practice."*

She said that this is inconsistent with the approach taken by the NMC in this matter as it is seeking to regulate you with reference to specified certain things which it says are outside the scope of your practice.

Ms Bayley submitted that a midwife's scope of practice might be taken to mean the range of things the midwife has the skills, knowledge and proficiency to do and should not be confused with their protected function. She said that your scope of practice means the range of thing that you specifically have the skills, knowledge and proficiency to do. She said that there is no evidence that you do not have the skills, knowledge of proficiency to see non-pregnant women. She said that you have previously held a nursing qualification and have been working on the NMC register since 1986 without any previous referrals.

Ms Bayley said that the NMC has not demonstrated what skills, knowledge and proficiency you possess. However, the panel has heard a lot of evidence from Witness 4 and Witness 5 who worked with you and said that you were incredibly knowledgeable, skilful and competent to see women who were survivors of FGM. Witness 5 also said that every eight weeks, you conducted a joint clinic and watched Witness 5 undertake more complex de-infibulations. Ms Bayley said that the panel can infer from this that your skills were up to date. Further, there is no evidence before the panel of any concerns or issues which arose from the de-infibulations which you undertook. She said that there have never been any

patient complaints, or any professional complaints, save for a concern from Witness 5 about recordkeeping, which predates these concerns.

In respect of your competency, Ms Bayley accepted that there are questions that remain to be answered by you about your competency to see children, which you will give evidence about. However, when considering non-pregnant women, there does not seem to be any disagreement that you had the skills, knowledge or experience to treat pregnant women. She said that Witness 5 gave evidence that the vulva of a pregnant woman may be more vascular than a non-pregnant woman, but would not present any practical difference which would mean that your skills, knowledge and proficiency did not apply equally to all women. She said that the evidence before the panel that these things were outside of your scope of practice are the opinions of individuals, and therefore not evidence.

Ms Bayley said that the panel may think that the witness statements provide a good starting point when considering witness evidence, however such statements represent the witnesses evidence before being asked questions and taken through patient notes. She said that a number of witnesses resiled from their statements when presented with evidence, therefore such statements should be considered alongside transcripts of oral evidence.

Ms Bayley invited the panel to have regard to her written submissions in respect of individual charges, but elaborated on these in respect of certain charges.

In respect of charge 1.1, and Adult 35 in particular, Ms Bayley said that the panel now has the benefit of this patient’s notes, and can see that she specifically came for de-infibulation to try for a baby, which is plainly in the scope of the midwifery role. She said the same may be said of Adults 89 and 109 who were newly married, as well as Adult 134 who was recently married but unable to have sexual intercourse. She said that this is a pre-requisite for getting pregnant and therefore might fall properly under pre-conceptual care.

Ms Bayley said that it is interesting that the NMC say that you should not have even accepted referrals when you are a specialist in FGM matters and are aware of the law. She said you are safeguarding trained to level 3 and that you were instrumental in campaigning for FGM being made illegal in this country. Further, she said you are very knowledgeable about FGM so even if it can properly be said that you should not have conducted reversals on or examined these women, surely you are able to accept referrals to talk to them about FGM. Ms Bayley said that the same point also arises in relation to charge 1.2.

In respect of charge 1.2, Ms Bayley submitted that if it is accepted that you had the competency, skills, knowledge and experience to assess and examine pregnant women, it follows that you have the same to assess and examine non-pregnant women. She invited the panel to consider her written submissions in respect of Adults 7, 8, 35, 89, 109 and 134.

In respect of charge 1.3 Ms Bayley submitted that if it is accepted that you are qualified, competent, knowledgeable, skilled enough to conduct de-infibulation on pregnant women, then those same competencies apply to non-pregnant women. She invited the panel to consider her written submissions in respect of Adults 135 and 146. She said that there must be some reference to Adult 146 having been recently married within her diary note.

Ms Bayley said that there appears to be a number of patients who attended the FGM clinic having recently got married, some of which were unable to have sexual intercourse. She said that they wanted to conceive, and this was the reason that a lot of these women self-referred to the clinic. She submitted that, as these women were newly married, there is potential that their names were different at the time of the audit.

Ms Bayley said that the evidence in respect of charge 1.4 came predominantly from Witness 3 who said she had concerns about five women. Ms Bayley reminded the panel that Witness 3 has not ever really worked with FGM survivors and is not a specialist. Ms Bayley invited the panel to consider the responses of Witness 5 who said that, when

asked about these patients, without being able to examine these women, and without sitting in the room with these women, during their examination, it is impossible to say whether or not second opinions were required. Ms Bayley submitted that, save for Adult 35, there are only diary notes before the panel so there is no evidence of how these appointments were conducted, or that there were complications which may have necessitated a second opinion. She said that Adult 35 was seen by Witness 5 on 16 July, so she had a second opinion on the outcome of the de-infibulation procedure. She said that there is no evidence in the patient notes that there were any complications.

Ms Bayley submitted that the panel may think it not possible to make a judgement about whether or not a second opinion should have been sought during a procedure based on your personal diary notes of these procedures. She said that none of these patients were ever contacted by the auditors or by the NMC. She said that there simply is not the evidence to support this charge.

In respect of charge 1.5, Ms Bayley said it seems that the NMC alleges that this relates to anaesthesia, pain relief and some antibiotics. She noted that the panel does not have access to clinical records, and it remains unclear how medication was prescribed to patients in clinics, for example how a prescription would be given to patients. She said that it also remains very unclear as to how the clinic room had access to the medications used routinely in de-infibulation, such as Voltorol and Lidocaine. She said that Witness 5 described the rooms where these treatments took place as a *"very well stocked clinic room"*, which does not explain how the medications were prescribed or dispensed into the clinic.

Ms Bayley said that there are no blue notes before the panel, save for those which relate to Adult 35. She said that the panel has heard that the medications routinely used for de-infibulation were Voltorol and Lidocaine, which appear within the Midwifery Exemption. She invited the panel to have regard to the NMC circular "Changes to midwives exemptions", dated 17 June 2011, which states:

> *“Registered midwifes may supply and administer on their own initiative any of the substances specified in the Medicines Legislation under the Midwives Exemptions provided it is in the course of their professional practice. They may do without the need for a prescription or a patient's specific direction from medical practitioner."*

She said that the Trust guidance mirrors this, in that it states:

> *“These drugs may be administered by midwives in the course of their professional practice."*

Ms Bayley submitted that the medications used by you in the FGM clinic, namely Voltorol and Lidocaine, fall within the midwifery exemptions, and that you were using these medications within the course of your professional practice, however, the question for the panel’s consideration is whether or not it was outside your scope of practice to do so when not undertaking perineal suturing and perineal repair. She said that the midwifery witnesses were unclear about the midwifery exemptions, and that it is for the NMC to demonstrate that using such medications falls outside of those exemptions, bearing in mind the guidance that is given by the Regulator on that and locally, that those substances specified in the legislation may be used by midwives in the course of their professional practice.

In respect of the allegations which relate to antibiotics, Ms Bayley said, when considering Adult 12, there are no blue notes, and the notes which are before the panel state *“antibiotics prescribed”,* which she submitted is prima facie evidence that there was a prescription in place for those antibiotics. She said that it is insufficient on the basis of the evidence before the panel, and in the absence of a prescription, to assume that you gave the medication without a prescription.

In respect of charge 1.6, Ms Bayley submitted that in the evidence of Witness 3 it was agreed that there was no evidence that you had provided psychosexual or psychological counselling to the patients charged.

Ms Bayley submitted that, in relation to charge 1.7, there is no clear evidence before the panel as to what sexual health counselling is, nor is there any evidence to suggest that you provided any such sexual health counselling.

In relation to charge 1.8, Ms Bayley submitted that there is no evidence about your training, skills, competence or qualifications in relation to taking smear tests. She reminded the panel that the burden of proof lies on the NMC to demonstrate that you are not competent to do so, and not on you to show that you are. She said that, in respect of Adult 8, it is known that the test was ordered by Ms 7, and it is not known if anything was written in Adult 8's records by Ms 7. She said however that the smear test was successful in that the result was returned with no abnormalities. Ms Bayley said that there is no documentation available at all for Adult 32, and the panel has received no evidence of what the necessary competencies and trainings were for undertaking smear tests at the Trust at the time.

In relation to charge 1.9, Ms Bayley said that Witness 5's evidence was that there was not a qualitative difference between the anatomy of children aged 16 to 18 years old to that of adults, and FGM would be more recognisable in those over 16. She said that there is no evidence that you are not competent to see children. She reminded the panel that your safeguarding training was up to date and that you sat on the Vulnerable Persons Assurance Committee.

In respect of Child 28, Ms Bayley reminded the panel that you were asked by the paediatric intensive care team to review this child due to concerns about potential FGM. She said that you reviewed Child 28 alongside Ms 14, and the panel has various notes relating to this. Ms Bayley submitted that Child 28 was not referred to you as you were

asked by your Paediatric Colleagues at the Trust to come and give an opinion, following which you then made a referral on to Professor 15.

Ms Bayley repeated her submissions in respect of Child 28 in relation to charge 1.10, and referred the panel to her written submissions in respect of Children 21, 22, 23, 28 and 29.

In respect of charge 2.1, Ms Bayley submitted that there is no evidence that any of the patients contained within the schedule required onward referrals to specialist counsellors. In relation to Adult 15, she said that the highest the NMC's case could be put is "unclear whether referral was made or not", and the diary notes imply that she should have been referred to a psychosexual counsellor. She therefore submitted that Adult 15 should not appear at charge 2.2, however it is unclear who the NMC says that Adult 15 should have been referred to.

In respect of Adults 2, 7, 15, 23 and 36, Ms Bayley said the only information before the panel is the diary entries in respect of these patients. She submitted that it is very difficult to judge just from the diaries and audit that these women required specific referral which was then not made. Ms Bayley submitted that Adult 36 was referred from sexual health services so was presumably already being seen. She reminded the panel that Witness 3 suggested that it would be acceptable for you to recommend a referral in an outcome letter rather than make the referral yourself.

Ms Bayley said that your emails were not investigated for the audit, nor were any queries made of professionals that the FGM clinic had relationships with. She said that it appears that the NMC has oversimplified a serious matter and charged you where a referral letter could not be found on the file. Further, Ms Bayley asked the panel to consider whether an outcome letter back to the patient's GP would amount to a failure to refer in line with charge 2.1.

In respect of Charge 2.2, Ms Bayley submitted that it is unclear what sexual health counselling is, and that the panel only has before it diary entries for these adults, therefore

it is not going to be possible for the panel to establish what action was necessary on the basis of the diary entries.

In respect of the audit, Ms Bayley said that this was done for the purpose of the Trust, who had concerns raised to them about your practice, in order to ensure the welfare of patients and children who were seen at the AWWC, to ensure things that ought to have been done were done or followed up. She said that a lot of the children's audit was to ensure about safeguarding and so things have been recorded as they ought to have. She said the purpose of this audit was not necessarily to criticise your record keeping, but to identify gaps in your care. She submitted that the audit was not done for the purpose of a fitness to practise case, and does not have the safeguards expected of such case. She said that the Trust do not have any obligations of rules of evidence or fairness or to undertaking of full and frank investigation of having that same sort of regulatory curiosity and investigation that an NMC investigation would require.

Furthermore, Ms Bayley submitted that the conclusions of the Trust's auditors were not necessarily on the basis of the same standards expected for a NMC investigation. She said that there were problems and limitations with the audits, for example clinical notes were not available to the auditors. Ms Bayley invited the panel to consider her written submissions at paragraphs 15 to 37 when considering the information and notes available to the auditors. She said that there were a number of different sources of material, and for the purposes of the audit really it was just the diaries, the proforma clinic notes and the blue/brown notes that were interrogated.

In respect of the records, Ms Bayley submitted that the NMC investigation is limited by these as the panel only has the clinical notes for three adults and some selected child patients. She reminded the panel that the diaries do not reflect your clinical record keeping skills as they are not an accurate reflection of all the records. She submitted that it is not possible for the panel to make a judgment about the adequacy and content of clinical notes without seeing them. She said that the panel is being asked to accept the judgment of Witness 3, Ms 12 and Ms 13, who were not specialist FGM midwives, about the

contents and adequacy of these notes, which is opinion evidence. Ms Bayley submitted that, where your notes are available, they are relatively detailed, especially compared to those of Witness 5.

Ms Bayley further submitted that there is evidence before the panel that the audit is demonstrably wrong, and referred the panel to paragraphs 20 to 26 of her written submissions. She highlighted that, in respect of Adult 19, Witness 3 had written on the front sheet of the audit note:

> *"If this woman is saying she has not had FGM and she was seen by [Ms 9] in 2011, what has Comfort de-infibulated?"*

She said that this is a serious assertion, however the notes of Adult 19, which were requested by the panel demonstrate that Dr 10 identified FGM as a concern for Adult 19 in August 2011, with evidence of further gynaecological examination undertaken by another doctor, prior to the identification of FGM by Dr 10, accompanied by an outcome letter which states:

> *"On examination there are features to suggest that this lady has had female genital mutilation although she denies any previous surgery to the area."*

Ms Bayley highlighted this as an example of where the audit is wrong. She said that the panel cannot rely on diary pages and the audit in order to find these allegations proved on the balance of probabilities.

In respect of charge 2.4, Ms Bayley submitted that the NMC has not adduced any evidence of a requirement for a second opinion. She said that there is evidence to suggest that Adult 35 did receive a second opinion from Witness 5, Adult 19's notes demonstrate that she had been seen by Dr 10 and Dr 16 in 2011, and a further referral was made in 2015. She said that, in relation to Adult 2, the only evidence is the diary which provides insufficient evidence that there was any requirement for a second opinion. She submitted

that it is impossible on the basis of the evidence before the panel to find a case to answer in respect of this charge, especially given the oral evidence of Witness 5, who said that she trusted your judgment as an FGM specialist midwife of 20 years' experience.

In respect of charge 3, Ms Bayley submitted that the panel is being asked to accept the judgment of auditors as to what is an adequate clinical record for an FGM appointment. She said that the panel also cannot fairly, realistically or practically make that judgment without seeing patient notes. Furthermore, she said that neither Ms 12 nor Ms 13 have given evidence, so the panel cannot be clear why they noted certain things, such as *"poor documentation".*

Furthermore, Ms Bayley submitted that many of the sub-charges in charge 3 are duplicitous in that they charge that you did not record adequate details of consultations in various patient record bundles and notes. She further said that the panel does not have before it many of the notes that it is alleged you did not make adequate notes in, therefore it is not possible for the panel to determine whether any such notes were adequate.

In respect of Adult 2, Ms Bayley said that, in her diary entry, there is some information about the patient's history and the audit stated, *"did not record that this person's anatomy could have been due to birth trauma*". She questioned whether this was required when you used your specialist clinical judgment to conclude that Adult 2 had FGM.

Ms Bayley submitted that charge 3.1.4, like many of the charges in 3, is duplicitous and has similar wording to other charges.

In relation to charge 3.2, Ms Bayley submitted that the panel only has before it the diary. She said that, in Witness 3's evidence, there was criticism about not including a history of domestic violence in relation to this patient when it is captured within the diary.

Ms Bayley said, in respect of charge 3.2.3, that the panel has been taken to the policy and heard lots about risk assessments. She said that Witness 5's evidence highlighted the

importance of speaking to someone who is working within the FGM service. She said that, where people have come to the clinic because they have had FGM, there is not a risk to be assessed. She submitted that, in any event, there is no specific evidence about a requirement to undertake a risk assessment with these women. Similarly, in respect of charge 3.3.3, Ms Bayley submitted that there is no evidence of Adult 4's chronic pain which it is alleged that you should have recorded.

Ms Bayley said that she has made submissions of no case to answer in respect all of the adult patients within charge 3. She described this as a symptom of the NMC taking the audits at their word, rather than properly investigating the records. She said, in relation to Adult 4, there was a note in the concerns box at the front of the audit sheet which states *"no record of whether a swab or a urine sample had been taken".* She said that Witness 3 gave evidence that *"if somebody is saying there is pain or itching that perhaps that was an appropriate course of action",* which the NMC has charged as a failure to record whether you have done a swab or urine sample. She said that the NMC seems to be putting a non-existent obligation on you to record things which you have not done.

In respect of charge 3.4, Ms Bayley said that there are no patient notes and some duplicity with other charges. She said that, in any event, there is insufficient evidence to find this charge proved without the blue notes or records, therefore the panel cannot be certain whether or not the reason for referral was contained within your notes. She noted that Witness 3's evidence was that recording the reason for a referral would be good practice, which may cause difficulty in judging the distinction between adequacy, good and best practice. She said that, if it is not adequate there is no case to answer in relation to the sub-charge because they all come under the overarching Charge 3, "failed to maintain adequate records", or, "did not maintain adequate records". If there is no obligation to record something there cannot be a case to answer in relation to it.

In respect of charge 3.5, Ms Bayley said that Witnesses 3 and 5 were unable to comment on the adequacy of the clinical notes which were not before the panel, therefore it is not possible for the panel to make decision on the same issues without the patient records.

She reminded the panel that, in respect of Adult 7's daughters, risk assessments for children, if they are undertaken, would be kept on the children's own records, which have not been sought for the audit or the NMC investigation, therefore, without seeing these records, it is not possible to say whether a risk assessment was or was not done.

In respect of Adult 8, Ms Bayley reminded the panel that you performed a smear test, not an FGM consultation, and that there is no evidence before the panel about the level of detail which would be required of such notes. She said that a difficulty of having adopted the concerns on the audit sheets is that you have subsequently been charged with not recording or informing Adult 8 of their smear test result, when it the test is sent off for analysis and the patient is later informed of their results automatically. Further, she said that there was no obligation on you to inform Adult 8 of her smear test result, or that it should be repeated in three years.

Ms Bayley described charge 3.8 in relation to Adult 10 as good practice only as there is no evidence of an obligation on you to record what has or has not been done. She reminded the panel that Witness 3 said that recording whether a urine sample was taken was good practice only and would not fall foul of the adequacy level.

In respect of charge 3.9.3, Ms Bayley said that the panel has before it only diaries which specifically say, *"personal hygiene advised",* which suggests the discussion of personal hygiene was recorded. She said there is no evidence of what the NMC allege is adequate recording.

In respect of charge 3.10.2, Ms Bayley submitted that there is a note on the file that states *"all issues related to FGM discussed with Adult 15, well understood".* She said that it is fair to assume that included the fact that FGM is illegal.

Ms Bayley said, in respect of Adult 16, there is no documentation provided on which the panel can make any judgment on the adequacy of the content of the notes.

In respect of Adult 19 at charge 3.13, Ms Bayley said that the panel has before it the notes and can make its own judgment the adequacy of the details of the consultation. She said that it is also duplicitous with charge 13.1.1 and 13.1.2.

Ms Bayley submitted that, in relation to charge 3.14, the panel has received no evidence that it was necessary to record the timing of the administration of Lidocaine. She said that Witness 5 gave evidence that there is not a requirement to record the timing or frequency of the administration of Lidocaine.

In respect of charge 3.15.3, Ms Bayley said you are criticised for not recording a risk assessment for Adult 23's children, when there is evidence that these children's records were not considered for by the audit or NMC investigation. She said that the GP referral letter discussed the children's risk of FGM, and, in these circumstances, it would be reasonable to conclude that the GP would have already undertaken a risk assessment. She said that, in any event, it is not possible to tell if a risk assessment has been undertaken or not because records have not been considered.

In relation to charge 3.16.2, Ms Bayley reminded the panel of Witness 3's evidence, that it was not for you to inform the Adult 24's GP that they had not attended an appointment with another healthcare professional. Further, she said that it is not clear whether you would have been aware if Adult 24 had attended the appointment or not. Accordingly, she submitted that the NMC have failed to raise sufficient evidence that you were required to do so and, in any event, this charge does not correspond with the overarching stem of charge 3, which relates to the adequacy of record keeping.

Ms Bayley submitted that charge 3.17 is a matter for the panel to consider whether or not the reason for prescribing or providing antibiotics to Adult 35 was required. She said that, on one view, whoever prescribed the antibiotics ought to have written the notes, however there are no patient files or prescriptions before the panel. She queried whether it is

required to record the reason, and if so, whether the duty to record should be on the prescriber. Further, she submitted that it is not clear as to why charge 3.17.5 has been charged. She said it appears in the NMC charges by nature of being contained within the audit front sheet, however there is nothing in the notes to suggest that Adult 35 had an allergy to antibiotics. She said that there is no evidence that you were required to record a patient's possible allergies to antibiotics any more than you were required to record a possible allergy to cats.

In respect of charge 3.20, Ms Bayley said that Witness 3 speculated that Adult 130 may have been seen by Witness 5. She said that, given that this was missed in relation to Adult 115, the panel cannot be assured that this was not also missed. She submitted that it can equally be said that it cannot be clear that any of these patients might have been seen at the joint clinic with Witness 5, other than the three patients the panel has notes for. She said that, as the joint clinic took place every eight weeks, a good proportion of your patients would have been seen with Witness 5. She said that this is another reason to approach these records and audits with extreme caution as it was another thing that got missed.

In respect of charge 3.20.3, Ms Bayley queried where the obligation existed to record whether Adult 130's condition/ assessment was escalated. She said that, if it was, presumably whoever escalated it would have written the notes. She said that these things are difficult to assess without the notes.

In respect of charge 3.21.1, Ms Bayley said that the panel has before it the blue notes records, where it states: *"referred to the African Well Woman's Clinic by her GP/Social worker re FGM"*. Accordingly she submitted that there is no case to answer that you did not clearly record the origin of Child 16's referral in the Patient's records. Ms Bayley made the same submission in respect of Child 17, in respect of charge 3.22.1.

In respect of charge 3.23.1, Ms Bayley submitted that the panel has notes which contain details about the referral, background, assessment and advice, and should make a

judgment on the adequacy of these details. Similarly, in respect of charge 3.23.3, she submitted that you did not have an obligation to say, *“no urine sample taken”,* and that there is no evidence in the blue notes to speculate that a urine sample was taken, and if it was not, there is no requirement to record that.

In respect of charge 3.24.2, Ms Bayley submitted that Child 19’s GP outcome letter contains a clear typographical error which could not amount to misconduct. She said that it cannot be said that a typographical error on one of two dates, when the correct date is contained within the letter, does amount or contribute to a failure to maintain adequate clinical records.

Ms Bayley submitted that, in respect of charge 3.27.1, there is insufficient evidence that any official clinical healthcare records were not created. She said the panel has before it the diary page and reference, and the audit with a crossed out note which stated, “*not available”.*

In respect of charge 3.27.3, Ms Bayley queried whether you were obliged to record the social impact of FGM on Child 23. If so, she submitted that this also comes under the charge related to *"not recording adequate details of the advice, examination, discuss and next steps".*

In respect of charge 3.27.5, Ms Bayley said that the outcome letter appears in the records and says specifically *“via email”,* however your emails were not searched for the purpose of the audit. She said that, in these circumstances, it is open to the panel to conclude that the outcome letter was sent.

Ms Bayley submitted that charge 3.28.2 is duplicitous with charge 3.28.1.

In respect of charges relating to risk assessments for children, Ms Bayley invited the panel to consider the policies and evidence, particularly from Witness 2 in respect of this issue. She said that there is no evidence that a risk assessment is required to be undertaken in a

tick box fashion for every contact with every child. She said that the referral for Child 25 came from Southwark Social Services, there was police involvement and was a case conference in relation to this child. She submitted that, in these circumstances, there is not a requirement to record a risk assessment. She said that Witness 1 gave evidence that if a child had not had FGM, such as in the circumstances of Child 25, there is no requirement for a risk assessment.

Ms Bayley submitted that, in respect of Charge 3.30.4, there is evidence that there were two letters on EPR with two different dates. She said that one of them wrongly recorded that Child 26 had undergone de-infibulation, but there is no evidence that the letter was sent. She said that Witness 1 said that the expectations that letters on EPR had been sent. However, she said that there is no evidence that the letter was sent, despite the fact that it was open to the NMC to contact the GP to ask which letters have been received, and it has not. She said that the panel cannot assume because a letter is on the EPR, it has been sent and therefore the GP has been incorrectly informed. She further submitted that there is evidence from Witness 1 that there was no requirement for a further risk assessment in relation to Child 26.

In respect of Child 28, Ms Bayley reminded the panel that this child was in the Paediatric Intensive Care Unit (PICU). She asked the panel to consider the stem of charge 3.32, being: *"On or around 20 July 2017, during or following your consultation with Child 28".* She submitted that there was not a consultation as Child 28, and that there is no evidence that you were required to record a full risk assessment for Child when she was in PICU under the care of a paediatric intensive care team, seen by you in the company of the safeguarding lead midwife. She said that there is no evidence that can demonstrate that you should have recorded a full risk assessment in Child 28's notes. Ms Bayley reminded the panel that it also has in evidence Child 28's safeguarding referral form to consider when deciding on whether there is a case to answer in respect of this charge.

In respect of charge 3.32.2, Ms Bayley submitted that the safeguarding referral form in respect of Child 28 was provided to the NMC at a later date because it appears to have

been overlooked by the Trust audit. She said that it is a matter for the panel to judge whether there is evidence to suggest that you did not record adequate details in Child 28's notes. She made the same submission in respect of Child 29.

Ms Bayley said that charge 4, *"did not record the offer/ confirmation of consent"* comes from the evidence of NMC witnesses who did not work in the service, excluding Witness 5. She queried whether they were looking at hypothetical best practice. Furthermore, she said that this charge appears to be duplicitous in that it is not clear on the evidence what an FGM assessment would be as opposed to an FGM examination or de-infibulation procedure.

She said that, if an FGM assessment involves an examination requiring consent, this mischief is already covered by charge 5. However, if an assessment does not involve an examination, there is no evidence that consent is required.

Ms Bayley said that the panel has heard evidence from Witnesses 3 and 5, that consent would have been verbal, not written. She said that Witness 3 said that it was good practice for adults to have consent recorded, and Witness 5 said that consent was not always recorded, and her notes are silent on consent. She said that the panel must be satisfied that there is sufficient evidence that consent had to be recorded.

In respect of Adult 8, she said that there was no FGM assessment as this woman's appointment was for a smear test, therefore there was no FGM assessment or examination and there is no case to answer in respect of charge 4.

Ms Bayley made an application in respect of Adult 19, if the panel considers that this assessment does not involve examination. Ms Bayley said that it is interesting that Dr 10 did not record consent when she did her examination, nor was it part of Dr 10 or Witness 5's practice to record specifically consent for the examination or de-infibulation procedure.

She said that the panel may consider the practicalities of how these clinics worked at a later stage in this hearing, however the panel should at this stage consider whether there is sufficient evidence that consent is required to be recorded for an assessment.

Ms Bayley said that it may be tempting for the panel to consider what your usual record keeping practice is. She said that approximately 1065 records considered for the hearing, only 163 of them had concerns. She said that it is worth bearing in mind that these are the worst examples of your record keeping. Further, she said that there are only three patient records before the panel, which is insufficient to conclude what your typical standard or record keeping it is.

Ms Bayley said that it is not possible to conclude that consent was generally not recorded from the evidence before it, especially given the oral evidence of Witness 3 that this is not necessarily required. In respect of Adult 2, she said that the panel only has the diary page and the audit. Ms Bayley said that for this and a number of other adult patients, the audit does not say "*not recorded*" and others it does. She said that there are no records to verify whether they are correct. She submitted that it is a matter for the panel if the audit can be relied on at this stage to find charges proved on the balance of probabilities.

Ms Bayley said, as an example, there is nothing on the face of the audit that demonstrates that consent was not recorded for Adult 2, and it does not appear on the front sheet where the concerns are outlined, specifically where it says, *"examination consent, nothing".* She submitted that there is insufficient evidence for the panel to find a case to answer in respect of this and the other adults highlighted within this charge.

In respect of Adult 8, Ms Bayley repeated her submission that this patient attended the clinic for a smear test so there is no case to answer in respect of charge 5, which related to FGM.

In relation to Adult 35, Ms Bayley submitted that there is no case to answer in respect of 16 July as the appointment was carried out by Witness 5.

Ms Bayley submitted that the audits alone, because of the demonstrable failings, errors and things overlooked, cannot be blindly relied on and accepted without question in the circumstances where they are known to be flawed. She said that, where the only evidence before the panel is the diaries and audits, it is insufficient evidence for there to be a case to answer that these things were not recorded in the clinical records.

In respect of charge 6, Ms Bayley submitted that Witness 3's evidence that recording the offer or confirmation of a chaperone for adult patients specifically for FGM examinations/de-infibulation procedures was good practice only. In respect of Adult 2, the audit is silent on whether a chaperone was recorded in the notes. She said Adult 8 attended for a smear test, not an FGM examination or de-infibulation procedure. She said that the application is made in respect of Adult 22 on the basis that the panel does not have the clinical records for this patient and the panel cannot rely on the audit alone. She said that a submission of no case to answer is made in respect of Adult 19, in relation to whether or not recording the offer or confirmation of a chaperone is actually required.

In relation to Adult 35, for whom the panel have notes, Ms Bayley said that she has only made an application of no case to answer in respect of 2 and 9 July and 6 August 2015 in relation to whether or not recording the offer or confirmation of a chaperone is actually required. In relation to 16 July 2015, she said that there is evidence before the panel that this patient was seen at a joint clinic with Witness 5.

In respect of charge 7, Ms Bayley said that the notes indicate that the patient's daughter was translating the appointment. She submitted that there is insufficient evidence to demonstrate that you had a duty to record whether a translator had been offered.

In respect of charge 8, Ms Bayley repeated her submission about the difficulty in accepting what the audits found, or did not find. She invited the panel to approach the EPR records with care given that Witness 3 made it clear that she did not find the EPR to be intuitive, and that things were not easy to find, which resulted in her seeking the assistance of a

colleague. Ms Bayley said that Witness 3 said that she thought she had found everything but could not be sure that there was not something else which she did not find on EPR. Ms Bayley said, in the absence of direct EPR access or EPR records which the panel can check, the NMC is relying on what the audit was able to find.

Ms Bayley said that it was perhaps outside of the remit of the audit to verify what information individual GPs had received, however, the NMC has charged that you did not send an outcome letter to GPs, with readily available addresses, without verifying whether or not the letters were sent. She said that it is not possible for the panel to be satisfied that outcome letters were not recorded or sent where no checks have been made with the GPs. She said that it is likely that GP outcome letters are currently emailed rather than sent by post, and that there is evidence before the panel that your emails were not checked by the audit. She therefore submitted that the panel cannot be satisfied on the basis of the records before it that the outcome letters were not sent. She said that there is also a difficulty with them not being recorded given the difficulties which the auditors had with the EPR. She said that the panel has heard that empty EPR outcome letters were generated, and the witnesses were unable to assist in explaining how that would happen. Ms Bayley said that her overarching submission in respect of Charge 8, is that without making proper enquiries or investigating whether or not outcome letters were sent, on the basis of the audits alone, there is no sufficient evidence for there to be a case to answer in relation to Charge 8.

Ms Bayley submitted that charge 9 is saying that there is either no record of follow up with the multi-disciplinary team, or there was no follow up of the multi-disciplinary team. She said that, in her evidence, Witness 5 was confused as she was unsure of who the multi-discipline team is, and that unless you were particularly concerned about a patient, you would not necessarily follow up their care. She said that, for a large number of patients, there is no evidence that any follow up with the multi-discipline team was required, and in some cases it is unsure who the follow up should have been with, and who the multi-discipline team is.

In respect of charge 10, Ms Bayley first submitted that if people came to the FGM clinic with confirmed FGM, there is no evidence before the panel that you were required to record an FGM risk assessment. She said that Witness 5 gave evidence that it was contrary to any sense to say that you need to record a risk assessment for somebody at risk of FGM if they have already been subjected to FGM.

Ms Bayley said that, in respect of this charge, the panel has only diary entries for the patients in the schedule, and on the basis of these there is evidence of adequate information provided about advice, discussion, next steps, details of assessment and examination. She submitted that Adult 136 was seen by Ms 6, who replaced you at the Trust, so there is no case to answer in respect of this adult. She said that Adult 150's notes were not obtained for the audit, which was based solely on the diary for this patient. She said the audit says that there is an outcome letter on EPR, which is not before the panel.

In respect of charge 11, Ms Bayley said that the only evidence before the panel are the diaries in relation to these patients. She said that some diaries do state where the referral has come from. In respect of Adult 11, she said that it is charged that you have not adequately recorded the referral, although the diary says that it is a self-referral and there are no patient notes before the panel.

Ms Bayley said that, in respect of Adult 46, the diary states Dr 11 as a referral. She set out that the audit says, *"the reason for referral is FGM III",* which suggests that the auditors may have seen the referral letter.

Ms Bayley submitted that a note in the diary or records which states *"referred by"* with a line though is evidently a self-referral because, if that person had been referred by somebody, it would have been recorded.

Ms Bayley said that Adult 131 was Witness 5's patient who was seen by you and Witness 5 at a joint clinic. She said that no clinical notes were found for this patient and the

outcome letter on EPR has not been provided to the panel. She said that, as with a number of the later adults, the audit seems to have been based on the diary alone and not individual patient records. She submitted that it is not possible in those circumstances for the audit to have concluded whether or not the notes recorded the original referral of the patient, therefore it is not possible for the panel to determine this.

In respect of Adult 160, Ms Bayley highlighted that the Trust investigators audited only the diary and proforma, therefore the audit cannot provide evidence about what was in the clinical notes which they did see. She said that there was also an outcome letter about this patient, which has not been made available to the panel.

Ms Bayley submitted that Charge 12 is similarly worded to charges 10, 3.1.1 and 3.1.2. She said that rather than not recording adequate details of their appointment, this charge relates to not recording adequate details of clinical consultations so slightly different but the same thing. She said that there is no evidence that any details of clinical consultations ought to have been recorded in the EPR. She said that there are no physical patient record bundles for these patients, therefore insufficient evidence for a panel to find this proved. In respect of Adults 30 and 38, Ms Bayley submitted that charges 10 and 12 are duplicitous in that they allege the same mischief.

In respect of Adult 156, Ms Bayley said that the audit says "*EPR nothing*", but the diary page indicates that you have written "*EPR*" with a tick which suggests that you had created an EPR for this patient. She submitted that, given the issues known about EPR, the panel cannot conclude that there was nothing on EPR. She said that given that the patient was recently married, it is possible that her name had changed. Accordingly, she submitted that a panel cannot properly conclude that the notes were not raised or completed for Adult 156. She made the same submission in respect of Adult 159.

Ms Bayley said that the only two audits before the panel relate to Adults 161 and 162, and there are two separate page numbers and perhaps different appointment dates. In any event, she submitted that Adult 162 also appears at charge 10, therefore this charge is

duplicitous. Ms Bayley said that blue notes were not available to auditors for either of these patients, but there is evidence before the panel that Adult 161 was seen and treated by Witness 5 on 7 July 2016, which would tend to suggest that the notes did exist. She said that the alternative is that neither you nor Witness 5 wrote in any clinical notes at all, which is unlikely. She said that the audit notes that an outcome letter was seen so there is something on EPR for both Adults 161 and 162.

Ms Bayley invited the panel to apply extreme caution to patients where the audit does not consider clinical notes, and it is being asked to find proved that insufficient information is recorded in such notes that no one has seen.

In respect of charge 13, Ms Bayley submitted that it is not clear on the basis of the evidence before the panel that a community paediatrician was required. She said that there is a letter in evidence which suggests that Child 17 was already under the community paediatrician and had multiple referrals to the Evelina Bladder Clinic. She said that there is insufficient evidence for there to be a case to answer.

In respect of charge 14.1, Ms Bayley said that the blue notes and outcome letter for Child 18 states that she needed further investigation and support. She questioned whether you were obliged to make a referral to a paediatric urologist, or whether it was sufficient to refer her back to the referrer with that advice.

Ms Bayley described charges 14.2 and 14.4 as a *“Catch-22”,* in that charge 14.2 criticises you for not referring Child 18 to Witness 5, a consultant gynaecologist for adults, where charge 14.4 states that you incorrectly referred Child 18 to this service. She submitted that it can only be one or the other.

Ms Bayley submitted that charge 15 is duplicitous with charge 3.28.1, and therefore the panel should find no case to answer on one or the other.

In respect of charge 16, Ms Bayley submitted that there is no clear evidence that this 16-year-old child required a referral for psychological services. She said that, in the absence of full notes, it is not possible to determine what care Child 23 was receiving at the time.

Ms Bayley submitted that Charge 18 is duplicitous with Charge 1.10, and additionally asked the panel to consider whether there is a case to answer that you were willing to do any assessment at all in the particular circumstances in relation to Child 28.

Ms Bayley made submissions in relation to Charge 20. In respect of Child 23, the panel only has before it the diary page, which was the only page available to the auditors, therefore it is not possible for the panel to conclude the offer or confirmation of consent was not recorded. In respect of Child 28, Ms Bayley submitted that it is unclear whether the child was conscious or not, however the circumstances surrounding that examination and the notes that the panel has are insufficient evidence to demonstrate that you specifically should have separately recorded consent for the assessment of that Child in those circumstances.

In respect of charge 21, Ms Bayley submitted that Children 21 and 22 were siblings who were seen by Dr 8 with their mother present. She said that, in those circumstances there is insufficient evidence for there to be a case to answer that the chaperone should have been offered and it was unnecessary to record that offer in the notes. She said that Child 23 was over 16, and, as with charge 20, the panel only has before it the diary page which was available to the auditors, therefore cannot conclude what was or was not recorded in their notes. In respect of Child 28, she queried whether you were required to offer a chaperone or record the offer of a chaperone in the circumstances of Child 28's admission.

Ms Bayley invited the panel to have regard to her written submissions when considering the legal framework of its consideration of no case to answer, alongside her written submissions about the allegations charged by the NMC, such as second opinions, psychosexual counselling and risk assessments.

In conclusion, Ms Bayley invited the panel to find that there is insufficient evidence that a panel could properly conclude there is a case to answer in respect of the charges submitted, in accordance with Rule 24(7).

Ms Mustard's Written Response to Ms Bayley's Submissions of No Case to Answer

"Introduction

1. *These submissions should be read alongside the evidence matrix and schedule evidence matrix previously provided to the panel.*

2. *On behalf of the Registrant the panel were invited to treat the NMC witness statement evidence with care as it was suggested that a number of witnesses resiled from their written statements during the course of oral evidence – the panel will recall that [Witness 3] had concerns around adopting her witness statement but the other witnesses all confirmed the accuracy and content of those statements so it is submitted that reference to those other statements (i.e. not [Witness 3]'s) within the schedules can – and should – still be referred to and relied upon.*

The Law

3. *No issue is taken with the law as it relates to this legal argument as it has been set out on behalf of the Registrant.*

No Positive Submissions

4. *The NMC do not intend to make positive submissions in response to the Registrant's application on the following charges and leave these as a matter for the panel's discretion **[This doesn't amount to agreeing/accepting all submissions that were made on behalf of the Registrant in respect of these charges]**:*

Charge 1.1 (Schedule 1) in respect of the following:

- *Adult 35 in respect of 16 July 2015 only*

Charge 1.2 (Schedule 1) in respect of the following:

- *Adult 35 in respect of 16 July 2015 only*

Charge 1.5 (schedule 4) in respect of the following:

- *Adult 19 in respect of 15 May 2015 and 10 September 2015 only*
- *Adult 22 in respect of 28 Jan 2016 and 30 June 2016 only*
- *Adult 35 in respect of 2 July, 16 July and 6 August 2015 only*
- *Adult 43 in respect of 8 August 2014 only*
- *Adult 44 in respect of 12 December 2013 only*

Charge 1.6 (schedule 5) in respect of the following:

- *Adult 2*

Charge 1.7 (schedule 6) in respect of the following:

- *Adult 3*
- *Adult 19*

Charge 2.2 (schedule 9) in respect of the following:

- *Adult 2*
- *Adult 15*
- *Adult 23*

Charge 2.3 (schedule 9) in respect of the following:

- *Adult 10*
- *Adult 17*
- *Adult 124*

Charge 2.4 (schedule 9) in respect of the following:

- *Adult 19*
- *Adult 35*

Charge 3.6.1 / 3.6.3 in respect of 'informing' only

Charge 3.8.2 / 3.8.3 and 3.8.4

Charge 3.9.3

Charge 3.11.2 and 3.11.4

Charge 3.12.2

Charge 3.14.2 and 3.14.3 and 3.14.4

Charge 3.16.2 and 3.16.3

Charge 3.18.1 and 3.18.2

Charge 3.20.3

Charge 3.23.3

Charge 3.27.3

Charge 3.28.3

Charge 3.29.2

Charge 3.30.5

Charge 3.32.1 and 3.32.2

Charge 3.33.1

Charge 4 in its entirety

Charge 5 in respect of the following:

- *Adult 2*
- *Adult 8*
- *Adult 22 in respect of 28 Jan 2016 and 30 June 2016*
- *Adult 35 in respect of 16 July 2015*
- *Adult 44 in respect of 12 Dec 2013*

Charge 6 in respect of the following:

- *Adult 2*
- *Adult 8*
- *Adult 22 in respect of 28 Jan 2016 and 30 June 2016*
- *Adult 35 in respect of 16 July 2015*
- *Adult 44 in respect of 12 Dec 2013*

Charge 10 (schedule 12) in respect of:

- *Adult 25*
- *Adult 136*
- *Adult 162*

Charge 11 (schedule 13) in respect of:

- *Adult 11*

Charge 12 (schedule 14) in respect of:

- *Adult 30*
- *Adult 38*
- *Adult 142*
- *Adult 153*
- *Adult 159*
- *Adult 161*
- *Adult 162*

Charge 13

Charge 14.2

Charge 15

Charge 16

Charge 18

Charge 20 (schedule 8) in respect of:

- *Child 23*

Charge 21 (schedule 8) in respect of:

- *Child 21*
- *Child 22*
- *Child 28*

<u>Submissions</u>

5. *The NMC opposes the argument in respect of all other charges to which this application relates in the following terms:*

1. Acted/practised outside the scope of your clinical competence/role, in that you:

1.1. On one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.

1.2. On one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.

6. *The above two charges are dealt with together for the purpose of submissions as they relate to the issue of 'scope of practice' and to the same schedule of patients.*

7. *It is not disputed that the Registrant's nursing registration with the NMC lapsed on 1 April 2013 and has not been reinstated since. Further, it is undisputed that the Registrant only has two registered qualifications, Adult Nurse (registered 1986) and Midwifery (registered 1988). The Registrant does not hold any additional qualifications, including that of non-medical prescriber.*

8. *All of the adult patients listed in schedule 1 were seen by the Registrant after April 2013 (i.e. when she was only registered as a midwife) so it must first be established whether it was outside the scope of the Registrant's clinical competence/ role **as a midwife** for her to accept referrals for non-pregnant patients.*

9. *It is clear that the Registrant was applying for a **midwifery** role. Her application from 1997 refers to the fact she was applying for the post of 'Genital mutilation midwife' which she had seen advertised in 'Midwives classified'.*

10. *Whilst there is some uncertainty about which job description pertained to the Registrant in her capacity as a Band 8B midwife it is apparent (from their content and titles) that all of the available job descriptions were for **midwifery** posts.*

11. *Both [Witness 2] and [Witness 1] stated that the document with job title 'FGM/Public Health Specialist – African Women's Reproductive Health Support Service' was not a job description – it doesn't have a grade banding and the language doesn't fit with what is expected of a job description (e.g. 'The following bid'…). Although [Witness 4] thought this may have been the Registrant's job description for when she was in post, she couldn't recall whether she had seen the document prior to it being sent to her by the Registrant in 2011 or why the Registrant even sent it then.*

12. *All witnesses ultimately agreed (although there had been earlier confusion) that the job description for the band 7 role was for the Registrant's replacement and did not relate to the Registrant. [Witness 4] also said that this particular job description should not have made reference to the post holder being responsible for the clinical care of 'girls' – that was an oversight as the post holder was not seeing girls.*

13. *Whilst it is acknowledged that [Witness 2] is not a registered midwife, she does have experience of managing midwives. [Witness 2] gave evidence that a midwife's scope of practice only includes seeing or treating women who are pregnant, in labour or during post-natal care. [Witness 2] also points to the documentation pertaining to the Registrant's role at the Trust and says that this clearly indicates this was a **midwifery** role and therefore no nursing duties were required to be carried out. In these circumstances [Witness 2] says that the only time she would expect a midwife to care for a non-pregnant woman is in the post-natal ward or, rarely, in intensive care as part of midwifery examination and postnatal checks.*

14. *Although [Witness 5] had assessed the Registrant as competent to carry out deinfibulation (in 1997 and the years shortly after and had not observed her in a clinical capacity thereafter) and as she understood it the FGM clinic were accepting referrals for non-pregnant women she did also say that it*

*was her understanding that once the Registrant was only registered as a midwife (which she wasn't aware of until the end of last year) she assumed that she should **not** have been seeing women who were not pregnant. [Witness 5] also stressed on a number of occasions during her evidence that she is not a midwife herself nor was she the Registrant's line manager and when asked questions about the scope of the Registrant's role/practice she said 'you would have to ask midwifery seniors' […].*

15. *So turning to the midwifery seniors and what they said on this topic – [Witness 4]'s evidence about the scope of the Registrant's role was given on the basis that she had understood the Registrant to be dual registered as a nurse and midwife throughout her time at the Trust. It only become apparent to [Witness 4] during her evidence to the Panel that the Registrant's nursing registration had lapsed. She said that if an individual lets their registration lapse completely, they shouldn't be practicing in that field because they have not kept up to date with hours and training.*

16. *[Witness 4] agreed that there are circumstances when a midwife can see non-pregnant women, specifically for pre-conceptive care and for up to 6 weeks post-natally. She said that a midwife can give family planning advice although they would usually require additional knowledge and qualifications to allow them to do that.*

17. *[Witness 4] accepted that none of the job descriptions pertaining to the clinic specified that a nursing registration was a requirement (as above, they were midwifery posts), but she said that she believed it was 'needed' in addition to a midwifery qualification because the work being done at the clinic went 'beyond' normal midwifery registration. [Witness 4] believed that the Registrant's replacement was on the NMC register as both a nurse and midwife.*

18. *It is acknowledged that [Witness 4] evidence somewhat changed overnight, and she latterly said in evidence that perhaps it wasn't necessary for an individual doing the Registrant's clinic role to be registered as a nurse so long as they had 'something extra' (to their midwifery registration) to inform them about the impact of FGM and how to perform reversals. However, her evidence on this point was somewhat equivocal and she said she was 'still considering it'. The panel may also think it is of note that in terms of additional training [Witness 4]'s evidence was that the Registrant had undertaken her FGM training prior to 1997 and although she attended conferences to enhance her learning around FGM there was no specific training package that [Witness 4] was aware of, and she believed that the majority of the Registrant's knowledge came from the initial training done prior to 1997 in North London.*

19. *[Witness 3] also agreed that there are circumstances when a midwife can see non-pregnant women, namely for pre conceptual care or for a reproductive health purpose. She did however say that she would expect it to be clear from the records that patient's [sic] were being seen for one of these purposes and at the clinic it was often 'unclear as to what the overall purpose of the attendance was'. This uncertainty left her and her fellow reviewers 'concerned…because there was the question of why were these women being seen with potentially a midwife that was only practicing as a midwife at that particular time'. [Witness 3] said that a midwife's role in pre-conceptual care is usually a 'brief intervention conversation' where the midwife can act as a "change agent" to assist the woman in achieving optimum health for pregnancy.*

20. *[Witness 3] acknowledged that the 'Practising as a midwife in the UK' document does not "directly" say under the heading 'scope of practice' that midwives cannot see non-pregnant women. However, [Witness 3] later described this definition as quite brief, a simplistic overview and said that any*

skills, knowledge or proficiency should be within the core curriculum. [Witness 3] also said that this definition should be read alongside the 'International Definition of the Midwife' which says that a midwife provides 'support, care and advice during pregnancy, labour and the postpartum period' and also says that the midwife has an important task in health counselling and education which 'may extend to women's health, sexual or reproductive health and child care'. When asked questions by the panel about this document in particular [Witness 3] said "I would marry it up with more in depth expectations of the role" [Witness 3] also said there is an element of personal accountability in terms of defining 'scope of practice'.

21. *[Witness 3] said that if the Registrant could demonstrate that she had the 'skills, knowledge and proficiency' then it would suggest that it would be within the scope of her practice to see (and treat) non-pregnant women. In re-examination she said that she would expect that the relevant skills, knowledge and proficiency would be demonstrated by a collaboration with the organisation to set the standards for this work. She said she would expect to see an acknowledgement that this conduct was on the 'boundaries' of the relevant scope of practice and the skills could be achieved through education and clinical expertise and reflected in, for example, meetings with a mentor and reflective logs. As [Witness 4] said the Registrant did not have any specific training packages and [Witness 3] saw no evidence of a patient group directive (PGD), or similar, setting out the basis on which the Registrant's role was agreed and permitted to be extended beyond the scope of usual midwifery practice.*

22. *Although there may be some circumstances where a midwife can see/accept a referral for a non-pregnant woman these are limited to pre conceptual care or for a reproductive health purpose. In those instances, it is [Witness 3]'s evidence (supported by the International Definition of a Midwife) that the midwife's role is in an advisory capacity. Further, it is expected that it is*

evident from the records that this is the purpose of the midwife seeing the patient so that it is possible "to demonstrate in what aspect of the scope of practice of a midwife that is being done"

23. *In order to demonstrate that the midwife has the skills, knowledge and proficiency to act outside the usual/permitted scope of their role as a midwife there needs to be a formalised agreement with the organisation/employer as to the limits of those additional responsibilities to ensure that standards are set and can be monitored. This is not something which was evident in this case.*

24. *It was submitted on behalf of the Registrant that the witnesses' opinions on scope of practice is effectively irrelevant. These were professional witnesses giving those opinions in the course of their evidence for the* ***very purpose*** *of these proceedings so it is submitted that they are relevant and helpful opinions that the panel can – and should -take into account.*

25. *The panel were referred to […] and it was pointed out that other FGM clinics have contacts with a job title 'FGM specialist midwife'. It is submitted that this has no bearing on this case – we don't know the registration status of these individuals, the set-up, history or operation of these clinics and the panel are not being asked to decide on anything to do with the running or staffing of these other clinics. The panel's task is confined to consideration of the charges and evidence before them and not to speculate, including speculation on wider issues.*

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

Adult 2 on or around 27 October 2016

26. The Registrant's diary page confirms she saw this patient on 27 October 2016. The EDD has a line next to it indicating there was no 'estimated date of delivery' because this woman was not pregnant.

<u>Adult 3 on or around 22 September 2016</u>

27. The Registrant's diary page confirms she saw this patient on 22 September 2016. The EDD has a line next to it indicating there was no 'estimated date of delivery' because this woman was not pregnant.

<u>Adult 4 on or around 21 April 2016</u>

28. The Registrant's diary page confirms she saw this patient on 21 April 2016. The EDD has a line next to it indicating there was no 'estimated date of delivery' because this woman was not pregnant.

<u>Adult 6 on or around 15 June 2017</u>

29. The Registrant's notes confirm that she saw this patient on 15 June2017 [sic]. In the box 'Pregnant Y/N' the Registrant has written 'No' because this woman was not pregnant.

<u>Adult 7 on or around 18 August 2016</u>

30. The Registrant's diary page confirms she saw this patient on 18 August 2016. The EDD is crossed through indicating there was no 'estimated date of delivery' because this woman was not pregnant.

31. Although it appears from the diary entry that the Registrant did not examine this patient it does seem (from the content of [Witness 3]'s follow up welfare letter) that she had an effective consultation appointment with her and as per [Witness 3]'s evidence an assessment is the whole consultation, including taking a patient's history, symptoms and problems etc.

<u>Adult 8 on or around 3 December 2015</u>

32. *The Registrant's notes confirm she took a smear test from this patient on 3 December 2015. As per [Witness 3]'s evidence smear tests are not generally taken during pregnancy indicating this patient was not pregnant when seen by the Registrant.*

Adult 9 on or around 4 June 2015

33. *The Registrant's notes confirm she saw this patient on 4 June 2015. 'Not pregnant' is circled because this woman was not pregnant.*

Adult 12 on or around 11 June 201~~6~~5 [charge amendment suggested]

34. *The Registrant's notes confirm she saw this patient on 11 June 2015. 'Not pregnant' is circled because this woman was not pregnant.*

Adult 15 on or around 6 August 2015

35. *The Registrant's notes confirm she saw this patient on 6 August 2015. 'Not pregnant' is circled because this woman was not pregnant.*

Adult 17 on or around 22 August 2013/12 May 2016

36. *The Registrant's diary pages confirm she saw this patient on both 22 August 2013 and 12 May 2016. The EDD has a line next to it on both occasions indicating there was no 'estimated date of delivery' because this woman was not pregnant at either appointment.*

Adult 19 on or around 1~~5 1~~4May 2015/20 August 2015/10 September 2015 [charge amendment suggested]

37. *The Registrant's diary pages confirm she saw this patient on 14 May 2015, 20 August 2015 and 10 September 2015. Not pregnant is circled for both the August and September appointments and it is noted in the audit that this woman was 'post-menopausal' so not pregnant.*

Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

38. *The Registrant's notes confirm that she saw this patient on 16 April 2015. Not pregnant is circled in these notes because the patient was not pregnant.*

39. *Whilst there are no notes from the Registrant for 28 January 2016 there is reference to that appointment on the audit front sheet which also refers to the patient being 'not pregnant'.*

40. *There is a diary page for 30 June 2016 appointment where the EDD has a line next to it indicating no estimated delivery date as this woman was not pregnant.*

<u>Adult 23 on or around 28 April 2016</u>

41. *The Registrant's diary page confirms she saw this patient on 28 April 2016. The EDD is crossed through indicating there was no 'estimated date of delivery' because this woman was not pregnant.*

<u>Adult 24 on or around 20 October 2016</u>

42. *The Registrant's diary page confirms she saw this patient on 20 October 2016. The EDD is crossed through indicating there was no 'estimated date of delivery' because this woman was not pregnant.*

<u>Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015 [no positive submissions made in respect of 16 July 2015]</u>

43. *The Registrant's diary equivalent records are for the 16 July 2015 and 6 August 2015 appointments and both of these records have 'not pregnant' circled.*

44. *It is clear from the above records that deinfibulation took place on 9 July 2015 and the audit states that this was a reversal when the woman was 'not pregnant'. The first appointment of 2 July 2015 is also referred to both in the record of 16 July 2015 and the audit.*

45. *The recently disclosed records ([…]) confirm that deinfibulation was carried on 9 July 2015 and then [Witness 5] saw the patient as she was asked to review. The fact the Registrant also has a record from 16 July 2015 indicates she was also involved in the consultation.*

Adult 89 on or around 8 October 2015

46. *The Registrant's notes confirm that she saw this patient on 8 October 2015. Not pregnant is circled in these notes because the patient was not pregnant.*

Adult 109 on or around 14 May 2015

47. *The Registrant's notes confirm that she saw this patient on 14 May 2015. Not pregnant is circled in these notes because the patient was not pregnant.*

Adult 124 on or around 21 July 2016

48. *The Registrant's diary page confirms she saw this patient on 21 July 2016. The EDD is crossed through indicating there was no 'estimated date of delivery' because this woman was not pregnant.*

Adult 130 on or around 10/24 November 2016

49. *The Registrant's diary pages confirm that she saw this patient on both 10 and 24 November 2016. The EDD is crossed through in respect of 10 November and blank in respect of 24 November indicating there was no 'estimated date of delivery' because this woman was not pregnant.*

Adult 134 on or around 5 January 2017

50. *The Registrant's notes confirm that she saw this patient on 5 January 2017. 'No' is written in the box for 'Pregnant Y/N' indicating that this woman was not pregnant.*

1.3. On one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.

51. *If the panel conclude that it was outside the scope of the Registrant's clinical competence/role to accept referrals for, and/or examine, non-pregnant women then it must follow that it was also outside that same clinical competence/role for her to perform de-infibulation on non-pregnant women.*

52. *However, even if the panel consider that it was within the Registrant's role to see and examine non-pregnant women then different, and further, considerations should apply as to whether it was within her role to conduct deinfibulatoin [sic] on these patients.*

53. *[Witness 3] was concerned about the application of the midwives' exemptions to allow for local anaesthetic to be given in these situations. She said 'I think performing de-infibulation on women who had FGM would require – it's a practical, surgical technique that would require analgesia. The need for a local anaesthetic to be given and the administering of Lidocaine is appropriate when a midwife is attending a woman in childbirth. But these women were not pregnant that application of the midwife's exemption didn't feel right to us within the review team.'*

54. *In re-examination [Witness 3] stated that the use of Lidocaine in terms of the NMC exemptions related to use during childbirth and she further said that if the Trust exemptions allowed for use in FGM repair then she would expect it to be specifically noted, which it isn't. As above, [Witness 3] saw no evidence of a PGD or clinical guideline which allowed for use of Lidocaine for FGM repair and consequently 'supported Ms Momoh to have extended her practice'.*

55. *It is submitted that where there is no agreed or stated exemption to allow the Registrant to have used Lidocaine for FGM repair it falls outside her role as a midwife (who would be bound by those stated exemptions) to use it for those purposes and perform the connected de-infibulation procedure.*

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

<u>Adult 9 on or around 4 June 2015</u>

56. *The Registrant's notes circle 'not pregnant', tick 'deinfbulation' and the Registrant's name is written in the space next to the sentence 'performed same day under local anaesthesy by' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.*

<u>Adult 12 on or around 11 June 2015</u>

57. *The Registrant's notes circle 'not pregnant' and the Registrant's name is written in the space next to the sentence 'performed same day under local anaesthesy by' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.*

<u>Adult 17 on or around 22 August 2013</u>

58. *The diary page had EDD with a line next to it indicating this woman was not pregnant. The Registrant has then written 'Deinfibulation of small closed area 28/08/13' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.*

<u>Adult 19 on or around 20 August 2015</u>

59. *The Registrant's notes circle 'not pregnant', tick 'deinfbulation' and the Registrant's name is written in the space next to the sentence 'performed*

same day under local anaesthesy by' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.

Adult 22 on or around 16 April 2015

60. The Registrant's notes circle 'not pregnant', tick 'deinfbulation' and the Registrant's name is written in the space next to the sentence 'performed same day under local anaesthesy by' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.

Adult 41 on or around 3 August 2017

61. The Registrant's notes state 'No' in the 'Pregnant Y/N' box and deinfibulation is written and ticked at the bottom of the page demonstrating the Registrant performed deinfibulation on this non-pregnant woman.

Adult 73 on or around ~~1~~ 8 October 2015 [charge amendment suggested]

62. The Registrant's notes circle 'not pregnant' and the Registrant's name is written in the space next to the sentence 'performed same day under local anaesthesy by' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.

Adult 123 on or around 30 June 2016

63. The diary page had EDD with a line next to it indicating this woman was not pregnant. The Registrant has then written 'Reversal today – local by Comfort' demonstrating the Registrant performed deinfibulation on this non-pregnant woman.

Adult 135 on or around 10 August 2017 [no positive submissions]

Adult 146 on or around 7 January 2016

64. The diary page records EDD “Not pregnant” and then further down states “for deinfibulation – reversal same day” It is submitted there is not anything to show that it was for pre-conceptual care.

1.4. On one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule 3.

65. Whilst [Witness 5] largely stated that her view was that a second opinion would not have been required during deinfibulation in respect of these Adult’s she also said it was difficult to make a value judgement without seeing the patients, or at least the records (clinical notes). In that regard [Witness 5] was in a different position to the auditors (including [Witness 3]) who we know did see and review the records themselves (to the extent they were available) as part of undertaking the audit.

66. In re-examination [Witness 3] said that if there is anything difficult or unusual about a case she would expect that it is good practice to obtain a second opinion.

Schedule 3. Did not obtain second opinion during de-infibulation

Adult 14 on or around ~~20 December 2013~~ 27 February 2014 [charge amendment suggested]

67. *It is noted in the Registrant’s diary for the appointment when the de infibulation took place (i.e. 27 February 2014) ‘fainted was call by paramedics’. Although [Witness 3] was realistic about the fact it is difficult to*

tell when the fainting occurred, she did wonder "Was it a positional effect of having the de infibulation that contributed to the faint?"

68. *[Witness 3] said that the fainting (which, it is submitted, would amount to a complication) required some follow up which wasn't evident. She said 'And just probably some help was required'*

69. *[Witness 5]'s evidence was that it wouldn't be a normal or usual occurrence to have a patient faint during deinfibulation.*

<u>Adult 17 on or around 22 August 2013</u>

70. *Whilst it is acknowledged that [Witness 3] referred to this as a 'routine deinfibulation' in her evidence she did also query whether '..if a cyst is there and then it's not there, then do you ask for somebody else's opinion as what the possible cause that might be and if there's anything else that needs to be done'*

71. *[Witness 3] went on to state that she considered that a 'simple swab' should have been taken in this scenario, but this is not evidenced.*

<u>Adult 19 on or around 20 August 2015</u>

72. *[Witness 3] described this patient as 'very complicated' and therefore said '…it seemed like a really strange thing for me to think that somebody wouldn't ask for help…'*

73. *In answer to panel questions [Witness 5] said that it would be a "very good idea" to obtain a second opinion as to whether a patient has had FGM or not as this would protect the clinician and give clarity to the woman.*

74. *In the audit of this case, [Witness 3] has recorded 'Really concerned that if this woman didn't have FGM why/what did CM deinfib – no mention of 2nd*

opinion from other prof.' The panel now have the benefit of further records ([…]) which do demonstrate the previous uncertainty around this patient's FGM diagnosis.

Adult 35 on or around ~~2~~ 9 July 2015 [charge amendment suggested]

75. *The Registrant's notes record that this was a 'difficult deinfibulation' and this is further reflected in the audit form which states 'Notes stated 'very, very difficult deinfibulation' No evidence that advice was sought'*

76. *Although in [Witness 5]'s assessment these are not difficult procedures there was obviously something which the Registrant considered 'difficult' about this particular one as she recorded it as such in the notes. [Witness 3]'s evidence was that it would have been "good practice" to obtain a second opinion in these circumstances. She said that 'Something being described as very very difficult leads you to think that you don't have to do these things alone.'*

Adult 130 on or around 24 November 2016

77. *As recorded in the audit form this was a complicated deinfibulation because it was noted that 'unable to completely separate as fused together anteriorly' [Witness 3] thought as recorded in the audit, '? Should have been reviewed by another person? Offered day case procedure'*

78. *[Witness 3] adopted and repeated this concern in evidence when she said "..I appreciate the difficulty and the complexity and that is why I thought possible that this case should have been referred by another person but reviewed by another person for a second opinion"*

79. *During XIC [examination in chief] [Witness 5] referred to this as a 'quite a tricky one' and said that normally the Registrant would have got her to look at this case, indicating that she considered a second opinion should have been sought for this Adult.*

1.5. On one or more occasion administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber, as listed in schedule 4.

80. *The concerns in this regard predominantly relate to the Registrant's administration of anaesthetic for the purpose of performing deinfibulation procedures. [Witness 3]'s concerns about this (and how it falls outside the midwives' exemptions) are outlined in relation to charge 1.3.*

81. *The panel were taken to the Trust guidance on Midwife Exemptions ([…]). [Witness 3]'s evidence on this was "If it was meant to include FGM repair, I would have expected that to have been explicitly said in there…" [Witness 3] also said she didn't agree with things evolving and becoming normalised so as to effectively have an informal PGD and it would have been open to the Registrant to have created a PGD to update the use of Lidocaine etc for FGM purposes.*

82. *As referred to above, the Registrant is not a non-medical prescriber and there is no evidence on the available records that authorisation was given from a medical prescriber. In those circumstances it is outside the Registrant's role as a midwife to have administered medication.*

Schedule 4: Administered medication without a prescription

1. ***<u>Adult 9 on or around 4 June 2015</u>***

83. *The audit ticks 'local' under 'anesthesia' heading ([…]). The Registrant's own records also tick 'deifnibulation' and the Registrant has written her name to say it was under 'local anaesthesy' ([…]).*

*2. **Adult 12 on or around 11 June 2016***

84. The audit ticks 'local' under 'anesthesia' heading ([…]). In the Registrant's own she has written her name to say it was under 'local anaesthesy' ([…]).

*3. **Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015 [no positive submissions made in respect of 15 May and 10 September 2015]***

85. The audit ticks 'local' under 'anesthesia' heading ([…]). The Registrant's own records also tick 'deifnibulation' and the Registrant has written her name to say it was under 'local anaesthesy' ([…]).

4. Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016 [no positive submission made in respect of 28 January and 30 June 2016]

86. The audit ticks 'local' under 'anesthesia' heading ([…]). The Registrant's own records also tick 'deifnibulation' and the Registrant has written her name to say it was under 'local anaesthesy' ([…]).

5. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015 [no positive submissions made in respect of 9 July, 16 July and 6 August 2015]

87. The recently disclosed clinical records ([…]) show the Registrant's recording of 'Anitbiotics given (Erythromycin)'.

88. The audit sheet records 'Antibiotics given…Unclear how these were prescribed'. In evidence [Witness 3] said this was something identified in the hospital notes and that she did 'recall not being able to find any prescription

sheet or any other notes to indicate somebody else had prescribed erythromycin [sic]'

89. *During XX [cross-examination] [Witness 3] referred to the fact that erythromycin 'doesn't appear on our exemption list'*

90. *The 9th July was also the date the deinfibulation procedure took place and 'local' is ticked on the audit sheet ([…]).*

6. Adult 43 on or around 8/14 August 2014 [no positive submissions made in respect of 8 August 2014]

91. *Deinfibulation took place on 14 August 2014 and the Registrant has written 'under local' in the diary page ([…]) and the audit has ticked 'local' ([…]).*

7. Adult 44 on or around 5/12 December 2013 [no positive submissions made in respect of 12 December 2013]

92. *The diary notes reflect that deinfibualtion took place on 5 December 2013 ([…]) and the audit ticks 'local' under 'anaesthesia' ([…]).*

8. Adult 123 on or around 30 June 2016

93. *The diary notes reflect that deinfibualtion took place on 30 June 2016 ([…]) and the audit ticks 'local' under 'anaesthesia' ([…]).*

9. Adult 124 on or around 21 July 2016

94. *The diary notes reflect that deinfibualtion took place on 21 July 2016 ([…]) and the audit ticks 'local' under 'anaesthesia' ([…]).*

<u>10. Adult 138 on or around 29 June 2017</u>

95. *The Registrant's notes reflect that deinfibualtion took place on 29 June 2017 ([…]) and the audit ticks 'local' under 'anaesthesia' ([…]).*

1.6. On one or more occasion provided psychological/psychosexual counselling to patients, as listed in schedule 5.

96. *[Witness 4] said that if psychosexual counselling was required this was "something formal" – i.e. not something a midwife could provide within the scope of their practice. ([…])*

Schedule 5. Provided psychological/psychosexual counselling

<u>1. Adult 2 on or around 27 October 2016 [no positive submissions]</u>

<u>2. Adult 3 on or around 22 September 2016</u>

97. *[Witness 3]'s evidence was that there was a reason she wrote 'advised and reassured noted only' next to 'psychosexual/psychological' on the audit form and therefore it is submitted that this is a significantly placed note which demonstrates that the Registrant had provided this type of counselling to this patient. [Witness 3] was clear that in this case she had interpreted 'advised and reassured' as the <u>provision</u> of counselling*

1.7. On one or more occasion provided patients with sexual health counselling for dyspareunia, as listed in schedule 6. [no positive submissions]

Schedule 6: Provided sexual health counselling

<u>1.Adult 3 on or around 22 September 2016</u>

<u>2.Adult 19 between May & September 2015</u>

1.8. On one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;

Schedule 7: Undertook smear test without training/competency

<u>1.Adult 8 on or around 3 December 2015</u>

98. *[Witness 3]'s evidence was that taking a smear test would have been within Registrant's scope of practice if she kept the skills up to date because "something that you may have been trained in 20 years previously may not be valid and appropriate for something that you are doing in a current day practice" and this is particularly so when it is borne in mind that "Few midwives…would undertake smears as a routine in their practice because you do not take smears during pregnancy"*

99. *Whilst [Witness 3] was not sure when the quality assurance programme for smear tests came into existence she did say – in respect of Adult 8 – that she recalled speaking to [Ms 7] whose name was on the order and [Ms 7] had told her that you could "only order smear tests if you are on the quality assurance database….so only she was…able to order that test' It is submitted that it can safely be inferred from this that the Registrant was not on that database and hence why she did not make the order herself.*

100. *[Witness 4] said that she was not aware the Registrant was performing smear tests and she said "I wouldn't have thought it was within*

her scope of practice to take smears. She could have referred on to somebody else to do that" ([…]).

2.Adult 32 on or around 28 April 2014

101. *'SMEAR TEST TAKEN' is written in capitals on the audit form. [Witness 3] was challenged about whether the lack of records about the smear test may mean that one wasn't taken, and the auditors([Ms 12]) just assumed it had been and her response was 'No. Because she came to me. I remember her saying, you know, it has got here that a smear test has been taken and there is no record of it.' [Witness 3] was therefore clear that reference to a smear being taken was in the notes and that was evidence of it having been conducted.*

1.9. On one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.

Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

7. Child 23 on or around 18 February 2016

102. *An application is made in respect of this child on the basis that the child was 16 years old.*

103. *The Service Standards for commissioning FGM care ([…]) has a stated purpose 'this guidance describes service standards expected to be commissioned for the confirmation of FGM in **children under the age of 18**.' [emphasis added] If this guidance envisaged – or thought necessary – a*

distinction between children under 16 and those aged 16-18 it could and would have said so.

104. *This guideline says that "Any physical examination needs to be undertaken by a medical professional…" [Witness 1]'s evidence was "It doesn't say healthcare practitioner, it is quite specific that it is a medical practitioner and when I view the term "medical practitioner" I view that as a Dr not as any other healthcare professional"*

105. *The guidance goes on to say "In all cases involving children, an experienced clinician should be involved in setting up a sensitive, thorough* ***pediatric examination****…' [emphasis added] [Witness 1]'s evidence was that "…Ms Momoh had no paediatric qualification which allowed her to see* ***children and/or adolescents****" [emphasis added] ([…]).*

106. *The Trust's safeguarding the welfare of children policy states that "Physical examination of the child must and can only be undertaken by an appropriately qualified paediatrician" ([…]). [Witness 1] discussed this in her evidence […] although it is acknowledged that this is in respect of general procedures and not specifically FGM assessments. There is nothing within this policy which states the age of "children" or suggests there should be different considerations for young children and adolescents. [Witness 1]'s evidence was that "In the eyes of the law, anyone under 18 is still technically classed as a child"*

107. *Specifically in respect of Child 23 [Witness 1]'s concerns included practicing beyond her competence by seeing a child under 18 who was not pregnant ([…]).*

12. Child 28 on or around 20 July 2017

108. An application is made in respect of this child on the basis that the Registrant didn't accept the referral because she went to see the child in the PICU. It is submitted that this amounts to the same thing – the Dr on the PICU contacted the Registrant and asked for her to assess the patient so this was still a manner of the case being referred on to her albeit internally from another part of the Trust.

109. Although the Registrant did then refer the child on to another practitioner it is the NMC's case that she shouldn't have gone to see the child in the first place and that by doing so she was effectively accepting the referral for that child ([…]).

110. [Witness 1] refers to the fact that the child was in a safe place in the PICU and therefore there was no urgency requiring her to be assessed and the Registrant could – and should have – referred on immediately before going to the child herself ([…]).

13. Child 29 on or around 10 August 2017

111. The application is made on the basis that the child was 17, going on 18. The submissions as above re: under 18 are repeated. Further, [Witness 1 was asked in evidence whether she thought seeing a 17 year old in the service would be acceptable and she said "my view on that is in relation to a 17 year old who is being seen by a gynecologist as opposed to a 17 year old non-pregnant person being seen by a midwife" ([…]) and when she was later asked specifically in respect of this child she said that her views were as before ([…]).

1.10. On one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.

5. Child 21 on or around 22 October 2015

6. Child 22 on or around 22 October 2015

112. The above two children are siblings and were seen on the same day and therefore dealt with together as some of the same issues arise.

113. The Registrant's clinical notes ([…]) indicate she assessed/examined both girls and then [Dr 8] 'confirmed' her assessment. It isn't clear at what stage that happened, and the evidence suggests that the Registrant undertook an examination first which is what is alleged to be outside the scope of her practice. Furthermore, [Witness 1]'s evidence was that she couldn't ascertain who [Dr 8] is and therefore what their qualifications are and the appropriateness (or otherwise) of them 'confirming' the Registrant's assessment ([…]).

7. Child 23 on or around 18 February 2016

*114. The application is made on the basis of the child being 16 years old. In respect of this patient, it was put to [Witness 1] that in some clinics children start transitioning to adult clinics from the age of 15. Her response was "…I would be expecting a 16 year old to be seen by a practitioner who has got **Paediatric** experience of FGM" [emphasis added] ([…]).*

12. Child 28 on or around 20 July 2017

115. The Registrant's clinical notes ([…]) refer to what she saw 'on assessment' and a diagram indicating that she did assess/examine this child patient.

13. Child 29 on or around 10 August 2017

116. The Registrant's clinical notes ([…]) refer to what she saw 'on assessment' and a diagram indicating that she did assess/examine this child patient. The Registrant also wrote 'only 17'.

2. On one or more occasion did not, for adult patients as listed in schedule 9

2.1. Refer adult patients to specialist counsellors

Schedule 9: Failed to refer/investigate

Charge 2.1

Adult 2 on or around 27 October 2016

117. In [Witness 3]'s outcome letter she records that the adult was referred to the clinic regarding 'psychosexual problems' and it is unclear whether there was onward referral to a counsellor.

118. In evidence [Witness 3] said that management of psychosexual problems is quite complicated, would potentially have required onward referral and it was not clear that was actioned in this case.

119. In re-examination [Witness 3] said that she would have expected a record to have been made either in the notes or in the electronic patient record of an onward referral but she couldn't find that, hence the content of her outcome letter.

Adult 7 on or around 18 August 2016

120. The audit captures that this patient was referred to the clinic for 'Emotional distress, flashbacks, dyspaueurina, concern re: welfare for daughters' but again [Witness 3] saw no evidence of any onward referral – she said 'there just seems like there was nothing done' [Witness 3] said that she would have expected more enquiry and it is submitted that given the range of problems referred in an onward referral should have been made.

Adult 15 on or around 6 August 2015

121. The audit records 'Notes state that patient will need psychosexual counselling but no evidence that patient was referred or given any information about counselling'

122. [Witness 3] described that in this case '…it almost feels like this was just left with nowhere to go.'

Adult 23 on or around 28 April 2016

123. The audit states (in patient journey section) 'psychosexual issues…' and [Witness 3] said in evidence that she didn't believe anything had been done in respect of these issues (that she could see) hence the outcome letter she sent which says "…the woman may require further investigation and treatment for her psychosexual problems."

Adult 36 on or around 3 January 2013

124. The audit says 'Notes state 'will benefit from psychosexual counsellor' but no evidence that referral was made' It appears that the Registrant identified that an onward referral would be required but there was no evidence that had been done – [Witness 3] said she would have expected 'A letter of referral perhaps, something to suggest that that had actually occurred'

2.2. Refer adult patients for sexual health counselling

Charge 2.2

1.Adult 2 on or around 27 October 2016 [no positive submissions]

2.Adult 7 on or around 18 August 2016

125. [Witness 3] explained that sexual health counselling is more related to physical health problems (as opposed to psychosexual counselling which encompasses emotional and mental issues).

126. Adult 7 was referred by a sexual health nurse due to dyspareunia (i.e. physical problem) but there was 'no evidence that any further follow up was offered' according to the audit. The fact that the sexual health nurse had referred with these problems and didn't indicate they were being dealt with is suggestive of them not being able to be dealt with by the referrer.

3.Adult 15 on or around 6 August 2015 [no positive submissions]

4.Adult 23 on or around 28 April 2016 [no positive submissions]

5.Adult 36 on or around 3 January 2013

127. The audit states this adult was referred by sexual health services for 'dyspareunia and reduced sensation/unsatisfactory intercourse. Also c/o rash/itchiness' (i.e. physical problems) and there was no evidence of onward referral.

2.3. Refer adult patients for further investigation

Charge 2.3

1.Adult 4 on or around 21 April 2016

128. The audit records that the adult was complaining of pain and infection with 'vaginal infection' and 'chronic genital pain' being ticked but that 'no investigation or treatment offered by CM' In evidence [Witness 3] said "Because there is some pain noted that would have alerted me to some further assessment.."

2.Adult 10 on or around 19 November 2015 [no positive submissions]

3.Adult 17 on or around 22 August 2013/12 May 2016 [no positive submissions]

4.Adult 56 on or around 29 May 2014

129. The Registrant recorded in the diary page 'Needs referral to gynecologist' and [Witness 3]'s evidence was that it was unclear if that referral was ever made

5.Adult 124 on or around 28 July 2016 [no positive submissions]

2.4. Obtain a second opinion for adult patients during/following an FGM assessment.

Charge 2.4

1.Adult 2 on or around 27 October 2016

130. *This case was for a legal opinion re: FGM and [Witness 5]'s evidence was that sometimes it is difficult to see if someone has had FGM (particularly if they had had 3 children as was the case here) and you would want a second opinion if trying to obtain a medico legal opinion.*

2. Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015 [no positive submissions]

3. Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015 [no positive submissions]

3.On one or more occasion failed to maintain adequate clinical records for adult/children/patients under the age of 18, in that you:

131. *It is submitted that the diary pages are not the clinical record, and the panel cannot make decisions about 'clinical records' without them. The NMC*

would submit that the audit record sheets are a detailed and reliable source reflecting what was in the clinical records (where available). [Witness 3] explained that the audit was undertaken by means of a 'review in situ'. Furthermore, [Witness 3] told the panel that 'quite often there was almost a replica of what was written in the diary page then in the hospital records'

132. [Witness 3] explained part of the methodology for doing the audit as "pulling the lists of all the clinics over this period of time…pulling all the hospital notes, and then marrying up an audit proforma with a diary page and the set of notes so that we could – and then checking the EPR ***so the we could look at all sources of information****" [sic] (emphasis added). When [Witness 3] was asked about how many of the records she went back to and did a second search her answer was "I would say all of them…There was an awful lot of time spent trying to decipher what was going on, and I wanted to be sure that I had not missed anything…it's not to say that I did miss something, but I know that there was [Ms 12] looking, me looking, and then me looking again with another colleague.."*

133. It is suggested that the audit sheets cannot be relied upon as they are demonstrably unreliable. Whilst it is acknowledged that there are a few instances when the notes themselves do not seem to align with the audit it is an enormous leap to then suggest on that basis that the whole audit process was flawed and the contemporaneous notes of the audit (i.e. the record sheets) should effectively be disregarded in their entirety. The panel may remember that in certain instances [Witness 3] could remember sets of notes she had seen so the panel have the benefit of her recall (which was gone through extensively in evidence) as well as the audit itself. It is submitted that the audit process was a thorough one – in the large majority of cases [Witness 3] was effectively acting as a 'second checker' and the panel will no

doubt remember seeing two sets of handwriting on the vast majority of the audit sheets.

3.1. On or around 27 October 2016 during/following your consultation with Adult 2

<u>3.1.1. Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.</u>

<u>3.1.2. Did not record information about Adult 2's background.</u>

<u>3.1.3. Did not record that Adult 2's anatomy change could have been due to birth trauma.</u>

<u>3.1.4. Did not record adequate details of the advice/assessment/discussion/next steps for Adult 2.</u>

134. *The Registrant's notes in this case ([…]) are a diary page* ***[NB – these references at the outset of each of the adult charge 3 charges were inserted into the written submissions prior to receipt of [patient notes]]***

135. ***Charge 3.1.1 –*** *there is a blank outcome letter from EPRwhich it is submitted amounts to inadequate details of this consultation in the electronic patient record (EPR), as alleged. The panel will no doubt recall [Witness 5]'s evidence as to the importance of the outcome letter as a record of the consultation – it is key because it will have been checked by the clinician and it is typed rather than hand written. [Witness 4] also echoed this and said that the outcome letter is "seen as the appropriate process for concluding that consultation" and therefore should still exist, even if the patient requests no letter to be sent out in their case ([…]).*

136. ***Charge 3.1.2 and 3.1.3** – [Witness 3]'s evidence was that the there was a chance the 'labial tears occurred during birth….' And there 'would have been an opportunity….to note the mode of delivery for her children. Just give a little bit more of a background to the overall assessment'*

137. ***Charge 3.1.4** – the audit captures that 'All issues related to FGM discussed, well understood' It is submitted that this stock phrase does not give sufficient detail. Although [Witness 5] felt it was adequate she acknowledged in re-examination that she would understand what 'advised and reassured' by the Registrant would mean due to working with her over a number of years but she said you would have to ask others as to their perceived understanding of this. Further, in evidence [Witness 3] said that the diary entry was a 'bit messy' and didn't necessarily contain all the relevant details.*

3.2. On or around 22 September 2016 during/following your consultation with Adult 3;

<u>3.2.1. Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.</u>

138. *The Registrant's notes in this case ([…]) is the diary page.*

139. *The audit captures that the majority of things were 'not recorded' which indicates that there was inadequate detail of the consultation.*

<u>3.2.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 3.</u>

140. *Although [Witness 3] said in cross examination that writing 'all issues discussed' or similar was potentially adequate (although not ideal) she did*

say that it relies on the assumption that the practitioner is competent and skilled and knowledgeable and has asked the right questions. It is submitted that this is inadequate detail because it is entirely lacking in setting out what advice etc was actually given to the patient -as [Witness 3] said 'It is difficult to ascertain what 'all issues' were'. As above, [Witness 5] felt this was adequate but that was perhaps only because of her experience working with the Registrant.

<u>3.2.3. Did not record a risk assessment for Adult 3.</u>

141. Whilst [Witness 5] said that she didn't believe the Registrant was required to fill out the risk assessment pro forma she did caveat that with the fact she is not a midwife nor the Registrant's line manager and she couldn't say who the risk assessment tools were aimed at.

142. Furthermore, [Witness 5] said that she would assume that the original referring midwife would have done a risk assessment but there are many instances, this case included, where the referral was not from a midwife and therefore there may not already be a risk assessment on file.

143. Whilst [Witness 5] said that the risk assessments had less relevance where the woman knows she has FGM there are again examples – which [Witness 5] acknowledged – of women attending the FGM clinic for assessment/confirmation of their FGM. Adult 3 was referred for 'assessment'.

144. [Witness 4] said that midwives were being encouraged to undertake initial safeguarding responsibilities themselves (and not rely on e.g. [Ms 14]) and this included that they were expected to have "certainly done the risk assessment and recorded that" ([…]).

145. *The risk assessment forms themselves do state that they are to help with decisions about whether the woman has had FGM "…or whether the woman herself is at risk of further harm in relation to her FGM" so it is submitted they have wider use/context than simply identifying the risk of having had FGM.*

146. *It was put to [Witness 3] in XX [cross-examination] that it is not stated within the policy that the risk assessment needs to be written down. Her response was "I would say that we do not need to be told to write it down.*

3.3. On or around 21 June 2016 during/following your consultation with Adult 4;

3.3.1. Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle.

147. *The Registrant's notes for this case ([…]) are the diary page.*

148. *Blank outcome letter as noted in audit ([…]) – inadequate detail in EPR.*

3.3.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 4

149. *'All issues discussed – well understood' recorded as noted in audit ([…]) – inadequate to show what advice was given.*

3.3.3. Did not record information about Adult 4's risk of infection/chronic pain.

*150. Audit form states 'c/o pain and infection mention by CM **<u>but nothing else' [emphasis added]</u>** and there is a query around whether the infection is related to FGM ([…]). In evidence [Witness 3] referred to this as a 'brief mention within the notes' ([…]). It is submitted that this reference to infection/pain does not amount to 'information' about that and any associated risks – as can be seen from the audit it was unclear whether this was related to FGM as there was no detail in the notes or exploration of that.*

<u>3.3.4. Did not record a risk assessment for Adult 4</u>

151. This was a self-referral ([…]) [i.e. cannot rely on the 'referrer' having already risk assessed] and nothing to do with risk assessment was recorded ([…]).

<u>3.3.5. Did not record whether a swab/urine sample had been taken for Adult 4.</u>

152. [Witness 3] said that to send an investigation off you would log it on the system and this was not done at the time the patient was seen at the Trust ([…]).

3.4. On or around 15 June 2017 during/following your consultation with Adult 6;

<u>3.4.1. Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.</u>

153. The Registrant's notes for this case ([…]) are the single sheets headed 'Date of appointment' which [Witness 5] said may be obstetric notes although she wasn't familiar with them but that they looked like hospital records to her.

154. Audit records 'empty letter' (insufficient EPR) and also 'not recorded' throughout the 'AWWC Assessment and symptoms box' (insufficient in clinical notes) ([…]).

***3.4.2. Did not record the reason for Adult 6's referral to the FGM clinic*.**

155. When [Witness 3] was first asked about the necessity of recording the reason for a referral she said 'I think it gives you the basis for why the person has presented to you and the reason for them being there and guides you with what your expected to then do.' ([…]). It is submitted this is important information to inform the clinical picture and when it is absent alongside other information any future professionals looking at the file is likely to struggle to understand the patient's journey.

3.4.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 6

156. 'All issues relating to FGM discussed with Adult 6' noted in audit ([…]).

3.5. On or around 18 August 2016 during/following your consultation with Adult 7;

157. The Registrant's notes for this case ([…]) are diary notes.

3.5.1. Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle.

158. Audit records 'EPR – empty letter' ([…]).

3.5.2. Did not record a risk assessment of Adult 7/Adult 7's daughters.

159. The only note in the safeguarding section of the audit refers to what was reported by the referring nurse ([…]). [Witness 3] said she didn't think "there was anything to indicate anything more than what has been written in the audit proforma" ([…]).

3.5.3. Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

160. The only note in the safeguarding section of the audit refers to what was reported by the referring nurse ([…]). [Witness 3] said she didn't think "there was anything to indicate anything more than what has been written in the audit proforma" ([…]) and that "…just seems like there was nothing done" ([…]).

3.5.4. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 7

161. Audit records 'no evidence that any follow up was offered' ([…]).

3.6. On or around 3 December 2015 during/following your consultation with Adult 8;

162. The Registrant's notes for this case ([…]) are the Guys headed paper notes which [Witness 5] referred to as formal hospital records.

3.6.1. Did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle. [no positive submissions made]

3.6.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8

163. *'Advised and reassured' written by Registrant on notes ([…]).*

3.6.3. Did not record/inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years.

3.7. On or around 4 June 2015 during/following your consultation with Adult 9;

164. *The Registrant's notes for this case ([…]) are the Guys headed paper notes which [Witness 5] referred to as formal hospital records.*

3.7.1. Did not record adequate details of Adult 9's consultation in the EPR/physical patient records bundle.

165. *'Not recorded' is marked throughout the 'AWWC Assessment and Symptoms' box ([…]).*

3.7.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 9

166. *The Registrant recorded 'advised and reassured' within the notes ([…]).*

3.8. On or around 19 November 2015 during/following your consultation with Adult 10;

3.8.1. Did not record adequate details of Adult 10's consultation in the EPR/physical patient records bundle.

167. The Registrant's notes for this case ([…]) are the Guys headed paper notes which [Witness 5] referred to as formal hospital records.

168. [Witness 3]'s evidence was that "there could have been more explanation about the extent of the declining assessment" ([…]). Without this it is not possible to tell what was declined and on what basis and therefore the rationale for not taking swabs etc.

3.8.2. Did not record whether a urine sample had been taken for Adult 10. [no positive submissions]

3.8.3. Did not record whether Adult 10 was checked for a urinary tract infection/infections. [no positive submissions]

3.8.4. Did not record adequate details of the advice provided to Adult 10 [no positive submissions]

3.9. On or around 11 June 2015 during/following your consultation with Adult 12;

3.9.1. Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle.

169. The Registrant's notes for this case ([…]) are the Guys Headed paper notes which [Witness 5] referred to as formal hospital records.

170. The audit records 'nothing in blue notes' ([…]). In her evidence [Witness 3] confirmed that the reference to 'nothing in blue notes' was

indicative they were available, just didn't have certain information within them e.g regarding bleeding or antibiotics ([…]). If this information was not in the blue notes then there was inadequate detail of that consultation in the physical patient records bundle.

3.9.2. Did not record whether the de-infibulation procedure was discussed with Adult 12

171. This was noted specifically on the audit form ([…]). [Witness 3] agreed that the advantages and disadvantages of the procedure should be discussed and recorded as such and it be recorded that patient understood the procedure and was making a fully informed decision ([…]).

3.9.3. Did not record a discussion around personal hygiene with Adult 12. [no positive submissions]

3.9.4. Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

172. The Registrant has written 'Antibiotics prescribed' and no further detail ([…]) and [Witness 3] said this is brief and does not help ([…]

3.9.5. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 12.

173. The audit refers to no follow up being organised ([…]) and a line is struck through all the 'follow up' boxes ([…]) showing not adequate recording of advice/next steps.

3.10. On or around 6 August 2015 during/following your consultation with Adult 15;

174. The Registrant's notes for this case ([…]) are the Guys headed paper notes which [Witness 5] referred to as formal looking hospital notes.

3.10.1. Did not record adequate details of Adult 15's consultation in the EPR/physical patient records bundle.

175. There is a line through 'Not recorded' on all boxes in AWWC Assessment and symptoms on the audit ([…]).

3.10.2. Did not record a discussion about the illegality of FGM with Adult 15.

176. There is a line through 'Not recorded' for "informed about the illegalities of FGM" and 'FGM leaflet given' ([…]) evidencing that these things were not recorded. There are other examples where one or the other of these boxes are ticked showing that the auditors were recording where there was evidence of this information being given (see for e.g. Adult 12 – […]).

3.10.3. Did not record a risk assessment for Adult 15.

177. There is a line through 'Not recorded' on all boxes on the safeguarding risk assessment box ([…]). In evidence [Witness 3] said this was indicative of "There doesn't seem to have been one" ([…]).

3.10.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 15.

178. The Registrant has recorded 'All issues relating to FGM discussed with XXXX – well understood' in the notes ([…]).

3.11. On or around 3 November 2016 during/following your consultation with Adult 16;

179. *There are no diary pages or other records within the bundle for this case. A diary page could not be found.*

3.11.1. Did not record adequate details of Adult 16's consultation in the EPR/physical patient records bundle.

180. *'Not recorded' is marked through on all boxes for the AWWC Assessment and symptoms on the audit ([…]).*

3.11.2. Did not record the reasons for Adult 16's referral. [no positive submissions]

3.11.3. Did not record Adult 16's gestation period.

181. *'not clear what gestation' is recorded on the audit record sheet. In evidence [Witness 3] said that recording the gestation period is '…part of gathering as much information as you possibly can about the patient and it's not there' ([…]).*

3.11.4. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 16. [no positive submissions]

3.12. On or around 22 August 2013/12 May 2016 during/following your consultation with Adult 17;

182. The Registrant's notes for this case ([…]) are diary pages.

<u>3.12.1. Did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.</u>

183. 'Not recorded' is marked throughout AWWC Assessment and symptoms box ([…]).

<u>3.12.2. Did not record adequate details about Adult 17's de-infibulation procédure. [no positive submissions]</u>

<u>3.12.3. Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 17.</u>

184. The Registrant recorded 'advised and reassured' within the diary notes ([…]).

3.13. On or around 14 May 2015/20 August 2015/10 September 2015 during/following your consultation with Adult 19;

185. The Registrant's records in this case ([…]) are the Guys's patients headed documents/formal records.

<u>3.13.1. Did not record adequate details of Adult 19's consultations in the EPR/physical patient records bundle.</u>

186. The EPR letter is described as 'basic' on the audit ([…]) and 'not recorded' is marked through within the AWWC Assessment and symptoms box ([…]).

3.13.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 19

187. ‘Informed about illegalities of FGM’ and ‘FGM leaflet given’ are marked as ‘not recorded’ on the audit ([…]) and on the last consultation the Registrant wrote ‘Advised and reassured’ ([…]). As above, it is submitted that these are both evidence of the Registrant not having recorded adequate details about advice given to this patient.

3.13.3. Did not record information surrounding the history of domestic abuse of Adult 19.

188. This is not evident in any of the ‘formal records’ made by the Registrant and [Witness 3] said she ‘picked that up from the GP printout and tracing the history of this woman’ ([…]). It is also not recorded in the clinical notes recently disclosed ([…]).

3.14. On or around 16 April 2015~~6~~ during/following your consultation with Adult 22;

189. The Registrant’s records for this case ([…]) are a diary page and Guy’s formal headed paper. The Guys’ headed paper is for 16 April 2015 deinfibuation appointment, and the diary is for a later 30 June 2016.

3.14.1. Did not record adequate details of Adult 22’s consultation in the EPR/physical patient records bundle.

190. ‘Not recorded’ is marked through on each line in the AWWC Assessment and symptoms box ([…]).

3.14.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 22. [no positive submissions]

3.14.3. Did not record the timing of the administration of Lidocaine to Adult 22. [no positive submissions]

3.14.4. Did not record the frequency of the administration of Lidocaine to Adult 22. [no positive submissions]

3.15. On or around 28 April 2016 during/following your consultation with Adult 23;

191. The Registrant's records for this case ([…]) are a diary page.

3.15.1. Did not record adequate details of Adult 23's consultation in the EPR/physical patient records bundle

192. The audit states 'EPR – letter empty' ([…]).

3.15.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 23

193. The audit captures that the stock phrase 'All issues discussed' was used ([…]) and [Witness 3]'s evidence was it was 'unclear the extent of all what was discussed' ([…]).

3.15.3. Did not record a risk assessment for Adult 23/Adult 23's children.

194. 'Not recorded' is marked through with an arrow for all lines in the 'safeguarding risk assessment box ([…]).

3.16. On or around 20 October 2016 during/following your consultation with Adult 24;

195. The Registrant's notes for this case ([…]) consist of a diary page.

<u>3.16.1. Did not record adequate details of Adult 24's consultation in the EPR/physical patient records bundle</u>

196. [Witness 3]'s evidence was that her letters were created in circumstances when she could not locate a letter produced by the Registrant ([…]). [Witness 3] was unable to find an outcome letter in this case ([…]) which it is submitted amounts to inadequate recording of the consultation in the EPR.

<u>3.16.2. Did not inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment. [no positive submissions]</u>

<u>3.16.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 24 [no positive submissions]</u>

3.17. On or around 2 July 2015/ 9 July 2015/ 16 July 2015/6 August 2015 during/following your consultation with Adult 35; [charge amendment suggested]

197. The Registrant's records ([…]) for this case are the Guy's headed formal sheets and relate to the last two appointments on 16 July 2015 and 6 August 2015.

3.17.1. Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

198. The audit marks up 'not recorded' for every box in the AWWC Assessment and symptoms box ([…]).

3.17.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 35.

199. 'Informed about the illegalities of FGM' has a line through it saying 'not recorded' ([…]) and on the final appointment notes the Registrant has recorded 'advised and reassured' ([…]).

3.17.3. Did not record the reason for prescribing/providing antibiotics to Adult 35.

3.17.4. Did not record the dosage of antibiotics prescribed/provided to Adult 35.

3.17.5. Did not record details surrounding Adult 35's possible allergies to antibiotics

200. The above three charges are dealt with together as they were covered by the same evidence. The audit records 'Antibiotics given…unclear how these were prescribed' ([…]). In evidence [Witness 3] said "The dosage, the route of administration, any possible side effects, any contraindications…"Antibiotics given" isn't very much information at all as to why and, as I say, the dose, the route, the duration" ([…]).

3.18. On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 44;

201. *The Registrant's notes for this adult ([…]) consist of diary pages for 2013 and Guys headed paper for a later consultation in 2015.*

<u>3.18.1. Did not record adequate details of Adult 44~~45~~'s consultations in the EPR/physical patient records bundle [charge amendment suggested and no positive submissions]</u>

<u>3.18.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 44 [no positive submissions]</u>

3.19. On or around 21 July 2016/28 July 2016/11 August 2016 during/following your consultation with Adult 124; [charge amendment suggested]

202. *The Registrant's notes for this adult ([…]) are diary pages.*

<u>3.19.1. Did not record adequate details of Adult 124's consultations in the EPR/physical patient records bundle.</u>

203. *The audit marks 'not recorded' in each line of the AWWC Assessment and symptoms box ([…]).*

<u>3.19.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 124</u>

204. *'Advised and reassured' is noted as part of the audit ([…]).*

3.20. On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130;

205. The Registrant's notes for this adult ([…]) are diary pages.

<u>3.20.1. Did not record adequate details of Adult 130's consultations in the EPR/physical patient records bundle.</u>

206. The audit describes the EPR outcome letter as 'basic – no mention of above' ([…]) and 'not recorded' is marked up for each line on the AWWC Assessment and symptoms box.

<u>3.20.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 130</u>

207. 'All issues related to FGM discussed' is noted in the audit ([…]). The auditorshas written 'poor documentation' and [Witness 3]'s evidence was that "I would say that that would relate to the hospital records" ([…]).

<u>3.20.3. Did not record whether Adult 130's condition/assessment was escalated. [no positive submissions]</u>

3.21. On or around 6 August 2015 during/following your consultation with Child 16;

<u>3.21.1. Did not clearly record the origin of referral in Child 16's patient records.</u>

208. The Registrant has recorded 'Referred to the AWWC by her GP/Social worker' ([…]) so therefore it is not clear whether it was the GP or social worker – they are separate people/organisations.

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

<u>3.22.1. Did not clearly record the origin of referral in Child 17's patient records.</u>

209. The Registrant has recorded 'GP/Social Worker referral ([…]) so therefore it is not clear whether it was the GP or social worker.

3.23. On or around 13 August 2015 during/following your consultation with Child 18;

<u>3.23.1. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father</u>

210. The Registrant wrote 'father was advised and reassured' in the clinical notes ([…]) without any further information about the advice given and discussion re: next steps. [Witness 1]'s evidence is that these notes, although more appropriate than some still "lacked detail" ([…]).

<u>3.23.3. Did not record whether a urine sample had been taken for Child 18. [no positive submissions]</u>

3.24. On or around 11 September 2015 during/following your consultation with Child 19;

<u>3.24.2. Incorrectly stated in Child 19's GP letter dated 14 October 2015 that Child 19 was assessed on 9 September 2015.</u>

211. *The application is made on the basis that an obvious typographical error could not amount to misconduct. Misconduct is a matter for the panel's professional judgement.*

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

<u>3.25.1. Did not adequately record the origin of referral in Child 21's patient records.</u>

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

<u>3.26.1. Did not adequately record the origin of referral in Child 22's patient records.</u>

212. *As above, these siblings are dealt with together due to the appointment being on the same day.*

213. *The Registrant has recorded 'social services/police referral ([…]) so therefore it is not clear whether it was social services or the police. [Witness 1]'s evidence is that this recording "would not determine who the actual referral was from" ([…]).*

3.27. On or around 18 February 2016 during/following your consultation with Child 23;

<u>3.27.1. Did not create any official clinical healthcare records for Child 23</u>

214. 'Not available' was scribbled out on the audit but underneath 'nil documented' was written ([…]) which accords with [Witness 1]'s witness statement ([…]) and what she repeated in cross examination ([…]) that there were no records for this patient.

<u>3.27.3. Did not record the social impact of FGM on Child 23. [no positive submissions]</u>

<u>3.27.5. Did not send an outcome letter to Child 23's GP.</u>

*215. It is not clear where it is being suggested that the audit refers to the outcome letter being sent via email – this isn't apparent […]. In any event there is a blank outcome letter ([…]) which as per other evidence (particularly [Witness 3]) there is a presumption this would **<u>not</u>** be sent.*

3.28. On or around 26 May 2016 during/following your consultation with Child 24; [no positive submissions]

<u>3.28.2. Did not record whether Child 24 required additional services/support. [no positive submissions]</u>

<u>3.28.3. Did not record which kind of support/plans were in place for Child 24 [no positive submissions]</u>

3.29. On or around 9 June 2016 during/following your consultation with Child 25; [no positive submissions]

<u>3.29.2. Did not record a risk assessment for Child 25 [no positive submissions]</u>

3.30. On or around 9 June 2016, during/following your consultation with Child 26;

3.30.4. Incorrectly informed Child 26's GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

216. *This relates to the letter said to be electronically signed by the Registrant ([…]). [Witness 1]'s evidence was "If the letter is on the system, I am of the view that the letter has then been sent out to the GP….my understanding is if it's on the system it then gets sent to the GP" ([…]).*

3.30.5. Did not record a risk assessment for Child 26 [no positive submissions]

3.32. On or around 20 July 2017, during/following your consultation with Child 28; [no positive submissions]

3.32.1. Did not record a full risk assessment for Child 28. [no positive submissions]

3.32.2. Did not Did not record adequate details of the advice/examination/discussion/next steps provided to Child 28/Child 28's father [no positive submissions]

3.33. On or around 10 August 2017, during/following your consultation with Child 29; [no positive submissions]

3.33.1. Did not record a full risk assessment for Child 29 [no positive submissions]

4. Did not record the offer/confirmation of consent for FGM assessments for one or more adult patients as listed in schedule 10. [no positive submissions]

Schedule 10: Failed to record the offer of consent for examination/de-infibulation [no positive submissions]

5. Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.

217. [Witness 5] said that it is 'standard practice' to make a record re: consent for intimate examinations ([…]). An FGM examination is an intimate examination. [Witness 3] also referred to it as a "basic standard" ([…]).

218. [Witness 4]'s evidence was that "I think if you documented that informed consent had been given, if that was documented and agreed with the patient, that would be adequate" ([…]).

219. The Trust's consent policy (effective from May 2015 but [Witness 3] said that the origins of this were something from 2012 – […] states that it is essential to document the patient's agreement and discussion leading up to it for "any procedure where the patient might reasonably be expected to consider the risks and options for treatment to be significant" ([…]). [Witness 3] called this line 'significant' and said this may range from taking blood pressure to performing deinfibulation but if you are doing something to a patient being clear you have informed consent is "crucially important" ([…]).

220. Although [Witness 5] referred to deinfiibulation as routine and low risk she did also agree that para 9.1 of the consent policy ([…]) would apply to these procedures. [Witness 3] said although the practitioner themselves may think deinfibulation is routine if they are carrying out a number of them, they are not routine for the individual patient as they are minor surgical procedures and there are risks of pain, bleeding and infection ([…]).

Schedule 10: Failed to record the offer of consent for examination/de-infibulation

1.Adult 2 on or around 27 October 2016 [no positive submissions]

2.Adult 8 on or around 3 December 2015 [no positive submissions]

3.Adult 9 on or around 4 June 2015 *([…])*

4.Adult 12 on or around 11 June 2016 *([…])*

5.Adult 19 on or around ~~15~~ 14 May 2015/20 August 2015/10 September 2015 [charge amendment suggested] *([…])*

6.Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016 [no positive submissions in respect of 28 January and 30 June 2016] *([…])*

7.Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015 [no positive submissions in respect of 16 July 2015] *([…])*

8.Adult 44 on or around 5/12 December 2013 [no positive submission in respect of 12 December 2013] *([…])*

9.Adult 69 on or around 15 October 2015 *([…])*

10.Adult 74 on or around 3 October 2013 *([…])*

11.Adult 124 on or around 21 July 2016 *([…])*

12. Adult 130 on or around 10/24 November 2016 *([…])*

***13. Adult 138 on or around 29 June 2017** ([…])*

***14. Adult 143 on or around 12 March 2013** ([…])*

***15. Adult 154 on or around 25 May 2017** ([…])*

6. Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10;

221. The Trust guidance states that the name of the chaperone should be recorded in the patients records and it should be recorded if the patient declines a chaperone ([…]).

222. The panel will note that other practitioners at the Trust were following this approach, as far back as 2011 […].

Schedule 10:

***1.Adult 2 on or around 27 October 2016 [no positive submissions]** ([…] - consent box blank or struck through indicating not recorded)*

2.Adult 8 on or around 3 December 2015 [no positive submissions]

***3.Adult 9 on or around 4 June 2015** ([…] – not recorded circled next to consent)*

***4.Adult 12 on or around 11 June 2016** ([…])*

***5.Adult 19 on or around 15 May 2015/20 August 2015/10 September 2015** ([…])*

***6.Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016 [no positive submissions in respect of 28 January and 30 June 2016]** ([…])*

7.Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015 [no positive submissions in respect of 16 July 2016] *([…])*

8.Adult 44 on or around 5/12 December 2013 [no positive submissions in respect of 12 December 2013] *([…])*

9.Adult 69 on or around 15 October 2015 *([…])*

10.Adult 74 on or around 3 October 2013 *([…])*

11.Adult 124 on or around 21 July 2016 *([…])*

12. Adult 130 on or around 10/24 November 2016 *([…])*

13. Adult 138 on or around 29 June 2017 *([…])*

14. Adult 143 on or around 12 March 2013 *([…])*

15. Adult 154 on or around 25 May 2017 *([…])*

7. Did not record the offer of a translator to Adult 10

223. The audit records 'Does not speak English' ([…]) and [Witness 3] said that there was "perhaps something else to indicate that" ([…]). She also said that it is not good practice to have a family member acting as translator as there is a risk of misinterpretation based on "power and control within a family" ([…]).

224. [Witness 3] said that a translator did not even appear to be considered in this case ([…]) and [Witness 5]'s evidence was that a practitioner should probably record the offer of a translator.

8. Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

Charge 8

<u>1.Adult 2 on or around 27 October 2016</u>

225. There is a blank outcome letter in this case ([…]). [Witness 3] said that she would hope that a blank letter was not sent because it does not help anybody ([…]). She further said that the system was moving away from printing and sending hard copy at the time ([…])

<u>2. Adult 6 on or around 15 June 2017</u>

226. Blank outcome letter ([…]).

<u>3. Adult 7 on or around 18 August 2016</u>

227. Audit states 'EPR – empty letter' ([…])

<u>4. Adult 9 on or around 4 June 2015</u>

228. Audit states 'No evidence of F/U or liaison w. GP in Birmingham' ([…])

<u>5. Adult 23 on or around 28 April 2016</u>

229. Audit states 'EPR – letter empty!' ([…]).

6. Adult 24 on or around 20 October 2016

230. [Witness 3]'s letter states that it is 'unclear' whether there were communication with the Dr following the consultation ([…]).

9. Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.

Schedule 11

Charge 9

1.Adult 3 on or around 22 September 2016

231. [Witness 3] said she would have expected a safeguarding referral for this case, given the DV history. The Registrant refers to making a referral to the relevant department ([…]) but there was no evidence of that "either on the systems or in the records" ([…]) and [Witness 3] said she would have expected "a comment but there didn't seem to be a comment" ([…]).

2. Adult 4 on or around 21 April 2016

232. [Witness 3]'s evd [sic] was that the Registrant should have followed up with the MDT if there was an identified infection etc which would need to be ascertained first and in this case it wasn't clear whether the Registrant had passed this responsibility back to the GP ([…]).

3. Adult 7 on or around 18 August 2016

233. This woman was referred for 'painful intercourse' and the audit notes 'no evidence that any further follow up was offered' ([…]).

234. Whilst it is acknowledged that this woman did not want to be assessed and therefore there may have been a limit to what could be done in the consultation, [Witness 5] stated that she would make an onward referral if clinically indicated or required even if the woman said she didn't want one – she said it would be up to the patient if she went but as long as she made the referral she had effectively done her part.

4. Adult 23 on or around 28 April 2016

235. There were safeguarding concerns in this case re: the adults' daughter ([…]) and there was no evidence of follow up in that regard ([…]).

236. [Witness 3] was asked about whether she had seen documentation regarding [Ms 14] (safeguarding midwife) on any of the patient files and she said that she had not and there was 'not anything evidence to me from my recollection' ([…]).

5. Adult 30 on or around 13 March 2013

237. This woman had a fused area and deinfibulation was not possible ([…]). [Witness 3] said in those circumstances 'possibly a referral to an obstetrician or a gynecologist to get their opinion on the matter…it is possible that a woman might need to have general anesthetic to be able to have a complete deinfibulation" ([…]). There was no EPR or letters of evidence of follow up being offered in this case ([…]).

6. Adult 98 on or around 19 July 2012

238. [Witness 3] said that follow up with the MDT was potentially needed in this case because the procedure was recorded as being 'very difficult' by the Registrant ([…]). [Witness 3] was also concerned that there was reference to

the woman being 'very anxious, terrify' ([…]) and nothing was seemingly done to follow this up.

10. On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;

a) Advice/discussion/next steps with the patient

b) Details of assessment/examination

c) FGM risk assessments

239. *The charge is drafted as 'including' so it does not mean it is limited to those things and equally it doesn't have to include all those things and they are separate sub-charges and not drafted as 'and'*

Schedule 12: Did not record adequate details of the appointment/consultation.

<u>1. Adult 25 on or around 3 July 2014 [no positive submissions]</u>

<u>2. Adult 26 on or around 6/13 July 2017</u>

240. *The audit specifically records 'poor documentation' ([…]) and 'poor outcome letter to GP' ([…]). Further, 'informed about illegalities of FGM' and 'FGM leaflet given' are marked as 'not recorded' ([…]). [Witness 3]'s evidence was that [Ms 13] (who undertook this audit initially) had a tendency to write poor documentation to reflect the "brevity of it" ([…]).*

3.Adult 30 on or around 13 March 2013

241. The audit notes that a number of things were 'not recorded' ([…]). In evidence [Witness 3] said that this was [Ms 12]'s (who initially did this audit) way to "indicate the emptiness by – there wasn't anything that we could actually audit, which had suggested poor documentation" ([…]).

4.Adult 38 on or around 12 May 2016

242. The audit states 'nothing written in clinical notes' ([…]). In evidence [Witness 3] said "So I think this was a sort of an empty set of notes….Just a piece of paper, a clinical sheet which you write on, but there wasn't anything on it" ([…]).

5.Adult 41 on or around 3 August 2017

243. The audit records 'minimal documentation' ([…]) and a number of things are struck through as 'not recorded' ([…]).

6. Adult 48 on or around 24 July 2014

244. There are a number of things marked as 'not recorded' within the audit ([…]).

7. Adult 54 on or around 3 January 2013

245. The audit front sheet specifically records 'poor documentation' ([…]) and there are a number of things marked as 'not recorded' ([…]).

8. Adult 59 on or around 14 November 2013

246. *The audit front sheet states 'no EPR outcome' and 'not recorded' is indicated in the majority of the boxes under the heading 'AWWC Assessment and symptoms' ([…]).*

9. Adult 80 on or around 10/17 September 2015

247. *The audit front sheet specifically records 'poor documentation' ([…]) and a number of things are marked up as 'not recorded' in many of the other boxes ([…]).*

10. Adult 90 on or around 20 September 2012

248. *The audit front sheet specifically records 'poor documentation' ([…]) and a number of things are marked up as 'not recorded' in many of the other boxes ([…]).*

11. Adult 118 on or around 24 May 2012

249. *The audit front sheet specifically records 'poor documentation' ([…]) and a number of things are marked up as 'not recorded' in many of the other boxes ([…]).*

12. Adult 128 on or around 20 October 2016

250. *Clinical records ([…]) and diary page ([…]) provided in this case. Clinical records state "all issues related to FGM discussed…' which as previously outlined is submitted as being an inadequate record of the advice given and this is good evidence to show an example of the Registrant recording this on the clinical record itself, not just the diary page.*

13. Adult 136 on or around 16 August 2017 [no positive submissions]

14. Adult 150 on or around 22 September 2016

274. *The audit front sheet records 'nothing written in clinical notes' ([…]). In XX it was put to [Witness 3] that potentially the notes were written in the patient's maternity notes and her response was that "if the woman's pregnant potentially the maternity records were used for clinical notes" ([…]).*

11. Adult 162 on or around 25 August 2016 [no positive submissions]

12. Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

275. *[Witness 3] said that recording the origin of the referral is about understanding access points for services. Her evidence was "So it's a standard thing that does have a purpose about where a person comes from. It seems to me quite strange not to record that. I'm sure there is a knowing where they've come from but it just seems a bit of an omission as such not to note that bit of information" ([…]).*

Schedule 13: Did not clearly record the reason/origin of referral

1.Adult 11 on or around 20 December 2012 [no positive submissions]

2. Adult 28 on or around 25 April 2013

276. *Audit front sheet specifically states 'Not documented who made the referral' ([…]) as well as 'patient journey' box being marked as 'not recorded' ([…]) and 'ref by' is blank in the Reg's diary page ([…]).*

3.Adult 46 on or around 17 July 2014

277. The origin of the referral was unclear in the records leading the auditors to record "Referred by ? Dr" and marking 'uncertain' through the patient journey box ([…]).

4.Adult 50 on or around 8 August 2013

278. Audit front sheet specifically states 'No documentation of who referred' ([…]) as well as 'patient journey' box being marked as 'not recorded' ([…]) and 'ref by' is blank in the Reg's diary page ([…]).

5.Adult 86 on or around 25 April 2013

279. Audit front sheet specifically states 'Referral not recorded' ([…]) as well as 'patient journey' box being marked as 'not recorded' ([…]) and 'ref by' is blank in the Reg's diary page ([…]).

6. Adult 131 on or around ~~3/~~10/ 24 November 2016 [charge amendment suggested]

274. Audit front sheet specifically states 'Referral not specified' ([…]) as well as 'patient journey' box being marked as 'not recorded' ([…]) and 'ref by' is blank in the Reg's diary page ([…]).

7. Adult 158 on or around 7 November 2013

275. The audit records 'Not clear who referred' and the section for patient journey is all marked as 'not recorded' ([…]).

276. *It is submitted on behalf of the Registrant that the line by 'ref by' indicates self-referral but when this was put to [Witness 3] in XX [cross-examination] she said that it could potentially mean that "Or unknown, it could mean many things' ([…]). The point is it isn't 'clear' as is alleged in this charge. Also, there are examples where it is specifically recorded that a referral is by 'self' ([…]) indicating that when that is the case the Registrant notes it as such.*

8. Adult 160 on or around 17 September 2015 [no positive submission]

12. Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle for one or more adult patients, as listed in schedule 14.

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record (" EPR") /physical patient records bundles

1.Adult 30 on or around 13 March 2014 [no positive submission]

2. Adult 38 on or around 12 May 2016 [no positive submission]

3.Adult 142 on or around 16 March 2017 [no positive submission]

4.Adult 143 on or around 12 March 2013

277. *The audit states 'not on EPR' and 'no clinical record of procedure' ([…]) and there are a number of boxes marked as 'not recorded' throughout the audit ([…])*

5.Adult 147 on or around 9 December 2016

278. 'Not on EPR' is recorded next to 'hospital number' on the audit front sheet and repeated below and the front sheet also states 'no notes re deinfibulation' ([…]) and 'not recorded' is marked through in the 'AWWC Assessment and symptoms' box ([…]).

6. Adult 153 on or around 20 December 2012 [no positive submission]

7. Adult 156 on or around 24 January 2013

279. Audit states 'EPR nothing' and 'only diary notes have documentation' ([…]) which [Witness 3] said in evidence was suggestive of "…the blue notes were there and they had no documentation in them" ([…]). Also in relation to this adult [Witness 3] explained that she would have double-checked (at least) EPR before sending one of her letters ([…]).

8. Adult 159 on or around 13 February 2014 [no positive submission]

9. Adult 161 on or around 18 February 2016 [no positive submission]

10. Adult 162 on or around 25 August 2016 [no positive submission]

13. On or around 6 August 2015 did not refer Child 17 to a Community Paediatrician. [no positive submission]

14. On or around 13 August 2015;

14.1. Did not refer Child 18 to a specialist paediatric urologist.

280. [Witness 1] was critical of this in her statement ([…]) and also in evidence "So to refer a five-year-old to gynecology I believe is inappropriate and if her urinary symptoms are the main symptomology, I would be expecting that she would have a Paediatric assessment and a Paediatric urology service appointment" ([…]).

14.2. Did not refer Child 18 to the Consultant Lead Professor at the African Well Women Clinic (AWWC) [no positive submission]

14.4. Incorrectly referred Child 18 to the adult gynaecology service.

281. The audit records 'CM has advised GP to refer to gynae services' ([…]). The letter from [Dr 17] to the gynecology department ([…]) starts by saying "On the advice of Dr Comfort Momoh…'

282. If the submission is made on the basis that the Registrant did not make the referral herself then it is submitted that the panel should use their powers to amend the charge to reflect that the Registrant incorrectly advised referral to the adult gynecology service as a charge should not be permitted to fail on a technicality and the same mischief is being driven at.

15. On or around 26 May 2016 did not refer Child 24 for psychological Support [no positive submission].

16. On or around 18 February 2016, did not refer child 23 for psychological services [no positive submission].

18. On or around 7 July 2017 you initially assessed Child 28 rather than refer them for examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider [no positive submission].

20. Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

Schedule 8:

<u>7. Child 23 on or around 18 February 2016 [no positive submission]</u>

<u>12. Child 28 on or around 20 July 2017</u>

283. In her witness statement [Witness 1] says "There is no record that consent was given for the assessment…" ([…]). It doesn't appear from the transcripts that [Witness 1] was asked any further questions about this in evidence (either XIC [examination in chief] or XX [cross-examination])– i.e. about whether it would be necessary for the Registrant to record consent whilst the patient was on the PICU but it is submitted that it would be assumed to be required by the practitioner carrying out the examination.

21. Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

Schedule 8:

<u>5. Child 21 on or around 22 October 2015 [no positive submissions]</u>

6. Child 22 on or around 22 October 2015 [no positive submissions]

7. Child 23 on or around 18 February 2016

284. [Witness 1] statement records that she could only find diary notes for this child ([…]) and this is reflected in the audit which has case records as being unavailable crossed out and 'nil documented' written instead ([…]). There is no record re: chaperone on the diary page ([…]) which was the only record for this patient.

12. Child 28 on or around 20 July 2017 [no positive submission]

Conclusion

285. For all of the above reasons the panel are invited to reject the Registrant's application on all the charges outlined with submissions in this document.

Ms Mustard's Supplementary Oral Submissions on No Case to Answer

Ms Mustard said that she would encourage the panel to take note of the evidence matrixes provided for this hearing. In respect of Ms Bayley's submission that the panel treat the witnesses' written statements with care, Ms Mustard said that this approach should only be adopted in relation to Witness 3, who did not adopt her statement. She said that the other witnesses confirmed the accuracy of their statements, which can be relied upon in the panel's decision making.

Ms Mustard referred the panel to the section of her written submissions headed *"no positive submissions",* but outlined that this does not amount to the NMC necessarily

agreeing or accepting all submissions made on behalf of the registrant in respect of those charges or patients, however they are not formally opposed and therefore left for the panel to consider.

Ms Mustard told the panel that there are some references within her written submissions to matters which require charges to be amended to reflect the correct date. She asked that the panel use its power to correct and amend such dates, and that this approach was not opposed by Ms Bayley, on your behalf.

Ms Mustard reminded the panel that, at this stage, it is considering whether there is sufficient evidence to take each charge forward, which is a different assessment to that at the facts stage. She said that this is important as, with so much for the panel to consider and in-depth arguments being made on general themes, it is easy for a panel to lose sight of the task at hand.

Ms Mustard submitted that charges 1.1 and 1.2 generally go to the same theme and issues about scope of practice when seeing and assessing non-pregnant women, both of which relate to the same schedule. She said that the allegation that you acted outside of the scope of your clinical practice and/or role after the time your nursing registration had lapsed, and when you were only registered as a midwife.

In respect of Witness 2's evidence, Ms Mustard said that, although she is not a registered midwife herself, she has a lot of experience in managing midwives and her evidence was clear about the scope of practice for a midwife, being limited to treating pregnant women, women in labour or postnatal care.

In respect of Witness 5, Ms Mustard said, whilst she has the knowledge and experience of working in FGM, she was not a midwife, so her ability to comment on a midwife's role is limited. She said that the panel should take into consideration the evidence of the people who did the same role or had management responsibilities for you, as to what was acceptable for you to do, or what was within your scope of practice. She reminded the

panel Witness 4's evidence was that, although there are certain circumstances when a midwife can see non-pregnant women, they are limited in scope, and anything effectively going beyond that scope is likely to require additional qualifications to allow somebody to approach that in a formalised and monitored way.

Ms Mustard said that Witness 4's evidence about job descriptions was that although they didn't have a nursing registration as a specific requirement, she felt that it was something that was needed because of the nature of the clinic and the duties, which extended beyond normal midwifery registration.

Ms Mustard said that Witness 3 said that there were some instances in which a midwife's role could go beyond seeing pregnant or labouring women, but these were narrow and should be clearly recorded, such as brief conversations which related to pre-conceptual care. She also highlighted that Witness 3 said that there is an element of personal accountability in terms of defining the scope of practice. She said that this links to the document before the panel regarding patient group directives and the fact that Witness 4 said it was something that would have been open and available for you to have initiated and discussed with your managers or the Trust in order to potentially create, formalise and put in place something to show why and how you did have the competence and ability to work outside the ordinary perimeters of a midwife.

Ms Mustard referred to Ms Bayley's submission that the evidence of what is within the scope of practice for a midwife was not within the expertise of the NMC witnesses, which was merely evidence of their opinion. Ms Mustard submitted that their evidence is relevant because these are all professional witnesses giving evidence to the panel with a clear purpose of why they were giving their evidence, and in full knowledge of the charges. She said that it is of note that Witness 5 felt that, although you had the clinical training which would make you competent in a clinical capacity, once your nursing registration had lapsed, it would have been inappropriate for you to see non-pregnant women.

In respect of the list of the other FGM clinics, Ms Mustard said that, although there is no objection to these lists being before the panel, this document has very little, if any, relevance to the panel's determination at this stage of these proceedings. She said that the panel does not know anything about the registration status of the staff at these clinics, the set up in terms of patients, supervision, clinical accountability or clinical governance. She submitted that this does not take the matter further.

Ms Mustard reminded the panel that Witness 3 said that there were various different ways that it could be shown or demonstrated within the documents that a woman was not pregnant, either through an estimated delivery date with a line through it or with *"N"* for no circled for no, next to *"pregnant Y/N"* in the proforma.

In respect of charge 1.3, Ms Mustard submitted that, if the panel concludes that it was outside of either your clinical competence or role to accept referrals and/or examine non-pregnant women, it must follow that it would also be outside of your clinical competence or role to perform de-infibulation on them. However, she submitted that, even if the panel found that it was within your scope of practice to accept the referral or assess/examine the patient, then there are different and further considerations that the panel must make to determine whether it was in your scope of practice to actually carry out de-infibulation.

Ms Mustard asked the panel to have regard to Witness 3's evidence, that she had concerns about the application of the midwives' exemptions to give local anaesthetic in these situations, especially when dealing with non-pregnant women. Ms Mustard submitted that, in Witness 3's evidence, she said, were it permitted for you to use Lidocaine as part of your role within the clinic, she would have expected the Trust's policy to effectively reflect and stage that in writing, therefore where there is an agreed or state exemption, it falls outside of your role and what is permitted as part of it.

In respect of charge 1.4, Ms Mustard reminded the panel that Witness 5 said that she was somewhat limited in what she could say about second opinions, having not assessed the patients or seen the clinical records. Ms Mustard said that this is different to the situation

in relation to Witness 3, who had the benefit of seeing and assessing the patient records, where such records were available, with some exceptions. Ms Mustard said that Witness 3 was in a very different position to Witness 5, and it is on this basis that Witness 3 has given the evidence which she has. She said that this charge is a result of instances where there was something about the individual patients, where there was something difficult or out of the ordinary about the de-infibulation procedures. She said that Witness 3's evidence was that, in those circumstances, she would expect a second opinion to have been obtained purely for that reason.

In respect of Adult 14, Ms Mustard said that there was evidence before the panel that this woman had fainted. She said that Witness 5 said that fainting is not necessarily normal or usual during this procedure, and that Witness 3 said that it is not clear from the records at what stage this occurred, however, it was recorded as part of the consultation and therefore seemingly a feature of it.

Ms Mustard invited the panel to consider the evidence of Witness 3, in relation to Adult 17, about the requirement for a swab when the patient had a cyst. In relation to Adult 19, she said that Witness 3 described this woman as *"very complicated"* and Witness 5 said that it would have been a good idea to have obtained a second opinion about the FGM, not only as protection for the clinician, but also to give clarity to the patient. She reminded the panel that it now has further records in relation to this patient and should note that the referral letter to you is included in these records, which states that the referral was made for analysis and assessment about Adult 19's FGM status.

In respect of Adult 35, whose records refer to it being "*a difficult de-infibulation*", which was picked up by the audit. Ms Mustard submitted that, because you felt it significant enough to record this de-infibulation as difficult, there must have been something unusual to support Witness 3's evidence that you should not have been working in isolation, and should have been seeking a second opinion.

In relation to Adult 130, Ms Mustard said that this patient's labia was fused together, and you were unable to completely separate it. She reminded the panel that Witness 3's evidence was that she queried during the course of the audit whether this patient should have been reviewed by another person. She submitted that Witness 5 also described this as a *"tricky case",* which she would have usually expected you to refer this to her.

In respect of charge 1.5, Ms Mustard said that there is a lot of cross-over with charge 1.3 because this charge predominately relates to your administration of anaesthetic for performing de-infibulations, save for limited issues relating to antibiotics. Ms Mustard invited the panel to consider Witness 3's evidence and the policy documents as to why this falls outside of the midwives' exemptions and your role as a FGM midwife.

Ms Mustard said, in respect of Adult 35, there is an additional allegation about antibiotics given. She said the panel has before it Adult 35's clinical records and can see exactly what you recorded on such records about the giving of antibiotics, and the fact the audit picked up on the fact that it was unclear how the antibiotics were prescribed. Ms Mustard submitted that, in respect of this charge, the panel should consider the evidence to support the charge in relation to both the anaesthetic and antibiotics given to this patient.

In respect of charge 1.6, Ms Mustard referred the panel to the evidence of Witness 3 who said that psychosexual counselling was something formal which went further than a midwife's role or scope of practice. She said that Witness 3's evidence was that such counselling relates to a therapeutic relationship which takes time to build up and cannot be done effectively in a one-off consultation. She said that no positive submissions are made in relation to Adult 2, however in respect of Adult 3, within the audit form you have specifically noted "advise and reassured" within a heading which deals with psychosexual or psychological counselling. In her evidence, Witness 3 said that the fact it was written must hold some significance, which led her to conclude that there had been a provision of counselling.

Ms Mustard invited the panel to have regard to Witness 3's evidence in respect of charge 1.8. Witness 3 said that if you are undertaking smear tests, a practitioner needs to demonstrate evidence of relevant up-to-date training and assessment of their competencies, and that it is insufficient to have been trained at some point in the past. She said that it is significant that very few midwives would ordinarily or routinely take smears, as smear tests are not routinely taken in the course of pregnancy.

Ms Mustard said that the panel has heard some reference to a quality assurance programme for smear tests, although Witness 3 could not definitively say when this became a requirement. In respect of Adult 8, Ms Mustard said that there is evidence before the panel that Ms 7 had ordered the smear test for this adult as only she had been able to order the test as her name appeared on the quality assurance database, although it is accepted that you conducted the smear test. Ms Mustard therefore submitted that, it must follow that if you are not on the quality assurance training database for conducting smear tests, it must be outside of your competency and training.

In respect of Adult 32, Ms Mustard said that it is clearly written on the audit form that a smear test had been taken in this case. She said that Witness 3 could clearly recall Ms 12 telling her that a smear test had been taken without a record in the file. On this basis, Ms Mustard submitted that there is a case to answer.

In respect of Child 23, under charge 1.9, Ms Mustard said that she understands that Ms Bayley's application is on the basis that Child 23 was 16 years old, and therefore her anatomy was more developed than a very young child. Ms Mustard referred the panel to the Service Standards for Commissioning FGM Care, which states: *"this guidance describes service standards expecting to be commissioned for the confirmation of FGM in children under the age of 18.".* She highlighted that it refers to children under the age of 18 and doesn't, at any point, distinguish between children under 16, or children at a certain level of development. She said that this guidance goes on to say that any physical examination should be undertaken by a *"medical professional".* Ms Mustard reminded the panel of Witness 1's evidence that this was specific phrase, which she views as being a

doctor. Ms Mustard submitted that this ties in with what the guidance goes on to say, that in all cases involving children, an experienced clinician should be involved in setting up a sensitive, thorough paediatric examination. Ms Mustard submitted that you have no paediatric qualifications, therefore nothing allows you to see children and/or adolescents, being anyone under the age of 18.

Ms Mustard said that the Trust's Safeguarding the Welfare of Children policy states that physical examinations of a child must and can only be undertaken by an appropriately qualified paediatrician. She said that this evidence was put to Witness 1 in her evidence, who acknowledged that it was not specific to FGM. However, Ms Mustard suggested that, as a physical examination, FGM assessment and examination would still fall under the category which would be captured by this policy. Ms Mustard said that similar to the service standards for FGM, the Trust's policy about children doesn't in any way distinguish or differentiate between children of different ages, therefore it appears it is applicable to all those under the age of 18.

In relation to Child 28, who was in the Paediatric Intensive Care Unit ("PICU"), Ms Mustard submitted that, the mere fact that you assessed her in the PICU, as opposed to a clinic, amounts to the same thing. She said that your paediatric colleagues directly contacting and specifically asking you to review Child 28 still amounts to you accepting the referral. She further submitted that there is evidence that you went on to refer this Child to another practitioner only after having accepted the referral. She said that the NMC's case is that you should never have gone to see the child and should have explained to your colleagues that an onward referral is necessary. Ms Mustard referred the panel to Witness 1's evidence that, by virtue of Child 28 being in the PICU, they were safe and being clinically managed, therefore there was no urgency for her to be assessed for FGM immediately. Ms Mustard said that it would not have been a problem for you to make an onward referral, rather than immediately attend to Child 28.

In respect of Child 29, who was 17 years old, Ms Mustard repeated her submissions about the various guidance documents referring to children under the age of 18, and not

distinguishing between adolescents and younger children. Ms Mustard invited the panel to consider Witness 1's evidence, in which she said a non-pregnant 17-year-old may be seen at a clinic, but she would expect that they would be seen by a gynaecologist, rather than a midwife.

In respect of Children 21 and 22, in relation to charge 1.10, Ms Mustard submitted that the evidence before the panel suggests that you undertook the examination, which was then confirmed by Dr 8. She submitted that it isn't clear at what stage Dr 8's confirmation happened, however it is clear from the way you made notes that you undertook the assessment which was subsequently confirmed by Dr 8. She said that it alleged that this was outside the scope of your practice to treat, see and examine children under the age of 18. She further highlighted for the panel that Witness 1's evidence was that she had not been able to ascertain who Dr 8 is, and whether it would be appropriate to see these patients or make any value judgment on their examination.

Ms Mustard said that, in respect of Child 23, Witness 1 said that it is unacceptable for a 16-year-old patient to be seen in an adult environment, and that she would expect them to be seen by a practitioner with paediatric experience of FGM.

In respect of Child 28, who was in the PICU, Ms Mustard submitted that the panel have the benefit of your clinical notes which include a diagram and summary of what you saw on assessment. She said that this is sufficient evidence for the panel to be satisfied that you saw, assessed and examined this patient. She said that the circumstances of this assessment, being in the PICU, not the clinic, are immaterial.

In respect of Child 29, Ms Mustard submitted that it is clear that you examined and assessed this patient, and repeated her submissions in respect of whether you should have been seeing children who were under 18.

In respect of Adult 2, in relation to charge 2.1, Ms Mustard said that Witness 3's outcome letter following her review of the record as part of the audit refers to the fact that Adult 2

was referred to the clinic for psycho-sexual problems, and she was unable to find evidence that an onward referral to a counsellor was done. For Adult 7, the audit refers to the fact that the patient was referred to the clinic for emotional distress, flashbacks, dyspareunia and concerns surrounding the welfare of her daughters, however there is no evidence of any onward referral.

Ms Mustard set out that the evidence before the panel in relation to Adult 15 notes *"patient will need psychosexual counselling*", and the audit, in relation to Adult 23, states "psychosexual issues" in the patient journey section. She said that there is evidence before the panel that a note was contained within Adult 36's notes stating that they would benefit from a psychosexual counsellor, but no evidence that such referral was made. She said that all of the adults which this charge relates to is in reference to psychosexual issues.

In respect of charge 2.2, Ms Mustard submitted that Witness 3's evidence was that sexual health counselling related to physical sexual health issues, as opposed to psychosexual, which would encompass emotional and mental issues. Ms Mustard said that, as Adults 7 and 36 had been referred by a sexual health for dyspareunia, which could be properly described as a physical concern.

Ms Mustard said that the NMC has made positive submissions in respect of Adult 4, in relation to charge 2.3, because the audit found that this patient had been complaining of pain and infection, with the *"vaginal infection"* and *"chronic genital pain"* boxes ticked. She told the panel that Witness 3's evidence was that, because pain was noted, it would have triggered an alert for the requirement of further assessment, which was not apparent in this case. Similarly, Ms Mustard said that Adult 56's record in your notes indicated that she needed a referral to a gynaecologist. Ms Mustard said that, from this, you seemingly identified that there was a need for additional investigation or expertise or specialisms from the gynaecologist, but it isn't clear that that had been done from the evidence before the panel.

In respect of charge 2.4, Ms Mustard said that she has only made positive submissions in respect of Adult 2. She said that this case was referred for a legal opinion regarding FGM. She invited the panel to have regard to the oral evidence of Witness 5, who said that it is sometimes difficult to identify FGM, particularly if the woman has had children, therefore a practitioner may want to seek a second opinion if trying to obtain a medico-legal opinion.

Ms Mustard moved on to charge 3. She said that a large number of submissions made on your behalf are on the basis that the notes before the panel are your personal records of these consultations, which do not form part of the clinical records, and therefore the panel should not make any decisions about the adequacy or otherwise of the clinical records without having sight of them. Ms Mustard said that the NMC's position is that the panel should rely on the audit of those records. She said that the audit sheets are a detailed and reliable source which reflects what the auditors saw contemporaneously, when looking at the records.

Ms Mustard said that Witness 3 explained in detail the process of how the audit was undertaken, and that she said that, quite often, there was almost a replica of what was in the diary pages in the hospital records. Ms Mustard said that the panel has before it records for two patients and may think it is worthwhile to compare these clinical records to the diary and proforma pages, to make a valued judgment on whether the panel agrees with Witness 3 as, if the panel does find the records to be a mirror image, that lends further corroboration to Witness 3's account.

Ms Mustard submitted that the panel can rely on the audit being an accurate reflection of what was seen on the notes. She said that Witness 3 described the audit process, which involved seeking the lists of all the clinics over the relevant period, locating all of the hospital notes and then marrying up the audit pro forma with a diary page and notes, and then checking the EPR so that the auditors could look at all sources of information. Ms Mustard said that, when asked how many of the records she did a second search on, due to the limits and difficulties in the EPR, Witness 3 said: *"I would say all of them. There was an awful lot of time spent trying to decipher what was going on, and I wanted to be sure*

that I'd not missed anything. Not to say that I did miss something, but I know there was [Named colleague] looking, me looking, and then we looking again with another colleague."

Ms Mustard submitted that the audit was detailed in that every effort was made to go through and find all available information. She said that it was not just one person looking once and ticking boxes on a form, and that Witness 3 was clear in her oral evidence as to where a double check was done. Ms Mustard said that it is understandable that there will be some level of human error in the audit, however this does not make the audit unreliable, given the lengths taken to ensure that the records were properly assessed.

In respect of Ms Bayley's submission that there is duplicity between charges 3.1.1 and 3.1.4, Ms Mustard submitted that there is a distinction and differentiation between those two types of charges. She said 3.1.1, not recording adequate details in either the EPR/physical patient records bundle would include information about the consultation itself, i.e. what happened during the consultation, a record of why the patient is there and what's happened to them, is distinct from the mischief in 3.1.4, about not recording adequate details of the advice, assessment and discussions more about what physically happened in the consultation, and what has been told to the patient, including advice on next steps and future plans for care. She said the difference in these charges is that one is to record what has happened in the past, and one is to record what will happen in the future. Further, she said that the separated in the evidence, she said that the charge relates to not recording adequate details in the EPR and/or physical patient records bundle, in that some evidence relates to inadequacy in either one of the electronic or physical patient records, and some relate to both.

In relation to the allegation that you did not record adequate details in the EPR, this would relate to not recording adequate details in an outcome letter, which would be on the EPR. She said that it is submitted that the outcome letter is part of the clinical picture, and therefore need to be adequate. Ms Mustard reminded the panel that Witness 5 described the outcome letters as a record of everything that happened in the consultation, which is

then assessed by the clinician, before it is more widely circulated. She said that given the evidence before the panel that a clinician may use such records to see what happened in previous consultations, it is a key source of information, which is a necessary place for adequate details of the consultation to be recorded. Ms Mustard said that the blank outcome letters before the panel, as well as the audit records referring to the outcome letters being blank, are a demonstration of inadequate details being recorded in the EPR.

In respect of the element of the charge which relates to not recording adequate details of the consultation in the physical patient records bundle, Ms Mustard submitted that this largely related to the evidence before it that the audit recorded inadequate records being made in the physical patient bundles. She referred the panel to her written submissions on this point.

Ms Mustard compared this charge with the charge relating to not recording adequate details of the advice, discussion and next steps, she said that this is where the audit has picked up on something such as "*advised and reassured only*", which is a phrase which you often used within records. She submitted that that this would not be adequate detail of advice and discussion. Ms Mustard said that this charge also covers instances where it is specifically marked on the audit that the leaflet about FGM and advising about illegalities about FGM are marked as *"not recorded"* and referred the panel to her written submissions as to where it can be compared and contrasted to cases where the auditors ticked to indicate that there was something in the records which indicated that the leaflet was given, or that the patient was told about the illegalities, because it is ticked on the audit as such. She submitted that, when it's ticked on the audit as not being recorded, it can be inferred that this is the position, and the NMC would say not recording that you've given that advice about the illegalities, given that the advice comes within those leaflets, it is inadequate detail about the advice given to those patients.

In respect of charge 3.2.3, Ms Mustard said that this this type of charge appears frequently within charge 3, in relation to you not recording risk assessments. Ms Mustard said that the application of no case to answer in relation to these types of charges relies on the

evidence of Witness 5 about the necessity or otherwise of you undertaking these risk assessments. Ms Mustard submitted that Witness 5's evidence in this regard was largely based on saying what would be the point of doing a risk assessment for somebody who is known to have FGM, however Ms Mustard said that the guidance document speaks to risk assessments being used to help with decisions about whether a woman has had FGM, or whether she was at risk of further harm in relation to her FGM. Ms Mustard submitted that it is clear from the risk assessment forms that they weren't just aimed at that single limited purpose or idea, and it is envisaged from that wording that there would still be merit in undertaking a risk assessment even with known FGM because it may be that risks of further harm in relation to FGM could be identified by going through that process.

Ms Mustard said that, in any event, there are more instances where some of the women attending the clinic weren't going there with known FGM, and the primary purpose of their initial consultations there was to determine or confirm FGM. Ms Mustard said there seems to be some presumption in Witness 5's evidence that a risk assessment would be unnecessary at the clinic because it could, or should, have been done elsewhere, for example before the patient is referred on. However, Ms Mustard said that there are a number of instances where somebody isn't referred by another professional or practitioner. In respect of this, Ms Mustard said that Witness 5's evidence was that patients were referred by a midwife, other healthcare practitioners, or that they were self-referrals.

In respect of charge 3.21.1, "did not clearly record the origin of referral in child 16's patient records", Ms Mustard said that there are few like charges than an application of no case to answer is made on, on the basis that there has been a recording of where the referral was from. She said that there is some information given in that regard, but it is unclear who it was if there is reference to two different and separate organisations or individuals.

Ms Mustard submitted that the NMC are not making any positive submissions in relation to charge 4, which is a matter for the panel to consider.

In respect of charge 5, Ms Mustard said that Witness 3's evidence was that it was a standard practice to record consent when dealing with an intimate examination, such as an FGM assessment.

She said that Witness 4 had similar views and referred to documenting agreement with the patient and that would be adequate. Ms Mustard referred the panel to the Trust's consent policy which states that it is essential to document a patient's agreement for any procedure where the patient might reasonably be expected to consider the risk and options for treatment to be significant. Ms Mustard reminded the panel that Witness 3 said that this extract was a significant part of the policy, and that a procedure that a patient might reasonably be expected to consider the risks and options to be significant can vary drastically and be individual to the patient. Ms Mustard submitted that it is particularly relevant when talking about an intimate examination or procedure, such as FGM assessments and de-infibulations.

Ms Mustard said that, although Witness 5 said that de-infibulation is a routine procedure which is largely considered low risk and a standard procedure for a practitioner, this does not necessarily mean that such a procedure is not something which a patient would consider to be significant. Ms Mustard submitted that de-infibulation is significant because the Trust policy specifically speaks to any procedure where the patient might reasonably be expected to feel that way.

In respect of charge 6, Ms Mustard submitted that the Trust guidance is clear that the offer or confirmation of a chaperone for FGM examinations or de-infibulations should be recorded if it is declined. She drew the panel's attention to the recently disclosed clinical notes in which another practitioner at the Trust had recorded information in relation to a chaperone saying, *"chaperone offered – declined".*

In respect of charge 7, Ms Mustard invited the panel to have regard to the evidence of Witnesses 3 and 5. She said, when specifically asked whether you should have recorded the offer of a translator to Adult 10, Witness 5 said *"probably".*

In respect of charge 8, Ms Mustard said that the evidence before the panel relates to blank outcome letters and the oral evidence of Witness 3, who said that she would hope and assume that a blank letter had not been sent. Ms Mustard also said that there are other instances where the audit identified that there is an EPR record but an empty letter, or similar.

In respect of charge 9, Ms Mustard invited the panel to have regard to her written submissions, alongside the evidence of Witness 3, who was asked in detail about who, if anyone, it would be relevant to follow up with in relation to a multi-disciplinary team.

In respect of charge 10, "on one or more occasions, the adult patients, as listed in Schedule 12 didn't record adequate details of their appointment/consultation, including advice, discussion, next steps, details of assessment, examination, FGM risk assessments", Ms Mustard submitted that these are all separate sub-charges, which say "including" but not "exhaustive of" the things which are illustrative of record keeping issues for those particular patients.

Ms Mustard said that there are some records where the audit has noted "poor documentation" or "something not recorded". Ms Mustard reminded the panel that "poor documentation" was a comment largely used by Ms 13 to reflect the brevity of the notes. Ms Mustard said that the examples which said "*not recorded*" was Ms 12's way of indicating that the clinical records were "*empty*". She said that Witness 3 could assist the panel in identifying where there were no clinical records, and where the documentation was minimal.

In respect of charge 11, Ms Mustard said that Witness 3's evidence was that knowing the origin of a referral is about being able to understand access points of the services, which she called a "standard thing" to have recorded as it helps clinicians know where a patient has come from, and how they've accessed the service. Ms Mustard said that, within the audit pr-forma "patient journey" is marked as not recorded, and on certain records, on the

front of the audit pro-forma, the auditors has specifically written *“not documented who made the referral”* or *“referred by?”.* She said that, in your diary records before the panel, there are examples of where you have crossed through or left the “*referred by”* box blank, therefore the panel can infer that Witness 3’s notes in relation to this issue are accurate, in relation to what she saw in the clinical notes.

In respect of charge 12, Ms Mustard highlighted that the NMC is making no positive submissions in respect of a number of patients in relation to this charge. However, she said that, where positive submissions are made, they are similar to those made where those charges appeared in charge 3, where there is some evidence or information from the audit to suggest that there was nothing on EPR, or that or that there was insufficient detail recorded on the EPR, and/or the audit recorded issues relating to the consultation not being recorded.

Ms Mustard said that no submissions are made in respect of charge 13.

In respect of charge 14.1, Ms Mustard said that Witness 1 said that referring that referring a five-year-old to gynaecology is inappropriate, and if urinary symptoms were the pain issue, she would have expected a paediatric assessment with a paediatric urology service appointment. Ms Mustard said that no positive submissions are made in respect of charge 14.2.

Ms Mustard submitted that charge 14.4 links to charge 14.1, in that the audit captured that you had advised the GP to refer on to gynaecological service. She said that the letter of referral, which states *“on the advice of Dr Comfort Momoh”,* suggests that the referral to the adult gynaecology service was on the basis of your advice. She said, although you did not yourself refer this patient, that you made or advised on the wrong referral and ensured that the child was effectively referred to the wrong place, and therefore didn’t ensure that they were referred to the correct place. Ms Mustard said that if the panel is satisfied that the referral was made because of you and your advice, the charge should not fail because of technical wording.

Ms Mustard highlighted that the NMC are offering no positive submissions in respect of charges 15, 16 and 18.

In respect of charge 20, Ms Mustard submitted that the NMC are only making positive submissions in relation to Child 28. She said that Witness 1’s witness statement refers specifically to the issue of not recording the offer/confirmation of consent for children in relation to this patient. Ms Mustard said that, given the issues known about this Child, there is nothing to suggest that you shouldn’t have done so. Ms Mustard said that there is evidence that you assessed this Child, which is reflected in the notes. She submitted that, in these circumstances, consent should have been recorded.

In respect of charge 21, Ms Mustard said that the NMC are only making positive submissions in relation to Child 23. She said that this Child was one where Ms 1 said that she could only find diary notes which was then documented in the audit. Ms Mustard said that, within the audit, there is a handwritten note saying that the diary notes were unavailable, which is then crossed out with “nil documented” written underneath. She submitted that, with that position, the only record of the consultation is the diary page, which contains no record about a chaperone.

Charge Amendments

Prior to making a decision on Ms Bayley’s application of no case to answer, the panel heard submissions from Ms Mustard, supported by Ms Bayley, that charge amendments were required for a number of charges to correct typographical errors, provide clarity, accuracy and properly reflect the evidence in this case.

The panel accepted the advice of the legal assessor.

The panel made the following charge amendments, to correct typographical errors and properly reflect the evidence:

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

[…]

8. Adult 12 on or around 11 June ~~2016~~ **2015**

[…]

11. Adult 19 on or around ~~15~~ **14** May 2015/20 August 2015/10 September 2015

Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

[…]

7. Adult 73 on or around ~~1~~ **8** October 2015

Schedule 3. Did not obtain second opinion during de-infibulation

1. Adult 14 on or around ~~20 December 2013~~ **27 February 2014**

[…]

4. Adult 35 on or around ~~2~~ **9** July 2015

Schedule 4: Did not obtain second opinion during de-infibulation

[…]

2. Adult 12 on or around 11 June ~~2016~~ **2015**
3. Adult 19 on or around ~~15~~ **14** May 2015/20 August 2015/10 September 2015

Schedule 8: Did not record the confirmation of consent for one or more children/patients under 18 not pregnant

[…]

12. Child 28 on or around ~~20~~ **7** July 2017

Schedule 9: Failed to refer/investigate

Charge 2.4

[…]

3. Adult 19 on or around **14** ~~15~~ May 2015/20 August 2015/10 September 2015

Schedule 10: Failed to record the offer of consent for examination/de- infibulation

[…]

5. Adult 19 on or around ~~15~~ **14** May 2015/20 August 2015/10 September 2015

Schedule 13: Did not clearly record the reason/origin of referral

[…]

6. Adult 131 on or around ~~3~~/10/ **24** November 2016

Charge 3.17

On or around 2 July 2015/ 9 July 2015/ **16 July 2015**/ 6 August 2015 during/following your consultation with Adult 35

Charge 3.18

On or around 5 December 2013/12 December 2013 during/following your consultation with Adult ~~45~~ **44**

Charge 3.18.1

Did not record adequate details of Adult ~~45~~ **44's** consultations in the EPR/physical patient records bundle

Charge 3.19

On or around 21 July 2016/28 July 2016/**11 August 2016** during/following your consultation with Adult 124;

Charge 3.32

On or around ~~20~~ **7** July 2017, during/following your consultation with Child 28;

Panel Decision on No Case to Answer

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

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

Charge 1.1:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

The panel first considered if there is a case to answer in respect of the stem of charge 1.1; whether you acted or practised outside the scope of your clinical competence or role in that you accepted referrals for adult patients that were not pregnant.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context. However, it found that the issues concerning your clinical competence and your role are distinct.

The panel first considered the evidence before it in respect of your clinical competence. It bore in mind the evidence of your clinical colleagues, and notably Witness 5, who spoke highly of your clinical competence. The panel was satisfied that this evidence was not contradicted by any other evidence.

The panel therefore concluded that the NMC has not discharged its duty to demonstrate that you acted or practised outside of your clinical competence in that you accepted referrals for adult patients that were not pregnant, and there is no case to answer in this respect (clinical competence), in relation to charge 1.1.

The panel next considered whether you acted outside of your role as an FGM midwife. It noted that it is agreed that your nursing registration lapsed on 1 April 2013, and several witnesses have given evidence as to the potential impact of this in respect of your role when treating non-pregnant women. Those witnesses have cast doubt as to whether your midwifery registration was sufficient on its own for this purpose.

It therefore concluded that there is a case to answer that you acted outside of your role, in that you accepted referrals for adult patients that were not pregnant.

The panel therefore will consider whether there is a case to answer on each charge in schedule 1 in relation to your role only.

1.1.1 Adult 2 on or around 27 October 2016
1.1.2 Adult 3 on or around 22 September 2016
1.1.3 Adult 4 on or around 21 April 2016
1.1.5 Adult 7 on or around 18 August 2016
1.1.10 Adult 17 on or around 22 August 2013/12 May 2016
1.1.13 Adult 23 on or around 28 April 2016
1.1.14 Adult 24 on or around 20 October 2016
1.1.18 Adult 124 on or around 21 July 2016

The panel had regard to the evidence before it at this stage in respect of these charges.

It noted that there was evidence before the panel that these patients were either referred by their GPs or made self-referrals to the service.

It noted that there is evidence before the panel that these patients were not pregnant as there is a line next to, or scored through, the entry that states "EDD" (estimated delivery date) on entries for the relevant dates.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on these charges, on the basis of the potential limitations of your role as an FGM midwife.

1.1.4 Adult 6 on or around 15 June 2017

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that this patient was not pregnant as “not pregnant” is noted within the diary entry.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.1.6 Adult 8 on or around 3 December 2015

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that the proforma document relates to you performing a smear test for Adult 8 at this appointment. The panel had regard to the evidence of the Witness 3, that smear tests were not normally carried out during pregnancy.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.1.7 Adult 9 on or around 4 June 2015
1.1.8 Adult 12 on or around 11 June 2015
1.1.9 Adult 15 on or around 6 August 2015

The panel had regard to the evidence before it at this stage in respect of these charges. It noted that there is evidence before the panel that these patients are not pregnant as “not pregnant” is circled within the diary entry.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on these charges, on the basis of the potential limitations of your role as an FGM midwife.

1.1.11 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that this patient was not pregnant as “not pregnant” is circled within the diary entry for 20 August 2015. The panel also noted that this patient had been recorded as post-menopausal in the audit, and therefore extremely unlikely to become pregnant.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.1.12 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that this patient was not pregnant as there is a line next to the entry that states EDD on the entry for 30 June 2016.

The panel looked at the evidence before it in relation to each date alleged. It bore in mind that the audit sheet in relation to Adult 22’s appointment on 28 January 2016 noted that she was not pregnant on 28 January 2016. However, the panel noted that the evidence before it in respect of this appointment indicated that she was seen in the gynaecology outpatients clinic. The panel found no evidence that you saw Adult 22 on this date.

The panel therefore found that there is no evidence before it to support a case to answer on this charge in relation the appointment on 28 January 2016.

However, it had regard to your diary entry and other records which state that you saw this patient on 16 April 2015, and 30 June 2016, when she was latterly referred to the urogynaecology department.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge in relation to the appointments on 16 April 2016 and 30 June 2016, on the basis of the potential limitations of your role as an FGM midwife.

1.1.15 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

The panel had regard to the evidence before it at this stage in respect of this charge. It bore in mind that it had sight of this patient's medical notes which provided a more comprehensive history of her care.

The panel first took into account that the notes indicated that Adult 35 was seen by Witness 5, and not you, on 16 July 2015. Therefore it found that there is no case to answer in respect of this date.

In relation to 2 and 9 July 2015 and 6 August 2015, the panel had regard to the evidence before it in relation to this patient. The panel noted that it was clearly recorded on Adult 35's medical records that she had been referred to the AWWC for pre-conceptual care, in that she was planning to conceive.

The panel concluded that such clinical consultation falls within the scope of a midwife, and therefore there is no case to answer in respect of this charge.

1.1.16 Adult 89 on or around 8 October 2015
1.1.17 Adult 109 on or around 14 May 2015

The panel had regard to the evidence before it at this stage in respect of these charges. It noted that there is evidence before the panel that these patients were not pregnant as “not pregnant” is circled within the diary entry.

The panel had regard to Ms Bayley’s submissions in respect of these patients, that, as they were recently married, it would logically follow that any subsequent intervention at the AWWC could be considered as pre-conceptual care. However, the panel noted that the only information before it in respect of these patients was that they were experiencing difficulty having penetrative sex. The panel did not consider that it automatically follows that Adults 89 and 109 were referred to the clinic for pre-conceptual care.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on these charges, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.1.19 Adult 130 on or around 10/24 November 2016</u>

The panel had regard to the evidence before it at this stage in respect of this charge.

It noted that there is evidence before the panel that this patient was not pregnant as there is a line scored through the EDD entry for 10 November 2016. The panel noted that entry was blank on the record of 24 November 2016.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.1.20 Adult 134 on or around 5 January 2017</u>

The panel had regard to the evidence before it at this stage in respect of this charge.

The panel had regard to Ms Bayley's submissions in respect of this patient, that, as she was recently married, it would logically follow that any subsequent intervention at the AWWC could be considered as pre-conceptual care. However, the panel noted that the only information before it in respect of this patient was that she was unable to have penetrative sex. The panel did not consider that that automatically follows that Adult 134 was referred to the clinic for pre-conceptual care.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

Charge 1.2:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.

Schedule 1 – Accepted Referrals/Assessed/Examined Patients who were not pregnant as listed below.

The panel first considered if there is a case to answer in respect of the stem of charge 1.2; whether you acted or practised outside the scope of your clinical competence or role in that you assessed/examined adult patients that were not pregnant.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words "acted" and "practised" are synonymous in this context. However found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence. It bore in mind the evidence of your clinical colleagues, and notably Witness 5, who spoke highly of your clinical competence, and that this evidence had not been contradicted. The panel therefore concluded that the NMC has not discharged its duty to demonstrate that you acted or practised outside of your clinical competence in that you assessed/examined adult patients that were not pregnant, and there is no case to answer in this respect, in relation to charge 1.2.

The panel next considered whether you acted outside of your role as an FGM midwife. It noted that it is agreed that your nursing registration lapsed on 1 April 2013, and several witnesses have given evidence as to the potential impact of this in respect of your role when treating non-pregnant women.

It therefore concluded that there is a case to answer that you acted or practised outside of your role, in that you assessed/examined adult patients that were not pregnant, and there is a case to answer in this respect, in relation to charge 1.2.

The panel therefore will consider whether there is a case to answer on each charge in schedule 1 in relation to your role only.

<u>1.2.1 Adult 2 on or around 27 October 2016</u>
<u>1.2.2 Adult 3 on or around 22 September 2016</u>
<u>1.2.3 Adult 4 on or around 21 April 2016</u>
<u>1.2.4 Adult 6 on or around 15 June 2017</u>
<u>1.2.7 Adult 9 on or around 4 June 2015</u>
<u>1.2.9 Adult 15 on or around 6 August 2015</u>
<u>1.2.13 Adult 23 on or around 28 April 2016</u>
<u>1.2.14 Adult 24 on or around 20 October 2016</u>
<u>1.2.16 Adult 89 on or around 8 October 2015</u>
<u>1.2.17 Adult 109 on or around 14 May 2015</u>

1.2.18 Adult 124 on or around 21 July 2016

1.2.19 Adult 130 on or around 10/24 November 2016

1.2.20 Adult 134 on or around 5 January 2017

The panel had regard to the evidence before it at this stage in respect of these charges. It had regard to its findings in respect of there being a case to answer on the basis that these patients were not pregnant, and not receiving pre-conceptual care, as outlined in relation to these patients at charge 1.1 above and followed the same conclusions in relation to this charge.

The panel went on to consider whether there was any evidence to support the charge that you assessed and/or examined these patients as charged. It had regard to the evidence before it and noted that you had completed a diagram in the notes available for each of these patients following their appointment.

It therefore determined that there is sufficient evidence before it to establish a case to answer on these charges, on the basis of the potential limitations of your role as an FGM midwife.

1.2.5 Adult 7 on or around 18 August 2016

The panel had regard to the evidence before it at this stage in respect of this charge. It had regard to its findings in respect of there being a case to answer on the basis that Adult 7 was not pregnant as outlined in charge 1.1 above and followed the same conclusions in relation to this charge.

The panel went on to consider whether there was any evidence to support the charge that you assessed and/or examined Adult 7 as charged. It had regard to the evidence before it. It bore in mind that your diary note states that you did not assess this patient. However, there is evidence before the panel that you took a clinical history from Adult 7, although there is no evidence before it that you

examined her. The panel concluded that taking such a history is evidence of an assessment taking place.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge in respect of assessment only, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.2.6 Adult 8 on or around 3 December 2015</u>

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that the proforma document relates to you performing a smear test for Adult 8 at this appointment. The panel had regard to the evidence of Witness 3, that smear tests were not normally carried out during pregnancy. The panel was satisfied that there was evidence before it to establish that this appointment amounted to an assessment and/or examination, albeit not for FGM.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.2.8 Adult 12 on or around 11 June 2015</u>

The panel had regard to the evidence before it at this stage in respect of this charge. It had regard to its findings in respect of there being a case to answer on the basis that this patient was not pregnant as outlined at charge 1.1 above and followed the same conclusions in relation to this charge.

The panel went on to consider whether there was any evidence to support the charge that you assessed and/or examined these patients as charged. It had regard to the evidence before it and noted that you had recorded that de-infibulation

had been carried out, and completed a diagram in the notes available for this patient in respect of this appointment.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.2.10 Adult 17 on or around 22 August 2013/12 May 2016

The panel had regard to the evidence before it at this stage in respect of this charge. It had regard to its findings in respect of there being a case to answer on the basis that this patient was not pregnant as outlined at charge 1.1 above and followed the same conclusions in relation to this charge.

The panel went on to consider whether there was any evidence to support the charge that you assessed and/or examined this patient as alleged. It had regard to the evidence before it and noted that you had recorded clinical notes about Adult 17's presentation, and completed a diagram in the notes available for this patient in respect of these appointments.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.2.11 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015

The panel had regard to the evidence before it at this stage in respect of this charge. It had regard to its findings in respect of there being a case to answer on the basis that this patient was not pregnant as outlined at charge 1.1 above and followed the same conclusions in relation to this charge.

The panel then went on to consider whether there was evidence that you had assessed or examined Adult 19 on each of the dates alleged. In respect of 14 May 2015, the panel bore in mind that it had before it patient notes which set out that Adult 19 had been examined and assessed, which were stamped and signed by you. The panel had similar patient notes for the appointments on 20 August and 10 September 2015.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.2.12 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016</u>

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that this patient was not pregnant using the same rationale as set out in charge 1.1.12.

The panel looked at the evidence before it in relation to each date alleged. It bore in mind that the audit sheet in relation to Adult 22's appointment on 28 January 2016 noted that she was not pregnant on 28 January 2016. However, the panel noted that the evidence before it in respect of this appointment indicated that she was seen in the gynaecology outpatients clinic. The panel found no evidence that you saw Adult 22 on this date.

The panel therefore found that there is no evidence before it to support a case to answer on this charge in relation the appointment on 28 January 2016.

However, it had regard to your diary entry and other records which state that you saw this patient on 16 April 2015, and 30 June 2016, when she was latterly referred to the urogynaecology department. The panel went on to consider whether there was any evidence to support the charge that you assessed and/or examined this

patients as charged. It had regard to the evidence before it and noted that there is evidence that you assessed this patient during these appointments.

The panel therefore determined that there is sufficient evidence before it to establish a case to answer on this charge in relation to the appointments on 16 April 2016 and 30 June 2016, on the basis of the potential limitations of your role as an FGM midwife.

<u>1.2.15 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015</u>

The panel had regard to the evidence before it at this stage in respect of this charge. It bore in mind that it had sight of this patient's medical notes which provided a more comprehensive history of her care.

The panel first took into account that the notes indicated that Adult 35 was seen by Witness 5, and not you, on 16 July 2015. Therefore it found that there is no case to answer in respect of this date.

In relation to 2 and 9 July 2015 and 6 August 2015, the panel had regard to the evidence before it in relation to this patient. The panel noted that it was clearly recorded on Adult 35's medical records that she had been referred to the AWWC, and subsequently assessed and examined, for pre-conceptual care, in that she was planning to conceive. The panel concluded that such clinical contact falls within the scope of a midwife, and therefore there is no case to answer in respect of this charge.

<u>Charge 1.3:</u>
Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.
Schedule 2 - Conducted de-infibulation on patients who were not pregnant.

The panel first considered if there is a case to answer in respect of the stem of charge 1.3; whether you acted or practised outside the scope of your clinical competence or role in that you conducted de-infibulation on adult patients that were not pregnant.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context. However it found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence. It bore in mind the evidence of your clinical colleagues, and notably Witness 5, who spoke highly of your clinical competence. The panel was satisfied that this evidence was not contradicted by any other evidence. The panel therefore concluded that the NMC has not discharged its duty to demonstrate that you acted or practised outside of your clinical competence in that you conducted de-infibulation on adult patients that were not pregnant, and there is no case to answer in this respect, in relation to charge 1.3.

The panel next considered whether you acted outside of your role as a FGM midwife. It noted that it is agreed that your nursing registration lapsed on 1 April 2013, and several witnesses have given evidence as to the potential impact of this in respect of your role when treating non-pregnant women. Those witnesses have cast doubt as to whether your midwifery registration was sufficient for this purpose.

It therefore concluded that there is a case to answer that you acted outside of your role, in that you conducted de-infibulation on adult patients that were not pregnant.

The panel therefore will consider whether there is a case to answer on each charge in schedule 2 in relation to your role only.

1.3.1 Adult 9 on or around 4 June 2015
1.3.2 Adult 12 on or around 11 June 2015
1.3.3 Adult 17 on or around 22 August 2013
1.3.4 Adult 19 on or around 20 August 2015
1.3.5 Adult 22 on or around 16 April 2015

The panel had regard to the evidence before it at this stage in respect of these charges. It had regard to its findings in respect of there being a case to answer on the basis that these patients were not pregnant, and not receiving pre-conceptual care, as outlined in relation to these patients at charge 1.1 above and followed the same conclusions in relation to this charge.

The panel had regard to the evidence before it in relation to each patient's appointments on the relevant dates charged and noted that there is evidence before it to suggest that de-infibulation was carried out by you on the dates as charged.

It therefore determined that there is sufficient evidence before it to establish a case to answer on these charges, on the basis of the potential limitations of your role as an FGM midwife.

1.3.6 Adult 41 on or around 3 August 2017

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that this patient was not pregnant as no, "no" is marked next to the box which states "Pregnant Y/N".

The panel had regard to the evidence before it in relation to Adult 41's appointments on or around 3 August 2017, and noted that there is evidence before it to suggest that de-infibulation was carried out by you on the date as charged.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.3.7 Adult 73 on or around 8 October 2015

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that Adult 73 was not pregnant as "not pregnant" is circled on entries in respect of these patients for the relevant dates.

The panel had regard to the evidence before it in relation to Adult 73's appointment on or around 8 October 2015, and noted that there is evidence before it to suggest that de-infibulation was carried out by you on the date as charged.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.3.8 Adult 123 on or around 30 June 2016

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that these patients were not pregnant as there is a line next to EDD on the notes available for this patient.

The panel had regard to the evidence before it in relation to Adult 123's appointment on or around 30 June 2016, and noted that there is evidence before it to suggest that de-infibulation was carried out by you on the date as charged.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

1.3.9 Adult 135 on or around 10 August 2017

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that the NMC has made no positive submissions in respect of this charge.

The panel had regard to the date of this charge, which post-dates the date which you had retired and ceased working for the Trust. It also noted that there was evidence before that this patient was seen by Ms 6 on 10 August 2017.

The panel therefore found no case to answer in respect of this charge.

1.3.10 Adult 146 on or around 7 January 2016

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that there is evidence before the panel that these patients are not pregnant as the notes for this patient reads "EDD not pregnant".

The panel had regard to the evidence before it in relation to Adult 146's appointment on or around 7 January 2016, and noted that there is evidence before it to suggest that de-infibulation was carried out by you on the date as charged.

It therefore determined that there is sufficient evidence before it to establish a case to answer on this charge, on the basis of the potential limitations of your role as an FGM midwife.

Charge 1.4:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule 3.

Schedule 3. Did not obtain second opinion during de-infibulation

The panel first considered if there is a case to answer in respect of the stem of charge 1.4; whether you acted or practised outside the scope of your clinical competence or role in that you did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context. However it found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence. It bore in mind the evidence of your clinical colleagues, and notably Witness 5, who spoke highly of your clinical competence. The panel was satisfied that this evidence was not contradicted by any other evidence. The panel therefore concluded that the NMC has not discharged its duty to demonstrate that you acted or practised outside of your clinical competence in that you did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, and there is no case to answer in this respect, in relation to charge 1.4.

The panel next considered whether you acted outside of your role as an FGM midwife. It noted the evidence of Witness 3, who said that it would be good practice of a midwife to obtain a second opinion if there was anything difficult or unusual about a case. It also had regard to the evidence of Witness 5, who said it would be difficult to assess whether the patients required a second opinion without seeing them, or at least the records.

In light of this evidence, the panel therefore concluded that there is a case to answer that you acted outside of your role, in that you did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures

The panel therefore will consider whether there is a case to answer on each charge in schedule 3 in relation to your role only.

<u>1.4.1 Adult 14 on or around 27 February 2014</u>

The panel had regard to the evidence before it at this stage.

It took account of the records before it, including the audit and diary records, which indicate that on or around 27 February 2014, Adult 14 fainted, and paramedics were called for assistance.

The panel also bore in mind the evidence of Witness 5, who was clear that, when someone had fainted, it would be ordinary procedure to seek medical assistance, but it may not require a second opinion on the procedure.

The panel concluded that, it was clear on the basis of the records before it that Adult 14 fainted at some point on or around 27 February 2014, however, there was no evidence before it of when this happened, the circumstances surrounding Adult 14 fainting, or if it was caused by the de-infibulation procedure.

Accordingly, the panel found that there is insufficient evidence to support a case to answer in respect of this charge.

1.4.2 Adult 17 on or around 22 August 2013

The panel had regard to the evidence before it at this stage. It noted that the audit indicated that there was no diary entry for this appointment, however the panel had before it in evidence the diary entry which set out that Adult 17 was referred for assessment by her GP on 22 August 2013. It further set out that Adult 17 was seen by you at the AWWC on 22 August 2013.

The panel was satisfied that you performed de-infibulation on Adult 17 on 22 August 2013. However, there was no evidence before it to suggest that there were any complications related to Adult 17's de-infibulation which may have required a second opinion. Therefore the panel found no case to answer in respect of this charge.

1.4.3 Adult 19 on or around 20 August 2015

The panel had regard to the evidence before it, including that Adult 19 had seen both a psychologist and a pain management specialist, and that Adult 19 denied having FGM.

The panel considered whether there is a case to answer, that you acted outside of your role in not seeking a second opinion in respect of Adult 19. The panel noted that there was evidence before it which suggests that such specialist intervention indicates clinical complexities, including psychological concerns, which may have required a second opinion.

The panel bore in mind the evidence it had received in respect of the set-up of the clinic. It was located within the gynaecology outpatient department, where gynaecology clinicians were available, from whom you could have asked for a second opinion. It also bore in mind the evidence of Witness 5, that you had the option to request that patients returned to a joint FGM clinic with the lead clinician.

The panel concluded that there is a case to answer that you were under a duty to seek a second opinion where required to in the circumstances of a complex de-infibulation, based on the evidence of Witness 3.

In light of this the panel concluded that there is a case to answer that you acted outside of your role on the basis of the potential limitations of your role as an FGM midwife in relation to Adult 19 on or around 20 August 2015.

1.4.4 Adult 35 on or around 2 July 2015

The panel had regard to all of the evidence before it, including the diary notes which record this as a “difficult de-infibulation”.

The panel bore in mind the oral evidence of Witness 3, who said *“something being described as very, very difficult leads you to think that you don’t have to do these things alone.”*

The panel bore in mind the evidence it had received in respect of the set-up of the clinic. It was located within the gynaecology outpatient department, where gynaecology clinicians were available, from whom you could have asked for a second opinion. It also bore in mind the evidence of Witness 5, that you had the option to request that patients returned to a joint FGM clinic with the lead clinician.

The panel concluded that there is a case to answer that you were under a duty to seek a second opinion where required to in the circumstances of a complex de-infibulation, based on the evidence of Witness 3.

In light of this the panel concluded that there is a case to answer that you acted outside of your role on the basis of the potential limitations of your role as an FGM midwife in relation to Adult 35 on or around 2 July 2015.

1.4.5 Adult 130 on or around 24 November 2016

The panel had regard to all of the evidence before it, including the audit notes, which recorded, in respect of Adult 130's de-infibulation procedure on or around 24 November 2016:

> *"unable to completely separate as fused together anteriorly […] '? Should have been reviewed by another person? Offered day case procedure".*

Witness 3 also gave oral evidence in this charge. She said:

> *"I appreciate the difficulty and the complexity and that is why I thought possible that this case should have been referred by another person but reviewed by another person for a second opinion".*

The panel also received evidence from Witness 5, who said that it is difficult to assess individual patient's needs without assessing them, or at the very least reviewing their records. However, from the information before her, she referred to the procedure as "quite a tricky one".

The panel bore in mind the evidence it had received in respect of the set-up of the clinic, including that gynaecology clinicians were on site from whom you could have asked for a

second opinion. It also bore in mind the evidence of Witness 5, that you had the option to request that patients returned to a joint FGM clinic with the lead clinician.

The panel concluded that there is a case to answer that you were under a duty to seek a second opinion where required to in the circumstances of a complex de-infibulation, based on the evidence of Witness 3. In light of this the panel concluded that there is a case to answer that you acted outside of your role on the basis of the potential limitations of your role as an FGM midwife in relation to Adult 130 on or around 24 November 2016.

Charge 1.5:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber, as listed in schedule 4.
Schedule 4: Administered medication without a prescription

The panel had regard to the stem of this charge. It took into account its previous conclusion that the terms “acted” and “practised” are synonymous in this context. However, It considered that the circumstances of the medication alleged to be administered without prescription in respect of each patient in schedule 4 may result in a different and distinct conclusion in relation to your clinical competence or role, especially when considering the medication listed under the Midwives’ Exemptions.

The panel therefore determined to consider whether you acted/practised outside the scope of your clinical competence/role in relation to each charge in turn,

1.5.1 Adult 9 on or around 4 June 2015

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical

competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to its finding in relation to charge 1.1.7, that Adult 9 was not pregnant on the relevant date. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 9 on or around 4 June 2015.

It therefore found that there is sufficient evidence to support a case to answer that on the basis of the potential limitations of your role as an FGM midwife, which included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 9, a non-pregnant woman on or around 4 June 2015.

1.5.2 Adult 12 on or around 11 June 2015

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that the NMC alleges that this charge relates to both the prescription of antibiotics and Lidocaine.

In relation to the prescription of antibiotics, the panel bad regard to the evidence before it which states: *""antibiotics prescribed"* in relation to this appointment. The panel found this evidence to be tenuous and insufficient to support an allegation

that it was you who prescribed or administered antibiotics to Adult 12 on the relevant date.

The panel went on to consider the allegation that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to its finding in relation to charge 1.1.8, that Adult 12 was not pregnant on the relevant date. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations, and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 12 on or around 11 June 2015.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role as an FGM midwife, which included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 12, a non-pregnant woman on or around 11 June 2016, in respect of the administration of Lidocaine only.

<u>1.5.3 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015</u>

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical

competence/ role in that you administered Voltarol to this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Voltarol was readily available at the AWWC. It also had regard to the Midwives' Exemptions, which Voltarol forms part of.

The panel had regard to its finding in relation to charge 1.1.11, that Adult 19 was not pregnant on the relevant dates. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Voltarol as part of such procedure.

The panel had regard to the dates charged, it noted that there is no evidence that you prescribed or administered Votarol or any other medication on 15 May and/or 10 September 2015. It concluded that there is no case to answer on this charge in respect of those dates.

The panel noted that there is no evidence before it of any prescription for Voltarol for Adult 19 on or around 20 August 2015.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role on the basis of the potential limitations of your role as an FGM midwife, which included acting outside the Midwives' Exemptions, in administering Voltarol without a prescription to Adult 9, a non-pregnant woman, on or around 20 August 2015.

1.5.4 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical

competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to its finding in relation to charge 1.1.12, that Adult 22 was not pregnant on the relevant date. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel had regard to the dates charged, it noted that there is no evidence that you prescribed or administered Lidocaine or any other medication on 28 January and/or 30 June 2016. It concluded that there is no case to answer on this charge in respect of those dates.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 22 on or around 16 April 2015.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role as an FGM midwife, which included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 22, a non-pregnant woman on or around 16 April 2015.

<u>1.5.5 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015</u>

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that the NMC alleges that this charge relates to both the prescription of antibiotics and Lidocaine.

In relation to the prescription of antibiotics, the panel had regard to the evidence before it which states: *"antibiotics prescribed"*, although there is no specificity as to the date it is alleged that these antibiotics were given to Adult 35. The panel found this evidence to be tenuous and insufficient support an allegation that it was you who prescribed or administered antibiotics to Adult 35 on any of the dates charged.

The panel went on to consider the allegation that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the dates alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to its finding in relation to charge 1.1.15, that Adult 35 was not pregnant. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations, and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel had regard to the dates charged, it noted that there is no evidence that you prescribed or administered Lidocaine or any other medication on 2 July, 16 July and/or 6 August 2015. It concluded that there is no case to answer on this charge in respect of those dates

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 35 on or around 9 July 2015.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of role on the basis of the potential limitations of your role as an

FGM midwife. This included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 35, a non-pregnant woman on or around 9 July 2015, in respect of the administration of Lidocaine only.

<u>1.5.6 Adult 43 on or around 8/14 August 2014</u>

The panel had regard to all the evidence before it in relation to this charge at this stage, it bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the dates alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to the evidence before it that Adult 43 was not pregnant on the relevant dates because there is a line marked next to the EDD included within your diary notes in respect of her appointment on 8 August 2014. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel had regard to the dates charged, it noted that there is no evidence that you prescribed or administered Lidocaine or any other medication on 8 August 2014. It concluded that there is no case to answer on this charge in respect of this date.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 43 on or around 14 August 2014.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role as an FGM midwife. This included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 43, a non-pregnant woman on or around 14 August 2014.

1.5.7 Adult 44 on or around 5/12 December 2013

The panel had regard to all the evidence before it in relation to this charge at this stage, it bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the dates alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to the evidence before it and that Adult 43 was not pregnant on the relevant dates because there is a line marked next to the EDD included within your diary notes in respect of her appointment on 5 December 2013. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel had regard to the dates charged, it noted that there is no evidence that you prescribed or administered Lidocaine or any other medication on 12 December 2013. It concluded that there is no case to answer on this charge in respect of this date.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 44 on or around 5 December 2013.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role on the basis of the potential limitations of your role as an FGM midwife. This included acting outside the Midwives' Exemptions, in administering on the basis of the potential limitations of your role as an FGM midwife Lidocaine without a prescription to Adult 44, a non-pregnant woman on or around 12 December 2013.

1.5.8 Adult 123 on or around 30 June 2016.

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the dates alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to the evidence before it and that Adult 123 was not pregnant on the relevant dates because there is a line marked next to the EDD included within your diary notes in respect of her appointment on 30 June 2016. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 123 on or around 30 June 2016.

It therefore found that there is sufficient evidence to support a case to answer that you acted outside of your role as an FGM midwife. This included acting outside the

Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 123, a non-pregnant woman on or around 30 June 2016.

<u>1.5.9 Adult 124 on or around 21 July 2016</u>

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to its finding in relation to charge 1.1.18, that Adult 124 was not pregnant. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations, and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 124 on or around 21 July 2016.

It therefore found that there is sufficient evidence to support a case to answer on the basis of the potential limitations of your role as an FGM midwife. This included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 124, a non-pregnant woman on or around 21 July 2016.

<u>1.5.10 Adult 138 on or around 29 June 2017</u>

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you administered Lidocaine to perform a de-infibulation on this patient on the date alleged.

The panel bore in mind the evidence of Witness 5, that Lidocaine was readily available at the AWWC, in order to perform de-infibulations. It also had regard to the Midwives' Exemptions, which Lidocaine forms part of.

The panel had regard to the evidence before it and that Adult 138 was not pregnant on the relevant date because "N" is circled on the entry which states "Pregnant Y/N" on the pro forma for her appointment on 29 June 2017. It had regard to its previous finding, that there is no case to answer that you acted outside your clinical competence in performing de-infibulations, and was satisfied that this equally applied to your administration of Lidocaine as part of such procedure.

The panel noted that there is no evidence before it of any prescription for Lidocaine for Adult 138 on or around 29 June 2017. It therefore found that there is sufficient evidence to support a case to answer that you acted outside of role as an FGM midwife, which included acting outside the Midwives' Exemptions, in administering Lidocaine without a prescription to Adult 138, a non-pregnant woman on or around 29 June 2017.

Charge 1.6:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion provided psychological/psychosexual counselling to patients, as listed in schedule 5.
Schedule 5. Provided psychological/psychosexual counselling

The panel first considered if there is a case to answer in respect of the stem of charge 1.6; whether you acted or practised outside the scope of your clinical

competence or role in that you provided psychological/psychosexual counselling to patients.

The panel took into account all of the evidence adduced at this stage. It noted that, in her oral evidence, Witness 4 told the panel that formalised counselling was not within your role as an FGM specialist midwife. Additionally, Witness 3 said that such counselling was a specialised service.

The panel had regard to all of the evidence before it and concluded that there is no evidence to suggest that you have provided psychological or psychosexual counselling to patients, or any counselling at all outside of the advisory role which may be expected of you as an FGM specialist midwife.

Accordingly, the panel found that that the NMC has not discharged its duty to demonstrate that you acted or practised outside the scope of your clinical competence or role in that you provided psychological/psychosexual counselling to patients. The panel therefore found no case to answer in respect of charge 1.6 as a whole.

1.6.1 Adult 2 on or around 27 October 2016
1.6.2 Adult 3 on or around 22 September 2016
Having found no case to answer in respect of the duty imposed by the stem of charge 1.6, it was not required to consider each charge in the schedule individually.

The panel therefore found no case to answer in respect of charge 1.6.1 and 1.6.2.

Charge 1.7:
Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion provided patients with sexual health counselling for dyspareunia, as listed in schedule 6.
Schedule 6: Provided sexual health counselling

The panel first considered if there is a case to answer in respect of the stem of charge 1.7; whether you acted or practised outside the scope of your clinical competence or role in that you provided patients with sexual health counselling for dyspareunia.

The panel took into account all of the evidence adduced at this stage. It noted that, in her oral evidence, Witness 4 told the panel that formalised counselling was not within your role as an FGM specialist midwife. It noted that, although Witness 3 provided the panel with a limited description of what sexual health counselling may entail, the majority of witnesses, including your clinical colleagues and those who supervised you, were unable to assist the panel with a description of what sexual health counselling for dyspareunia may consist of. The panel therefore had limited assistance in identifying what would constitute such counselling, and whether you provided this.

The panel had regard to all of the evidence before it and concluded that there is no evidence to suggest that you provided sexual health counselling for dyspareunia to any patients.

Accordingly, the panel found that that the NMC has not discharged its duty to demonstrate that you acted or practised outside the scope of your clinical competence or role in that you provided sexual health counselling for dyspareunia to patients. The panel therefore found no case to answer in respect of charge 1.7 as a whole.

1.7.1 Adult 3 on or around 22 September 2016
1.7.2 Adult 19 between May & September 2015

Having found no case to answer in respect of the duty imposed by the stem of charge 1.7, it was not required to consider each charge in the schedule individually.

The panel therefore found no case to answer in respect of charge 1.7.1 and 1.7.2.

Charge 1.8:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;
Schedule 7: Undertook smear test without training/competency

The panel first considered if there is a case to answer in respect of the stem of charge 1.8; whether you acted or practised outside the scope of your clinical competence or role in that you undertook a smear test of patients as listed in schedule 7, without having the required training/competence.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context, however found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence/ role as an FGM midwife. It noted that it is agreed that your nursing registration lapsed on 1 April 2013. It also had regard to the evidence of Witness 3, that, although it is not prohibited, it is not routinely the practice of a midwife, she said that *“few midwives…would undertake smears as a routine in their practice because you do not take smears during pregnancy”.*

Furthermore, the panel took into consideration the oral evidence of Witness 4 who said, when asked whether you should have taken smear tests: *“I wouldn’t have thought it was within her scope of practice to take smears. She could have referred on to somebody else to do that”.*

In respect of training, the panel had regard to the evidence of Witness 4 and Witness 5 who said that a mandatory Quality Assurance training scheme was in place at the time, which any practitioner was required to complete in order to carry out smear tests. The panel had regard to your training records before it and noted that, at this time, there is no evidence to suggest that you had completed the relevant training to carry out smear tests.

On the basis of the evidence before it, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as a FGM midwife, in that there is evidence before the panel that you undertook a smear test of patients as listed in schedule 7, without having the required training/competence.

1.8.1 Adult 8 on or around 3 December 2015

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you performed a smear test on this patient on the date alleged.

The panel had regard to the oral evidence of Witness 3 in relation to this charge. It noted that she recalled speaking to Ms 7 whose name was on the order and Ms 7 had told her that you could "*only order smear tests if you are on the quality assurance database….so only she was…able to order that test'.* The panel concluded that the audit carried out by Witness 3 and her colleagues is reliable evidence, which has been tested in cross-examination, and therefore sufficient to support a case to answer in respect of this charge.

The panel had regard to its finding that there is a case to answer in relation to both your clinical competence and role as an FGM midwife in relation to the stem of this charge. Accordingly the panel found a case to answer in respect of charge 1.8.1 in relation to both your clinical competence and role.

1.8.2 Adult 32 on or around 28 April 2014

The panel had regard to all the evidence before it in relation to this charge at this stage, It bore in mind that this charge alleges that you acted outside of your clinical competence/ role in that you performed a smear test on this patient on the date alleged.

The panel had regard to the documentary evidence to support this charge, that "smear test taken" is noted on the audit sheet for this patient. It also took into account oral evidence of Witness 3, who said that she had a conversation with another auditor, Ms 12, about a smear test being taken for this patient. The panel concluded that the audit carried out by Witness 3 and her colleagues is reliable evidence, which has been tested in cross-examination, and therefore sufficient to support a case to answer in respect of this charge.

The panel had regard to its finding that there is a case to answer in relation to both your clinical competence and role as an FGM midwife in relation to the stem of this charge. Accordingly the panel found a case to answer in respect of charge 1.8.2 in relation to both your clinical competence and role.

Charge 1.9:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.
Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

The panel first considered if there is a case to answer in respect of the stem of charge 1.9; whether you acted or practised outside the scope of your clinical competence or role in that you accepted referrals for patients who were children/under the age of 18 and not pregnant.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context. However, it found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence/ role as an FGM midwife. It noted that it is agreed that your nursing registration in respect of adult nursing lapsed on 1 April 2013. It noted that this lapsed nursing registration was in respect of adult nursing only.

The panel considered the documentary evidence before it and noted the Trust’s Safeguarding The Welfare of Children Policy, which states: *“physical examination of the child must and can only be undertaken by an appropriately qualified paediatrician”.*

There is further evidence before the panel to support this assertion by way of The Service Standards for commissioning FGM care, which sets out its stated purpose as: *‘this guidance describes service standards expected to be commissioned for the confirmation of FGM in children under the age of 18”.*

Furthermore, the panel took into account the oral evidence of Witness 1 who said, when asked whether you should have treated children: “In the eyes of the law, anyone under 18 is still technically classed as a child”. This was supported by the views of Witness 3, Witness 4 and Witness 5, who gave clear evidence that any reference to “children” included any patient under the age of 18.

The panel accepted this evidence as sufficient to support a case to answer on this charge, using the methodology that any person under the age of 18 should be regarded as a child for the purpose of this charge.

On the basis of the evidence before it, the panel concluded that there is sufficient evidence to support a case to answer that you acted or practised outside of your clinical competence and role as a FGM midwife, where there is evidence before the panel that you accepted referrals for patients who were children/under the age of 18 and not pregnant.

<u>1.9.7 Child 23 on or around 18 February 2016</u>

The panel had regard to its conclusion of the evidence in relation to the stem of charge 1.9. It bore in mind that there is evidence before it that this child was 16 years old at the relevant time, and therefore legally a child.

The panel also took into account that there is evidence before it that Child 23 was not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as an FGM midwife, in that there is evidence before the panel that you accepted a referral for Child 23, who was a child under the age of 18 and not pregnant on or around 20 July 2017

<u>1.9.12 Child 28 on or around 7 July 2017</u>

The panel had regard to its conclusion of the evidence in relation to the stem of charge 1.9. It bore in mind that there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child. The panel had regard to the evidence before it that Child 28 was referred to you by another clinician, which falls within the scope of a referral.

The panel also took into account that there is evidence before it that Child 28 was not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as an FGM midwife, in that there is evidence before the panel that you accepted a referral for Child 28, who was a child under the age of 18 and not pregnant on or around 20 July 2017.

1.9.13 Child 29 on or around 10 August 2017

The panel had regard to its conclusion of the evidence in relation to the stem of charge 1.9. It bore in mind that there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child.

The panel also took into account that there is evidence before it that Child 29 was not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as an FGM midwife, in that there is evidence before the panel that you accepted referral for Child 29, who was a child under the age of 18 and not pregnant on or around 10 August 2017.

Charge 1.10:

Acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.
Schedule 8: Accepted referrals/Assessed/treated children/under age of 18 not pregnant

The panel first considered if there is a case to answer in respect of the stem of charge 1.10; whether you acted or practised outside the scope of your clinical competence or role in that you assessed/examined patients who were children/under the age of 18 and not pregnant.

The panel took into account all of the evidence adduced at this stage.

The panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context, however found that the issues concerning your clinical competence and your role are distinct.

The panel bore in mind the evidence before it in respect of your clinical competence/ role as an FGM midwife. It noted that it is agreed that your nursing registration in respect of adult nursing lapsed on 1 April 2013. It noted that this lapsed nursing registration was in respect of adult nursing only.

The panel considered the documentary evidence before it and noted the Trust’s Safeguarding The Welfare of Children Policy, which states: *“physical examination of the child must and can only be undertaken by an appropriately qualified paediatrician”.*

There is further evidence before the panel to support this assertion by way of The Service Standards for Commissioning FGM Care, which sets out its stated purpose as: *‘this guidance describes service standards expected to be commissioned for the confirmation of FGM in children under the age of 18”.*

Furthermore, the panel took into account the oral evidence of Witness 1 who said, when asked whether you should have treated children: “In the eyes of the law, anyone under 18 is still technically classed as a child”. This was supported by the views of Witness 3, Witness 4 and Witness 5, who gave clear evidence that any reference to “children” included any patient under the age of 18.

The panel accepted this as sufficient evidence to support a case to answer on this charge, using the methodology that any person under the age of 18 should be regarded as a child for the purpose of this charge.

On the basis of the evidence before it, the panel concluded that there is sufficient evidence to support a case to answer that you acted or practised outside of your clinical competence and role as a FGM midwife, where there is evidence before the panel that you assessed/examined patients who were children/under the age of 18 and not pregnant.

1.10.5 Child 21 on or around 22 October 2015
1.10.6 Child 22 on or around 22 October 2015

The panel had regard to its conclusion of the evidence in relation to the stem of charge 1.10. It bore in mind that there is evidence before it that these children, who are siblings, were under 18 years old at the relevant time, and therefore legally children.

The panel had regard to the evidence before it, which included diary notes which indicate that you assessed and examined these children in a joint clinic with Dr 8.

The panel also took into account that there is evidence before it that Children 21 and 22 were not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as an FGM midwife, in that there is evidence before the panel that you accepted assessed/examined Children 21 and 22, on or around 22 October 2015, who were children/under the age of 18 and not pregnant.

1.10.7 Child 23 on or around 18 February 2016
The panel had regard to its conclusion of the evidence in relation to the stem of Charge 1.10. It bore in mind that there is evidence before it that Child 23 was under 18 years old at the relevant time, and therefore legally a child.

The panel had regard to the evidence before it, which included diary notes which indicate that you assessed and examined these children.

The panel also took into account that there is evidence before it that Child 23 was not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as an FGM midwife, in that there is evidence before the panel that you accepted assessed/examined Child 23, who was a child under the age of 18 and not pregnant, on or around 18 February 2016.

<u>1.10.12 Child 28 on or around 7 July 2017</u>
<u>1.10.13 Child 29 on or around 10 August 2017</u>

The panel had regard to its conclusion of the evidence in relation to the stem of Charge 1.10. It bore in mind that there is evidence before it that these children were under 18 years old at the relevant time, and therefore legally children.

The panel had regard to the evidence before it, which included diary notes which indicate that you assessed and examined these children, and included diagrams with your signature and the words *"on assessment"* noted.

The panel also took into account that there is evidence before it that Children 28 and 29 were not pregnant at the relevant time.

Accordingly, the panel concluded that there is a case to answer that you acted or practised outside of your clinical competence and role as a FGM midwife, in that there is evidence before the panel that you accepted assessed/examined Children

28 and 29, on the relevant dates, who were children/under the age of 18 and not pregnant.

Charge 2.1:

On one or more occasion did not, for adult patients as listed in schedule 9
Refer adult patients to specialist counsellors
Schedule 9: Failed to refer/investigate

2.1.1 Adult 2 on or around 27 October 2016

The panel had regard to whether there is a case to answer as to whether you had a duty to refer this adult patient to a specialist counsellor. It had regard to Witness 3's evidence, who outlined that Adult 2 was referred to AWWC for confirmation of FGM/ psychosexual problems. She said, in her oral evidence, that psychosexual problems can be complicated and require an onward referral.

The panel had regard to the documentary evidence from the audit which outlined that no onward referral was made in respect of Adult 2 on or around 27 October 2016, including a letter from Witness 3 which outlined this concern to Adult 2's GP.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

2.1.2 Adult 7 on or around 18 August 2016

The panel considered whether there is a case to answer as to whether you had a duty to refer this adult patient to a specialist counsellor. It had regard to Witness 3's evidence, who outlined that Adult 7 was referred to AWWC for emotional distress, dyspareunia and safeguarding concerns about her daughters.

The panel had regard to documentary evidence from the audit which outlined that no onward referral was made in respect of Adult 7.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

<u>2.1.3 Adult 15 on or around 6 August 2015</u>

The panel considered whether there is a case to answer as to whether you had a duty to refer this adult patient to a specialist counsellor. The panel had regard to documentary the evidence from the audit which outlined that no onward referral was made, and records *"notes state that patient will need psychosexual counselling but no evidence that patient was referred or given any information about counselling"*

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

<u>2.1.4 Adult 23 on or around 28 April 2016</u>

The panel first considered whether there is a case to answer as to whether you had a duty to refer this adult patient to a specialist counsellor. The panel had regard to documentary the evidence from the audit which highlighted *"'psychosexual issues".* It had regard to Witness 3's oral evidence that she did not believe that anything had been done about these issues.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

<u>2.1.5 Adult 36 on or around 3 January 2013</u>

The panel considered whether there is a case to answer as to whether you had a duty to refer this adult patient to a specialist counsellor. The panel had regard to documentary the evidence from the audit which outlined that no onward referral was made, and records: *"notes state 'will benefit from psychosexual counsellor' but no evidence that referral was made".*

It had regard to Witness 3's oral evidence that she would have expected to have seen a letter of referral in such case.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

Charge 2.2:

On one or more occasion did not, for adult patients as listed in schedule 9 Refer adult patients for sexual health counselling
Schedule 9: Failed to refer/investigate

The panel had regard to all of the evidence before it at this stage. It noted that, although Witness 3 provided the panel with a limited description of what sexual health counselling may entail, the majority of witnesses, including your clinical colleagues and those who supervised you, were unable to assist the panel with a description of what sexual health counselling actually is. The panel also took into account that Witness 3 was not an expert on this matter.

The panel therefore found that the NMC had not provided sufficient evidence as to what sexual health counselling is to support a charge that you failed to refer patients to such service.

Additionally, the panel found that this charge is duplicitous with the mischief alleged in Charge 2.1.

Accordingly, the panel found insufficient evidence to support a case to answer in respect of this charge as a whole.

2.2.1 Adult 2 on or around 27 October 2016
2.2.2 Adult 7 on or around 18 August 2016
2.2.3 Adult 15 on or around 6 August 2015
2.2.4 Adult 23 on or around 28 April 2016
2.2.5 Adult 36 on or around 3 January 2013

Having found no case to answer in respect of the duty imposed by the stem of Charge 2.1, it was not required to consider each charge in the schedule individually.

The panel therefore found no case to answer in respect of Charges 2.2.1, 2.2.2, 2.2.3, 2.2.4 and 2.2.5.

Charge 2.3:

On one or more occasion did not, for adult patients as listed in schedule 9 Refer adult patients for further investigation
Schedule 9: Failed to refer/investigate

2.3.1 Adult 4 on or around 21 April 2016

The panel first considered whether there is a case to answer as to whether you had a duty to refer this adult patient for further investigation. The panel had regard to documentary evidence from the audit which notes that Adult 2 complained of pain and infection. It had regard to Witness 3's oral evidence that she would have expected further assessment to have taken place where pain is noted.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

2.3.2 Adult 10 on or around 19 November 2015

The panel had regard to the evidence before it in relation to this charge. It noted that within the pro forma for Adult 10's appointment on 19 November 2015 you recorded *"referred back to her GP – might need some antibiotics".*

The panel was satisfied that this is clear evidence that you had made a referral for Adult 10 to her GP for further investigation. In light of this, the panel concluded that there was no evidence before it to support this charge, and found no case to answer in respect of charge 2.3.2.

2.3.3 Adult 17 on or around 22 August 2013/12 May 2016

The panel had regard to the evidence before it in relation to this charge. It noted that Adult 17 had previously complained of the presence of a cyst on her vulva. However, on the basis of the evidence before it, the cyst was not present at the appointments as charged. The panel noted that there is evidence that you advised Adult 17 to re-contact the AWWC if the cyst re-appeared.

In these circumstances, the panel was not satisfied that there was evidence of a requirement for you to make a further referral in respect of Adult 17 on or around 22 August 2013 and/or 12 May 2016. In these circumstances, the panel found no case to answer in respect of charge 2.3.3.

2.3.4 Adult 56 on or around 29 May 2014

The panel first considered whether there is a case to answer as to whether you had a duty to refer this adult patient for further investigation. The panel had regard to documentary the evidence from your diary entry, which notes *“needs referral to gynaecologist”.* It had regard to Witness 3’s oral evidence that there was no evidence available to the auditors that such referral was ever made.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

The panel therefore found a case to answer in respect of this charge.

2.3.5 Adult 124 on or around 28 July 2016

The panel had regard to the evidence before it in relation to this charge. It noted that there is evidence that the EPR letter had been completed for Adult 124, and outcome letters had been sent to her GP.

The panel was not satisfied that this is clear evidence that you were required to refer Adult 124 for further investigation in the circumstances where you had provided outcome letters following her appointment. In light of this, the panel concluded that there was no evidence before it to support this charge, and found no case to answer in respect of charge 2.3.5.

Charge 2.4:

On one or more occasion did not, for adult patients as listed in schedule 9 Obtain a second opinion for adult patients during/following an FGM assessment.

Schedule 9: Failed to refer/investigate

2.4.1 Adult 2 on or around 27 October 2016

The panel found that the mischief alleged by this charge is duplicitous with charge 2.1.1. The panel there is no case to answer in respect of charge 2.4.1.

2.4.2 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015

The panel had regard to the clinical notes which were available for this patient. It took into account that FGM had been confirmed for this patient by Ms 9 and Dr 10 in 2011, before your involvement with Adult 19.

In the circumstances where FGM had already been identified and recorded, the panel concluded that there was no duty for you to obtain a second opinion in relation to this patient. The panel therefore found no case to answer in respect of this charge.

2.4.3 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

The panel had regard to the clinical notes which were available for this patient. It noted that you had recorded that the de-infibulation was difficult in your diary records and diagram, however you completed the procedure successfully.

It also had regard to the evidence before it that Adult 35 was seen by Witness 5 in her clinic on 16 July 2016. When asked about this patient in her oral evidence, Witness 5's evidence was that the records demonstrate that the de-infibulation procedure had been successful.

In light of this, she did not consider that a second opinion was necessary.

Accordingly, the panel concluded that there was no duty for you to obtain a second opinion in relation to this patient. The panel therefore found no case to answer in respect of this charge.

Charge 3.1

On or around 27 October 2016 during/following your consultation with Adult 2

3.1.1 Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation. The provision of an outcome letter, which she said is a record of a patient's consultation

with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 2's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 2's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record before it in relation to Adult 2, and Witness 3 wrote to Adult 2's GP and stated *"our records do not indicate that the GP practice was notified about the consultation or the outcome of the consultation".* It concluded that there is evidence before it from the audit that Adult 2's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.1.2 Did not record information about Adult 2's background</u>

The panel had regard to all the information before it. It took into account your diary entry for this appointment, in which you recorded details about Adult 2's family, religion, immigration status and her history before coming to the UK. The panel was therefore satisfied that there is evidence before it that you recorded information about Adult 2's background On or around 27 October 2016 during/following your consultation with Adult 2.

The panel therefore found no case to answer in respect of this charge.

3.1.3 Did not record that Adult 2's anatomy change could have been due to birth trauma.

The panel had regard to all the information before it. It had regard to the evidence of Witness 3, that Adult 2's anatomy change could have been as a result of labial tears which occurred during childbirth. The panel bore in mind that this evidence was Witness 3's opinion, and that she accepted that she was not an expert in FGM.

The panel noted that, although there is no evidence that you recorded that Adult 2's anatomy change could have been due to birth trauma, you have recorded that she has had three children, so such conclusion could be logically reached on the basis of the records. Further, it was not satisfied that the NMC has adduced any evidence that you had a duty to record potential alternative reasons for anatomy change within Adult 2's clinical notes.

The panel therefore found no case to answer in respect of this charge.

3.1.4 Did not record adequate details of the advice/assessment/discussion/next steps for Adult 2.

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.1.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.2

On or around 22 September 2016 during/following your consultation with Adult 3

3.2.1 Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 3's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 3's consultation in the EPR /physical patient records bundle. The panel noted that there is an EPR record before it in relation to Adult 3. However, Witness 3 wrote to Adult 3's GP to ask the GP to review Adult 3's records and check that the appropriate care and safeguards were in place for Adult 3. It concluded that there is evidence before it from the audit that Adult 3's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.2.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 3.

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.2.1. Accordingly, the panel found no case to answer in respect of this charge.

3.2.3 Did not record a risk assessment for Adult 3

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record a risk assessment for Adult 3. It first took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, which states:

> *"It should be used to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk."*

It further had regard to the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016, co-authored by you, Witness 1 and Witness 5, which included a risk assessment tool for non-pregnant women over the age of 18. It took particular note of the following extracts:

> *"For non pregnant women where you suspect FGM use the risk assessment took in Appendix 4. Examples could include a woman presenting with*

physical or emotional behaviours that triggers a concern e.g. frequent UTI, severe menstrual pain, infertility, symptoms of Post Traumatic Stress Disorder (PTSD), reluctance to have her genital area examined. As outlined above no assessment undertaken should simply be a tick-box exercise. When managing suspected or actual FGM good communication skills are required for establishing a rapport with the woman/family, asking questions in a straightforward, open way that develops understanding and trust, and being empathetic and non-judgmental.

If a women discloses she has adult daughter(s) over 18 years of age who have already undergone FGM, even if the daughter does not want to take her case to the police, it is important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context. If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution, or due to lack of opportunity or other motivations."

The panel was therefore satisfied that there is sufficient evidence before it for there to be a case to answer that you had a duty to record risk assessments.

The panel went on to consider, on the basis of the evidence before it, whether there is a case to answer that you did not record a risk assessment for Adult 3. The panel had regard to the evidence from the audit that such risk assessment was not fulfilled in that "not recorded" was marked.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

Charge 3.3

On or around 21 June 2016 during/following your consultation with Adult 4

3.3.1 Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 4's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, there is a case to answer that you did not record adequate details of Adult 4's consultation in the EPR /physical patient records bundle. The panel noted that the audit noted an empty EPR record before it in relation to Adult 4. Further, Witness 3 wrote to Adult 4's GP and stated, *"our records do not indicate that the GP practice was notified about the consultation or the outcome of the consultation".* It concluded that there is evidence before it from the audit that Adult 4's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.3.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 4

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.3.1. Accordingly, the panel found no case to answer in respect of this charge.

3.3.3 Did not record information about Adult 4's risk of infection/chronic pain

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details about risk of infection/ chronic pain would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.3.1. Accordingly, the panel found no case to answer in respect of this charge.

3.3.4 Did not record a risk assessment for Adult 4

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record a risk assessment for Adult 4. It took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016 as outlined in charge 3.2.3.

The panel was therefore satisfied that there is sufficient evidence before it for there to be a case to answer that you had a duty to record risk assessments.

The panel went on to consider, on the basis of the evidence before it, whether there is a case to answer that you did not record a risk assessment for Adult 4. The panel had regard to the evidence from the audit that as such a risk assessment was not fulfilled, in that "not recorded" was marked.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.3.5 Did not record whether a swab/urine sample had been taken for Adult 4</u>

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record whether a swab/ urine sample had been taken for Adult 4. The panel noted that there was no evidence before it that either a swab or urine sample had been taken, nor was one required, for Adult 4.

The panel concluded that the NMC had not adduced sufficient evidence to establish a duty that you should have taken a swab or urine sample for Adult 4. It bore in mind that you would be under an obligation to record such sample were one taken, however the NMC has not established sufficient evidence to support an obligation to record something which you had not done.

Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.4</u>

On or around 15 June 2017 during/following your consultation with Adult 6

3.4.1 Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 6's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 6's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record before it in relation to Adult 6. It concluded that there is evidence before it from the audit that Adult 6's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.4.2 Did not record the reason for Adult 6's referral to the FGM clinic

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details about Adult 6's referral to the FGM clinic would also form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.4.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>3.4.3 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 6</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.4.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.5</u>

On or around 18 August 2016 during/following your consultation with Adult 7

<u>3.5.1 Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle</u>

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 7's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 7's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record before it in relation to Adult 7. It concluded that there is evidence before it from the audit that Adult 7's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.5.2 Did not record a risk assessment of Adult 7/Adult 7's daughters</u>

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record a risk assessment for Adult 7 or her daughters. It took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016 as outlined in charge 3.2.3.

It also had regard to the following extract from the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, specifically in relation to Adult 7's daughters:

> *"Successful implementation will be dependent upon the clinician understanding that there is a potential risk of FGM, and on their continuing awareness and consideration of this through the early years of a girl's life. For the system to succeed, a critical factor will be the use of a tool such as the FGM Safeguarding Risk Assessment ([…]). Therefore, it is*

recommended that organisations look to adopt this guidance which will act as preparation for this new change."

The panel was therefore satisfied there is sufficient evidence before it for there to be a case to answer that you had a duty to record risk assessments for both Adult 7 and her children.

The panel went on to consider, on the basis of the evidence before it, whether there is a case to answer that you did not record a risk assessment for Adult 7 or her children. It also took into account Witness 5's oral evidence that issues concerning children would be recorded in their mother's clinical notes where records are not available for the children. The panel had regard to the evidence from the audit that such risk assessment was not fulfilled, in that "not recorded" was marked.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.5.3 Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind that there is evidence before it which outlines the reasons for and importance of recording communication with safeguarding professionals, within the Trust Safeguarding the Welfare of Children: Children in Need and Child Protection Procedure, effective from May 2014.

The panel had regard to the evidence from the audit and from Witness 3 that nothing was recorded in respect of communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.5.4 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 7</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.5.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.6</u>

On or around 3 December 2015 during/following your consultation with Adult 8

<u>3.6.1 Did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle.</u>

The panel had regard to all the evidence before it at this stage. The panel first considered whether there was a duty to record such details. It bore in mind that Adult 8's consultation on 3 December 2015 is distinct from other patients particularised at charge 3, in that this appointment related to a smear test and not FGM. The panel had regard to the evidence before it, that this smear test had been recorded in a pro forma document, and a follow up welfare letter was sent to her GP via email on 7 December 2015.

It concluded that there has been insufficient evidence adduced by the NMC which would support a case to answer that you did not record adequate details of Adult 8's consultation in the EPR/physical patient records bundle.

Accordingly, the panel found no case to answer in respect of this charge.

<u>3.6.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8</u>

The panel had regard to all the evidence before it at this stage. The panel first considered whether there was a duty to record such details. It bore in mind that Adult 8's consultation on 3 December 2015 is distinct from other patients particularised at charge 3, in that this appointment related to a smear test and not FGM. The panel had regard to the evidence before it, that this smear test had been recorded in a pro forma document, and a follow up welfare letter was sent to her GP via email on 7 December 2015.

The panel noted that the audit highlighted an absence of detail in Adult 8's notes, including the recording of consent and the offer of a chaperone, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.6.3 Did not record/inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years</u>

The panel had regard to all the evidence before it at this stage. The panel first considered whether there was a duty to record, or inform Adult 8 of such details. It bore in mind that Adult 8's consultation on 3 December 2015 is distinct from other patients particularised at charge 3, in that this appointment related to a smear test and not FGM. The panel had regard to the evidence before it, that this smear test was a standard test which would be sent for analysis, following which the results would later be circulated to Adult 8 from a centralised administration team.

The panel heard evidence that there was an established national process which follows such appointments, and the results of such tests are communicated via that process.

It concluded that there has been insufficient evidence adduced by the NMC which would support a case to answer that you had a duty to record or inform Adult 8 of their smear test result/that the smear test should be repeated in 3 years.

Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.7

On or around 4 June 2015 during/following your consultation with Adult 9

3.7.1 Did not record adequate details of Adult 9's consultation in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had

a duty to record adequate details of Adult 9's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 9's consultation in the EPR /physical patient records bundle. The panel noted that the audit recorded that there was no EPR record, or outcome letter contained within Adult 9's physical patient records bundle. It concluded that there is evidence before it from the audit that Adult 9's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.7.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 9.</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.7.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.8</u>

3.8 On or around 19 November 2015 during/following your consultation with Adult 10

3.8.1 Did not record adequate details of Adult 10's consultation in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 10's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 10's consultation in the EPR /physical patient records bundle. The panel had regard to the pro forma document which you completed in respect of this appointment. It noted that this would form part of Adult 10's patient notes. The panel bore in mind that clearly documented that Adult 10 declined assessment, you were unable to determine the type of FGM which she had, and that you referred her back to her GP for antibiotics. You further documented that Adult 10's daughter reported her to feel scared and uncomfortable.

The panel concluded that there was evidence before it of adequate details being recorded of Adult 10's physical patient notes, given the limited scope of your involvement in this case, and the fact that you referred her back to her GP. Therefore it found no case to answer in respect of this charge.

3.8.2 Did not record whether a urine sample had been taken for Adult 10

The panel had regard to all the evidence before it at this stage. The panel had regard to the pro forma document which you completed in respect of this appointment. It noted that this would form part of Adult 10’s patient notes. The panel bore in mind that clearly documented that Adult 10 declined assessment, you were unable to determine the type of FGM which she had, and that you referred her back to her GP for antibiotics.

The panel concluded that the taking of a urine sample would likely form part of an assessment. In the circumstances where you have recorded that Adult 10 has declined assessment, it concluded that there is no evidence before it that you also had a duty to separately record whether a urine sample has been taken for Adult 10.

The panel therefore it found no case to answer in respect of this charge.

<u>3.8.3 Did not record whether Adult 10 was checked for a urinary tract infection/infections</u>.

The panel had regard to all the evidence before it at this stage. The panel had regard to the pro forma document which you completed in respect of this appointment. It noted that this would form part of Adult 10’s patient notes. The panel bore in mind that clearly documented that Adult 10 declined assessment, you were unable to determine the type of FGM which she had, and that you referred her back to her GP for antibiotics.

The panel concluded that checking for a urinary tract infection would likely form part of an assessment. In the circumstances where you have recorded that Adult 10 has declined assessment, it concluded that there is no evidence before it that you also had a duty to separately record whether Adult 10 was checked for a urinary tract infection/infections.

The panel therefore it found no case to answer in respect of this charge.

<u>3.8.4 Did not record adequate details of the advice provided to Adult 10</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.8.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.9

On or around 11 June 2015 during/following your consultation with Adult 12

3.9.1 Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 12's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 12's consultation in the EPR /physical patient records bundle. The panel noted that the audit recorded *"EPR checked nothing noted"*. It had regard to Witness 3's oral evidence that reference to "*nothing noted*" in the audit was indicative that patient notes were available, however they were missing pieces of information. It concluded that there is evidence before it from the audit that Adult 12's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.9.2 Did not record whether the de-infibulation procedure was discussed with Adult 12

The panel had regard to all of the evidence before it at this stage. The panel noted that the NMC has not adduced any evidence before it to establish that you were under any duty to record whether the de-infibulation procedure was discussed with Adult 12 at this appointment.

Further, the panel found that this charge is duplicitous with the mischief alleged in charge 5.4, which relates to you recording the offer of consent to Adult 12, in relation to the de-infibulation procedure.

Accordingly, the panel found no case to answer in respect of this charge.

3.9.3 Did not record a discussion around personal hygiene with Adult 12

The panel had regard to all of the evidence before it at this stage. The panel noted that *"hygiene advised"* is recorded on the audit in relation to this appointment.

The panel therefore concluded that there is evidence before it to directly contradict this charge. Accordingly, the panel found no case to answer in respect of this charge.

3.9.4 Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

The panel had regard to all the evidence before it at this stage. It noted that there is evidence before it that the purpose of recording the reasons for prescribing antibiotics is to provide a rationale for such prescription for patients and clinical colleagues.

The panel bore in mind that there is no evidence before it that you have recorded the purpose/reasons for prescribing antibiotics to Adult 12.

Accordingly, it found a case to answer in respect of this charge.

3.9.5 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 12.

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.9.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.10
On or around 6 August 2015 during/following your consultation with Adult 15

3.10.1 Did not record adequate details of Adult 15's consultation in the EPR/physical patient records bundle

The panel had regard to all of the evidence before it at this stage. The panel noted that the audit marked "not recorded" in respect of AWWC assessment and symptoms in respect of this patient. However, the panel had regard to your diary entry for this appointment, in which you recorded the reasons for the consultation, why Adult 15 had presented at the AWWC, details of the discussion you had with her and what the outcome was. It also

noted that you had completed an EPR record for this patient in respect of this appointment.

Accordingly, the panel was satisfied that, on the basis of the evidence before it, the documentation is adequate in relation to this appointment save for the absence of evidence in respect of any onward referral. The panel bore in mind that this mischief is alleged at 2.1.3, therefore it would be duplicitous to find a case to answer in respect of this charge on the sole basis of this concern.

The panel therefore found no case to answer in respect of this charge.

3.10.2 Did not record a discussion about the illegality of FGM with Adult 15

The panel had regard to all the evidence before it at this stage. It bore in mind the evidence of Witness 5, that all women who attended the AWWC were provided with a leaflet which informed them about the illegality of FGM. Witness 5 also informed the panel that she had witnessed your approach to this matter when you provided advice to patients during your consultations. However, the panel noted that the audit marked "not recorded" for of both "informed about the illegalities of FGM" and "FGM leaflet given". The panel bore in mind that your note on the diary page for this appointment set out *"all issues relating to FGM discussed […] well understood".* However, bearing in mind the findings of the audit, it concluded that there is not any evidence before it to satisfy conclusively that such note should be taken to include the illegality of FGM.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.10.3 Did not record a risk assessment for Adult 15.

The panel had regard to all of the evidence before it at this stage. The panel bore in mind that the audit marked “not recorded” in respect of risk assessment. It took into account the evidence of Witness 3, who said that such note was indicative of an assessment not being available within a patient’s notes. Further, the panel had regard to its findings in respect of risk assessments at charge 3.2.3.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.10.4 Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 15

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5’s evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.10.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.11

On or around 3 November 2016 during/following your consultation with Adult 16;

The panel had regard to the evidence before it at this stage in relation to this charge as a whole. It bore in mind that there are no diary notes before the panel in respect of this patient. It noted that the audit is unclear as to where the information for its conclusions came from, and that there is a conflict within the audit as to the source of referral for Adult 16, in that the audit front sheet records “unknown”, and the welfare letter that Witness 3 sent to Adult 16’s GP outlines that Adult 16 was seen at the AWWC on 3 November 2016,

following a referral for antenatal de-infibulation. The panel found that this conflict within the audit is material so as to make it tenuous and unreliable in respect of this charge as a whole.

Accordingly, the panel found insufficient evidence to support a case to answer in respect of this charge as a whole.

3.11.1 Did not record adequate details of Adult 16's consultation in the EPR/physical patient records bundle
3.11.2 Did not record the reasons for Adult 16's referral
3.11.3 Did not record Adult 16's gestation period
3.11.4 Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 16

Having found no case to answer in respect of the duty imposed by the stem of charge 3.11, it was not required to consider each charge in the schedule individually.

The panel therefore found no case to answer in respect of charges 3.11.1, 3.11.2, 3.11.3 and 3.11.4.

Charge 3.12

On or around 22 August 2013/12 May 2016 during/following your consultation with Adult 17

3.12.1 Did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that

of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 17's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 17's consultation in the EPR /physical patient records bundle. The panel noted that the audit had "not recorded" marked in respect of the AWWC assessment and symptoms box. Your diary notes for both appointments note EPR with a score through, however the panel took into account the oral evidence of Witness 2, that the auditors had searched for an EPR for these appointments and no such records were available.

In respect of the appointment on 22 August 2013, the panel regard to the conclusions of the audit and bore in mind the evidence of Witnesses 4 and 5 about the importance of adequate patient records. It concluded that there is evidence on the basis of the audit and these witnesses to support this charge in respect of this date.

In respect of the appointment on 12 May 2016, the panel noted that you had recorded that Adult 17 had presented at the AWWC with a cyst on her clitoris, which was not present on examination. In light of this, the panel concluded that there was no case to answer that you did not record adequate details of Adult 17's consultations in the EPR/physical patient records bundle.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge in relation to 22 August 2013 only.

<u>3.12.2 Did not record adequate details about Adult 17's de-infibulation procedure</u>

The panel had regard to the evidence before it at this stage. It first considered your diary entry in respect of Adult 17's appointment on 22 August 2013, when you performed de-infibulation on this patient. It bore in mind that you noted the type of FGM Adult 17 had, the age at which it had been initially done, and that FGM had been done three times to this patient. It also noted that you had recorded "*de-infibulation of small closed area*" and included a diagram within the diary entry. It also had regard to the audit, which suggested that adequate details had been recorded in relation to Adult 17's de-infibulation procedure.

Accordingly, the panel found no case to answer in respect of this charge.

3.12.3 Did not record complete/adequate details of the advice/assessment/discussion/next steps provided to Adult 17

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.12.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.13

On or around 14 May 2015/20 August 2015/10 September 2015 during/following your consultation with Adult 19

3.13.1 Did not record adequate details of Adult 19's consultations in the EPR/physical patient records bundle

The panel had regard to all of the evidence before it at this stage. This included the audit, your diary notes and Adult 19's clinical notes. The panel found these notes to be adequate

and contained details of the events of each of the consultations on 14 May, 20 August and 10 September 2015, including the action taken and advice given to Adult 19.

Accordingly, the panel found there was no evidence to support this charge, and therefore no case to answer.

<u>3.13.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 19</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.13.1, on which it had also found no case to answer. Accordingly, the panel found no case to answer in respect of this charge.

<u>3.13.3 Did not record information surrounding the history of domestic abuse of Adult 19</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind the evidence of Witness 3 that where there is a history of domestic abuse this should be recorded within a patient's notes.

The panel had regard to Adult 19's clinical records and noted the following excerpt from a letter from the Pain Management Team at the Trust, to Adult 19's GP, dated 23 December 2015, which reads:

> *"Adult 19 fled from a domestically violent relationship in 2006 to this country. She explained that at that time she lost contact with friends who knew the perpetrator, and she has worked to build up a new life in this country. She*

stated that she now feels safe in this country, however finds thoughts of the previous relationship affect her mood."

The panel noted that there is no evidence before it of any recent or current domestic abuse, or any current risk of domestic abuse.

The panel considered that, in the absence of any evidence of any current domestic abuse, and in the circumstances where Adult 19's history of domestic abuse has been well documented within her clinical notes, the NMC has not adduced sufficient evidence of a duty for you to record information surrounding the history of domestic abuse of Adult 19 since she arrived in the UK.

Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.14

On or around 16 April 2015 during/following your consultation with Adult 22

3.14.1 Did not record adequate details of Adult 22's consultation in the EPR/physical patient records bundle.

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 22's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 22's consultation in the

EPR /physical patient records bundle. It noted that the audit records *“no follow-up documented”*. It also took into account Witness 3’s oral evidence, that your record keeping was universally poor. The panel therefore concluded that there is evidence before it from the audit that Adult 22’s patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.14.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 22.</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5’s evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.14.1.

Accordingly, the panel found no case to answer in respect of this charge.

<u>3.14.3 Did not record the timing of the administration of lidocaine to Adult 22</u>

The panel had regard to all of the evidence before it at this stage. It could not identify any evidence adduced by the NMC which would establish that you had a duty to record the timing of the administration of Lidocaine to Adult 22, or any other patient. This formed an essential part of an ongoing medical procedure, as stated by Witness 5 in her oral evidence, who said that in such circumstances recording specific timings were not required.

Accordingly, the panel found no case to answer in respect of this charge.

3.14.4 Did not record the frequency of the administration of lidocaine to Adult 22

The panel had regard to all of the evidence before it at this stage. It could not identify any evidence adduced by the NMC which would establish that you had a duty to record the frequency of the administration of Lidocaine to Adult 22, or any other patient. This formed an essential part of an ongoing medical procedure, as stated by Witness 5 in her oral evidence, who said that in such circumstances recording the frequency of the administration of lidocaine is not required.

Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.15

On or around 28 April 2016 during/following your consultation with Adult 23

3.15.1 Did not record adequate details of Adult 23’s consultation in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5’s evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient’s consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 23’s consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 23’s consultation in the

EPR /physical patient records bundle. The panel noted that the audit recorded that the EPR letter was empty, and that Adult 23 needed a follow up welfare letter to her GP regarding her psychosexual concerns. It concluded that there is evidence before it from the audit that Adult 23's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.15.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 23

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.15.1. Accordingly, the panel found no case to answer in respect of this charge.

3.15.3 Did not record a risk assessment for Adult 23/Adult 23's children

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record a risk assessment for Adult 23 or her daughters. It took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016 as outlined in charge 3.2.3.

It also had regard to the following extract from the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, specifically in relation to Adult 23's daughters:

> *"Successful implementation will be dependent upon the clinician understanding that there is a potential risk of FGM, and on their continuing awareness and consideration of this through the early years of a girl's life. For the system to succeed, a critical factor will be the use of a tool such as the FGM Safeguarding Risk Assessment ([…]). Therefore, it is recommended that organisations look to adopt this guidance which will act as preparation for this new change."*

The panel heard evidence that the Trust Clinical Guidance for Female Genital Mutilation, co-authored by yourself in 2016 adopted the above safeguarding risk assessment.

The panel was therefore satisfied that there is evidence before it from which it may find a case to answer that you had a duty to record risk assessments for both Adult 23 and her children.

The panel went on to consider, on the basis of the evidence before it, whether there is a case to answer that you did not record a risk assessment for Adult 23 or her children. It also took into account Witness 5's oral evidence that issues concerning children would be recorded in their mother's clinical notes where records are not available for the children. The panel had regard to the evidence from the audit that such risk assessment was not fulfilled, in that "not recorded" was marked.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

Charge 3.16

On or around 20 October 2016 during/following your consultation with Adult 24

3.16.1 Did not record adequate details of Adult 24's consultation in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 24's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 24's consultation in the EPR /physical patient records bundle. It considered that the audit for this patient is incomplete, and does not specify the auditors' findings on many of the areas of concern recorded in respect of other patient records audited. Additionally, the panel noted that the auditors had outlined commentary in relation to this appointment on the front sheet of the audit.

Further, the panel noted that your diary entry in respect of this appointment contained adequate details of the consultation, including that a referral was made to the gynaecology department at the Trust.

Accordingly, the panel found no case to answer in respect of this charge.

3.16.2 Did not inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment

The panel had regard to all of the evidence before it at this stage. It noted the oral evidence of Witness 3, who said that it was not your responsibility to follow up whether Adult 24 attended, nor to inform Adult 24's GP that she failed to attend her gynaecological appointment.

Accordingly, the panel could not identify any evidence adduced by the NMC which would establish that you had a duty to inform Adult 24's GP that Adult 24 failed to attend her gynaecological appointment. It therefore found no case to answer in respect of this charge.

3.16.3 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 24

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.16.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.17

On or around 2 July 2015/ 9 July 2015/ 6 August 2015 during/following your consultation with Adult 35

3.17.1 Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 35's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of Adult 35's consultation in the EPR /physical patient records bundle. The panel noted that you had not recorded consent, the offer of a chaperone or a risk assessment for the appointments on 2 July, 9 July and 6 August 2015 in Adult 35's records. It concluded that there is evidence before it from the audit that Adult 35's patient notes may have been inadequate, in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.17.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 35</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.17.1. Accordingly, the panel found no case to answer in respect of this charge.

3.17.3 Did not record the reason for prescribing/providing antibiotics to Adult 35.

The panel had regard to all of the evidence before it at this stage. It had particular regard to Adult 35's clinical notes, in which you had documented: *"antibiotics given (Erythromycine)".* The panel bore in mind there was no reason recorded in these notes for why these antibiotics were prescribed.

Accordingly, the panel found a case to answer on the basis of the evidence before it.

3.17.4 Did not record the dosage of antibiotics prescribed/provided to Adult 35

The panel had regard to all of the evidence before it at this stage. It was not satisfied that the NMC has adduced any evidence in relation to 9 July 2015 when the antibiotics were given to demonstrate that you had a duty to record the dosage of antibiotics prescribed/ provided to Adult 35. Further, the panel found that this charge is duplicitous with the mischief alleged in charge 3.17.3.

Accordingly, the panel found no case to answer in respect of this charge.

3.17.5 Did not record details surrounding Adult 35's possible allergies to antibiotics.

The panel had regard to all of the evidence before it at this stage. It noted the evidence of Witness 3, that recording such details would be good practice, but there is no implicit duty to do so. In light of this, the panel was not satisfied that the NMC has adduced sufficient evidence to demonstrate that you had a duty to record details surrounding Adult 35's possible allergies to antibiotics.

Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.18

On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 44;

3.18.1 Did not record adequate details of Adult 44's consultations in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 44's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, there is a case to answer that you did not record adequate details of Adult 44's consultation in the EPR /physical patient records bundle. There is evidence from the audit that you did not record consent, Witness 3 had outlined that you had not recorded consent, the offer of a chaperone or a risk assessment for these appointments in Adult 44's records. It concluded that there is evidence before it from the audit that Adult 44s patient notes may have been inadequate, in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.18.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 44

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.18.1. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.19

On or around 21 July 2016/28 July 2016 during/following your consultation with Adult 124

3.19.1 Did not record adequate details of Adult 124's consultations in the EPR/physical patient records bundle

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 124's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, there is a case to answer that you did not record adequate details of Adult 124's consultation in the EPR /physical patient records bundle. There is evidence from

the audit that you did not record Adult 124's assessment and symptoms, and the notes are limited as to this patient's history at these appointments. The panel bore in mind the evidence of Witness 3, that your notes were universally inadequate. It concluded that there is evidence before it from the audit that Adult 124s patient notes may have been inadequate, in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.19.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 124</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 3.19.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.20</u>

On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130

<u>3.20.1 Did not record adequate details of Adult 130's consultations in the EPR/physical patient records bundle</u>

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and

especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of Adult 130's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, there is a case to answer that you did not record adequate details of Adult 130's consultation in the EPR /physical patient records bundle. The panel noted that the audit noted that you did not record the source of referral or Adult 130's prescription. Further, it noted that the auditors had assessed your notes as basic in respect of both appointments. The panel bore in mind the evidence of Witness 3, that your notes were universally inadequate. It concluded that there is evidence before it from the audit that Adult 130's patient notes may have been inadequate, in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>3.20.2 Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 130</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in Charge 3.20.1. Accordingly, the panel found no case to answer in respect of this charge.

<u>3.20.3 Did not record whether Adult 130's condition/assessment was escalated</u>

The panel had regard to all the evidence before it at this stage. It bore in mind the evidence of Witness 5, who said that she could not comment on whether Adult 130's condition/ assessment was required to be escalated on the basis of the notes before the panel and without seeing the patient.

Accordingly, the panel was not satisfied that the NMC has adduced sufficient evidence that you had a duty to record whether Adult 130's condition/assessment was escalated. Accordingly, it found no case to answer in respect of this charge.

<u>Charge 3.21</u>

On or around 6 August 2015 during/following your consultation with Child 16

<u>3.21.1 Did not clearly record the origin of referral in Child 16's patient records</u>

The panel had regard to all of the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"GP/Social Worker".*

The panel bore in mind that there is some evidence as to the origin of referral. However, there remains a case to answer that such records are not sufficiently clear.

Accordingly, the panel found a case to answer in respect of this charge.

<u>Charge 3.22</u>

On or around 6 August 2015 during/following your consultation with Child 17

<u>3.22.1 Did not clearly record the origin of referral in Child 17's patient records.</u>

The panel had regard to all of the evidence before it at this stage It noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"GP/Social Worker".*

The panel bore in mind that there is some evidence as to the origin of referral. However, there remains a case to answer that such records are not sufficiently clear.

Accordingly, the panel found a case to answer in respect of this charge.

Charge 3.23

On or around 13 August 2015 during/following your consultation with Child 18

3.23.1 Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father.
The panel noted that, in your diary entry in respect of this appointment, you wrote "*advised and reassured*". The panel did not find that the outcome letter for this

appointment contained details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father.

Accordingly, the panel found that there is a case to answer in respect of this charge.

<u>3.23.3 Did not record whether a urine sample had been taken for Child 18</u>

The panel had regard to all of the evidence before it at this stage. It first considered whether there is a case to answer that you had a duty to record whether a urine sample had been taken for Child 18. The panel noted that there was no evidence before it that a urine sample had been taken, nor was there sufficient evidence a urine sample was required, for Child 18, although it bore in mind that there is evidence that you had referred her for further investigation.

The panel concluded that the NMC had not adduced sufficient evidence to establish a duty that you should have taken a urine sample for Child 18. It bore in mind that you would be under an obligation to record such if a sample was taken, however the NMC has not established sufficient evidence to support an obligation to record something which you had not done.

Accordingly, the panel found no case to answer in respect of this charge.

<u>Charge 3.24</u>
<u>On or around 11 September 2015 during/following your consultation with Child 19</u>

<u>3.24.2 Incorrectly stated in Child 19's GP letter dated 14 October 2015 that Child 19 was assessed on 9 September 2015</u>

The panel had regard to all of the evidence before it. It noted that the outcome letter records that the clinic was on 11 September 2015. However, the panel considered that it was more likely than not that this was an obvious typographical error which did not result in harm to any patients.

In light of this, the panel concluded that, even if found proved, this charge could not amount to misconduct. Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.25

On or around 22 October 2015 during/following your consultation with Child 21

3.25.1 Did not adequately record the origin of referral in Child 21's patient records.

The panel had regard to all of the evidence before it at this stage It noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"Social Services/Police Referral".*

The panel bore in mind that there is some evidence as to the origin of referral. However, there remains a case to answer that such records are not adequate.

Accordingly, the panel found a case to answer in respect of this charge.

Charge 3.26

On or around 22 October 2015 during/following your consultation with Child 22

3.26.1 Did not adequately record the origin of referral in Child 22's patient records

The panel had regard to all of the evidence before it at this stage It noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted

that your records from this Child's appointment indicate that she was referred by *"Social Services/Police Referral".*

The panel bore in mind that there is some evidence as to the origin of referral. However, there remains a case to answer that such records are not adequate.

Accordingly, the panel found a case to answer in respect of this charge.

Charge 3.27

On or around 18 February 2016 during/following your consultation with Child 23

3.27.1 Did not create any official clinical healthcare records for Child 23

The panel had regard to all of the evidence before it at this stage. It had regard to the audit which recorded that healthcare records were not documented. The panel also bore in mind the evidence of Witness 3, who said that there were no records available for this patient. It concluded that there is evidence before it from the audit that no official clinical healthcare records may have been created for Child 23, in respect of this appointment. The panel bore in mind that you completed a diary record for this patient, however, these were not official clinical healthcare records.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

3.27.3 Did not record the social impact of FGM on Child 23.

The panel had regard to all of the evidence before it at this stage. It concluded that the NMC has not adduced sufficient evidence as to what this charge means to satisfy the panel that it is capable of being found proved.

Accordingly, the panel found no case to answer in respect of this charge.

3.27.5 Did not send an outcome letter to Child 23's GP

The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to send an outcome letter to Child 23's GP.

The panel went on to consider whether, on the basis of the evidence before it, that there is a case to answer that you did not send an outcome letter to Child 23's GP. The panel noted that there is an empty outcome letter in respect of this appointment contained within the bundle. It also bore in mind Witness 3's evidence, who said that where a blank outcome letter exists, the presumption is that it would not have been sent. The panel concluded that there is evidence before it that you may not have sent an outcome letter to Child 23's GP.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

Charge 3.28

On or around 26 May 2016 during/following your consultation with Child 24

3.28.2 Did not record whether Child 24 required additional services/support.

The panel had regard to the wording of this charge. It concluded that *“additional services/ support”* would fall under the requirement of *“optimal”* support. Accordingly, the panel found that this charge is duplicitous with the mischief alleged in charge 3.28.1: “*Did not record/consider whether the support Child 24 was receiving was optimal.”*

The panel therefore found no case to answer in respect of this charge.

3.28.3 Did not record which kind of support/plans were in place for Child 24

The panel had regard to all of the evidence before it at this stage. It noted that there is evidence from the blue notes that Child 24 was receiving some support. Further, it had regard to the wording of this charge, which it found duplicitous with the mischief alleged in charge 3.28.4: “*Did not record adequate details of the advice/examination/discussion/next steps provided to Child 24.”*

The panel therefore found no case to answer in respect of this charge.

Charge 3.29

On or around 9 June 2016 during/following your consultation with Child 25

3.29.2 Did not record a risk assessment for Child 25

The panel had regard to all of the evidence before it at this stage. It first noted the oral evidence of Witness 1, who said that there is evidence that this child did not have FGM, and where a clinical decision was made that a child did not have FGM, it probably negates the need for a risk assessment.

However, the panel noted the Guy’s and St Thomas’ Clinical Guidance on FGM, dated 10 February 2016, co-authored by you, Witness 1 and Witness 5, which sets out:

“The aim is to make an initial assessment of risk and then support the ongoing assessment of the child or young person and any potential safeguarding concerns. Always consider other girls and women in the family who may be at risk of FGM when dealing with a particular girl. Please undertake a risk assessment as outlined […]; this is to include family, social and medical history taking. No assessment undertaken by a practitioner should simply be a tick-box exercise.”

The panel noted that there is a conflict in the NMC evidence in relation to this charge at this stage which would be more appropriately tested at the facts stage.

Accordingly, the panel concluded that there is sufficient evidence to support a case to answer in respect of this charge.

Charge 3.30

On or around 9 June 2016, during/following your consultation with Child 26

3.30.4 Incorrectly informed Child 26’s GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

The panel had regard to all of the evidence before it at this stage. It noted that there are two letters to Child 26’s GP before the panel. The first, dated 22 August 2016, reads:

“Assessment confirmed a normal vulva – no sign of FGM.

She had de-infibulation the same day under local anaesthetic”

The second letter, dated 10 June 2016 reads:

“Examination shows normal vulva, clitoris and labias appears normal”

The panel had regard to the oral evidence of Witness 2, who said that if a letter is saved on the EPR system, it should have been sent to the addressee.

Accordingly, the panel was satisfied that there is sufficient evidence to establish a case to answer in respect of this charge.

3.30.5 Did not record a risk assessment for Child 26

The panel had regard to all of the evidence before it at this stage. It first noted the oral evidence of Witness 1, who said that there is evidence that this child did not have FGM, and where a clinical decision was made that a child did not have FGM, it probably negates the need for a risk assessment.

However, the panel noted the Guy's and St Thomas' Clinical Guidance on FGM, dated 10 February 2016, as outlined above at charge 3.29.2.

The panel noted that there is a conflict in the NMC evidence in relation to this charge at this stage which would be more appropriately tested at the facts stage.

Accordingly, the panel concluded that there is sufficient evidence to support a case to answer in respect of this charge.

Charge 3.32

On or around 7 July 2017, during/following your consultation with Child 28

3.32.1 Did not record a full risk assessment for Child 28

The panel had regard to all of the evidence before it at this stage. It bore in mind the oral evidence of Witness 2 who said that for a patient who was in the care of the paediatric team, as was Child 28 who was in PICU, it would be for that team to update the risk assessment which would have been started by the paediatric team, and updated by them.

In these circumstances, where Child 28 was under the care of multiple professionals within the paediatrics team at the Trust who would have been responsible for updating a full risk assessment for Child 28, which your input would have formed part of, the panel was satisfied that there was no evidence before it to establish that you had a duty to record a full risk assessment for Child 28.

Accordingly, the panel found no case to answer in respect of this charge.

3.32.2 Did not record adequate details of the advice/examination/discussion/next steps provided to Child 28/Child 28's father

The panel had regard to all of the evidence before it at this stage. It had particular regard to your diary entry in respect of this Child, which states:

> *"Had FGM at some point but father denied any surgery to the vulva – he requested a second opinion – I will make a referral to UCLH FGM clinic for a second opinion"*

The panel also noted that this diary entry contained a diagram with the detail of assessment which you had performed on Child 28.

Accordingly, the panel found no case to answer in respect of this charge.

Charge 3.33

On or around 10 August 2017, during/following your consultation with Child 29

3.33.1 Did not record a full risk assessment for Child 29

The panel had regard to all of the evidence before it at this stage. It first noted the oral evidence of Witness 1, who said that there is evidence that this child did not have FGM, and where a clinical decision was made that a child did not have FGM, it probably negates the need for a risk assessment.

However, the panel noted the Guy's and St Thomas' Clinical Guidance on FGM, dated 10 February 2016, as outlined above at charge 3.29.2.

The panel noted that there is a conflict in the NMC evidence in relation to this charge at this stage which would be more appropriately tested at the facts stage.

Accordingly, the panel concluded that there is sufficient evidence to support a case to answer in respect of this charge.

Charge 4

Did not record the offer/confirmation of consent for FGM assessments for one or more adult patients as listed in schedule 10.
Schedule 10: Failed to record the offer of consent for examination/de- infibulation

The panel had regard to all of the evidence before it at this stage. The panel found that this charge is duplicitous with the mischief alleged in charge 5. Accordingly, the panel found insufficient evidence to support a case to answer in respect of this charge as a whole.

4.1 Adult 2 on or around 27 October 2016
4.2 Adult 8 on or around 3 December 2015
4.3 Adult 9 on or around 4 June 2015
4.4 Adult 12 on or around 11 June 2015
4.5 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015
4.6 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016
4.7 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015
4.8 Adult 44 on or around 5/12 December 2013
4.9 Adult 69 on or around 15 October 2015
4.10 Adult 74 on or around 3 October 2013
4.11 Adult 124 on or around 21 July 2016

4.12 Adult 130 on or around 10/24 November 2016

4.13 Adult 138 on or around 29 June 2017

4.14 Adult 143 on or around 12 March 2013

4.15 Adult 154 on or around 25 May 2017

Having found no case to answer in respect of the duty imposed by the stem of charge 4, it was not required to consider each charge in the schedule individually.

The panel therefore found no case to answer in respect of charges 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.11, 4.12, 4.13, 4.14 and 4.15.

Charge 5

Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.
Schedule 10: Failed to record the offer of consent for examination/de- infibulation

5.1 Adult 2 on or around 27 October 2016

The panel had regard to all the evidence before it at this stage. It noted that the audit is silent as to whether consent was obtained in respect of Adult 2's appointment on or around 27 October 2016.

Although the panel has concluded that the audit is reliable as to where it has recorded what has been seen, or recorded the absence of something which would be expected to have been seen, the panel could not be satisfied that consent had not been recorded where this has not been addressed in the audit at all. The absence of any comment in the audit as to whether or not consent had been recorded could be interpreted either way.

The panel therefore found that the evidence to support this charge is tenuous, and concluded that there is no case to answer in respect of charge 5.1.

5.2 Adult 8 on or around 3 December 2015

The panel had regard to all the evidence before it at this stage. It noted that Adult 8 is recorded to have attended the AWWC on 3 December 2015 for a smear test. In light of this, the panel found that there is no case to answer that you did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures, as no such procedure was carried out.

The panel therefore found no case to answer in respect of charge 5.2.

5.3 Adult 9 on or around 4 June 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 9 on 4 June 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been circled in respect of Adult 9 on 4 June 2015.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.4 Adult 12 on or around 11 June 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 12 on 11 June 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 12 on 11 June 2015.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.5 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you assessed Adult 19 on 14 May 2015, performed a de-infibulation procedure on Adult 19 on 20 August 2015 and examined Adult 19 on 10 September 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked. It also had regard to Adult 19's clinical notes and consent had not been recorded on any of these dates.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge on the aforementioned dates.

5.6 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 22 on 16 April 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 22 on 16 April 2015.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge on 16 April 2015.

The panel had regard to the evidence before it in respect of 28 January 2016, which stated that Adult 22 had attended the gynaecology clinic on this date. In light of this, the panel did not consider that there was any evidence of a case to answer that you did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for Adult 22 on this date. The panel therefore found no case to answer in respect of 28 January 2016.

The panel had regard to the evidence before it in respect of 30 June 2016. It noted that there was no audit form in relation to this appointment. It therefore could not be clear on the basis of that evidence that your consultation on that date had been audited. In light of this, the panel did not consider that there was any evidence of a case to answer that you did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for Adult 22 on this date. The panel therefore found no case to answer in respect of 30 June 2016.

<u>5.7 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit, Adult 35's medical notes and your diary notes that you examined Adult 35 on 2 July and 6 August 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of these dates.

The panel further noted that there is evidence before it that you performed a de-infibulation procedure on Adult 35 on 9 July 2015. The audit records the box which states that consent was not recorded has been circled in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge on 2 and 9 July and 6 August 2015.

The panel had regard to the evidence before it in respect of 16 July 2015. It noted that there is evidence before it that Adult 35 was seen by Witness 5 on this date. The panel therefore found no case to answer in respect of Adult 35 on 16 July 2015.

5.8 Adult 44 on or around 5/12 December 2013

The panel had regard to all the evidence before it at this stage. It noted that there is evidence before it that you performed a de-infibulation procedure on Adult 44 on 5 December 2014. The audit records the box which states that consent was not recorded has been marked in respect this appointment.

The panel further noted that there is evidence before it that, on 12 December 2013, you cleaned Adult 44's surgical wound following the de-infibulation procedure. The audit records that the box which states that consent was not recorded has been circled in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge on 5 and 12 December 2013.

5.9 Adult 69 on or around 15 October 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and proforma record that you performed a de-infibulation procedure on Adult 69 on 15 October 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 69 on 15 October 2015.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its

consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.10 Adult 74 on or around 3 October 2013

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 74 on 3 October 2013. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 74 on 3 October 2013.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.11 Adult 124 on or around 21 July 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 124 on 21 July 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 124 on 21 July 2016.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.12 Adult 130 on or around 10/24 November 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined Adult 130 on 10 November 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of this date.

The panel further noted that there is evidence before it that you performed a de-infibulation procedure on Adult 130 on 24 November 2016. The audit records the box which states that consent was not recorded has been circled in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>5.13 Adult 138 on or around 29 June 2017</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 138 on 29 June 2017. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 138 on 29 June 2017.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>5.14 Adult 143 on or around 12 March 2013</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 143 on 12 March 2013. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 143 on 12 March 2013.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

5.15 Adult 154 on or around 25 May 2017

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 154 on 25 May 2017. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 154 on 25 May 2017.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

Charge 6

Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10

Schedule 10: Failed to record the offer of consent for examination/de-infibulation

The panel first considered whether you were under a duty to record the offer/ confirmation of a chaperone to adult patients for FGM examinations/de-infibulation procedures. It had regard to all of the evidence before it at this stage. It noted that it had been provided with various copies of the Guidance for Chaperones, which were in place between 2012 and 2021, each of which states:

> *"All women having an examination/procedure should be offered a chaperone regardless of the gender of the Health Care Professional.*
>
> *Failure to offer one deprives patients of the support that they might need and non-availability is an unacceptable excuse."*

The panel also bore in mind the evidence of Witnesses 3, 4 and 5 who said that it was best practice to record the offer/confirmation of a chaperone.

Accordingly, the panel found there was sufficient evidence to support a duty to record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation.

6.1 Adult 2 on or around 27 October 2016

The panel had regard to all of the evidence before at this stage. It bore in mind that the audit is silent as to whether Adult 2's notes contained detail of whether a chaperone had been offered.

Accordingly, the panel was not satisfied that there was sufficient evidence before it to support this charge and therefore found no case to answer.

6.2 Adult 8 on or around 3 December 2015

The panel had regard to all of the evidence before at this stage. It noted that Adult 8 attended the AWWC for a smear test. The panel found that this charge is incapable of being found proved, given that the stem alleges that you *"did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation".*

Accordingly, the panel found no case to answer in respect of this charge.

<u>6.3 Adult 9 on or around 4 June 2015</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 9 on 4 June 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>6.4 Adult 12 on or around 11 June 2015</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you examined and performed a de-infibulation procedure on Adult 12 on 11 June 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be

reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.5 Adult 19 on or around 14 May 2015/20 August 2015/10 September 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you examined and assessed Adult 19 on 14 May 2015, and performed a de-infibulation procedure on Adult 19 on 20 August 2015 and examined her again on 10 September 2015. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.6 Adult 22 on or around 16 April 2015/28 January 2016/30 June 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 22 on 16 April 2015 and examined her again on 30 June 2016. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge, in relation to 16 April 2015.

In respect of the appointment on 28 January 2016, the panel had regard to the evidence before it, that Adult 22 was seen in the gynaecology clinic, and not by you. Accordingly, it found no case to answer in respect of this date.

The panel had regard to the evidence before it in respect of 30 June 2016. It noted that there was no audit form in relation to this appointment. It therefore could not be clear on the basis of that evidence that your consultation on that date had been audited. In light of this, the panel did not consider that there was any evidence of a case to answer that you did not record the offer of a chaperone procedures for Adult 22 on this date. The panel therefore found no case to answer in respect of 30 June 2016.

6.7 Adult 35 on or around 2/9/16/ July 2015/ 6 August 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you assessed and examined Adult 35 on 2 July 2015, performed a de-infibulation procedure on Adult 35 on 9 July 2015 and examined her again on 6 August 2015. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge, in relation to 16 April 2015 and 30 June 2016.

In respect of the appointment on 16 July 2015, the panel had regard to the evidence before it, that Adult 35 was seen by Witness 5 at her clinic, and not by you. Accordingly, it found no case to answer in respect of this date.

6.8 Adult 44 on or around 5/12 December 2013

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 44 on 5 December 2013. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge, in relation to 5 December 2013.

In respect of the appointment on 12 December 2013, the panel bore in mind that the audit is silent as to whether Adult 44's notes contained detail of whether a chaperone had been offered.

Accordingly, the panel was not satisfied that there was sufficient evidence before it to support this charge and therefore found no case to answer in relation to 12 December 2013.

6.9 Adult 69 on or around 15 October 2015

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 69 on 15 October 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be

reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.10 Adult 74 on or around 3 October 2013

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 74 on 3 October 2013. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.11 Adult 124 on or around 21 July 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 124 on 21 July 2016. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.12 Adult 130 on or around 10/24 November 2016

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit that you examined Adult 130 on 10 November 2016 and you performed a de-infibulation procedure on Adult 130 on 24 November 2016. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.13 Adult 138 on or around 29 June 2017

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 138 on 29 June 2017. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

6.14 Adult 143 on or around 12 March 2013

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 143 on 12 March 2013. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>6.15 Adult 154 on or around 25 May 2017</u>

The panel had regard to all the evidence before it at this stage. It noted that there is evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 154 on 25 May 2017. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>Charge 7</u>
Did not record the offer of a translator to Adult 10

The panel had regard to all of the evidence before it at this stage. It first considered whether you had a duty to record the offer of a translator to Adult 10.

It had regard to the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, which sets out:

> *"Care must be taken to ensure that an interpreter is available, as this will be required in many appointments relating to FGM.*

The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community."

The panel also had regard to the evidence of Witness 5, who said that a practitioner should probably record the offer of a translator.

The panel was therefore satisfied that there is a case to answer that you had a duty to record the offer of a translator to Adult 10.

The panel next considered whether there is a case to answer that you did not record the offer of a translator to Adult 10. It bore in mind the audit front sheet records "does not speak English – daughter translated".

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

Charge 8

Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

The panel first considered whether you had a duty to record/send an outcome letter to the GP for your adult patients at the AWWC. It had regard to all of the evidence before it at this stage. It bore in mind that the witnesses had differing understandings of the workings of the EPR software at the Trust at the relevant time. However, the panel took account of the evidence of Witness 4, who said that the provision of an outcome letter provides a record of a patient's consultation with the clinician. It also bore in mind that this evidence

was supported by that of Witness 5, who said that an outcome letter is the appropriate process for concluding a consultation with a patient, and that it is the responsibility of the clinician in the consultation to ensure that the outcome letter is correct

The panel bore in mind the Trust FGM Policy, co-authored by you and Witness 5, which was in place between 28 April 2012 and 27 April 2016, which set out:

> *"Documentation should be clear and the type of FGM should be clearly recorded. FGM should be documented in the antenatal notes, postnatal records before the transfer home after delivery and discharge summary. All staff are accountable and responsible for their practice and in the exercise of professional accountability there is a requirement to maintain their own level of competence with evidence of relevant continued professional development. (NMC 2004 & 2008)"*

It also took into account the Trust's Health Records Management Policy March 2016, which states:

> *"Scope*
> *This policy sets out the Trust's objectives in relation to the health records of its patients. A health record constitutes all information relating to the physical or mental health or condition of a patient that has been made by or on behalf of a health professional in connection with the patient's care.*
>
> *[…]*
>
> *Rationale and Principles*
> *Accurate, timely and legible health records are critically important to the quality and safety of patient care and to providing credible and authoritative evidence of service delivered."*

The panel bore in mind that it does not have before it full patient records. It noted that the NMC is reliant on the evidence contained within the audit in support of this charge. It took into account Witness 3's evidence that, although there were difficulties in using the EPR system, the auditors sought the advice of experts to check the system and request further documentation. The panel therefore found that the findings of the audit are sufficient to support a case to answer in respect of the stem of charge 8.

8.1 Adult 2 on or around 27 October 2016

The panel had regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 2's GP following the audit, and stated: "our records do not indicate that the GP practice was notified about the consultation or outcome of the consultation".

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

8.2 Adult 6 on or around 15 June 2017

The panel had regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that the audit front sheet states "no evidence of letter to GP".

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

8.3 Adult 7 on or around 18 August 2016

The panel had regard to all the evidence before it at this stage. The panel noted that the audit front sheet records “EPR – empty letter”. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 7’s GP following the audit, and stated: “it is unclear from our records that a complete FGM risk assessment was made and the woman may require further investigation and treatment for dyspareunia as there is no record of an outcome letter”.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

8.4 Adult 9 on or around 4 June 2015

The panel had regard to all the evidence before it at this stage. The panel noted that the audit front sheet records “no evidence of F/U or liaison with GP in Birmingham”.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

8.5 Adult 23 on or around 28 April 2016

The panel had regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 23's GP following the audit, and stated: "it is unclear from our records that a complete FGM risk assessment was made and the woman may require further investigation and treatment for psychosexual problems as there is no record of an outcome letter".

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

8.6 Adult 24 on or around 20 October 2016

The panel had regard to all of the evidence before it at this stage. It bore in mind that the audit is incomplete in respect of this patient, and does not make reference to whether an EPR letter was seen or reviewed in respect of this appointment.

The panel concluded that the evidence before it in relation to this charge from the audit is insufficient and tenuous, and therefore not capable of supporting a case to answer.

Accordingly, the panel found no case to answer.

Charge 9

Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.
Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

The panel first considered whether you had a duty to record/conduct follow up with the multidisciplinary team. The panel had regard to all of the evidence before it at this stage. It took account of the oral evidence of the witnesses, notably Witness 3 who said that referrals to other teams, such as safeguarding, would form part of the patient path. The panel also took into account the evidence of Witness 5, who said that she was unsure exactly who the multidisciplinary team was, but understood it to be other professionals who may provide support, treatment and counselling in the circumstances, and would be dependent on the needs of each patient.

Further, the panel took into account that it had before it the Multi-Agency Statutory Guidance on Female Genital Mutilation, and the NMC Code, which you were bound by in your practice as an FGM Midwife.

The panel had regard to the Commissioning Service to Support Women and Girls with FGM Guidance, dated March 2015, which states:

> *"Services should provide as minimum the defined activities outlined below as part of a multidisciplinary team approach associated with interdependent services."*

Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record/conduct follow up with the multidisciplinary team.

<u>9.1 Adult 3 on or around 22 September 2016</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about Adult 3's low mood, requirement for psychosexual counselling and domestic violence which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 3's GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>9.2 Adult 4 on or around 21 April 2016</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about Adult 4's chronic pain and risk of infection which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 4's GP in a follow up welfare letter by the auditor. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>9.3 Adult 7 on or around 18 August 2016</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about dyspareunia and the safeguarding risk of FGM in relation to Adult 7’s daughters, which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 7’s GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

9.4 Adult 23 on or around 28 April 2016

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about psychosexual problems and the safeguarding risk of FGM in relation to Adult 23’s daughters, which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 23’s GP in a follow up welfare letter by the auditor. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

9.5 Adult 30 on or around 13 March 2013

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded that this patient's vulva had become fused, and de-infibulation was not possible at this appointment, the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 30's GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances. It also considered the evidence of Witness 5, who said that in difficult cases you would usually refer your concerns on to other clinicians.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>9.6 Adult 98 on or around 19 July 2012</u>

The panel had regard to all of the evidence before it at this stage. It bore in mind that the audit is complete in respect of this patient, but does not make reference to any specific complication which may have required an onward referral in respect of this appointment.

The panel concluded that the evidence before it in relation to this charge from the audit is insufficient and tenuous, and therefore not capable of supporting a case to answer.

<u>Charge 10</u>

On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;

a) Advice/discussion/next steps with the patient
b) Details of assessment/examination
c) FGM risk assessments
Schedule 12: Did not record adequate details of the appointment/consultation.

The panel first considered whether you had a duty to record adequate details, as specified in charge 10. It bore in mind all the evidence before it at this stage which included: the Trust's Policy on FGM, the Trust's Health Records Policy, the Department of Health Guidance on FGM and the NMC Code.

The panel also bore in mind the evidence before it about the illegality of FGM and the safeguarding duties established by the legal framework.

Accordingly, the panel concluded that there is a case to answer that you had a duty to record adequate details, as specified in charge 10.

10.1 Adult 25 on or around 3 July 2014

The panel had regard to all of the evidence before it at this stage. It noted that the audit recorded "EPR Letter comprehensive", and did not detail any concerns in respect of your recording of the matters alleged in charge 10 a – c.

The panel therefore could not identify any evidence before it at this stage which would support a case to answer. Accordingly, the panel found no case to answer.

10.2 Adult 26 on or around 6/13 July 2017

The panel had regard to all of the evidence before it at this stage. It noted that the audit records "no follow up", "poor documentation" and "EPR poor outcome letter to GP". It bore in mind the oral evidence of Witness 3, who said that such comments

indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>10.3 Adult 30 on or around 13 March 2013</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “no EPR” and “no further follow-up offered”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>10.4 Adult 38 on or around 12 May 2016</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “nothing written in clinical notes”, “EPR – nothing” and “hard to determine outcome of clinical visit”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice,

discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.5 Adult 41 on or around 3 August 2017

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “minimal documentation”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.6 Adult 48 on or around 24 July 2014

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “no follow up, no prescription”, although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM

risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.7 Adult 54 on or around 3 January 2013

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “*poor documentation, no follow up appt [sic], EPR letter empty”* although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.8 Adult 59 on or around 14 November 2013

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “*no further follow up advised, no EPR outcome”*. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>10.9 Adult 80 on or around 10/17 September 2015</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit records "*poor documentation, no referral, especially as client was 'very tearful'"* although it indicates that there was an outcome letter for both appointments. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>10.10 Adult 90 on or around 20 September 2012</u>

The panel had regard to all of the evidence before it at this stage. It noted that the audit records "*poor documentation, no prescription, no follow up'"* although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not

recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.11 Adult 118 on or around 24 May 2012

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “*poor documentation, no prescription, no follow up’”* although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.12 Adult 128 on or around 20 October 2016

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “*poor documentation, no prescription, no follow up’*”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not

recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.13 Adult 136 on or around 16 August 2017

The panel had regard to the evidence before it at this stage in respect of this charge. It noted that the NMC has made no positive submissions in respect of this charge.

The panel had regard to the date of this charge, which post-dates the date which you had retired and you had ceased working for the Trust. It also noted that there was evidence before that this patient was seen by Ms 6 on 16 August 2017.

The panel therefore found no case to answer in respect of this charge.

10.14 Adult 150 on or around 22 September 2016

The panel had regard to all of the evidence before it at this stage. It noted that the audit records “*nothing written in clinical notes’*”, although the audit indicates that an EPR outcome letter had been completed for this appointment/ It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes. It bore in mind the evidence of Witness 5, that your diary notes were inadequate.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

10.15 Adult 162 on or around 25 August 2016

The panel had regard to all of the evidence before it at this stage. It noted that there are two audits, it noted that EPR outcome letter is ticked on both audits. However there are inconsistencies between the audits in relation to whether or how advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments had been recorded in Adult 162’s clinical records.

In light of the inconsistencies between these audits, the panel concluded that the evidence was unclear, tenuous and insufficient to be relied upon to support a case to answer in respect of this charge.

Accordingly, the panel found no case to answer.

Charge 11

Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

Schedule 13: Did not clearly record the reason/origin of referral

The panel first considered whether there is a case to answer that you have a duty to record the reason/ origin of referral for patients under your care. It bore in mind the oral evidence of Witness 3, who explained the importance of recording the origin of referral for providing the root of a clinical audit trail for a patient. In her oral evidence, she said:

"It's a standard thing that does have a purpose about where a person comes from. It seems to me quite strange not to record that. I'm sure there is a knowing where they've come from but it just seems a bit of an omission as such not to note that bit of information"

Accordingly, the panel was satisfied that, on the basis of the evidence before it, there is a case to answer that you had a duty to record such details.

<u>11 1. Adult 11 on or around 20 December 2012</u>

The panel had regard to all of the evidence before it at this stage. The panel noted that the auditor, in a letter to Adult 11's GP, indicated that Adult 11 was a self-referral to the AWWC.

Accordingly, the panel found that there was evidence before it which directly contradicts this charge, and therefore found no case to answer.

<u>11.2 Adult 28 on or around 25 April 2013</u>

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which stated that Adult 28 was referred to AWWC by her GP. However, the panel noted that the reason for Adult 28's referral is not recorded within your diary notes.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>11.3 Adult 46 on or around 17 July 2014</u>

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which stated that Adult 46 was referred to AWWC by "*?*", via a Hotmail account. The panel also noted that the reason for Adult 46's referral is not recorded within your diary notes.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>11.4 Adult 50 on or around 8 August 2013</u>

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which states: "no documentation of who referred". The panel also noted that the reason for Adult 50's referral is not recorded within your diary notes.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

<u>11.5 Adult 86 on or around 25 April 2013</u>

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which states: "referral not recorded". The panel also noted that the reason for Adult 86's referral is not recorded within your diary notes, and is noted "ref by" with a line next to it.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be

reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

11.6 Adult 131 on or around 10/24 November 2016

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which states: “referral not specified” in relation to these appointments. The panel also noted that the reason for Adult 131’s referral is not recorded within your diary notes, and is noted “ref by” with nothing written next to it, in respect of her appointment on 24 November 2016.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

11.7 Adult 158 on or around 7 November 2013

The panel had regard to all of the evidence before it at this stage. It had regard to the audit, which states: “not clear who referred”. The panel also noted that the reason for Adult 158’s referral is not recorded within your diary notes, and is noted “ref by” with a line next to it.

The panel noted Ms Bayley’s criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

11.8 Adult 160 on or around 17 September 2015

The panel had regard to all of the evidence before it. It noted that the audit stated, "not clear who referred" Adult 160 to the AWWC. However, the panel took account of your diary entry, which states that she was first seen at the AWWC on 10 September 2015. Witness 5 said that in such circumstances, the origin and reasons for referral are likely to form part of Adult 160's hospital notes for that initial appointment. It noted that the audit does not refer to any inquiries into any documentation from 10 September 2015.

Accordingly, the panel concluded that the evidence to support this charge is unreliable and tenuous, and therefore not capable of supporting a case to answer.

Charge 12

Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle for one or more adult patients, as listed in schedule 14.

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundles

The panel first considered whether there is a case to answer that you had a duty to record adequate details of clinical consultations in the electronic patient record ("EPR") /physical patient records bundle. The panel had regard to all the evidence before it at this stage. It noted Witness 5's evidence about the importance of recording adequate details of a consultation. The provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient.

Accordingly, the panel found that there is sufficient evidence before it to establish a case to answer that you had a duty to record adequate details of clinical consultations in the EPR /physical patient records bundle.

12.1 Adult 30 on or around 13 March 2014

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 10.3. Accordingly, the panel found no case to answer in respect of this charge.

12.2 Adult 38 on or around 12 May 2016

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 10.4. Accordingly, the panel found no case to answer in respect of this charge.

12.3 Adult 142 on or around 16 March 2017

The panel had regard to all of the evidence before it at this stage. It noted that Adult 142 was a maternity patient within the Lewisham and Greenwich Trust. The panel noted that the auditors identified that an outcome letter was identified by the auditors within the Lewisham and Greenwich Trust EPR system, however the audit identifies that there were no clinical notes or a diary entry for this patient at this appointment. It concluded that there is evidence before it from the audit that Adult 142's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.4 Adult 143 on or around 12 March 2013

The panel had regard to all of the evidence before it at this stage. The panel noted the audit front sheet states "*not on EPR*", and Witness 3 recorded in the audit that it is not possible to follow up with this patient. It concluded that there is evidence before it from the audit that Adult 143's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.5 Adult 147 on or around 9 December 2016

The panel had regard to all of the evidence before it at this stage. The panel noted the audit front sheet states "not on EPR", and Witness 3 recorded in the audit that it is not possible to follow up with this patient. It concluded that there is evidence before it from the audit that Adult 147's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.6 Adult 153 on or around 20 December 2012

The panel had regard to all of the evidence before it at this stage. The panel noted the audit front sheet states "*no clinical notes found, no documentation found*". It concluded that there is evidence before it from the audit that Adult 153's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.7 Adult 156 on or around 24 January 2013

The panel had regard to all of the evidence before it at this stage. The panel noted the audit front sheet states "*EPR nothing, no documentation, only diary notes have documentation*". It concluded that there is evidence before it from the audit that Adult 156's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.8 Adult 159 on or around 13 February 2014

The panel had regard to all of the evidence before it at this stage. The panel noted the audit front sheet states "*all from diary extract only*", although a note stating EPR outcome letter is ticked. However, the panel noted that the audit notes "not recorded" in relation to matters such as risk assessment, chaperone and consent. It

concluded that there is evidence before it from the audit that Adult 159's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.9 Adult 161 on or around 18 February 2016

The panel had regard to all of the evidence before it at this stage. The panel noted there are two audits. The first of which records "poor documentation", and the second "minimal documentation", although a note stating EPR outcome letter is ticked. However, the panel noted that the audit notes "not recorded" in relation to matters such as risk assessment, chaperone and consent. It concluded that there is evidence before it from the audit that Adult 161's patient notes may have been inadequate, in respect of this appointment.

The panel noted Ms Bayley's criticisms of the reliability of the audit where patient notes are not before the panel. However, it found the evidence of the audit to be reliable for its consideration at this stage, and sufficient to support a case to answer in respect of this charge.

12.10 Adult 162 on or around 25 August 2016

The panel had regard to all of the evidence before it at this stage. It bore in mind Witness 4 and Witness 5's evidence about the purpose of physical patient records and EPR records. The panel concluded that details of advice, assessment, discussion and next steps would form part of such records.

The panel found that this charge is duplicitous with the mischief alleged in charge 10.15. Accordingly, the panel found no case to answer in respect of this charge.

Charge 13

On or around 6 August 2015 did not refer Child 17 to a Community Paediatrician

The panel had regard to all of the evidence before it at this stage. It noted that Child 17 was referred to the AWWC by her GP. It noted there is evidence that you assessed her for FGM on 6 August 2015, no treatment was deemed necessary at that time, and an outcome letter for this consultation was sent to Child 17's GP on 14 August 2015. The panel noted that there is also evidence before it that Child 17 was treated at the Evelina Bladder Clinic on 15 September 2015.

Accordingly, in the circumstances where there is evidence before the panel that Child 17 was already under the care of the paediatrics team at the Trust, the panel concluded that there is no case to answer that there was a duty for you to refer Child 17 to a Community Paediatrician.

Charge 14

On or around 13 August 2015

14.1 Did not refer Child 18 to a specialist paediatric urologist

The panel had regard to all of the evidence before it at this stage. It noted that Child 18 was referred to the AWWC by her GP, who sought advice as to the appropriate place to refer Child 18. It noted that an outcome letter for this consultation was sent to Child 18's GP on 21 August 2015, which set out:

> *"Assessment of the vulva shows FGM 2, performed at age 2 in […]. Child 18 is now 5 years old.*

Presented to ger GP with recurrent UTIs and sometimes urgency to pass urine (according to her father this started about 8 months ago).

No known incident or situation that triggered this, unfortunately, the complications of FGM for some women and girls last a life time.

At this stage Child 18 and her family will need support and she will need further investigations"

The panel also had sight of a letter from Child 18's GP to the Gynaecology Department at the Trust, dated 10 November 2016, referring Child 18, on your advice, for referral.

The panel considered the evidence adduced by the NMC in support of this charge to be tenuous. It noted that Child 18 was under the care of her GP, who then made a subsequent referral to the gynaecology department nearly a year after you assessed Child 18 at the AWWC. The panel further noted that, as their patient, the GP would been aware of Child 18's age and history and had an obligation as the referrer to consider the appropriate department for referral.

Accordingly, the panel concluded that the evidence to support this charge is tenuous, and therefore found no case to answer.

<u>14.2 Did not refer Child 18 to the Consultant Lead Professor at the African Well Women Clinic (AWWC)</u>

The panel had regard to all the evidence before it at this stage. It noted that Child 18 was referred to the AWWC by her GP, who sought advice as to the appropriate place to refer Child 18. It noted that an outcome letter for this consultation was sent to Child 18's GP, as outlined above.

The panel considered whether you had a duty to refer Child 18 to the Consultant Lead Professor at the AWWC. It bore in mind the evidence of the witnesses, that you had a duty to refer patients to appropriate services. However, the panel had regard to the wording of this charge. It noted that this charge relates to your alleged failure to refer Child 18 to Witness 5 specifically, which would amount to an impractical obligation to place on either you or Witness 5.

Accordingly, the panel found that this charge is too narrow to be capable to be found proved.

<u>14.4 Incorrectly referred Child 18 to the adult gynaecology service.</u>

The panel had regard to all the evidence before it at this stage. It noted that Child 18 was referred to the AWWC by her GP, who sought advice as to the appropriate place to refer Child 18. It noted that an outcome letter for this consultation was sent to Child 18's GP, as outlined above.

The panel also had sight of a letter from Child 18's GP to the Gynaecology Department at the Trust, dated 10 November 2016, referring Child 18, on your advice, for referral.

The panel considered the evidence adduced by the NMC in support of this charge to be tenuous. It noted that Child 18 was under the care of her GP, who then made a subsequent referral to the gynaecology department nearly a year after you assessed Child 18 at the AWWC. The panel further noted that, as their patient, the GP would been aware of Child 18's age and history and had an obligation as the referrer to consider the appropriate department for referral.

Accordingly, the panel concluded that the evidence to support this charge is tenuous, and therefore found no case to answer.

Charge 15

On or around 26 May 2016 did not refer Child 24 for psychological support

The panel had regard to all of the evidence before it at this stage. The panel had regard to the wording of this charge. It concluded that *"psychological support"* would fall under the requirement of *"optimal"* support. Accordingly, the panel found that this charge is duplicitous with the mischief alleged in charge 3.28.1: "*Did not record/consider whether the support Child 24 was receiving was optimal."*

Accordingly, the panel found no case to answer in respect of this charge.

Charge 16

On or around 18 February 2016, did not refer child 23 for psychological services

The panel had regard to all of the evidence before it at this stage. The panel considered that both your diary entry and the audit were limited in respect of Child 23. It bore in mind that there was no referral letter, clinical notes or outcome letter before the panel, nor was there a summary from the auditors of the contents of Child 23's records.

Accordingly, the panel concluded that the evidence before it was unclear, tenuous and insufficient to be relied upon to establish a duty on you to refer Child 23 for psychological services, and to support a case to answer in respect of this charge.

Charge 18

On or around 7 July 2017 you initially assessed Child 28 rather than refer them for examination/assessment to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.

The panel had regard to all of the evidence before it at this stage.

The panel found that this charge is duplicitous with the mischief alleged in charge 10.10. Accordingly, the panel found no case to answer in respect of this charge.

Charge 20

Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

Schedule 8:

Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

20.7 Child 23 on or around 18 February 2016

The panel had regard to all the evidence before it at this stage. It had regard to the Trust Internal Safeguarding of Children Policy, effective between May 2015 and May 2017 which states:

"A Paediatrician should obtain written consent to medical examination from an adult with parental responsibility for the child. Consent should also be obtained from the child in a manner appropriate to their age and level of understanding."

The panel bore in mind there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child. It noted that consent is not recorded within your diary notes, or in the audit.

Accordingly, the panel concluded that there remains a case to answer in respect of this charge.

20.12 Child 28 on or around 7 July 2017

The panel had regard to all the evidence before it at this stage. It had regard to the Trust Internal Safeguarding of Children Policy, effective between May 2015 and May 2017, as outlined above

The panel bore in mind there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child. It noted that consent is not recorded within your diary notes, or in the audit. It bore in mind that there is evidence before the panel that Child 28's father was present at this consultation. However, the panel concluded that, on the basis of the policy, there remains a case to answer in respect of this charge.

Charge 21

Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

21.5 Child 21 on or around 22 October 2015
21.6 Child 22 on or around 22 October 2015

The panel had regard to all of the evidence before it at this stage. The panel bore in mind that these charges relate to a joint assessment on Children 21 and 22, between you and Dr 8, who was also present.

In these circumstances, the panel considered that the NMC had not adduced sufficient evidence that Dr 8 would not have been an appropriate chaperone. Accordingly, the panel found no case to answer in respect of these charges.

21.7 Child 23 on or around 18 February 2016

The panel had regard to all of the evidence before it at this stage.

The panel first considered whether you were under a duty to record the offer/ confirmation of a chaperone to children for FGM examinations/de-infibulation procedures. It had regard to all of the evidence before it at this stage. It noted the Trust's Internal Safeguarding of Children Policy, which was in place between May 2014 and May 2017, which states:

> *"Children should be offered a chaperone or be invited to have an appropriate relative or nominated person present with them during any examination or procedure provided the relative or nominated person understands their role as a chaperone. Their personal preference should be documented in their medical records."*

The panel also bore in mind the evidence of Witnesses 3, 4 and 5 who said that it was best practice to record the offer/confirmation of a chaperone.

Accordingly, the panel found there was sufficient evidence to support a duty to record the offer/confirmation of a chaperone for children/patients under the age of 18.

The panel had regard to the evidence before it in respect of this charge, it bore in mind that the offer/ confirmation of a chaperone is not recorded in either the audit or your diary note for this appointment.

Accordingly, the panel concluded that there remains a case to answer in respect of this charge.

21.12 Child 28 on or around 7 July 2017

The panel had regard to all of the evidence before it at this stage.
The panel first considered whether you were under a duty to record the offer/ confirmation of a chaperone to children for FGM examinations/de-infibulation

procedures. It had regard to all of the evidence before it at this stage. It noted the Trust's Internal Safeguarding of Children Policy, as outlined at charge 21.7, above

The panel also bore in mind the evidence of Witnesses 3, 4 and 5 who said that it was best practice to record the offer/confirmation of a chaperone.

Accordingly, the panel found there was sufficient evidence to support a duty to record the offer/confirmation of a chaperone for children/patients under the age of 18.

The panel had regard to the evidence before it in respect of this charge, it bore in mind that the offer/ confirmation of a chaperone is not recorded in either the audit or your diary note for this appointment. It noted that Child 28 was accompanied by her father, however, in light of the evidence from the Trust's Internal Safeguarding of Children Policy, a case to answer remains as to whether this was an appropriate chaperone.

Accordingly, the panel concluded that there remains a case to answer in respect of this charge.

Application to seek further evidence about how other FGM clinics operate

Before Ms Bayley made closing submissions on the facts, she referred the panel to the list of 16 FGM clinics which the panel should consider exploring in terms of how they are run and registration status and 'scope of practice'.

Ms Mustard submitted that both parties had closed their cases and there had been previous opportunities to put information before the panel before this late stage. She submitted this information could be a distracting factor and is not relevant to the matters that the panel has to consider which are specific charges relating to you.

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

The panel considered whether to seek further information relating to the other FGM clinics. It noted that the request had come at a late stage and that it had heard evidence from both parties in terms of 'scope of practice'. The panel considered that the charges were historic, case specific and it is unlikely that it would be assisted by the provision of such information. Further, obtaining such information could result in significant, undesirable delay to the progress of the hearing. The amount of detail required to investigate the practice of other FGM clinics could be protracted and could possibly result in contradictory evidence from the clinics concerned.

The panel concluded that having heard all the evidence, it would not be of assistance to pursue this potential line of enquiry.

Background

You were first registered as a nurse on 3 March 1986. You were first registered as a midwife on 5 September 1988. There were subsequent periods where both your nursing and midwifery registrations lapsed and were renewed.

You knowingly allowed your nursing registration to lapse for the final time on 1 April 2013. The charges you face relate to the period between 2013 and 2017. During this period you were registered as a midwife.

You commenced employment at Guys and St Thomas's NHS Foundation Trust (the Trust) in 1997. You remained employed there until your retirement on 31 August 2017. You were employed as a specialist Female Genital Mutilation (FGM) midwife working within the Trust's FGM clinic. You set up the African Well Women Clinic (AWWC) at the Trust. You have published articles and spoken in the UK and abroad about FGM.

On 8 August 2017, the NMC received a referral from a consultant obstetrician at University College London Hospitals (UCLH). Following this referral, the Trust conducted an internal review and commissioned an external review by the Royal College of Paediatrics and Child Health (RCPCH). The RCPCH was invited by NHS England and the Trust to conduct a case record review of 32 children who had been seen by the FGM service and report on the clinical governance of the service and the training and supervision of your practice. The reviews identified concerns surrounding your practice.

You did not engage fully with the Trust's investigation, and you were not interviewed as part of it. You provided some responses to the concerns, and you did speak to the RCPCH.

The regulatory concerns broadly covered three separate areas; that you acted outside your scope of practice and/or your professional competencies, that you failed to appropriately refer patients onto other medical or health care professionals and failures in record keeping.

In relation to the first regulatory concern, it is alleged that you assessed and examined non-pregnant children without the appropriate paediatric training or qualification. It is also alleged that you assessed and treated non-pregnant women, when you were not a registered nurse. It is further alleged that you administered prescription only medication, other than those within the midwifery exemptions, when you were not a non-medical prescriber. You do not deny that you treated the patients but deny that this was outside of your scope of practice/competencies.

The second regulatory concern is linked to the first in that it is alleged that you should have referred the patients to someone who could treat them within the scope of their competence. The concern relates to failing to seek a second opinion in complex cases, failing to appropriately refer patients for psychosexual/sexual health counselling and support, failing to redirect/refer children to a paediatrician, failing to refer for

urological/gynaecological review and failing to refer to an appropriately qualified practitioner.

The final regulatory concern relates to alleged failures to keep adequate records. These relate to not recording information in the correct documents/format, not recording information accurately/fully, not recording consent, not recording the presence/offer of a chaperone, not recording the use of an interpreter/translator, not completing/sending GP summary letters or other outcome letters or sending these letters with incomplete or inaccurate information, and not recording appropriate safeguarding steps.

Decision and reasons on facts

In the course of the hearing Ms Bayley informed the panel that you made admissions to the following charges:
Charge 1.5 in its entirety.
Charge 1.9 all children apart from Child 19.
Charge 1.10 all children apart from Child 19.

The panel received equivocal admissions in relation to charge 3, the stem of which was not accepted or admitted by you. On that basis, the panel considered it was safer to make a finding of fact on each of these charges and where admissions have been made this will be reflected in the determination.

Charge 5 in relation to Adults 19 and 35.
Charge 6 in relation to Adult 19 and 35.
Charge 12 in relation to Adults 143 and 147.
Charge 17.
Charge 19.
Charge 20 admitted apart from Child 19.
Charge 21 admitted apart from Child 19.

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 written submissions made by Ms Mustard on behalf of the NMC and the written and oral submissions made by Ms Bayley on your behalf.

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: Head of Nursing for Safeguarding Children at the Trust;
- Witness 2: Director of Nursing for Evelina London at the Trust;
- Witness 3: Director of Midwifery and Nursing at the Trust;
- Witness 4: Director of Midwifery and Head of Gynaecology Nursing at the Trust;
- Witness 5: Consultant Gynaecologist at the Trust.

The panel also heard evidence from you under oath. In addition, the panel heard from 11 witnesses called on your behalf. Their roles at the time were as follows:

- Witness 18: Professor Emerita;

- Witness 19: Senior Midwifery manager at the Trust (1996- 2003);
- Witness 20: Consultant Obstetrician and Gynaecologist at the Trust;
- Witness 21: Student Midwife at the Trust;
- Witness 22: Medical Student, now an Obstetrician and Gynaecologist with extensive experience in FGM;
- Witness 23: Former patient, now fellow campaigner for Violence Against Women and Girls;
- Witness 24: Band 7 Midwife who went on to practise with specialist interest in FGM;
- Witness 25: Midwife and Nurse who worked within a family planning clinic;
- Witness 26: Midwife;
- Witness 27: Receptionist at the Trust
- Witness 28: Campaigner.

The panel also received written evidence from a number of witnesses mainly consisting of references and testimonials.

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

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

Charge 1.1

1. Acted/practised outside the scope of your role, in that you:

1.1. On one or more occasion accepted referrals for adult patients that were not pregnant, as listed in Schedule 1.

This charge is found not proved.

In reaching this decision, the panel had regard to the wording of the charge. It considered the words “acted” and “practised” are synonymous in this context.

The panel considered whether you acted outside of your role as an FGM midwife. It noted that it is agreed that you knowingly allowed your nursing registration to lapse on 1 April 2013, and several witnesses have given evidence as to the potential impact of this in respect of your role when treating non-pregnant women. Those witnesses have cast doubt as to whether your midwifery registration was sufficient on its own for this purpose.

The panel heard from numerous witnesses and found their evidence, taken as a whole, was equivocal on this issue.

It considered there was a lack of clinical governance and supervisory oversight from the Trust in relation to your role and the Trust was content with you pursuing your role as an FGM specialist midwife. In fact, you became world renowned in this field. The panel had no evidence of any complaint about your skills, knowledge or proficiency.

The panel considered that nurses, midwives and nursing associates have to be professionally accountable and have a personal responsibility in relation to their skills/knowledge/qualifications and training. The panel heard evidence during the hearing that the Trust was aware of your scope of practice. It also heard that you regularly met with your line manager and your role was designated under women’s services, not maternity services. It noted that the clinic’s performance was reviewed regularly by senior managers within the Trust. It also had sight of a report prepared by

you which was co-written by the Director of Midwifery, who was your line manager, which was presented at a specialist committee with oversight of women and children and which included the number of patients and the demographics of patients who attended the specialist clinic to receive care and/or treatment.

However, the panel saw no definition anywhere about scope of practice or clear unequivocal evidence that you had acted outside the scope of your role. Furthermore, the panel referred to the 'The code: Standards of conduct, performance and ethics for nurses and midwives 2008' (the Code) and 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) both of which are relevant to the dates of the charges you face. Both documents contain no reference to scope of practice. However, both state that nurses and midwives must work within the limits of their competence.

The panel noted within the document Practising as a Midwife in the UK, the following comments are made:

> *"The term 'scope of practice' is frequently used in relation to professions such as midwifery, but UK health professionals tend not to be regulated with reference to a specified 'scope of practice'. A midwife's 'scope of practice' might be taken to mean 'the range of things that the midwife has the skills, knowledge and proficiency to do' and it should not be confused with 'protected function' which means 'something that only midwives can legally do' (see above).*
>
> *The standards of proficiency and the Code are important factors in thinking about scope of practice. A midwife's scope of practice may change depending on the nature of their roles and the learning they have undertaken. The Code requires midwives not to practise outside of their skills, knowledge or competence. It is important that providers of maternity services are mindful of this professional duty when they deploy midwives".*

In respect of your clinical competence, the panel bore in mind the evidence of your clinical colleagues, notably Witness 5, who spoke highly of your clinical competence and the panel was satisfied that this evidence was not contradicted by any other evidence.

It determined that the NMC had not discharged its burden of proof and the charge fell at the stem. It therefore found charge 1.1 not proved in its entirety.

Charge 1.2

1. Acted/practised outside the scope of your role, in that you:

1.2. On one or more occasion assessed/examined adult patients that were not pregnant, as listed in Schedule 1.

This charge is found not proved.

The panel took into account its findings at charge 1.1. The panel saw no clear, unequivocal evidence that you had acted outside the scope of your role as an FGM specialist midwife. It determined that the NMC had not discharged its burden of proof and the charge fell at the stem. It therefore found charge 1.2 not proved in its entirety.

Charge 1.3

1. Acted/practised outside the scope of your role, in that you:

1.3. On one or more occasion conducted de-infibulation on adult patients that were not pregnant, as listed in schedule 2.

This charge is found not proved.

The panel took into account its findings at charge 1.1 and 1.2. The panel saw no definition anywhere about scope of practice or clear, unequivocal evidence that you had practised outside the scope of your role. It determined that the NMC had not discharged its burden of proof and the charge fell at the stem. It therefore found charge 1.3 not proved in its entirety.

Charge 1.4

1. Acted/practised outside the scope of your role, in that you:

1.4. On one or more occasion, did not obtain a second opinion for adult patients suffering complications during the de-infibulation procedures, as listed in schedule 3.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence from other clinicians who had attended the clinic to observe your practice and it saw no evidence of any concerns reported about your clinical skills whilst performing de-infibulation or evidence of any complaints from patients.

The panel heard that you had been provided with clinical training in 1997 and it would not appear that there had been any further clinical oversight from the Trust or your line manager into your competence from that point.

Your evidence is that if you felt it was necessary to obtain a second opinion you would have done so.

The NMC evidence was based upon a paper review without the benefit of the patient being present. The records relied upon, in relation to the NMC case, lacked sufficient detail for witnesses to reach a reliable conclusion as to whether a second opinion was required. Furthermore, the panel was not provided with any evidence of any adverse outcomes or complications experienced by the patients involved.

The panel saw no definition anywhere about scope of practice, or clear, unequivocal evidence that you had practised outside the scope of your role and it had already established that it was within your role and scope of practice to undertake de-infibulation procedures.

It determined that the NMC had not discharged its burden of proof and the charge fell at the stem. It therefore found charge 1.4 not proved in its entirety.

Charge 1.8

> 1. Acted/practised outside the scope of your clinical competence/role, in that you:
>
> 1.8. On one or more occasion undertook a smear test of patients as listed in schedule 7, without having the required training/competence;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence before it in respect of your clinical competence/role as an FGM midwife. It noted that it is agreed that your nursing registration lapsed on 1 April 2013. It also had regard to the evidence of Witness 3, that, although it is not prohibited, it is not routinely the practice of a midwife, she said

that *"few midwives…would undertake smears as a routine in their practice because you do not take smears during pregnancy".*

Furthermore, the panel took into consideration the oral evidence of Witness 4 who said, when asked whether you should have taken smear tests: *"I wouldn't have thought it was within her scope of practice to take smears. She could have referred on to somebody else to do that".*

In respect of training, the panel had regard to the evidence of Witness 4 and Witness 5 who said that a mandatory Quality Assurance training scheme was in place at the time, which any practitioner was required to complete in order to carry out smear tests. The panel had regard to your limited training records before it and noted that, at this time, there is no evidence to suggest that you had completed the relevant training to carry out smear tests.

The panel heard evidence from Ms 25 who had worked with you at Barnet Family Planning Clinic. Ms 25 told the panel that you undertook smear tests regularly and attended the mandatory training.

The panel noted that the NMC had not conducted any investigation into your employment at Barnet Family Planning Clinic. It heard evidence that there was a national database in existence. The panel heard no categoric evidence about the database and when it became live or how the database was meant to work. It noted that you accepted in your evidence that you were not on the database. However, you did not accept that this meant that you were not competent to undertake the smears tests for Adult 8 or Adult 32. The panel heard from Witness 3 that in order for you to be able to send the sample to the laboratory, you had asked a colleague to send it on your behalf using their sign on to the system.

It determined that the NMC had not discharged its burden of proof. It therefore found charge 1.8 not proved in its entirety.

Charge 1.9

> 1. Acted/practised outside the scope of your clinical competence/role, in that you:
>
> 1.9. On one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8.

This charge is found not proved.

1.9.4 Child 19 on or around 11 September 2015

In reaching this decision, the panel took into account the evidence before it in respect of your clinical competence/role as an FGM midwife. It noted that it is agreed that your nursing registration in respect of adult nursing lapsed on 1 April 2013. It noted that this lapsed nursing registration was in respect of adult nursing only.

The panel considered the documentary evidence before it and noted the Trust's Safeguarding The Welfare of Children Policy, which states: *"physical examination of the child must and can only be undertaken by an appropriately qualified paediatrician".*

There is further evidence before the panel to support this assertion by way of The Service Standards for commissioning FGM care, which sets out its stated purpose as: *'this guidance describes service standards expected to be commissioned for the confirmation of FGM in children under the age of 18".*

Furthermore, the panel took into account the oral evidence of Witness 1 who said, when asked whether you should have treated children: “In the eyes of the law, anyone under 18 is still technically classed as a child”. This was supported by the views of Witness 3, Witness 4 and Witness 5, who gave clear evidence that any reference to “children” included any patient under the age of 18.

The panel took into account that you had admitted all of the particulars in charge 1.9 apart from in relation to Child 19. The panel was not provided with any evidence in relation to Child 19 and this was supported by the audit which stated that there is no documentation or patient records to support this charge in relation to Child 19.

The panel therefore found charge 1.9.4 not proved.

Charge 1.10

> 1. Acted/practised outside the scope of your clinical competence/role, in that you:
>
> 1.10. On one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8.

This charge is found not proved.

1.10.4 Child 19 on or around 11 September 2015

The panel noted its decision above in relation to Child 19 The panel took into account that you had admitted all of the particulars in charge 1.10 apart from in relation to Child 19. The panel was not provided with any evidence in relation to Child 19 and this was supported by the audit which stated that there is no documentation or patient records to support this charge in relation to Child 19.

The panel therefore found charge 1.10.4 not proved.

Charge 2.1

On one or more occasion did not, for adult patients as listed in schedule 9

2.1. Refer adult patients to specialist counsellors

Schedule 9: Failed to refer/investigate

2.1.1 Adult 2 on or around 27 October 2016

This charge is found not proved.

In reaching this decision, the panel had regard to the documentary evidence from the audit which outlined that no onward referral was made in respect of Adult 2 on or around 27 October 2016, including a letter from Witness 3 which outlined this concern to Adult 2's GP.

Your evidence is that you always referred patients to specialist counsellors if you deemed it appropriate and this was in line with each individual patient's wishes.

The panel was also provided with copies of clinical notes you made in an out of date diary instead of official patient records. You had recorded *'sexual problems'* noting you had a concern. However, the panel was aware of your evidence in that you made onward referrals by telephone or email. You said in your statement *"I would make the referrals by either telephone or email, mostly email. I do not remember ever printing out an*

email and including it within the notes, which I should have done. I would usually make a note on EPR and/or in the patient notes. I might not have the patient notes with me at the time of referral. I also kept a list of referrals I made for psychosexual support and to NGOs for community support in another diary. I do not have that list anymore and I do not know where it is. I handed the list over when I left [the Trust] with the rest of my diaries".

The panel took into account the evidence of Witness 3 who stated in evidence that management of psychosexual problems is quite complicated, would potentially have required onward referral and it was not clear whether that was actioned.

In re-examination Witness 3 said that she would have expected a record to have been made either in the notes or in the electronic patient record of an onward referral but she could not find that, hence the content of her welfare letter to the patient's GP.

The panel took into account the evidence in the audit in respect of Adult 2. The panel determined that there were significant potential gaps in the NMC case. Your NHS email account had not been examined. Whilst the panel considered using email for this purpose would not necessarily be an appropriate method, it could not be said with any confidence that you had not made a referral using this method. Additionally, no other avenues such as enquiries with relevant professionals was undertaken. Therefore, likewise you could have made direct contact with specialist counsellors. The NMC case has not reached the required evidential standard for the panel to be satisfied that you did not make a referral as you have stated in your own evidence. *"I always referred patients to specialist counsellors if I deemed it appropriate and this was in-line with the patient's wishes. For sexual health and vaginal infections, I would refer or signpost the patients to the Family Planning/sexual health Clinic. I am unable to recall a time where I had referred patients to the sexual health clinic".*

The panel therefore found charge 2.1.1 not proved.

2.1.2 Adult 7 on or around 18 August 2016

This charge is found not proved.

In reaching this decision the panel had regard to Witness 3's evidence, who outlined that Adult 7 was referred to AWWC for emotional distress, dyspareunia and safeguarding concerns about her daughters.

You stated in your written statement *"Regarding Adult 7, if she had come with children I would have discussed the risks to the children. I can only assume the EPR empty is some technical problem. I do not understand why there is an empty letter. This was a referral from the sexual and reproductive health team. From my diary note I can see that Adult 7 did not want to be assessed. Type 2 FGM cannot be reversed. If psychosexual counselling was indicated and the patient consented, I would have made the referral".*

The panel accepted the evidence in the audit in respect of Adult 7. However, it noted that it appears from the records that the consultation may have ended early. For the same reasons as outlined in the charge 2.1.1, the panel found this charge not proved.

2.1.3 Adult 15 on or around 6 August 2015

This charge is found not proved.

In reaching this decision, the panel had regard to documentary evidence from the audit which outlined that no onward referral was made, and records *"notes state that patient will*

need psychosexual counselling but no evidence that patient was referred or given any information about counselling".

This evidence from your written statement is that *"I remember that my opinion was that she needed psychosexual counselling in future. I remember that she refused to be referred but that she wanted to be referred for clitoral reconstruction".*

The panel took into account the evidence in the audit in respect of Adult 15. For the same reasons as outlined in charge 2.1.1, the panel found this charge not proved.

2.1.4. Adult 23 on or around 28 April 2016

This charge is found not proved.

In reaching this decision, the panel had regard to documentary the evidence from the audit which highlighted *"'psychosexual issues".* It had regard to Witness 3's oral evidence that she did not believe that anything had been done about these issues.

Your evidence is that you do not remember Adult 23.

The panel took into account the evidence in the audit in respect of Adult 23. For the same reasons as outlined in the previous charge, the panel found this charge not proved.

2.1.5 Adult 36 on or around 3 January 2013

This charge is found not proved.

In reaching this decision, the panel had regard to documentary the evidence from the audit which outlined that no onward referral was made, and records: *“notes state ‘will benefit from psychosexual counsellor’ but no evidence that referral was made”.*

It had regard to Witness 3’s oral evidence that she would have expected to have seen a letter of referral in such case.

Your evidence is that you do not remember Adult 36.

The panel took into account the evidence in the audit in respect of Adult 36. For the same reasons as outlined in charge 2.1.1, the panel found this charge not proved.

<u>Charge 2.3</u>

> On one or more occasion did not, for adult patients as listed in schedule 9
> Refer adult patients for sexual health counselling
> Schedule 9: Failed to refer/investigate

<u>*2.3.1 Adult 4 on or around 21 April 2016*</u>

This charge is found not proved.

In reaching this decision, the panel had regard to documentary evidence from the audit which notes that Adult 2 complained of pain and infection. It had regard to Witness 3’s oral evidence that she would have expected further assessment to have taken place where pain is noted.

The panel had sight of the clinical records you had made in an out of date diary instead of official patient records in relation to this patient. You said you do not recall Adult 4.

For the same reasons as outlined in charge 2.1.1, the panel found this charge not proved.

2.3.4. Adult 56 on or around 29 May 2014.

In reaching this decision, the panel had regard to documentary the evidence from your diary entry, which notes *"needs referral to gynaecologist".* It had regard to Witness 3's oral evidence that there was no evidence available to the auditors that such referral was ever made.

You said in you written statement *"I noted that Adult 56 needs a referral to the gynaecology clinic. I would have made that referral, probably to our joint clinic. Putting her on a general gynae referral would take a long time, so I would make an appointment for her to attend the joint clinic, which would be quicker".*

The panel considered this referral to be different to the rest in that this would probably have been an internal Trust referral. However, the NMC have failed to explore the possibility of a follow up appointment internally and the panel note that the audit records state 'unclear whether referral was made'. The panel therefore found this charge not proved.

Charge 3

> On one or more occasion failed to maintain adequate clinical records for adult/children/patients under the age of 18, in that you:

The panel received equivocal admissions from you in relation to charge 3, the stem of which was not accepted or admitted by you. On that basis, the panel considered it was

safer to make a finding of fact on each of these charges and where admissions have been made this will be reflected in the determination.

In reaching this decision, the panel first considered whether you had a duty to maintain adequate clinical records.

It had regard to the NMC Code 2008 and 2015, noting that both Codes require you to keep clear and accurate records in relation to your practice.

This was consistent with evidence from a number of witnesses who emphasised the importance of keeping accurate contemporaneous records. It noted that you also accepted in your written and oral evidence that at times your record keeping fell below the required standard.

You said in your written evidence *"I accept that my clinical record keeping fell below the accepted standard. This is something I deeply regret and I have since carried out steps to ensure my record keeping is now to an acceptable standard. Upon reflection, record keeping should contain clear, accurate information on the consultation, with information on what was discussed. The record should have information on the referral and who the matter was referred to. Record keeping is an integral part to every stage of the healthcare process and we need to ensure that a accurate record is kept for legal and professional elements".*

The panel also noted the evidence of Witness 5 who stated *"I recall that I also had concerns about Comfy's recordkeeping, which I also raised with [Witness 4]. Comfy's notes often lacked clinical detail and it was not uncommon for me to find a complete lack of clinical records for the work she was doing in the Outpatients Department. I spoke with Comfy about this on a number of occasions. I would highlight to her that notes did not have enough detail or were absent, remind her that this was medico-legally indefensible, and ask her to correct her notes and improve. Whenever I spoke to her about this she would accept what I was telling her and amend the notes".*

The panel noted in your oral evidence with regard to your standard of record keeping that you did not accept there was a problem with your record keeping.

"Q Just finally, in [Witness 5]'s evidence, she said that she discussed the concerns about your – I don't know what she said, about your quality, about your documentation with [Witness 4] and I believe yourself. Do you remember that ever being discussed?

A Definitely not, no, never.

Q Did [Witness 4] ever ---

A Never. None of them ever raised that concern and, obviously, as even the, what is it called, supervisors of midwives never raised the concern as well".

The panel preferred the evidence of Witness 5 which was supported by the evidence of Witness 4.

The panel also had regard to the numerous local Trust policies and national policies which encapsulate the duty within the Code to keep clear and accurate records. The panel was therefore satisfied that you had a duty to maintain adequate clinical records for adult/children/patients under the age of 18.

The panel recognised the audit was not undertaken for the purpose of an NMC investigation. However, it determined the audit was fair, robust, undertaken conscientiously and it had appropriate checks and balances in place. The panel also recognised there were occasional errors made in such an extensive audit. The panel accepts the overall reliability of the audit.

The panel had sight of the original contemporaneous clinical records you had made in out of date diaries instead of official patient records. It was also provided with other loose leaf records such as the FGM clinic proforma, which you also used to record your

consultations. These diaries were maintained separately and were stored in your office and not associated with the patients' clinical records.

The evidence before the panel was that your record keeping appeared to be somewhat chaotic.

The panel noted that your response to the majority of the charges within charge 3 was that without seeing your notes or your EPR entries for the particular patient, you were not able to agree that they are not adequate. The panel did not accept your position and determined that the audit was broadly accurate and reliable.

Finally, the panel saw the only official patient records in this case in relation to Adult 19, Adult 35 and Adult 118, together with a number of patient clinical records relating to children. The panel considered they were broadly consistent with the findings of the audit in that they were not adequate in terms of standard of record keeping.

Charge 3.1.1

> 3.1. On or around 27 October 2016 during/following your consultation with Adult 2
>
> 3.1.1. Did not record adequate details of Adult 2's consultation in the electronic patient record ("EPR") /physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation. The provision of an outcome letter, which she said is a record of a patient's consultation with the clinician is equally important. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for

concluding a consultation with a patient. Accordingly, the panel found that you had a duty to record adequate details of Adult 2's consultation in the EPR/physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 2's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record (apart from your digital signature) before it in relation to Adult 2, and Witness 3 wrote to Adult 2's GP and stated *"our records do not indicate that the GP practice was notified about the consultation or the outcome of the consultation".*

The panel noted that you do not accept the accuracy of the audit on the basis that you have not been able to see the patient notes in the vast majority of the cases.

You said in your written statement *"I would specifically record on the EPR the outcome of the consultation and a letter would be automatically generated. Typing up notes into the EPR is typically a task that is for the clerical team to complete, however I was not provided with the clerical support, so I had to find the time to update the EPR myself. Therefore I kept a handwritten diary and ticked off when I had completed the EPR so I would not forget to do so".*

The panel did not accept your reasoning in regard to this matter. It was provided with the Trust policies, and it heard from Witness 5 corroborated by Witness 4 that it is the duty of the consulting clinician to complete the EPR/outcome letter.

You said in your evidence that you do not understand why the outcome letter was blank. The only explanation offered came from Witness 3 who said they were blank because you had failed to complete them. The panel accepted this explanation.

The panel concluded that there is evidence before it from the audit that Adult 2's patient notes were inadequate, in respect of this appointment. The panel therefore found charge 3.1.1 proved.

Charge 3.2.1

> 3.2. On or around 22 September 2016 during/following your consultation with Adult 3;
>
> 3.2.1. Did not record adequate details of Adult 3's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 3's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 3's consultation in the EPR /physical patient records bundle. The panel noted that the audit recorded that there is no EPR record in Adult 3's clinical notes.

The panel noted Witness 3 wrote to Adult 3's GP to ask the GP to review Adult 3's records and check that the appropriate care and safeguards were in place for Adult 3.

You said in your written statement *"I would specifically record on the EPR the outcome of the consultation and a letter would be automatically generated. Typing up notes into the EPR is typically a task that is for the clerical team to complete, however I was not provided with the clerical support, so I had to find the time to update the EPR myself. Therefore I kept a handwritten diary and ticked off when I had completed the EPR so I would not forget to do so".*

The panel did not accept your reasoning in regard to this matter. It was provided with the Trust policies, and it heard from Witness 5 corroborated by Witness 4 that it is the duty of the consulting clinician to complete the EPR/outcome letter.

You said in your evidence that you do not understand why the outcome letter was blank. The only explanation offered came from Witness 3 who said they were blank because you had failed to complete them. The panel accepted this explanation.

The panel concluded from evidence before it from the audit, that Adult 3's patient notes were inadequate, in respect of this consultation. It therefore found charge 3.2.1 proved.

Charge 3.2.3

> 3.2. On or around 22 September 2016 during/following your consultation with Adult 3;
>
> 3.2.3. Did not record a risk assessment for Adult 3.

This charge is found proved.

In reaching this decision, the panel first considered whether you had a duty to record a risk assessment for Adult 3. It first took into account the Department of

Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, which states:

> *"It should be used to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk."*

It further had regard to the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016, co-authored by you, Witness 1 and Witness 5, which included a risk assessment tool for non-pregnant women over the age of 18. It took particular note of the following extracts:

> *"For non pregnant women where you suspect FGM use the risk assessment took in Appendix 4. Examples could include a woman presenting with physical or emotional behaviours that triggers a concern e.g. frequent UTI, severe menstrual pain, infertility, symptoms of Post Traumatic Stress Disorder (PTSD), reluctance to have her genital area examined. As outlined above no assessment undertaken should simply be a tick-box exercise. When managing suspected or actual FGM good communication skills are required for establishing a rapport with the woman/family, asking questions in a straightforward, open way that develops understanding and trust, and being empathetic and non-judgmental.*
>
> *If a women discloses she has adult daughter(s) over 18 years of age who have already undergone FGM, even if the daughter does not want to take her case to the police, it is important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context. If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in*

attitude, a fear of prosecution, or due to lack of opportunity or other motivations."

The panel was therefore satisfied that there is sufficient evidence before it that you had a duty to record risk assessments.

The panel went on to consider, on the basis of the evidence before it, whether you did not record a risk assessment for Adult 3. The panel had regard to the evidence from the audit that the duty to record such a risk assessment was not fulfilled in that "not recorded" was marked.

You said in your written statement *"All women I saw were risk assessed using a standardised risk assessment tool. The risk assessment was part of my general discussion with the patient. As far as recording, maybe I did not record the answers to each question in all my notes. Anything significant would definitely be recorded, eg domestic violence and making onward referrals. I wrote "All issues related to FGM discussed and well understood" as a standard note to demonstrate the discussion I have had with the patient and the level of understanding".*

The panel did not accept your evidence that the very broad statement *"All issues related to FGM discussed and well understood"* amounted to an adequate record to show you had carried out a risk assessment for FGM patients. The panel therefore found charge 3.2.3 proved.

Charge 3.3.1

> 3.3. On or around 21 April 2016 during/following your consultation with Adult 4;
>
> 3.3.1. Did not record adequate details of Adult 4's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted that the audit noted an empty EPR record (apart from your digital signature) before it in relation to Adult 4. Further, Witness 3 wrote to Adult 4's GP and stated, *"our records do not indicate that the GP practice was notified about the consultation or the outcome of the consultation".*

The panel noted that you do not accept the accuracy of the audit on the basis that you have not been able to see the patient notes in the vast majority of the cases.

The panel did not accept your reasoning in regard to this matter. It was provided with the Trust policies, and it heard from Witness 5 corroborated by Witness 4 that it is the duty of the consulting clinician to complete the EPR/outcome letter.

You said in your evidence that you do not understand why the outcome letter was blank. The only explanation offered came from Witness 3 who said they were blank because you had failed to complete them. The panel accepted this explanation.

The panel concluded from the evidence before it from the audit, that Adult 4's patient notes were inadequate, in respect of this appointment. It therefore found charge 3.3.1 proved.

Charge 3.3.4

3.3. On or around 21 April 2016 during/following your consultation with Adult 4;

3.3.4. Did not record a risk assessment for Adult 4

This charge is found proved.

In reaching this decision, the panel took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016 as outlined in charge 3.2.3.

The panel was therefore satisfied that there is sufficient evidence before it that you had a duty to record risk assessments.

The panel went on to consider, on the basis of the evidence before it, whether you did not record a risk assessment for Adult 4. The panel had regard to the evidence from the audit that the duty to record as such a risk assessment was not fulfilled, in that "not recorded" was marked.

The panel noted that you do not accept the accuracy of the audit on the basis that you have not been able to see the patient notes in the vast majority of the cases.

You said in your written statement *"All women I saw were risk assessed using a standardised risk assessment tool. The risk assessment was part of my general discussion with the patient. As far as recording, maybe I did not record the answers to each question in all my notes. Anything significant would definitely be recorded, eg domestic violence and making onward referrals. I wrote "All issues related to FGM discussed and well understood" as a standard note to demonstrate the discussion I have had with the patient and the level of understanding".*

The panel did not accept your evidence that the very broad statement *"All issues related to FGM discussed and well understood"* amounted to an adequate record to show you had carried out a risk assessment for FGM patients. The panel therefore found charge 3.3.4 proved.

Charge 3.4.1

> 3.4. On or around 15 June 2017 during/following your consultation with Adult 6;
>
> 3.4.1. Did not record adequate details of Adult 6's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 6's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record before it in relation to Adult 6.

The panel noted that you do not accept the accuracy of the audit on the basis that you have not been able to see the patient notes in the vast majority of the cases.

However, the panel concluded that there is evidence before it from the audit that Adult 6's patient notes were inadequate, in respect of this appointment. The panel was provided with a copy of the EPR/outcome letter for Adult 6 which contained the

GP's details, patient details but no record of the outcome of the consultation just your electronic signature. The panel therefore found charge 3.4.1 proved.

Charge 3.5.1

> 3.5. On or around 18 August 2016 during/following your consultation with Adult 7;
>
> 3.5.1. Did not record adequate details of Adult 7's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 7's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 7's consultation in the EPR /physical patient records bundle. The panel noted that there is an empty EPR record before it in relation to Adult 7.

You said in your written statement *"Without seeing my notes or my EPR entries for this patient, I am not able to agree that they are not adequate. The diary entires indicate that did input into EPR as there is a tick over EPR in the top left hand corner. I am not able to comment on how the risk assessment was recorded either".*

The panel accepted the evidence from the audit that Adult 7's patient notes were inadequate, in respect of this appointment. The audit found that the EPR letter was empty. The panel therefore found charge 3.5.1 proved.

Charge 3.5.2

> 3.5. On or around 18 August 2016 during/following your consultation with Adult 7;
>
> 3.5.2. Did not record a risk assessment of Adult 7/Adult 7's daughters.

This charge is found proved in respect of Adult 7 and not Adult 7's daughters.

In reaching this decision, the panel took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016 as outlined in charge 3.2.3.

It also had regard to the following extract from the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, specifically in relation to Adult 7's daughters:

> *"Successful implementation will be dependent upon the clinician understanding that there is a potential risk of FGM, and on their continuing awareness and consideration of this through the early years of a girl's life. For the system to succeed, a critical factor will be the use of a tool such as the FGM Safeguarding Risk Assessment ([…]). Therefore, it is recommended that organisations look to adopt this guidance which will act as preparation for this new change."*

The panel was satisfied there is sufficient evidence before it that you had a duty to record a standardised risk assessment tool for FGM for Adult 7 which includes a considered risk to any born or unborn child.

It also took into account Witness 5's oral evidence that issues concerning children would be recorded in their mother's clinical notes where records are not available for the children. The panel had regard to the evidence from the audit that such risk assessment was not fulfilled, in that "not recorded" was marked.

The audit makes no suggestion that Adult 7's children's records were reviewed. There is no evidence that Adult 7's children were present at the consultation. Therefore, the panel was satisfied that you were not under a duty to record a separate risk assessment for Adult 7's daughters. The only risk assessment that should have been recorded was that of Adult 7.

However, it was clear to the panel that there was no record of a risk assessment for Adult 7. The risk assessment for Adult 7 should have included any potential risks to any children who may be subject to FGM.

The panel therefore found charge 3.5.2 proved in respect of Adult 7 but not in respect of Adult 7's daughters.

Charge 3.5.3

> 3.5. On or around 18 August 2016 during/following your consultation with Adult 7;
>
> 3.5.3. Did not record communication with safeguarding professionals regarding Adult 7/Adult 7's daughters.

This charge is found proved in relation to Adult 7's daughters but not Adult 7.

In reaching this decision, the panel bore in mind that there is evidence before it which outlines the reasons for and importance of recording communication with safeguarding professionals, within the Trust Safeguarding the Welfare of Children: Children in Need and Child Protection Procedure, effective from May 2014 review date May 2017.

> *"In most cases concerns regarding children should be raised with parents/carers at the point of contact and consent obtained to share this information with other professionals, unless this puts the child/young person at risk".*

The panel had regard to the evidence from the audit and from Witness 3 that nothing was recorded in respect of communication with safeguarding professionals regarding Adult 7's daughters.

There was no evidence before the panel as to whether Adult 7's daughters were present at this consultation. The audit of your record keeping did not find any evidence that you considered the fact that Adult 7 had two daughters which had been outlined in the initial referral. You had a duty to inform safeguarding professionals with regard to these two daughters aged 8 and 11 who were at potential risk of FGM from their paternal grandmother, as recorded in the referral letter. There was no record in your documentation that you made any enquiries with safeguarding professionals as to whether the family were currently known to them or not.

There was no evidence to suggest that Adult 7 faced risks which required safeguarding. The panel therefore found charge 3.5.3 proved in relation to Adult 7's daughters but not Adult 7.

Charge 3.6.2

3.6. On or around 3 December 2015 during/following your consultation with Adult 8;

3.6.2. Did not record adequate details of the advice/assessment/discussion/next steps provided to Adult 8

This charge is found proved.

In reaching this decision, the panel first considered whether there was a duty to record such details. It bore in mind that Adult 8's consultation on 3 December 2015 is distinct from other patients particularised at charge 3, in that this appointment related to a smear test and not FGM. The panel had regard to the evidence before it, that this smear test had been recorded in a pro forma document.

The panel noted that the audit highlighted an absence of detail in Adult 8's notes, notwithstanding that this was a cervical smear test and not a FGM consultation, the record made was not adequate in relation to advice/assessment/discussion/next steps provided in respect of this appointment.

The panel considered that your standard phrase 'advised and reassured' in your diary notes does not adequately address what was discussed with the Adult 8 during this consultation for any other clinician reviewing the records to understand.

The panel therefore found charge 3.6.2 proved.

Charge 3.7.1

3.7. On or around 4 June 2015 during/following your consultation with Adult 9;

3.7.1. Did not record adequate details of Adult 9’s consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5’s evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient’s consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 9’s consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, whether you did not record adequate details of Adult 9’s consultation in the EPR /physical patient records bundle. The panel noted that the audit recorded that there was no EPR record, or outcome letter contained within Adult 9’s physical patient records bundle.

The panel noted that the audit highlighted an absence of detail in Adult 9’s notes, including the recording of consent, the offer of a chaperone a detailed clinical history and any record of a risk assessment, in respect of this consultation.

You said in your written statement *“Without seeing my notes or my EPR entries for this patient, I am not able to agree that they are not adequate. The diary entires indicate that I did input into EPR as there is a tick over EPR in the top left hand corner”.*

The panel considered that your standard phrase 'advised and reassured' in your diary notes does not adequately address what was discussed with Adult 9 during this consultation for any other clinician reviewing the records to understand. The panel therefore found charge 3.7.1 proved.

Charge 3.9.1

> 3.9. On or around 11 June 2015 during/following your consultation with Adult 12;
>
> 3.9.1. Did not record adequate details of Adult 12's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 12's consultation in the EPR /physical patient records bundle.

The panel noted that the audit recorded *"EPR checked nothing noted"*. It had regard to Witness 3's oral evidence that reference to "*nothing noted*" in the audit was indicative that patient notes were available, however they were missing pieces of information.

The panel noted that the audit highlighted an absence of detail in Adult 12's notes, including the recording of consent, the offer of a chaperone a detailed clinical history and any record of a risk assessment, in respect of this consultation.

The panel noted that you recorded in the Trust FGM proforma ‘had moderate bleeding’. The panel considered that any reader of this would be unable to identify cause, amount of bleeding or your immediate treatment to stem the bleeding.

Your written evidence is that *“The diary entires indicate this patient did not want an entry to be recorded on EPR and did not want a letter sent home. Because of the possible implications to some patients, I was sometimes asked not to send any letter home or record their consultation on the EPR”.*

The panel did not accept your explanation as a letter on EPR to the GP would not necessarily have to be copied and sent to Adult 12’s home. Furthermore, you did not record any reasons as to why a letter sent to Adult 12’s home would put her at risk. There was no evidence of any risk assessment highlighting concerns.

It concluded that there is evidence before it from the audit that Adult 12’s patient notes were inadequate, in respect of this appointment. It therefore found charge 3.9.1 proved.

Charge 3.9.4

3.9.4. Did not record the purpose/reasons for prescribing anti-biotics to Adult 12.

This charge is found proved.

In reaching this decision, the panel noted you admitted that you did not record the purpose/reasons for prescribing anti-biotics to Adult 12. But you do not admit that it amounts to a failure to maintain adequate clinical records.

The panel took into account your own admission in your written statement where you said *"I accept that I should have written the reasons for the antibiotics being prescribed in the notes".*

The Trust FGM proforma shows that you recorded 'antibiotics prescribed, nothing further'. The panel considered this to be an inadequate record.

In his oral evidence Witness 20 stated that he would have expected you to record the prescription of antibiotics in the patient notes. He said *"The name of the antibiotic, the way it was prescribed, orally or rectally or whatever, the number of times a day and the duration of the prescription is the standard of writing a prescription in the notes, and then I would put underneath, "Okayed by [Witness 20]" or [Witness 5] or whoever".*

The panel considered the fact that you did not record the purpose/reasons for prescribing antibiotics to Adult 12 is inadequate because such a failure significantly disadvantages other healthcare professionals and potentially the patient should they need to review these records in the future. The panel therefore found charge 3.9.4 proved.

Charge 3.10.2

> 3.10. On or around 6 August 2015 during/following your consultation with Adult 15;
>
> 3.10.2. Did not record a discussion about the illegality of FGM with Adult 15.

This charge is found proved.

In reaching this decision, the panel bore in mind the evidence of Witness 5, that all women who attended the AWWC were provided with a leaflet which informed them about the illegality of FGM. Witness 5 also informed the panel that she had witnessed your approach to this matter when you provided advice to patients during your consultations. However, the panel noted that the audit marked "not recorded" for of both "informed about the illegalities of FGM" and "FGM leaflet given". The panel bore in mind that your note on the diary page for this appointment set out *"all issues relating to FGM discussed […] well understood".*

You said in your written statement *"When I have written in the diary entry "All issues relating to FGM discussed with [Adult 15] - well understood" this indicates that I did discuss the illegality of FGM and undertook a risk assessment using the standardised tool. It was my practice to discuss the illegality of FGM with all my patients and provide a leaflet with more detail as well".*

The panel considered that your standardised statement "All issues relating to FGM discussed with [Adult 15] - well understood" to be inadequate. It does not indicate the level of discussion that was had during the consultation nor does it identify any risk to a future reviewing clinician. The panel therefore found charge 3.10.2 proved.

Charge 3.10.3

> 3.10. On or around 6 August 2015 during/following your consultation with Adult 15;
>
> 3.10.3. Did not record a risk assessment for Adult 15.

This charge is found proved.

The panel bore in mind that the audit marked “not recorded” in respect of risk assessment. It took into account the evidence of Witness 3, who said that such note was indicative of an assessment not being available within a patient’s notes.

You said in your written statement *“When I have written in the diary entry "All issues relating to FGM discussed with [Adult 15] - well understood" this indicates that I did discuss the illegality of FGM and undertook a risk assessment using the standardised tool. It was my practice to discuss the illegality of FGM with all my patients and provide a leaflet with more detail as well”.*

The panel consider that your standardised statement "All issues relating to FGM discussed with [Adult 15] - well understood" to be inadequate. It does not indicate the level of discussion that was had during the consultation, nor does it identify any risk to a future reviewing clinician. The panel therefore found charge 3.10.3 proved.

Charge 3.12.1

> 3.12. On or around 22 August 2013 during/following your consultation with Adult 17;
>
> 3.12.1. Did not record adequate details of Adult 17’s consultations in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5’s evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient’s consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly,

the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 17's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether, on the basis of the evidence before it, you did not record adequate details of Adult 17's consultation in the EPR /physical patient records bundle. The panel noted that the audit had "not recorded" marked in respect of the AWWC assessment and symptoms box. Your diary notes for both appointments note EPR with a score through, however the panel took into account the oral evidence of Witness 2, that the auditors had searched for an EPR for these appointments and no such records were available.

In respect of the appointment on 22 August 2013, the panel had regard to the conclusions of the audit and bore in mind the evidence of Witnesses 4 and 5 about the importance of adequate patient records. It concluded that there is evidence on the basis of the audit and these witnesses to support this charge in respect of this date.

The panel noted in your diary entry for Adult 17 you had recorded '??might want to talk'. This statement gave no detail to any reviewing clinician as to what this meant or what it relates to.

From the evidence heard, the panel found your records to be inadequate.

Having already found the audit to be reliable, the panel accepted the evidence within the audit and found charge 3.12.1 proved.

Charge 3.14.1

> 3.14. On or around 16 April 2015 during/following your consultation with Adult 22;

3.14.1. Did not record adequate details of Adult 22's consultation in the EPR/physical patient records bundle.

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient.

The FGM proforma for this patient lacked sufficient content as to the consultation and was therefore inadequate. The panel took into account Witness 3's oral evidence, that your record keeping was universally poor.

The panel therefore concluded that there is evidence before it from the audit that Adult 22's patient notes were inadequate, in respect of this appointment.

Having already found the audit reliable, the panel accepted the evidence within the audit. The panel therefore found charge 3.14.1 proved.

Charge 3.15.1

3.15. On or around 28 April 2016 during/following your consultation with Adult 23;

3.15.1. Did not record adequate details of Adult 23's consultation in the EPR/physical patient records bundle

This charge is found proved.

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient.

The panel noted that the audit recorded that the EPR letter was empty, and that Adult 23 needed a follow up welfare letter to her GP regarding her psychosexual concerns.

It concluded that there is evidence before it from the audit that Adult 23's patient notes were inadequate, in respect of this appointment.

Having already found the audit reliable, the panel accepted the evidence within the audit and found charge 3.15.1 proved.

Charge 3.15.3

> 3.15. On or around 28 April 2016 during/following your consultation with Adult 23;
>
> 3.15.3. Did not record a risk assessment for Adult 23/Adult 23's children.

This charge is found proved in relation to Adult 23 but not Adult 23's children.

In reaching this decision, the panel first considered that you had a duty to record a risk assessment for Adult 23 which should include her daughters. It took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016 and the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016.

It also had regard to the following extract from the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, specifically in relation to Adult 23's daughters:

> *"Successful implementation will be dependent upon the clinician understanding that there is a potential risk of FGM, and on their continuing awareness and consideration of this through the early years of a girl's life. For the system to succeed, a critical factor will be the use of a tool such as the FGM Safeguarding Risk Assessment ([…]). Therefore, it is recommended that organisations look to adopt this guidance which will act as preparation for this new change."*

The panel heard evidence that the Trust Clinical Guidance for Female Genital Mutilation, co-authored by yourself in 2016 adopted the above safeguarding risk assessment tool.

The panel went on to consider, on the basis of the evidence before it, whether you did not record a risk assessment for Adult 23 or her children. It also took into account Witness 5's oral evidence that issues concerning children would be recorded in their mother's clinical notes where records are not available for the children. The panel had regard to the evidence from the audit that such risk assessment was not fulfilled, in that "not recorded" was marked.

The panel was not provided with any evidence of a risk assessment of Adult 23 as per the audit, which covered the duty regarding Adult 23's children.

The audit makes no suggestion that Adult 23's children's records were reviewed. There is no evidence that Adult 23's children were present at the consultation. Therefore, the panel was satisfied that you were not under a duty to record a separate risk

assessment for Adult 23's children. The only risk assessment that should have been recorded was that of Adult 23.

However, it was clear to the panel that there was no record of a risk assessment for Adult 23. The risk assessment for Adult 23 should have recorded any potential risks to any children who may be subject to FGM.

The panel therefore found charge 3.15.3 proved in respect of Adult 23 but not in respect of Adult 23's children.

Charge 3.17.1

> 3.17. On or around 2 July 2015/ 9 July 2015 during/following your consultation with Adult 35;
>
> 3.17.1. Did not record adequate details of Adult 35's consultations in the EPR/physical patient records bundle

This charge is found proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is an important part of the process for concluding the record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient.

Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 35’s consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 35’s consultation in the EPR /physical patient records bundle. The panel noted that the information you had not recorded included consent, the offer of a chaperone or a risk assessment for the appointments on 2 July and 9 July in Adult 35’s records.

The panel saw a limited number of patient records in this case which included Adult 35. The panel considered they broadly mirrored your contemporaneous FGM proforma record for Adult 35 copies of which were provided to the panel.

The panel considered that in terms of the audit, the findings were broadly consistent with the official patient records seen by the panel, in that the official patient records were similar in content to your contemporaneous notes which you recorded in a variety of different formats throughout the relevant period.

The panel concluded that there is sufficient evidence before it from the audit and Adult 35’s clinical notes that they were inadequate, in respect of these appointments. The panel therefore found charge 3.17.1 proved.

Charge 3.17.3

> 3.17. On or around 2 July 2015/ 9 July 2015 during/following your consultation with Adult 35;
>
> 3.17.3. Did not record the reason for prescribing/providing antibiotics to Adult 35.

This charge is found proved

In reaching this decision, the panel noted that you admit that you did not record the purpose/reasons for prescribing anti-biotics to Adult 35, but you do not admit that it amounts to a failure to maintain adequate clinical records.

The panel took into account your own admission in your written statement where you said *"I accept that I should have written the reasons for the antibiotics being prescribed in the notes".*

The Trust FGM proforma shows that you recorded 'antibiotics prescribed, nothing further'. The panel considered this to be an inadequate record.

In his oral evidence Witness 20 stated that he would have expected you to record the prescription of antibiotics in the patient notes. He said *"The name of the antibiotic, the way it was prescribed, orally or rectally or whatever, the number of times a day and the duration of the prescription is the standard of writing a prescription in the notes, and then I would put underneath, "Okayed by [Witness 20]" or [Witness 5] or whoever".*

The panel noted that you had recorded the name of the antibiotic. However, you did not record the purpose/reasons for prescribing antibiotics to Adult 35. The panel therefore found this a failure which potentially significantly disadvantages other healthcare professionals reviewing the patient's clinical records and possibly the patient's future care. The panel therefore found charge 3.17.3 proved.

Charge 3.18.1

3.18. On or around 5 December 2013/12 December 2013 during/following your consultation with Adult 44;

3.18.1. Did not record adequate details of Adult 44's consultations in the EPR/physical patient records bundle

This charge is found proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 44's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 44's consultation in the EPR /physical patient records bundle. The panel noted from the audit that the information you did not record included consent, the offer of a chaperone or a risk assessment for these appointments in Adult 44's records.

The panel concluded that there is sufficient evidence before it from the audit that Adult 44s patient notes were inadequate, in respect of these appointments. It therefore found charge 3.18.1 proved.

Charge 3.19.1

3.19. On or around 21 July 2016/28 July 2016 during/following your consultation with Adult 124;

3.19.1. Did not record adequate details of Adult 124's consultations in the EPR/physical patient records bundle.

This charge is found proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 124's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 124's consultation in the EPR /physical patient records bundle. There is evidence from the audit that you did not record information which included Adult 124's clinical assessment, current symptoms, and the notes are limited as to this patient's medical and social history at these appointments. The panel bore in mind the evidence of Witness 3, that your notes were universally inadequate.

The panel was provided with copies of the two EPR/outcome letters for Adult 124 as per the charge. The letters lacked clinical detail, key points from the discussion with Adult 124, plan for next steps. It only included diagnosis of FGM 3 performed age 6/7 and de-infibulation done the same day under local anaesthesia.

The panel accordingly concluded that there is sufficient evidence before it from the audit and the EPR letters that Adult 124's patient notes were inadequate, in respect of these appointments. The panel therefore found charge 3.19.1 proved.

Charge 3.20.1

> 3.20. On or around 10 November 2016/24 November 2016 during/following your consultation with Adult 130;
>
> 3.20.1. Did not record adequate details of Adult 130's consultations in the EPR/physical patient records bundle.

This charge is found proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence before it to establish that you had a duty to record adequate details of Adult 130's consultation in the EPR /physical patient records bundle.

The panel went on to consider whether you did not record adequate details of Adult 130's consultation in the EPR /physical patient records bundle. The panel noted that the audit noted that you did not record the source of referral or Adult 130's prescription. Further, it noted that the auditors had assessed your notes as basic in respect of both appointments.

The panel bore in mind the evidence of Witness 3, that your notes were universally inadequate.

The panel noted that the audit recorded the presence of a EPR/outcome letter. However, the audit recorded that this was ‘basic’.

The panel concluded that there is sufficient evidence before it from the audit that Adult 130’s patient notes were inadequate, in respect of these appointments. It therefore found charge 3.20.1 proved.

Charge 3.21.1

> 3.21. On or around 6 August 2015 during/following your consultation with Child 16;
>
> 3.21.1. Did not clearly record the origin of referral in Child 16’s patient records.

This charge is found not proved

In reaching this decision, the panel noted Witness 5’s evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child’s appointment indicate that she was referred by *“GP/Social Worker”.*

The audit highlighted that there were no referral forms within the patient notes.

The panel noted that your clinical notes referred to the AWWC by GP/social worker re FGM thereby there is a sufficiently clear record of the origin of the referral. However, the panel noted the comments in the audit which stated ‘not usual to have two routes of

referral'. However, the panel had no reason to doubt that this may have been an exception to the general rule.

The panel considered that the evidence for this charge was not sufficiently convincing; it would not, in the panel's view, be difficult to identify who made the referral as it was Child 16's GP/Social worker.

The panel concluded that there is sufficient evidence as to the origin of referral. It therefore found charge 3.21.1 not proved.

Charge 3.21.2

> 3.21. On or around 6 August 2015 during/following your consultation with Child 16;
>
> 3.21.2. Did not record any correspondence with social workers.

This charge is found proved

In reaching this decision, the panel took into account that the audit found there was no evidence of any communication with social workers regarding Child 16.

There was no evidence from any other source before the panel that your documentation in relation to Child 16 included any reference to correspondence with social workers.

The panel therefore found charge 3.21.2 proved.

Charge 3.21.3

> 3.21. On or around 6 August 2015 during/following your consultation with Child 16;
>
> 3.21.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 16/Child 16's mother.

This charge is found proved

In reaching this decision, the panel noted that you admit that you did not record details of the advice and discussions provided to Child 16's mother.

Having reviewed the evidence before it, the panel noted you commented in Child 16's clinical notes 'plan for deinfibulation at some stage'. The panel was of the view that on its own this lacks sufficient detail and was therefore inadequate to set out the next steps.

You accepted in your oral evidence that you did not record consent, much detail of Child 16' history, the impact of FGM or the content of the discussion with Child 16's mother.

The panel concluded that record of the advice, discussion, assessment and next steps were all inadequate, in respect of this appointment. It therefore found charge 3.21.3 proved.

Charge 3.21.4

> 3.21. On or around 6 August 2015 during/following your consultation with Child 16;
>
> 3.21.4. Did not record a risk assessment for Child 16.

This charge is found proved

In reaching this decision, the panel took into account from your evidence and the oral submissions made on your behalf that you fully admit this charge.

The panel was satisfied there was a duty to record the risk assessment to ensure that safeguarding measures were put in place if necessary. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

The panel has extensively set out its reasoning in relation to the duty to carry out and record risk assessments at charge 3.2.3.

This duty is encapsulated in Tackling FGM in the UK Intercollegiate recommendations for identifying, recording and reporting (effective 1 November 2013) published by the Royal College of Midwives:

*"**2.6 Identifying girls affected by FGM***

Commissioning agencies, Local Safeguarding Children Boards (LSCBs), and regulatory authorities need to ensure that frontline professionals are adequately supported to identify girls affected by FGM.

Three main groups affected by FGM may be identified by frontline professionals:

- *A girl at risk of having FGM*
- *A girl who had undergone FGM*
- *A baby girl born to a mother who has undergone FGM*

Risk to the child must be considered if:

- *Any female child born to a woman who had undergone FGM*
- *Any female child whose older sibling had undergone FGM must be considered at immediate risk,*
- *Risk to other children in the woman's or child's household must be considered.*

2.6.1 Identifying girls at risk of FGM

Some professionals will have greater opportunities to identify girls at risk of FGM, and they should be alert to the risk of FGM. These include general practitioners, paediatricians, midwives, health visitors, school nurses, accident and emergency

professionals, teachers and nursery staff. These may also include specific health settings, such as sexual health clinics, sexual assault referral centres or community contraception services".

The panel considered that it was clearly necessary to record a risk assessment for Child 16 as previously set out. The panel concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.21.4 proved.

Charge 3.21.5

> 3.21. On or around 6 August 2015 during/following your consultation with Child 16;
>
> 3.21.5. Did not record any follow up communication/letter with Child 16's Social Worker

This charge is found proved

In reaching this decision, the panel took into account that you admitted that you did not record any follow up communication/letter with Child 16's Social Worker.

The panel considered that follow up communication with a referring social worker is a crucial element of a patient's clinical pathway and safeguarding pathway and must be recorded within the clinical records. The panel therefore concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.21.5 proved.

Charge 3.22.1

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.1. Did not clearly record the origin of referral in Child 17's patient records.

This charge is found not proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"GP/Social Worker".*

The panel noted that the audit highlighted that there were no referral forms within the patient's notes.

The panel noted that your clinical notes recorded the referral to the AWWC by GP/social worker re FGM thereby there is a sufficiently clear record of the origin of the referral. The panel noted the comments in the audit which stated 'not usual to have two routes of referral'. However, the panel had no reason to doubt that this may have been an exception to the general rule.

The panel considered that the evidence for this charge was not sufficiently convincing; it would not, in the panel's view, be difficult to identify who made the referral as it was Child 17's GP/Social worker.

The panel concluded that there is sufficient evidence as to the origin of referral. It therefore found charge 3.22.1 not proved.

Charge 3.22.2

> 3.22. On or around 6 August 2015 during/following your consultation with Child 17;
>
> 3.22.2. Did not record a full clinical history check of Child 17.

This charge is found proved

In reaching this decision the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel considered that a full clinical history is an integral part of any adequate clinical record which must be recorded, which you failed to do.

The panel concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.22.2 proved.

Charge 3.22.3

> 3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.3. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 17/Child 17's mother

This charge is found proved in relation to 'advice, assessment and discussion' but not proved in relation to 'next steps'

In reaching this decision, the panel noted that you admit that you did not adequately record adequate details of the advice and discussion provided to Child 17's/Child 17's mother.

Having reviewed the evidence before it, the panel noted your comment in Child 17's clinical notes "no treatment needed at this stage". The panel was of the view that this comment was a sufficiently adequate record in terms of next steps.

You accepted in your oral evidence that you did not record consent, 'much detail' of Child 16' history, the impact of FGM or the content of the discussion with Child 16's mother.

Your written statement said *"I will make sure that I record much more detail about the origin and reason for the visit, details about the discussion and advice given and plan for next steps".*

The panel concluded that the record of the advice, assessment and discussion was inadequate, in respect of this appointment. It therefore found charge 3.22.3 proved to this extent, but not proved in respect of next steps.

Charge 3.22.4

3.22. On or around 6 August 2015 during/following your consultation with Child 17;

3.22.4. Did not record a risk assessment for Child 17.

This charge is found proved

In reaching this decision the panel took into account that you admit this charge but did not accept that this amounts to a failure to maintain adequate clinical records.

The panel was satisfied there was a duty to record the risk assessment to ensure the safeguarding measures were put in place if necessary, for the reasons set out at charge 3.21.4. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

In your written evidence you said *"I have standardised tools that I followed to consider who referred, why they attended, why are they under social services referral, any siblings or female cousins within the family that might be at risk or FGM or has been through FGM that needs care. I accept that is not recorded".*

The panel considered that it was clearly necessary to record a risk assessment for Child 17. The panel concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.22.4 proved.

Charge 3.23.1

> 3.23. On or around 13 August 2015 during/following your consultation with Child 18;
>
> 3.23.1. Did not record adequate details of the advice/assessment/discussion/next steps provided to Child 18/Child 18's father

This charge is found proved in relation to 'advice, discussion and next steps' but not in relation to the 'assessment'

In reaching this decision, the panel noted that you admit that you did not adequately record adequate details of the advice and discussion provided to Child 18's/Child 18's father.

You admit in your statement *"I accept, particularly in the case of child patients, my notes should have been more detailed".*

In terms of your record of the assessment, the panel noted that there is more detail in this clinical record than in others it had seen in relation to other patients. The panel therefore considered the record of the assessment to be sufficiently adequate.

However, in relation to next steps, the panel considered your comments "Child 18 will need further investigation and support" did not adequately cover as it is vague and non-specific and does not provide any detail of practical next steps.

The panel therefore found charge 3.23.1 proved in terms of the record of advice, discussion and next steps but not proved in terms of the record of the assessment.

Charge 3.23.2

> 3.23. On or around 13 August 2015 during/following your consultation with Child 18;
>
> 3.23.2. Did not record a risk assessment for Child 18

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel was satisfied there was a duty to record the risk assessment to ensure that safeguarding measures were put in place if necessary, for the reasons set out at charge 3.21.4. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

In your written evidence you said *"I have standardised tools that I followed to consider who referred, why they attended, why are they under social services referral, any siblings or female cousins within the family that might be at risk or FGM or has been through FGM that needs care. I accept that is not recorded".*

You further said in your statement *“I am certain that I would have gone through the risk assessment tool, but I accept that is not recorded”.*

The panel considered that it was clearly necessary to record a risk assessment for Child 18. The panel concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.23.2 proved.

Charges 3.24.1, 3.24.3, 3.24.4, 3.24.5

> 3.24. On or around 11 September 2015 during/following your consultation with Child 19;
>
> 3.24.1. Did not create any official clinical healthcare records for Child 19.
>
> 3.24.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 19
>
> 3.24.4. Did not record a risk assessment for Child 19
>
> 3.24.5. Did not record any follow up with social care.

These charges are found not proved

In reaching this decision, the panel took into account your statement in which you said *“I don't recall having a consultation with Child 19. The mother must have been seeking asylum in the UK and wanted a letter confirming the risk to her child. If there are no notes, I assume I did not assess or examine child 19, but included her as part of a risk*

assessment for the mother. I have not been provided with the patient notes or EPR for Child 19's mother, which might confirm this. Having identified child 19 as potentially being at risk of FGM, I would have made a referral to [Ms 14] to ensure the child was safeguarded. Again, this may have been included within Child 19's mother's notes".

The audit team were unable to comment in relation to Child 19 as they were unable to find any records of Child 19.

The panel was not provided with any evidence of Child 19's records. On that basis the panel determined that the NMC had not discharged the burden of proof in relation to charges 3.24.1, 3.24.3, 3.24.4, 3.24.5.

Charge 3.25.1

> 3.25. On or around 22 October 2015 during/following your consultation with Child 21;
>
> 3.25.1. Did not adequately record the origin of referral in Child 21's patient records.

This charge is found not proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"Social Services/Police Referral".*

The evidence in your statement is *"I accept that my notes are brief for this child. I am not sure if I undertook the assessment, or if it was done by [Dr 8]. It is unlikely that I would ask for a reassessment or second opinion from [Dr 8], so I assume it was [Dr 8] who assessed Child 21. I cannot recall".*

The panel noted that the audit highlighted that there were no referral forms within the patient's notes.

The panel noted that your clinical notes referred to the AWWC by social services/police re FGM thereby there is a sufficiently clear record of the origin of the referral. The panel noted the comments in the audit which stated 'not usual to have two routes of referral'. The panel considered that the evidence for this charge was not sufficiently persuasive. However, the panel had no reason to doubt that this may have been an exception to the general rule.

The panel bore in mind that there is evidence as to the origin of referral. The panel concluded that there is sufficient evidence as to the origin of referral. It therefore found charge 3.25.1 not proved.

Charge 3.25.2

> 3.25. On or around 22 October 2015 during/following your consultation with Child 21;
>
> 3.25.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 21/Child 21's mother.

This charge is found proved in relation to 'advice and discussion' but not proved in relation to 'examination' and 'next steps'

In reaching this decision, the panel noted that you admit that you did not record details of the advice and discussions provided to Child 21's mother.

The panel had sight of the clinical records for Child 21. The panel noted in terms the examination, there was no diagram and very little recorded about the extent of the examination in the clinical notes. Your comments in the notes stated *"Vulva appears normal"… this was confirmed by [Dr 8]. Legal information discussed with child 21 mother" and this was stamped 'Dr Comfort Momoh'.* The panel considered this to be an adequate record of the examination. The panel therefore considered that there would not necessarily be anything further to record with regard to next steps.

The panel saw no evidence recorded within the clinical notes regarding next steps.

Your said in your written statement said *"I accept that my notes are brief for this child. I am not sure if I undertook the assessment, or if it was done by [Dr 8]. It is unlikely that I would ask for a reassessment or second opinion from [Dr 8], so I assume it was [Dr 8] who assessed Child 21. I cannot recall".*

The panel therefore found charge 3.25.2 proved in relation to advice and discussion but not in relation to examination and next steps.

Charge 3.25.3

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.3. Did not record a risk assessment for Child 21.

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

You said in your written statement *"I would have ensured a risk assessment had been carried out and send the information to [Ms 14] to liaise with social services".*

Upon reviewing the evidence, the panel noted there was no risk assessment recorded in Child 21's clinical notes.

The panel was satisfied there was a duty to record the risk assessment to ensure that safeguarding measures were put in place if necessary as previously stated in charge 3.21.4. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records. The panel therefore found charge 3.25.3 proved.

Charge 3.25.4

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.4. Incorrectly recorded information regarding Child 22 into Child 21's records.

This charge is found not proved

In reaching this decision, the panel had sight of the clinical records for Child 21 and Child 22 and noted that, in terms of content, they are identical.

The panel determined that NMC has not identified what was incorrectly recorded in relation to Child 21 and Child 22's records, potentially due to the redactions in the evidence before the panel.

On that basis, the panel determined that the NMC has not discharged the burden of proof. The panel therefore found charge 3.25.4 not proved.

Charge 3.25.5

3.25. On or around 22 October 2015 during/following your consultation with Child 21;

3.25.5. Did not send an outcome letter to Child 21's social services and/or the police

This charge is found proved

In reaching this decision, the panel took into account your written statement *"My practice was to print off the GP outcome letter and send a copy to the referrer. I believe I did that in this case".*

The panel saw no evidence in the audit of any communication with social services or the police nor did it see any record within your diary notes that you sent an outcome letter.

The panel therefore found charge 3.25.5 proved.

Charge 3.26.1

> 3.26. On or around 22 October 2015 during/following your consultation with Child 22;
>
> 3.26.1. Did not adequately record the origin of referral in Child 22's patient records.

This charge is found not proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation. It noted that your records from this Child's appointment indicate that she was referred by *"Social Services/Police Referral".*

The evidence in your statement is *“I accept that my notes are brief for this child. I am not sure if I undertook the assessment, or if it was done by [Dr 8]. It is unlikely that I would ask for a reassessment or second opinion from [Dr 8], so I assume it was [Dr 8] who assessed Child 21. I cannot recall”.*

The panel noted that the audit highlighted that there were no referral forms within the patients notes.

The panel noted that your clinical notes referred to the AWWC by social services/police re FGM thereby there is a sufficiently clear record of the origin of the referral. However, the panel noted the comments in the audit which stated ‘not usual to have two routes of referral’. However, the panel had no reason to doubt that this may have been an exception to the general rule.

The panel bore in mind that there is evidence as to the origin of referral. The panel concluded that there is sufficient evidence as to the origin of referral. It therefore found charge 3.26.1 not proved.

Charge 3.26.2

> 3.26. On or around 22 October 2015 during/following your consultation with Child 22;
>
> 3.26.2. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 22/Child 22’s mother.

This charge is found proved in relation to advice and discussion but not proved in relation to examination and next steps

In reaching this decision, the panel noted that you admit that you did not record details of the advice and discussions provided to Child 22's mother.

The panel had sight of the clinical records for Child 22. The panel noted in terms the examination, there was no diagram and very little recorded about the extent of the examination in the clinical notes. Your comments in the notes stated *"Vulva appears normal"… this was confirmed by [Dr 8]. Legal information discussed with child 21 mother" and this was stamped 'Dr Comfort Momoh'.* The panel considered this to be an adequate record of the examination. The panel therefore considered that there would not necessarily be anything further to record with regard to next steps.

The panel saw no evidence recorded within the clinical notes regarding next steps.

Your said in your written statement said *"I accept that my notes are brief for this child. I am not sure if I undertook the assessment, or if it was done by [Dr 8]. It is unlikely that I would ask for a reassessment or second opinion from [Dr 8], so I assume it was [Dr 8] who assessed Child 22. I cannot recall".*

The panel therefore found charge 3.26.2 proved in relation to advice and discussion but not proved in relation to examination and next steps.

Charge 3.26.3

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

3.26.3. Did not send an outcome letter to Child 22's social worker and/or the police

This charge is found proved

In reaching this decision, the panel took into account your written statement *"My practice was to print off the GP outcome letter and send a copy to the referrer. I believe I did that in this case".*

The panel saw no evidence in the audit of any communication with social services or the police nor did it see any record within your diary notes that you sent an outcome letter.

The panel therefore found charge 3.26.3 proved.

Charge 3.26.4

3.26. On or around 22 October 2015 during/following your consultation with Child 22;

3.26.4. Incorrectly recorded information regarding Child 21 into Child 22s records.

This charge is found not proved

In reaching this decision, the panel had sight of the clinical records for Child 21 and Child 22 and noted that, in terms of content, they are identical.

The panel determined that NMC has not identified what was incorrectly recorded in relation to Child 21 and Child 22's records, potentially due to the redactions in the evidence before the panel.

On that basis the NMC has not discharged the burden of proof. The panel therefore found charge 3.26.4 not proved.

Charge 3.27.1

> 3.27. On or around 18 February 2016 during/following your consultation with Child 23;
>
> 3.27.1. Did not create any official clinical healthcare records for Child 23

This charge is found proved

In reaching this decision, the panel had regard to the audit which recorded that healthcare records were not documented. The panel also bore in mind the evidence

of Witness 1, who said that there were no records available for this patient. It concluded that there is evidence before it from the audit that no official clinical healthcare records may have been created for Child 23, in respect of this appointment. The panel bore in mind that you completed a diary record for this patient, however, these were not official clinical healthcare records.

Your evidence in your written statement is that *"I have entered information on EPR as there is an outcome letter to Child 23's GP. I do not know why it is blank. For there to be an EPR, there must have been official records generated. I do not know why the audit did not have access to Child 23's notes. Without seeing my notes or my EPR entries for this patient, I am not able to agree that they are not adequate. The diary entires indicate that I did input into EPR as there is a tick over EPR in the top left hand corner".*

The panel therefore found charge 3.27.1 proved.

Charge 3.27.2

> 3.27. On or around 18 February 2016 during/following your consultation with Child 23;
>
> 3.27.2. Did not record a risk assessment for Child 23.

This charge is found proved

The panel did not have sight of Child 23's clinical records.

You said in your written statement *“I have entered information on EPR as there is an outcome letter to Child 23's GP. I do not know why it is blank. For there to be an EPR, there must have been official records generated. I do not know why the audit did not have access to Child 23's notes”.*

The panel noted that the audit stated under case records that ‘nil was documented’.

The panel was satisfied there was a duty to record the risk assessment to ensure the safeguarding measures were put in place if necessary, as previously stated at charge 3.21.4. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

From the evidence before the panel there is no evidence of a risk assessment or any clinical records for Child 23. It therefore found charge 3.27.2 proved.

Charge 3.27.4

> 3.27. On or around 18 February 2016 during/following your consultation with Child 23;
>
> 3.27.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 23

This charge is found proved

In reaching this decision, the panel had sight of the sparsely populated diary entry for Child 23. It also had sight of an electronically signed EPR letter without any content. The panel noted that the audit stated under the heading Evidence of onward communication ‘GP letter started with demographics but no clinical details’.

Your evidence in your written statement is *“Without seeing my notes or my EPR entries for this patient, I am not able to agree that they are not adequate. The diary entires indicate that I did input into EPR as there is a tick over EPR in the top left hand corner. I am not able to comment on how the risk assessment was recorded either”.*

The panel noted that the only plausible explanation in relation to EPR letters came from Witness 3 who said they were blank because you had failed to complete them. The panel accepted this explanation.

The panel concluded that the record of the assessment was inadequate, in respect of this appointment. It therefore found charge 3.27.4 proved.

Charge 3.27.5

> 3.27. On or around 18 February 2016 during/following your consultation with Child 23;
>
> 3.27.5. Did not send an outcome letter to Child 23’s GP.

This charge is found proved

In reaching this decision, the panel noted Witness 5's evidence about the importance of recording adequate details of a consultation and especially the provision of an outcome letter, which she said is a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient. Accordingly, the panel found that there is sufficient evidence to establish that you had a duty to send an outcome letter to Child 23's GP.

The panel went on to consider whether you did not send an outcome letter to Child 23's GP. The panel noted that there is an empty outcome letter in respect of this appointment contained within the bundle. It also bore in mind Witness 3's evidence, who said that where a blank outcome letter exists, the presumption is that it would not have been sent. The panel in any event considered that a blank outcome letter would not have amounted to a proper outcome letter.

The panel concluded that there is evidence before it that you did not send an outcome letter to Child 23's GP. It therefore found charge 3.27.5 proved.

Charge 3.28.1

> 3.28. On or around 26 May 2016 during/following your consultation with Child 24;
>
> 3.28.1. Did not record/consider whether the support Child 24 was receiving was optimal.

This charge is found not proved

In reaching this decision, the panel took into account your evidence.

You said in your written statement *"I cannot recall much on Child 24, however I know that she was referred to the clinic by the community Doctor. According to my own notes and my recollection, Child 24 was receiving some sort of support and counselling already in Stratford. I did ask what type of counselling and from their response, I thought the support was receiving was adequate, hence why I did not make a referral. If the patient was not receiving support, then I would have made the referral".*

The panel accepted your evidence on this matter. It therefore found charge 3.28.1 not proved.

Charge 3.28.4

> 3.28. On or around 26 May 2016 during/following your consultation with Child 24;
>
> 3.28.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 24.

This charge is found proved in relation to advice and discussion but not proved in relation to examination and next steps

In reaching this decision, the panel noted that you admit that you did not record adequate details of the advice and discussions provided to Child 24.

You said in your written statement ***"****I admit that the notes do not include sufficient detail about the advice/discussion with Child 24".*

The panel considered the record of the examination in your diary notes and Child 24's clinical notes were adequate in as much as it identified the type of FGM that Child 24 had been subjected to.

The panel considered your record for next steps did include that Child 24 was receiving counselling on a weekly basis. The panel had sight of the letter from the referrer, who was a community paediatric doctor. The letter clearly stated 'referring her to your service for psychological support'. The panel noted that the clinical record for Child 24 reflects they were receiving some 'support/counselling' on a weekly basis. The panel considered that this was an adequate record in relation for next steps.

The panel therefore found charge 3.28.4 proved in relation to advice and discussion and not proved in relation to the record of the examination and next steps.

Charge 3.28.5

> 3.28. On or around 26 May 2016 during/following your consultation with Child 24;
>
> 3.28.5. Did not send an outcome letter to Child 24's referrer

This charge is found proved

In reaching this decision, the panel took into account the evidence in your written statement *“The outcome letter to the GP would have been printed and sent to the referrer in the post”.*

The panel noted that the referral came from a community paediatrician. However, the panel saw no record of any communication with the referring paediatrician as identified in the audit.

The panel did not accept that you would have used a copy of the letter to the GP to communicate with a different specialist.

The panel therefore found charge 2.28.5 proved.

Charge 3.29.1

> 3.29. On or around 9 June 2016 during/following your consultation with Child 25;
>
> 3.29.1. Incorrectly recorded Child 25’s referrer as the safeguarding team/police.

This charge is found not proved

In reaching this decision, the panel noted the evidence of Witness 1 who is critical of the recording of the referrer saying that it could lead to a misunderstanding that the referral had come from one of the hospital's health teams as opposed to an external safeguarding team.

You said in your written statement *"I do not accept that my recording of the referrer was incorrect. The safeguarding team referred her to me, following a safeguarding referral from the police".*

The panel considered that the safeguarding team and social services could be synonymous with each other, furthermore, anybody who needed to enquire further into the source of the referral could access the referral letter which was in the patient's records.

The panel therefore found charge 3.29.1 not proved.

Charge 3.29.2

> 3.29. On or around 9 June 2016 during/following your consultation with Child 25;
>
> 3.29.2. Did not record a risk assessment for Child 25

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel first noted the oral evidence of Witness 1, who said that there is evidence that this child did not have FGM, and where a clinical decision was made that a child did not have FGM, it probably negates the need for a risk assessment.

However, the panel noted the Guy's and St Thomas' Clinical Guidance on FGM, dated 10 February 2016, co-authored by you, Witness 1 and Witness 5, which sets out:

> *"The aim is to make an initial assessment of risk and then support the ongoing assessment of the child or young person and any potential safeguarding concerns. Always consider other girls and women in the family who may be at risk of FGM when dealing with a particular girl. Please undertake a risk assessment as outlined […]; this is to include family, social and medical history taking. No assessment undertaken by a practitioner should simply be a tick-box exercise."*

The panel preferred the evidence that was set out in the policy to the evidence given by Witness 1.

You said in your written statement *"I accept that my record keeping was not adequate in relation to this child".*

You admit that you did not record a risk assessment and Child 25 was referred to you specially because they could have been at risk of FGM. The panel was satisfied there was a duty to record the risk assessment to ensure the safeguarding measures were put in place if necessary. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

The panel therefore found charge 3.29.2 proved.

Charge 3.29.3

> 3.29. On or around 9 June 2016 during/following your consultation with Child 25;
>
> 3.29.3. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 25/Child 25's mother

This charge is found proved in respect of all limbs of the charge

In reaching this decision, the panel noted that you admit that you did not record details of the advice and discussions provided to Child 25/Child 25's mother.

You said in your written statement "*I accept that my record keeping was not adequate in relation to this child. I do not accept that my recording of the referrer was incorrect. The safeguarding team referred her to me, following a safeguarding referral from the police".*

The panel had sight of Child 25's clinical notes and saw no record in relation to examination nor next steps. It noted that the notes does not include a record of history, consent, chaperone, risk assessment and on that basis the panel determined that it is an inadequate record with regard to this consultation on both these elements.

The panel therefore found charge 3.29.3 proved in respect of all the limbs of the charge.

Charge 3.29.4

> 3.29. On or around 9 June 2016 during/following your consultation with Child 25;
>
> 3.29.4. Did not record/send an outcome letter to the referrer/Children's Social Care

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge in so far as nothing was recorded but do not accept that this amounts to a failure to maintain adequate clinical records.

In your written statement you said *"I accept that my record keeping was not adequate in relation to this child. I do not accept that my recording of the referrer was incorrect. The safeguarding team referred her to me, following a safeguarding referral from the police".*

The panel noted that the initial referral came from the safeguarding team regarding concerns about the risk of FGM to Child 25 and her sister. The panel considered that a written record of the clinical assessment was crucial to the safeguarding team in order to safeguard Child 25. The panel had sight of a GP (who was not the initial referrer)

outcome letter. However, it noted the findings of the audit found no evidence of communication with Children's Social Care, the referrer, being sent or recorded.

The panel therefore found charge 3.29.4 proved.

Charge 3.29.5

> 3.29. On or around 9 June 2016 during/following your consultation with Child 25;
>
> 3.29.5. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 25's mother

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel saw no evidence of a risk assessment nor a record of the discussion with the Child 25's mother in your records.

The panel had sight of the referral letter which stated the family were due to travel back to… their mother had been subject to FGM at 15 years of age. The panel considered that discussion with Child 25's mother around the long term impact, risks and illegality of FGM was important in these circumstances and should have been discussed and recorded.

The panel therefore found charge 3.29.5 proved.

Charge 3.30.1

> 3.30. On or around 9 June 2016, during/following your consultation with Child 26;
>
> 3.30.1. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 26/Child 26's mother

This charge is found proved in respect of all limbs of the charge

In reaching this decision, the panel took into account that you admit this charge in respect of advice/discussion but do not accept that this amounts to a failure to maintain adequate clinical records.

You said in your statement *"I accept that my record keeping was not adequate in relation to this child. I accept that I did not record that I sent an outcome letter to the referrer but I believe that I did send an outcome letter, as previously discussed. I do not understand why there are two outcome letters on file for this child. I accept that the second appears to have included a typographical error. I have never performed deinfibulation on a child and I would never do so".*

The panel had sight of Child 26's clinical notes and saw no record in relation to examination or next steps. It noted that the notes for example, do not include a record

of history, consent, chaperone, risk assessment and on that basis the panel determined that it is an inadequate record with regard to this consultation on both these elements.

The panel therefore found charge 3.30.1 proved in respect of all limbs of the charge.

Charge 30.30.2

> 3.30. On or around 9 June 2016, during/following your consultation with Child 26;
>
> 3.30.2. Did not record the discussion surrounding the risk of FGM/FGM issues with Child 26's mother

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel saw no evidence of a risk assessment nor a record of the discussion with the Child 26's mother in your records.

The panel had sight of the referral letter which stated the family were due to travel back to… their mother had been subject to FGM at 15 years of age. The panel considered that discussion with Child 26's mother around the long-term impact, risks and illegality

of FGM was important in these circumstances and should have been discussed and recorded.

The panel therefore found charge 3.30.2 proved.

Charge 3.30.3

> 3.30. On or around 9 June 2016, during/following your consultation with Child 26;
>
> 3.30.3. Did not record/send an outcome letter to the referrer/Children's Social Care

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge in so far as nothing was recorded but do not accept that this amounts to a failure to maintain adequate clinical records.

In your written statement you said *"I accept that my record keeping was not adequate in relation to this child. I do not accept that my recording of the referrer was incorrect. The safeguarding team referred her to me, following a safeguarding referral from the police".*

The panel noted that the initial referral came from the safeguarding team regarding concerns about the risk of FGM to Child 26 and her sister. The panel considered that a written record of the clinical assessment was crucial to the safeguarding team in order to safeguard Child 26. The panel had sight of a GP (who was not the initial referrer)

outcome letter. However, it noted the findings of the audit found no evidence of communication with Children's Social Care, the referrer, being sent or recorded.

The panel therefore found charge 3.30.3 proved.

Charge 3.30.4

> 3.30. On or around 9 June 2016, during/following your consultation with Child 26;
>
> 3.30.4. Incorrectly informed Child 26's GP in a letter dated 22 August 2016, that Child 26 had undergone a de-infibulation procedure.

This charge is found proved

In reaching this decision, the panel had sight of two GP outcome letters in regards to Child 26.

It noted that one of the GP outcome letters stated "she had de-infibulation done same day under local anesthesia" after stating "normal vulva - no sign of FGM".

You said in your witness statement *"I do not understand why there are two outcome letters on file for this child. I accept that the second appears to have included a typographical error. I have never performed deinfibulation on a child and I would never do so".*

The panel considered this information in the GP letters to be inaccurate and contradictory and amounted to a failure to maintain adequate records of the appointment. The panel therefore found charge 3.30.4 proved.

Charge 3.30.5

> 3.30. On or around 9 June 2016, during/following your consultation with Child 26;
>
> 3.30.5. Did not record a risk assessment for Child 26

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

You said in your written statement "*I accept that my record keeping was not adequate in relation to this child"*.

The panel noted that you admit that you did not record a risk assessment even though Child 26 was specifically referred to you because they could have been at risk of FGM. The panel considered that you were under a duty to undertake a risk assessment and record it which you admit you did not do.

The panel was satisfied there was a duty to record the risk assessment. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

The panel therefore found charge 3.30.5 proved.

Charge 3.31.1

> 3.31. On or around 22 September 2016 during/following your consultation with Child 27;
>
> 3.31.1. Did not create official healthcare records for Child 27.

This charge is found not proved

In reaching this decision, the panel noted that there was nothing in your diary notes regarding Child 27. The outcome letter reflects that you had seen and examined Child 27 following a referral by social services.

Witness 1 said during her evidence:

> *"Q. PIM [Patient information management] system?*
> *A. Yes, so the patient has been registered.*
>
> *Q. Yes.*

A. *Which is what's blocked out on the NHS identifier… And then there was a pop-up box saying, "No patient documents have been found for this patient". So there are no official Trust paper records for this patient in the organisation.*

Q. *So we can see that Comfort's written on the EPR, because that's how this letter… has been created, is that right?*

A. *There is a letter being generated. However, I would question where this letter has gone to because it has got, "Doctor not known. GP practice not known", so that information does not look as if it has been translated anywhere".*

You said in your written evidence *"The letter… would have been created on EPR, therefore I do not understand why there is no EPR for this patient. There was a Dr [named] with me, according to the outcome letter. I cannot comment on the notes, as they have not been located".*

The panel noted the content of the outcome letter dated 23 September 2016, which contained some detail about your examination of Child 27. Therefore, the panel concluded that you must have made some record of your examination in order to populate the content of the outcome letter. The panel considered that your practice has been consistent in that you have recorded examinations on a variety of sources. The panel considered that a potential reason for the records not being found is that they could have been lost.

On that basis, the panel determined that the NMC has not discharged the burden of proof. The panel therefore found charge 3.31.1 not proved.

Charge 3.31.2

3.31. On or around 22 September 2016 during/following your consultation with Child 27;

3.31.2. Did not send/complete an outcome letter to/for Child 27's GP.

This charge is found proved

In reaching this decision the panel had sight of the EPR letter in respect of Child 27. It noted that the EPR letter is incomplete and is addressed to 'Dr Not Known' and 'GP Practice Not Known" therefore the letter could not have been sent.

The audit stated that a letter was sent retrospectively to the GP. Therefore, it must have been possible for you to have ascertained the identity of the GP.

The panel therefore found charge 3.31.2 proved.

Charges 3.31.3, 3.31.4, 3.31.5

3.31. On or around 22 September 2016 during/following your consultation with Child 27;

3.31.3. Did not record a full risk assessment for Child 27.

3.31.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 27/Child 27's mother

3.31.5. Did not record/send an outcome letter to the referrer/Children’s Social Care

These charges are found not proved

The panel found charges 3.31.3, 3.31.4, 3.31.5 not proved for the same reasons outlined at charge 3.31.1 that there were no clinical records found for Child 27.

Charge 3.33.1

3.33. On or around 10 August 2017, during/following your consultation with Child 29;

3.33.1. Did not record a full risk assessment for Child 29

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

You said in your written statement *“I accept my record keeping was not adequate in relation to the advice and discussion with child 29. I did not record a full risk assessment. I should have recorded, for all the children, who they attended with, who was shadowing me at the appointment, consent, detailed clinical history, full risk*

assessment and more detail about the advice given to the children and/or their mothers".

The panel was satisfied there was a duty to record the risk assessment to ensure the safeguarding measures were put in place if necessary, as previously stated at charge 3.21.4. Furthermore, the panel is of the view that recording such a risk assessment is an integral part of maintaining adequate clinical records.

The panel therefore found charge 3.33.1 proved.

Charge 3.33.2

> 3.33. On or around 10 August 2017, during/following your consultation with Child 29;
>
> 3.33.2. Did not record the symptoms/adverse effects suffered by Child 29.

This charge is found not proved

In reaching this decision, the panel noted that you said in your written statement "*I recorded Child 29's symptoms as severe period pain and back ache, in the outcome letter"*.

The panel had sight of the GP letter which supported your evidence. It also had sight of your diary notes stated for Child 29 "had implant about 3 weeks to help with her period

pain” The panel considered that would suggest symptoms and adverse effects for Child 29.

The panel therefore found charge 3.33.2 not proved.

Charge 3.33.3

> 3.33. On or around 10 August 2017, during/following your consultation with Child 29;
>
> 3.33.3. Did not record the benefit of a referral to a gynaecologist for Child 29.

This charge is found not proved

In reaching this decision, the panel took into account your written statement *“I do not accept that she needed a referral to a gynaecologist. It appears she has already been seen by someone about having had the implant three weeks prior to assist with period pain”.*

The panel found your reasoning in relation to not referring to a gynaecologist to be acceptable. It therefore found charge 3.33.3 not proved.

Charge 3.33.4

3.33. On or around 10 August 2017, during/following your consultation with Child 29;

3.33.4. Did not record adequate details of the advice/examination/discussion/next steps provided to Child 29/Child 29's mother

This charge is found proved in relation to Child 29 but not Child 29's mother

In reaching this decision, the panel noted that you admit that you did not record details of the advice and discussions provided to Child 29.

You said in your written statement you *"I accept my record keeping was not adequate in relation to the advice and discussion with child 29. I did not record a full risk assessment. I should have recorded, for all the children, who they attended with, who was shadowing me at the appointment, consent, detailed clinical history, full risk assessment and more detail about the advice given to the children…".*

The panel saw no evidence that Child 29's mother was present at this consultation, so it found this charge not proved in relation to Child 29's mother.

The panel had sight of Child 29's clinical notes and saw insufficient detail of a record in relation to examination and next steps. The panel noted your comments "All issues relating to FGM discussed' and 'Advised and reassured' and considered that this was an inadequate record. The notes do not for example include a record of history, consent, chaperone, risk assessment and on that basis the panel determined that it is an inadequate record within regard to this consultation in relation to both of these

elements. The panel therefore found charge 3.33.4 proved in respect of Child 29 but not Child 29's mother.

Charge 3.33.5

> 3.33. On or around 10 August 2017, during/following your consultation with Child 29;
>
> 3.33.5. Did not record/include sufficient information/understanding surrounding the type of FGM in Child 29's GP Letter

This charge is found proved

In reaching this decision, the panel took into account that you admit this charge but do not accept that this amounts to a failure to maintain adequate clinical records.

The panel had sight of the GP letter which stated that Child 29 was referred by their GP for assessment of FGM and the outcome.

The panel noted that the letter does not contain confirmation or type of FGM regarding Child 29.

The panel found charge 3.33.5 proved.

Charge 5

Did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures for one or more adult patients as listed in schedule 10.

The panel heard evidence from Witness 3 who was responsible for and oversaw the audit process. The panel recognised the audit was not undertaken for the purpose of an NMC investigation. However, the panel determined the audit was fair, robust, undertaken conscientiously and it had appropriate checks and balances in place. The panel also recognised there were occasional errors made in such an extensive audit. The panel accepts the overall reliability of the audit.

The duty to record consent is a fundamental requirement understood by medical professionals and indeed the general public.

The panel first considered the policies in relation to consent. It noted The Trust's consent policy states that it is essential to document the patient's agreement and discussion leading up to it for *"any procedure where the patient might reasonably be expected to consider the risks and options for treatment to be significant".* During her oral evidence Witness 3 called this line *'significant'* and said this may range from taking blood pressure to performing deinfibulation but if you are doing something to a patient being clear you have informed consent is "crucially important". The panel was satisfied from the policies that you had a duty to offer/confirm consent.

The panel noted that you have admitted this charge as it relates to Adult 19 and Adult 35 (i.e. where clinical notes are available). It is submitted that by establishing (through admission) that you did not always record the offer/confirmation of consent makes it more likely that you also did not do so on the other alleged occasions. The panel noted that you have not challenged that consent is necessary and you said that you always got verbal consent.

In your written statement you stated *"I would always talk a patient through and explain the procedure before taking consent to do this. It is regretful that I didn't always record this in my notes. I understood that verbal consent for examination and deinfibulation was sufficient to proceed with the assessment or procedure. I could not and would not carry out either without consent. I admit that I did not record consent in relation to patients 19 or 35. Without having sight of the notes for the other patients, I am unable to comment, with any certainty, on whether consent was recorded".*

The panel considered, given the intimate nature of these procedures, that it is crucial for a clinician to protect patients and themselves throughout this examination and therefore paramount that consent is documented for this purpose. However, the panel found that the evidential material it had been provided with does not contain any reference by you with regard to consent.

These reasons are relevant and consistent for each of the sub-charges within charge 5.

5.3 Adult 9 on or around 4 June 2015

This charge is found proved.

In reaching this decision the panel had regard to the audit. It noted that there is evidence from the audit that you performed a de-infibulation procedure on Adult 9 on 4 June 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been circled in respect of Adult 9 on 4 June 2015.

The panel accepted the evidence of the audit. It found the evidence within the audit to be sufficiently reliable and found this charge proved.

5.4 Adult 12 on or around 11 June 2015

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit that you performed a de-infibulation procedure on Adult 12 on 11 June 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 12 on 11 June 2015.

The panel accepted the evidence of the audit. It found the evidence within the audit to be sufficiently reliable and found this charge proved.

5.6 Adult 22 on or around 16 April 2015

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit that you performed a de-infibulation procedure on Adult 22 on 16 April 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 22 on 16 April 2015.

The panel accepted the evidence of the audit. It found the evidence within the audit to be sufficiently reliable and found this charge proved.

5.8 Adult 44 on or around 5/12 December 2013

This charge is found proved.

In reaching this decision the panel took into account the evidence before it that you performed a de-infibulation procedure on Adult 44 on 5 December 2014. The audit records the box which states that consent was not recorded has been marked in respect this appointment.

The panel further noted that there is evidence before it that, on 12 December 2013, you cleaned Adult 44's surgical wound following the de-infibulation procedure. The audit records that the box which states that consent was not recorded has been circled in respect of these appointments.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.9 Adult 69 on or around 15 October 2015

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and the contemporaneous proforma record page that you performed a de-infibulation procedure on Adult 69 on 15 October 2015. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 69 on 15 October 2015.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.10 Adult 74 on or around 3 October 2013

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 74 on 3 October 2013. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 74 on 3 October 2013.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.11 Adult 124 on or around 21 July 2016

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 124 on 21 July 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 124 on 21 July 2016.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.12 Adult 130 on or around 10/24 November 2016

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you examined Adult 130 on 10 November 2016. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of this date.

The panel further noted that there is evidence before it that you performed a de-infibulation procedure on Adult 130 on 24 November 2016. The audit records the box which states that consent was not recorded has been circled in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.13 Adult 138 on or around 29 June 2017

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you performed a de-infibulation procedure on Adult 138 on 29 June 2017. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 138 on 29 June 2017.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.14 Adult 143 on or around 12 March 2013

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 143 on 12 March 2013. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 143 on 12 March 2013.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

5.15 Adult 154 on or around 25 May 2017

This charge is found proved.

In reaching this decision the panel took into account the evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure

on Adult 154 on 25 May 2017. The panel noted that, in the audit, the box which states that consent was not recorded has been marked in respect of Adult 154 on 25 May 2017.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable and found this charge proved.

Charge 6

> Did not record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation procedures as listed in schedule 10;

The panel relies upon its reasoning in relation to the audit as set out in charge 5 and does not seek to repeat it for this charge.

The panel first considered whether you were under a duty to record the offer/ confirmation of a chaperone to adult patients for FGM examinations/de-infibulation procedures. It had regard to all of the evidence before it at this stage. It noted that it had been provided with various copies of the Guidance for Chaperones, which were in place between 2012 and 2021, each of which states:

> *"All women having an examination/procedure should be offered a chaperone regardless of the gender of the Health Care Professional.*
>
> *Failure to offer one deprives patients of the support that they might need and non-availability is an unacceptable excuse."*

The panel also bore in mind the evidence of Witnesses 3, 4 and 5 who said that it was best practice to record the offer/confirmation of a chaperone.

In your witness statement you said *"…I accept that I did not always record the offer or confirmation of a chaperone during my appointments and for this I am regretful".*

Accordingly, the panel found there was sufficient evidence to support a duty to record the offer/confirmation of a chaperone for one or more adult patients for FGM examinations/de-infibulation.

The panel also noted that you, having been provided with two sets of patient notes for Adult 19 and 35 in addition to the audit records and your own contemporaneous records, admitted the relevant charges in relation to Adult 19 and 35.

<u>6.3 Adult 9 on or around 4 June 2015</u>

This charge is found proved.

In reaching this decision, the panel took into account the evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 9 on 4 June 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 9. It therefore found this charge proved.

<u>6.4 Adult 12 on or around 11 June 2015</u>

This charge is found proved.

In reaching this decision, the panel took into account from the audit that you examined and performed a de-infibulation procedure on Adult 12 on 11 June 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 12. It therefore found this charge proved.

6.6 Adult 22 on or around 16 April 2015

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit that you performed a de-infibulation procedure on Adult 22 on 16 April 2015 and examined her again on 30 June 2016. However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 22. It therefore found this charge proved.

6.8 Adult 44 on or around 5 December 2013

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit that you performed a de-infibulation procedure on Adult 44 on 5 December 2013.

However, the panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 44. It therefore found this charge proved.

6.9 Adult 69 on or around 15 October 2015

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 69 on 15 October 2015. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 69. It therefore found this charge proved.

6.10 Adult 74 on or around 3 October 2013

This charge is found proved.

In reaching this decision, the panel took into account the evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 74 on 3 October 2013. The panel noted that, in the audit, the box which

states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 74. It therefore found this charge proved.

6.11 Adult 124 on or around 21 July 2016

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 124 on 21 July 2016. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 124. It therefore found this charge proved.

6.12 Adult 130 on or around 10/24 November 2016

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit that you examined Adult 130 on 10 November 2016 and you performed a de-infibulation procedure on Adult 130 on 24 November 2016. However, the panel noted that, in

the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of these appointments.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 130. It therefore found this charge proved.

6.13 Adult 138 on or around 29 June 2017

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 138 on 29 June 2017. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 138. It therefore found this charge proved.

6.14 Adult 143 on or around 12 March 2013

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 143 on 12 March 2013. The panel noted that, in the audit, the box which

states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer/confirmation of a chaperone in respect of Adult 143. It therefore found this charge proved.

6.15 Adult 154 on or around 25 May 2017

This charge is found proved.

In reaching this decision, the panel took into account evidence from the audit and your diary notes that you examined and performed a de-infibulation procedure on Adult 154 on 25 May 2017. The panel noted that, in the audit, the box which states that the offer of a chaperone was not recorded has been marked in respect of this appointment.

The panel accepted the evidence within the audit. It determined that the evidence within the audit was sufficiently reliable. It determined on the balance of probabilities that you did not record the offer of a chaperone in respect of Adult 154. It therefore found this charge proved.

Charge 7

Did not record the offer of a translator to Adult 10

This charge is found not proved.

In reaching this decision, the panel first considered whether you had a duty to record the offer of a translator to Adult 10.

It had regard to the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, which sets out:

> *"Care must be taken to ensure that an interpreter is available, as this will be required in many appointments relating to FGM.*
>
> *The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community."*

The panel also had regard to the evidence of Witness 5, who said that a practitioner should probably record the offer of a translator.

The panel was therefore satisfied that you had a duty to record the offer of a translator to Adult 10.

The panel bore in mind the audit front sheet records "does not speak English – daughter translated".

Your evidence in your written statement is that *"A translator would have been offered and provided had I deemed it necessary... I have noted in the diary entry that Adult 10's daughter translated… Some women did not want a male interpreter and a woman was not available. It is possible that women felt safer for family members to translate. Without having a look at the notes, I am unable to say whether they include more detail".*

The panel considered that although you did not strictly follow the guidance, you took a pragmatic approach and accepted your account as to why you did not record the offer of a translator to Adult 10. It therefore found charge 7 not proved.

Charge 8

Did not record/send an outcome letter to the GP for one or more adult patients as listed in schedule 11

Schedule 11: Failed to record/send GP outcome letter/follow up with multidisciplinary team

The panel relies upon its reasoning in relation to the audit as set out in charge 5 and does not seek to repeat it for this charge.

In reaching this decision, the panel first considered whether you had a duty to record/send an outcome letter to the GP for your adult patients at the AWWC. It had regard to all of the evidence before it at this stage. It bore in mind that the witnesses had differing understandings of the workings of the EPR software at the Trust at the relevant time. However, the panel took account of the evidence of Witness 4, who said that the provision of an outcome letter provides a record of a patient's consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 5, who said that an outcome letter is the appropriate process for concluding a consultation with a patient, and that it is the responsibility of the clinician in the consultation to ensure that the outcome letter is completed.

The panel heard from Witness 3 and was provided with copies of the welfare letters sent by Witness 3 to the patient's GP. Witness 3 told the panel that if the audit was unable to find any evidence of an outcome letter being sent to the GP, a welfare letter was generated and sent to the patient's GP highlighting potential gaps in communication regarding the outcome of the consultation at the clinic.

The panel bore in mind the Trust FGM Policy, co-authored by you and Witness 5, which was in place between 28 April 2012 and 27 April 2016, which set out:

"Documentation should be clear and the type of FGM should be clearly recorded. FGM should be documented in the antenatal notes, postnatal records before the transfer home after delivery and discharge summary. All staff are accountable and responsible for their practice and in the exercise of professional accountability there is a requirement to maintain their own level of competence with evidence of relevant continued professional development. (NMC 2004 & 2008)"

It also took into account the Trust's Health Records Management Policy, March 2016, which states:

"Scope
This policy sets out the Trust's objectives in relation to the health records of its patients. A health record constitutes all information relating to the physical or mental health or condition of a patient that has been made by or on behalf of a health professional in connection with the patient's care.

[…]

Rationale and Principles
Accurate, timely and legible health records are critically important to the quality and safety of patient care and to providing credible and authoritative evidence of service delivered."

The panel was therefore satisfied that you had a duty to record/send GP outcome letter/follow up with multidisciplinary team.

The panel bore in mind that it does not have before it full patient records. It noted that the NMC is reliant on the evidence contained within the audit in support of this charge. It took into account Witness 3's evidence that, although there were difficulties in using

the EPR system, the auditors sought the advice of experts to check the system and confirm their search was complete.

The evidence in your written statement is that "*As mentioned, I always sent an outcome letter to a patient's GP following an assessment unless a patient specifically requested I did not for reasons of their personal safety. I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community. As specified, my patient's safety is of the utmost importance and this is the only instance whereby I would not send the outcome letter to the GP. I cannot recall if any of the patients listed in schedule 11 had requested me not to send the letter".*

8.1 Adult 2 on or around 27 October 2016

This charge is found proved.

In reaching this decision, the panel had regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 2's GP following the audit, and stated: "our records do not indicate that the GP practice was notified about the consultation or outcome of the consultation".

Your evidence from your statement is *"I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community. As specified, my patient's safety is of the utmost importance and this is the only instance whereby I would not send the outcome letter to the GP".*

However, there was no evidence of any record that you had made in your contemporaneous notes that you had been asked not to send a referral letter in this case. The panel did not accept your reasoning in regards to this matter. It determined on the balance of probabilities that you failed to record/send GP outcome letter/follow up with multidisciplinary team in respect of Adult 2. It therefore found this charge proved.

8.2 Adult 6 on or around 15 June 2017

This charge is found proved.

In reaching this decision, the panel regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that the audit front sheet states “no evidence of letter to GP”.

Your evidence from your statement is *“I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community”.*

It determined on the balance of probabilities that you failed to record/send GP outcome letter/follow up with multidisciplinary team in respect of Adult 6. It therefore found this charge proved.

8.3 Adult 7 on or around 18 August 2016

This charge is found proved.

In reaching this decision the panel had regard to all the evidence before it at this stage. The panel noted that the audit front sheet records “EPR – empty letter”. It

took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 7's GP following the audit, and stated: "it is unclear from our records that a complete FGM risk assessment was made and the woman may require further investigation and treatment for dyspareunia as there is no record of an outcome letter".

Your evidence from your statement is *"I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community".*

It determined on the balance of probabilities that you failed to record/send GP outcome letter/follow up with multidisciplinary team in respect of Adult 7. It therefore found this charge proved.

8.4 Adult 9 on or around 4 June 2015

This charge is found proved.

In reaching this decision the panel had regard to all the evidence before it at this stage. The panel noted that the audit front sheet records "no evidence of F/U or liaison with GP in Birmingham".

Your evidence from your statement is *"I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community".*

It determined on the balance of probabilities that you failed to record/send GP outcome letter/follow up with multidisciplinary team in respect of Adult 9. It therefore found this charge proved.

8.5 Adult 23 on or around 28 April 2016

This charge is found proved.

In reaching this decision the panel had regard to all the evidence before it at this stage. The panel noted that the EPR letter before it in relation to this appointment was blank. It took into account the evidence of Witness 3, who said that she would not expect that a blank EPR letter had been sent as it would not assist anyone. The panel further noted that Witness 3 wrote to Adult 23's GP following the audit, and stated: "it is unclear from our records that a complete FGM risk assessment was made and the woman may require further investigation and treatment for psychosexual problems as there is no record of an outcome letter".

Your evidence from your statement is *"I accept that there were occasions when I did not record or send out an outcome letter to the GP if a patient asked me not to as their GP may have been known to the family and within the community".*

It determined on the balance of probabilities that you failed to record/send GP outcome letter/follow up with multidisciplinary team in respect of Adult 23. It therefore found this charge proved.

Charge 9

> Did not record/conduct any follow up with the multidisciplinary team for one or more patients as listed in schedule 11.

The panel relies upon its reasoning in relation to the audit as set out in charge 5 and does not seek to repeat it for this charge.

The panel first considered whether you had a duty to record/conduct follow up with the multidisciplinary team. The panel had regard to all of the evidence before it at this stage. It

took account of the oral evidence of the witnesses, notably Witness 3 who said that referrals to other teams, such as safeguarding, would form part of the patient pathway. The panel also took into account the evidence of Witness 5, who said that she was unsure exactly who the multidisciplinary team was, but understood it to be other professionals who may provide support, treatment and counselling in the circumstances, and would be dependent on the needs of each patient.

Further, the panel took into account that it had before it the Multi-Agency Statutory Guidance on Female Genital Mutilation, and the NMC Code, which you were bound by in your practice as an FGM Midwife.

The panel had regard to the Commissioning Service to Support Women and Girls with FGM Guidance, dated March 2015, which states:

> *"Services should provide as minimum the defined activities outlined… as part of a multidisciplinary team approach associated with interdependent services…*
>
> *…The type and number of health professionals working within an FGM service will vary depending on local prevalence of FGM and nature of services".*

You said in your statement:

> *"I accept that referrals should be recorded in the patient records. There are limited times when I would follow up with the multi disciplinary team. Generally I do not need to follow up once referrals are made.*
>
> *Very often I referred patients to the wide array of multidisciplinary teams that were available. This could be for anything but often included for psychological or psychosexual support, housing, gynaecology, back to their GP etc*

When making referrals, I would either call the team I was referring the patient to or send an email, for example to Maudsley Hospital where I often referred a lot of patients for psychosexual counselling. These referrals would have a paper trial.

The only instance where I would not refer a patient to another team that I had identified to be appropriate would be if a patient had refused for me to do this for them. As mentioned, often these women who have suffered FGM only attend for an assessment or procedure and do not want to see any other professionals about this. I accept and regret that I may not have recorded some referrals with the other teams in my own notes".

Accordingly, the panel found that there is sufficient evidence that you had a duty to record/conduct follow up with the multidisciplinary team.

9.1 Adult 3 on or around 22 September 2016

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about Adult 3's low mood, requirement for psychosexual counselling and domestic violence which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 3's GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient.

However, the panel had sight of a follow up letter to the referring GP who formed part of the multidisciplinary team. It determined on the balance of probabilities that you did

conduct a follow up with the multidisciplinary team in respect of Adult 3. It therefore found this charge not proved.

9.2 Adult 4 on or around 21 April 2016

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about Adult 4's chronic pain and risk of infection which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 4's GP in a follow up welfare letter by the auditor. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

Your evidence was that *"In relation to Adult 4, I have noted in the diary entry that she was seeking asylum. I would have provided her a letter to support her claim. I have ticked EPR in the top left hand corner, so there would have been a letter back to her GP. From what I can see, there was no need for an onward referral. She has a GP. I might have signposted Adult 4 to go back to the GP for investigation or raised it in the outcome letter as something that needs investigation. I do not have access to thepatient notes or EPR, so I cannot say what I recorded in the outcome letter".*

It determined on the balance of probabilities that you did not record/conduct a follow up as per the charge wording with the multidisciplinary team in respect of Adult 4. It therefore found this charge proved.

9.3 Adult 7 on or around 18 August 2016

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about dyspareunia and the safeguarding risk of FGM in relation to Adult 7's daughters, which the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 7's GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

Your evidence from your written statement is *"In relation to Adult 7, it is difficult to say anything without the patient notes or access to EPR. I cannot remember this case. My diary entry is brief and does not include the details set out in the audit. I would have sent Adult 7's daughter's names to [Ms 14], provided Adult 7 with information about FGM to allay her anxiety, reassure her and explain the illegalities of FGM. I would have made sure she hadall the phone numbers she needed. The referral came from a nurse and I would expect the letter to address whether a risk assessment had been completed for the children. I cannot comment on what was or wasn't recorded in the patient notes or EPR".*

It determined on the balance of probabilities that you did not record/conduct a follow up as per the charge wording with the multidisciplinary team in respect of Adult 7. It therefore found this charge proved.

9.4 Adult 23 on or around 28 April 2016

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It noted that the audit recorded concerns about psychosexual problems and the safeguarding risk of FGM in relation to Adult 23's daughters, which the auditors could not

find any evidence of follow up in relation to. These concerns were escalated to Adult 23's GP in a follow up welfare letter by the auditor. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to have been in such circumstances.

The evidence in your written statement is "*In relation to Adult 23, I would have discussed psychosexual support if Adult 23 needed and wanted it. Adult 23 was seeking asylum. I would have used the risk assessment tools to identify risks to the children and informed [Named Safeguarding Midwife at the Trust]. From the audit sheet, it is not clear that a social services referral was needed. There was no need to follow up with the multi-disciplinary team. I cannot comment on what was or wasn't recorded in the patient notes or EPR".*

It determined on the balance of probabilities that you did not record/conduct a follow up with the multidisciplinary team in respect of Adult 23. It therefore found this charge proved.

9.5 Adult 30 on or around 13 March 2013

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It noted that the audit recorded that this patient's vulva had become fused, and de-infibulation was not possible at this appointment, the auditors could not find any evidence of follow up in relation to. These concerns were escalated to Adult 30's GP in a follow up welfare letter by the auditors. The panel bore in mind the oral evidence of Witness 3, who said that there was no evidence before the auditors of any further referral to the multidisciplinary team in respect of this patient, although she would have expected it to

have been in such circumstances. It also considered the evidence of Witness 5, who said that in difficult cases you would usually refer your concerns on to other clinicians.

The evidence in your witness statement is that *"In relation to Adult 30, she came into the clinic for deinfibulation, according to the diary entry. Unfortunately there was nothing I could do, due to the type of FGM. She was referred by a community support group, so I was aware she was receiving some support. If anything, Adult 30 might have needed a referral for psychosexual counselling. I would have made a referral if Adult 30 needed or wanted it. I cannot comment on what was or wasn't recorded in the patient notes or EPR".*

It determined on the balance of probabilities that you did not record/conduct a follow up with the multidisciplinary team in respect of Adult 23. It therefore found this charge proved.

Charge 10

> 10. On one or more occasion for adult patients as listed in schedule 12, did not record adequate details of their appointment/consultation, including;
>
> a) Advice/discussion/next steps with the patient
>
> b) Details of assessment/examination
>
> c) FGM risk assessments

The panel considered that the issues within charge 10 as set out below are broadly similar, and in order to avoid an unnecessarily repetitive and lengthy determination, the panel considered that it may be helpful to set out in broad terms its analysis of the relevant evidence.

In reaching this decision, the panel first considered whether you had a duty to maintain adequate clinical records.

It had regard to the NMC Code 2008 and 2015, noting that both Codes require you to keep clear and accurate records in relation to your practice.

This was consistent with evidence from a number of witnesses who emphasised the importance of keeping accurate contemporaneous records. It noted that you also accepted in your written and oral evidence that at times your record keeping fell below the required standard.

You said in your written evidence *"I accept that my clinical record keeping fell below the accepted standard. This is something I deeply regret and I have since carried out steps to ensure my record keeping is now to an acceptable standard. Upon reflection, record keeping should contain clear, accurate information on the consultation, with information on what was discussed. The record should have information on the referral and who the matter was referred to. Record keeping is an integral part to every stage of the healthcare process and we need to ensure that a accurate record is kept for legal and professional elements".*

The panel also noted the evidence of Witness 5 who stated *"I recall that I also had concerns about Comfy's recordkeeping, which I also raised with [Witness 4]. Comfy's notes often lacked clinical detail and it was not uncommon for me to find a complete lack of clinical records for the work she was doing in the Outpatients Department. I spoke with Comfy about this on a number of occasions. I would highlight to her that notes did not have enough detail or were absent, remind her that this was medico-legally indefensible, and ask her to correct her notes and improve. Whenever I spoke to her about this she would accept what I was telling her and amend the notes".*

The panel noted in your oral evidence with regard to your standard of record keeping that you did not accept there was a problem with your record keeping:

“Q Just finally, in [Witness 5]’s evidence, she said that she discussed the concerns about your – I don’t know what she said, about your quality, about your documentation with [Witness 4] and I believe yourself. Do you remember that ever being discussed?

A Definitely not, no, never.

Q Did [Witness 4] ever ---

A Never. None of them ever raised that concern and, obviously, as even the, what is it called, supervisors of midwives never raised the concern as well”.

The panel preferred the evidence of Witness 5 which was supported by the evidence of Witness 4.

The panel also had regard to the numerous local Trust policies and national policies which encapsulate the duty within the Code to keep clear and accurate records. The panel was therefore satisfied that you had a duty to maintain adequate clinical records for adult/children/patients under the age of 18.

The panel recognised the audit was not undertaken for the purpose of an NMC investigation. However, it determined the audit was fair, robust, undertaken conscientiously and it had appropriate checks and balances in place. The panel also recognised there were occasional errors made in such an extensive audit. The panel accepts the overall reliability of the audit.

The panel had sight of the original contemporaneous clinical records you had made in out of date diaries instead of official patient records. It was also provided with other loose leaf records such as the FGM clinic proforma, which you also used to record your consultations. These diaries were maintained separately and were stored in your office and not associated with the patients’ clinical records.

The evidence before the panel was that your record keeping appeared to be somewhat chaotic.

The panel noted that your response to the majority of the charges within charge 3 was that without seeing your notes or your EPR entries for the particular patient, you were not able to agree that they are not adequate. The panel did not accept your position and determined that the audit was broadly accurate and reliable for the reasons set out under charge 5.

The panel saw the only official patient records in this case in relation to Adult 19, Adult 35 and Adult 118, together with a number of patient clinical records relating to children. The panel considered they were broadly consistent with the findings of the audit in that they were not adequate in terms of standard of record keeping.

It took into account the Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for Professionals, dated May 2016, which states:

> *"It should be used to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk."*

It further had regard to the Guy's and St Thomas' FGM Clinical Guidance, dated 10 February 2016, co-authored by you, Witness 1 and Witness 5, which included a risk assessment tool for non-pregnant women over the age of 18. It took particular note of the following extracts:

> *"For non pregnant women where you suspect FGM use the risk assessment took in Appendix 4. Examples could include a woman presenting with physical or emotional behaviours that triggers a concern e.g. frequent UTI, severe menstrual pain, infertility, symptoms of Post Traumatic Stress*

Disorder (PTSD), reluctance to have her genital area examined. As outlined above no assessment undertaken should simply be a tick-box exercise. When managing suspected or actual FGM good communication skills are required for establishing a rapport with the woman/family, asking questions in a straightforward, open way that develops understanding and trust, and being empathetic and non-judgmental.

If a women discloses she has adult daughter(s) over 18 years of age who have already undergone FGM, even if the daughter does not want to take her case to the police, it is important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context. If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution, or due to lack of opportunity or other motivations."

The panel was therefore satisfied that there is sufficient evidence before it that you had a duty to record risk assessments.

You said in your written statement *"All women I saw were risk assessed using a standardised risk assessment tool. The risk assessment was part of my general discussion with the patient. As far as recording, maybe I did not record the answers to each question in all my notes. Anything significant would definitely be recorded, eg domestic violence and making onward referrals. I wrote "All issues related to FGM discussed and well understood" as a standard note to demonstrate the discussion I have had with the patient and the level of understanding".*

The panel did not accept your evidence that the very broad statement *"All issues related to FGM discussed and well understood"* amounted to an adequate record to show you had carried out a risk assessment for FGM patients.

The panel also noted that you said in your written statement *“It is impossible for me to make comment on the adequacy of my consultation notes because I have not been provided with either my notes or access to the EPR. The outcome letters have not been provided for these patients”.*

The panel did not accept your evidence in this regard. For the reasons already given, the panel was satisfied that the audit accurately reflected the content of your original records.

Did not record adequate details of the appointment/consultation.

<u>10.2 Adult 26 on or around 6/13 July 2017</u>

This charge is found proved

In reaching this decision, the panel noted that the audit records “no follow up”, “poor documentation” and “EPR poor outcome letter to GP”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 26. The panel had sight of your notes in respect of Adult 26 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 26.

10.3 Adult 30 on or around 13 March 2013

This charge is found proved

In reaching this decision, the panel noted that the audit records “no EPR” and “no further follow-up offered”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 30. The panel had sight of your notes in respect of Adult 30 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 30.

10.4 Adult 38 on or around 12 May 2016

This charge is found proved

In reaching this decision, the panel noted that the audit records “nothing written in clinical notes”, “EPR – nothing” and “hard to determine outcome of clinical visit”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps,

details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 38. The panel had sight of your notes in respect of Adult 38 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 38.

<u>10.5 Adult 41 on or around 3 August 2017</u>

This charge is found proved

In reaching this decision, the panel noted that the audit records “minimal documentation”. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked “not recorded” in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 41. The panel had sight of your notes in respect of Adult 41 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 41.

<u>10.6 Adult 48 on or around 24 July 2014</u>

This charge is found proved

In reaching this decision, the panel noted that the audit records "no follow up, no prescription", although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 48. The panel had sight of your notes in respect of Adult 48 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 48.

<u>10.7 Adult 54 on or around 3 January 2013</u>

This charge is found proved

In reaching this decision, the panel noted that the audit records "*poor documentation, no follow up appt [sic], EPR letter empty"* although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 54. The panel had sight of your notes in respect of Adult 54 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 54.

10.8 Adult 59 on or around 14 November 2013

This charge is found proved

In reaching this decision, the panel noted that the audit records "*no further follow up advised, no EPR outcome*". It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 59. The panel had sight of your notes in respect of Adult 59 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 59.

10.9 Adult 80 on or around 10/17 September 2015

This charge is found proved

In reaching this decision, the panel noted that the audit records "*poor documentation, no referral, especially as client was 'very tearful'*" although it indicates that there was an outcome letter for both appointments. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 80. The panel had sight of your notes in respect of Adult 80 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 80.

10.10 Adult 90 on or around 20 September 2012

This charge is found proved

In reaching this decision, the panel noted that the audit records "*poor documentation, no prescription, no follow up'*" although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 90. The panel had sight of your notes in respect of Adult 90 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 90.

10.11 Adult 118 on or around 24 May 2012

This charge is found proved

In reaching this decision, the panel noted that the audit records "*poor documentation, no prescription, no follow up'"* although it indicates that there was an outcome letter for this appointment. It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

You said in your written statement *"In relation to Adult 118, the notes show the referrer, date and time of visit, type of FGM, history of FGM, all issues discussed, details of procedure, annotated diagram, advice given. I accept that I did not record the discussion about follow up. There is no risk assessment recorded. In my view, the notes are adequate. The notes make clear what happened during the appointment, sufficient for other professionals to be aware. I appreciate that there is further details I could have included, but that does not make the records inadequate".*

The panel does not accept that your records in relation to Adult 118 were adequate for the reasons previously outlined.

The panel noted that parts of the history taking for Adult 118 recorded in the diary entry are not replicated on the clinical outpatient notes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 118. The panel had sight of your notes in respect of Adult 118 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 118.

<u>10.12 Adult 128 on or around 20 October 2016</u>

This charge is found proved

In reaching this decision, the panel noted that the audit records "*poor documentation…*". It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

For the reasons given in the preamble, the panel was satisfied that you were under a duty to maintain adequate clinical records for Adult 128. The panel had sight of your notes in respect of Adult 128 which are extremely limited and/or incomplete.

The panel therefore found charge 10a, b and c proved in respect of Adult 128.

10.14 Adult 150 on or around 22 September 2016

This is charge is found not proved

In reaching this decision, the panel noted that the audit records "*nothing written in clinical notes'*", although the audit indicates that an EPR outcome letter had been completed for this appointment/ It bore in mind the oral evidence of Witness 3, who said that such comments indicated a lack of adequate information as to advice, discussion, next steps, details of assessment and examination, and details of FGM risk assessments, which are also marked "not recorded" in the audit tick boxes.

You said in your written statement *"Adult 150 was pregnant when I saw her and her clinical notes would be written in her handheld notes. They have not been provided to the audit or to me".*

In cross-examination it was put to Witness 3 that potentially the notes were written in the patient's maternity notes and her response was that "*If the woman's pregnant potentially the maternity records were used for clinical notes"*

The audit was not provided with the clinical notes therefore the panel determined that the NMC has not discharged its burden of proof in respect of this charge.

Charge 11

> 11. Did not adequately record the reason/origin of referral for one or more patients as listed in schedule 13.

Schedule 13: Did not clearly record the reason/origin of referral

The panel previously outlined the importance and duty of record keeping which it will not repeat here.

The panel first considered whether you have a duty to record the reason/origin of referral for patients under your care. It bore in mind the oral evidence of Witness 3, who explained the importance of recording the origin of referral for providing the root of a clinical audit trail for a patient. In her oral evidence, she said:

> *"It's a standard thing that does have a purpose about where a person comes from. It seems to me quite strange not to record that. I'm sure there is a knowing where they've come from but it just seems a bit of an omission as such not to note that bit of information"*

Accordingly, the panel was satisfied that you had a duty to record such details.

<u>11.2 Adult 28 on or around 25 April 2013</u>

This charge is found proved

In reaching this decision, the panel had regard to all of the evidence before it at this stage. It had regard to the audit, which stated that Adult 28 was referred to AWWC by her GP. However, the panel noted that the reason for Adult 28's referral is not recorded within your diary notes.

The panel therefore found this charge proved.

<u>11.3 Adult 46 on or around 17 July 2014</u>

This charge is found proved

In reaching this decision, the panel had regard to the audit, which stated that Adult 46 was referred to AWWC by "*?*", via a Hotmail account. The panel also noted that the reason for Adult 46's referral is not recorded within your diary notes.

Your evidence in your statement is *"In relation to Adult 46, my diary note records "? Dr [Named]". Dr [Named] was a community gynaecologist... I had lots of women referred by her. These would not be formal referrals, but women would be sent to me on her recommendation. She would call me and tell me "I'm sending you woman X for deinfibulation". I might have written a question mark if the patient didn't remember the doctor's name. I do not know what was written in the notes or outcome letter because they have not been provided".*

The panel also noted the submissions made on your behalf which, in summary suggest the auditor may have seen a referral letter in the file. The panel considered that your diary entry is unclear in relation to the reason/origin of the referral and the record is inadequate. reason/origin of referral.

The panel noted your response to this charge but determined that despite the fact that you might have known the community gynecologist quite well it is still necessary in patient records to formally and clearly record the reason for and origin of each referral. It therefore found this charge proved.

11.4. Adult 50 on or around 8 August 2013

This charge is found proved

In reaching this decision, the panel had regard to the audit, which states: “no documentation of who referred”. The panel also noted that the reason for Adult 50’s referral is not recorded within your diary notes.

For the same reasons outlined in the preamble to charge 11, the panel found this charge proved.

11.5 Adult 86 on or around 25 April 2013

This charge is found proved

In reaching this decision, the panel had regard to the audit, which states: “referral not recorded”. The panel also noted that the reason for Adult 86’s referral is not recorded within your diary notes, and is noted “ref by” with a line next to it.

The panel note the submissions made on your behalf that because the diary was struck through this indicated a self-referral.

The panel did not accept this as it had seen several of your entries for other patient you have recorded ‘self’ against referral.

The panel therefore found this charge proved.

11.6 Adult 131 on or around 10/24 November 2016

This charge is found proved

In reaching this decision, the panel had regard to the audit, which states: “referral not specified” in relation to these appointments. The panel also noted that the reason for Adult 131’s referral is not recorded within your diary notes, and is noted “ref by” with nothing written next to it, in respect of her appointments on 10/24 November 2016.

The panel therefore found this charge proved.

11.7 Adult 158 on or around 7 November 2013

This charge is found proved

In reaching this decision, the panel had regard to the audit, which states: “not clear who referred”. The panel also noted that the reason for Adult 158’s referral is not recorded within your diary notes, and is noted “ref by” with a line next to it.

Your evidence in your written statement was *“For example, Adult 158 was a self referral. There is a note in the diary to "email her". The reason was for deinfibulation. I assume this was the one stop clinic. I do not know what was recorded in the notes or outcome letter because it has not been provided to me”.*

The panel note that there was only a diary extract available to the auditors. Your evidence is that you made your contemporaneous notes and transferred them into the patient records at some later time. Therefore, what would have been transferred is what the panel saw evidenced in your diary entry.

The panel noted the submissions made on your behalf that because the diary was struck through this indicated a self-referral.

The panel did not accept this as the panel has seen several of your entries for other patient you have recorded ‘self’ against referral. It therefore found this charge proved.

Charge 12

> 12. Did not record adequate details of clinical consultations in the electronic patient record (“EPR”) /physical patient records bundle for one or more adult patients, as listed in schedule 14.

Schedule 14: Did not record adequate details of clinical consultations in the electronic patient record (“EPR”) /physical patient records bundles

The panel first considered whether you had a duty to record adequate details of clinical consultations in the electronic patient record (“EPR”) /physical patient records bundle. The panel had regard to all the evidence before it at this stage. It noted Witness 5’s evidence about the importance of recording adequate details of a consultation. The provision of an outcome letter, which she said is a record of a patient’s consultation with the clinician. It also bore in mind that this evidence was supported by that of Witness 4, who said that an outcome letter is the appropriate process for concluding a consultation with a patient.

You said in your written statement *"At the time, EPR was only used for outcome letters and not for full clinical notes. I assume that this charge means that my outcome letters were inadequate. I would have recorded information on EPR unless I had been instructed not to by the patient. Outcome letters have not been provided and I have no access to EPR, so it is impossible for me to comment on the adequacy of the outcome letters".*

The panel preferred the evidence provided by the witnesses, as set out above, to your evidence regarding this matter.

12.3 Adult 142 on or around 16 March 2017

This charge is found proved

In reaching this decision, the panel noted that Adult 142 was a maternity patient with the Lewisham and Greenwich Trust. The panel noted that the auditors identified that an outcome letter was identified by the auditors within the Lewisham and Greenwich Trust EPR system, however the audit identifies that there were no clinical notes or a diary entry for this patient at this appointment. The panel did have evidence before it of a template sheet in which you recorded the details of your consultation. Witness 5, in her evidence informed the panel that this would form part of the patient's clinical records.

The panel did accept your explanation that you may have written in Adult 142's handheld maternity notes. However, the panel did not accept that writing in the handheld maternity notes alone was adequate as they were not held at the Trust (because Adult 142 was a patient at a different trust). Therefore, you had a duty to write in the Trust's clinical records for evidence that she was seen at the Trust.

Witness 3 said in her evidence confirmed that she would have hoped that records should have been made in the Trust's clinical notes. Notwithstanding what had been potentially recorded in any handheld maternity notes.

It concluded that there is evidence before it from the audit that Adult 142's patient notes were inadequate, in respect of this appointment.

The panel therefore found this charge proved.

12.6 Adult 153 on or around 20 December 2012

This charge is found proved

In reaching this decision, the panel noted the audit front sheet states "*no clinical notes found, no documentation found*".

The panel had the evidence from your diary entry which was extremely limited in its content.

The panel concluded that there is evidence before it that Adult 153's patient notes were inadequate, in respect of this appointment.

The panel therefore found this charge proved.

12.7 Adult 156 on or around 24 January 2013

This charge is found proved

In reaching this decision, the panel noted the audit front sheet states "*EPR nothing, no documentation, only diary notes have documentation*".

The panel had the evidence from your diary entry which was extremely limited in its content.

The panel concluded that there is evidence before it from the audit that Adult 156's patient notes were inadequate, in respect of this appointment.

The panel therefore found this charge proved.

12.8 Adult 159 on or around 13 February 2014

This charge is found proved

In reaching this decision, the panel noted the audit front sheet states "*all from diary extract only*", although a note stating EPR outcome letter is ticked.
However, the panel noted that the audit notes "not recorded" in relation to matters such as risk assessment, chaperone and consent.

The panel had the evidence from your diary entry which was extremely limited in its content.

The panel concluded that there is evidence before it from the audit that Adult 159's patient notes were inadequate, in respect of this appointment.

It therefore found this charge proved.

12.9 Adult 161 on or around 18 February 2016

This charge is found proved

In reaching this decision, the panel noted there are two audits. The first of which records "poor documentation", and the second "minimal documentation", although a note stating EPR outcome letter is ticked. However, the panel noted that the audit notes "not recorded" in relation to matters such as risk assessment, chaperone and consent.

The panel had the evidence from your diary entry which was extremely limited in its content.

The panel concluded that there is evidence before it from the audit that Adult 161's patient notes were inadequate, in respect of this appointment.

The panel therefore found this charge proved.

Charge 20

> Did not record the offer/confirmation of consent for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.
>
> Schedule 8:
>
> Did not record the confirmation of consent for one or more children/patients under 18 not pregnant.

20.4. Child 19 on or around 11 September 2015

This charge is found not proved.

In reaching this decision, the panel had regard to the Trust Internal Safeguarding of Children Policy, effective between May 2015 and May 2017 which states:

> *"A Paediatrician should obtain written consent to medical examination from an adult with parental responsibility for the child. Consent should also be obtained from the child in a manner appropriate to their age and level of understanding."*

The panel bore in mind there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child. It noted that consent is not recorded within your diary notes, or in the audit.

The evidence in your witness statement is that *"I always took consent before carrying out an assessment, but I didn't always write this down. I am regretful of this and in hindsight I should have recorded that consent had been offered and confirmed".*

During cross-examination you told the panel that you do not recall having done any examination or assessing Child 19. When asked about the GP letter dated 14 October 2015 in relation to Child 19 which stated *"The child was seen at the African Well Woman's Clinic on 9 September 2015 for assessment of her FGM"* you said *"It might be my error. Instead of putting "the woman" I put "the child". I can't fully recollect this but most of the time I don't need, I didn't need to assess the child because obviously they haven't been through FGM and there's no need to confirm FGM or not in this case".*

There were no records available for the audit to review and therefore nothing before the panel in terms of evidence in relation to this charge.

The panel determined there was insufficient evidence to find on the balance of probabilities that you did not record the offer/confirmation of consent for FGM assessment/examinations in respect of Child 19. The panel therefore found this charge not proved.

Charge 21

> 21. Did not record the offer/confirmation of a chaperone for FGM assessment/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.
> Schedule 8:

21.4. Child 19 on or around 11 September 2015

This charge is found not proved.

In reaching this decision, the panel had regard to the Trust Internal Safeguarding of Children Policy, effective between May 2015 and May 2017 which states:

"A Paediatrician should obtain written consent to medical examination from an adult with parental responsibility for the child. Consent should also be obtained from the child in a manner appropriate to their age and level of understanding."

The panel bore in mind there is evidence before it that this child was under 18 years old at the relevant time, and therefore legally a child. It noted that consent is not recorded within your diary notes, or in the audit.

The evidence in your witness statement is that *"I always took consent before carrying out an assessment, but I didn't always write this down. I am regretful of this and in hindsight I should have recorded that consent had been offered and confirmed".*

During cross-examination you told the panel that you do not recall having done any examination or assessing Child 19. When asked about the GP letter dated 14 October 2015 in relation to Child 19 which stated *"The child was seen at the African Well Woman's Clinic on 9 September 2015 for assessment of her FGM"* you said *"It might be my error. Instead of putting "the woman" I put "the child". I can't fully recollect this but most of the time I don't need, I didn't need to assess the child because obviously they haven't been through FGM and there's no need to confirm FGM or not in this case".*

There were no records available for the audit to review and therefore nothing before the panel in terms of evidence in relation to this charge.

The panel determined there was insufficient evidence to find on the balance of probabilities that you did not record the offer/confirmation of consent for FGM assessment/examinations in respect of Child 19. The panel therefore found this charge not proved.

Charge 14.3

Ms Bayley informed the panel that a decision on the facts remained outstanding for charge 14.3. She submitted that charge 14.3 is duplicitous to charge 1.10. which was admitted by Ms Momoh.

Ms Bayley submitted that the panel must come to a decision on the facts for this charge by either finding no case to answer on this charge or finding the charge not proved.

Ms Mustard submitted that the NMC does not fully accept that this charge is duplicitous but does accept that perhaps the misconduct is covered in charge 1.10. Ms Mustard acknowledged that you accepted that position. She submitted that she did not dissuade the panel from the position being put by Ms Bayley.

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

The panel considered that charge 14.3 was duplicitous to charge 1.10 and covers the same mischief as charge 1.10.

The panel therefore determined that there is no case to answer in relation to charge 14.3.

Application to adjourn the hearing

Ms Bayley informed the panel that Ms Momoh was unable to attend the hearing and would therefore not be able to give evidence for the impairment stage. Ms Bayley submitted that the hearing could not proceed in Ms Momoh's absence and applied for the hearing to be adjourned until the next scheduled resuming dates in April 2024.

Ms Mustard indicated that she had nothing to add and submitted that it was a matter for the panel.

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

The panel considered that Ms Momoh has fully engaged with the NMC throughout these proceedings. It determined that it would be unfair to continue without Ms Momoh's attendance.

The hearing was therefore adjourned until 8 April 2023.

Submissions in relation to Article 6

The panel received submissions in writing from Ms Bayley which she expanded upon orally in relation to the delay in these proceedings commencing from the point of referral to the NMC.

The panel received in writing the NMC's response from Ms Mustard which she elaborated upon orally.

Ms Bayley submitted, without any criticism being levelled at the panel, that the length of delay in concluding the case was such that your rights under Article 6 of the European Convention on Human Rights and the human Rights Act 1998 to a fair hearing within a reasonable time had been breached.

Ms Bayley pointed out that the referral to the NMC had occurred in about August 2017, but the hearing only began on 16 May 2022, almost 5 years later.

Ms Bayley asked the panel to make a declaration that there has been such a breach.

In response, Ms Mustard submitted that the delay did not breach your right to a fair hearing under Article 6.

Ms Mustard provided a detailed chronology which, she submitted, showed that there had been a number of reasons for the delay which were understandable, given the nature, scale and complexity of the case and the evidence required.

The panel heard and accepted the advice of the legal assessor which included reference to a passage in the judgement of Lord Bingham in *Dyer v Watson* [2004] 1 AC 379, which states:

> *"The threshold of proving a breach of the reasonable time requirement is a high one, not easily crossed".*

In considering this matter, the panel was not unsympathetic to your frustrations in respect of the amount of time your case has taken to come to a hearing (2017- to the present day). However, the panel decided that the time taken in preparing and hearing this case was not unreasonable.

In reaching this decision the panel considered the highly complex nature of the case, the volume of evidential material and the wide-ranging nature of the evidence that some of the witnesses had to cover.

The chronology provided by the NMC demonstrates the efforts the NMC has made over the years to seek to gather the relevant evidence. The panel acknowledged the initial delay due to the need for internal enquiries to be conducted at the Trust. Clearly the issues surrounding the Covid pandemic created its own challenges. It also considered the significant delays with key witnesses from the Trust failing to deliver their evidential statements and exhibits in a timely manner to the NMC. The chronology reflected that the NMC persisted in trying to secure this evidence at regular intervals including escalating their requests to the Trust at the heart of this case.

Ms Bayley in her submissions remarked on the fact that there was an extensive look back of over 5 years of 1095 patient records identifying 163 concerns which she submitted was unreasonable. The panel saw evidence of the rationale behind the time frame selected which included the evidence of Witness 1. The panel accepted the evidence of Witness 1 whose statement reflected that "*The first report contains a review of Ms Momoh's practice from 2012 to 2017. This period was identified because there was specific FGM guidance introduced by the Department of Health in 2012 and later in 2015 which would have been relevant to Ms Momoh's practice".*

The panel considered that it is regrettable that it took so long for the necessary evidence from witnesses at the Trust to be provided to the NMC in order that the case could progress.

The panel acknowledged that the period of time that has passed since the referral to the NMC was made has caused significant personal stress and recognised that you have engaged fully with the process to date.

The panel determined that in all the circumstances, whilst there has been a significant period between referral and the current date, this period for the reasons outlined has not been so unreasonable as to constitute a breach of Article 6.

Accordingly, the panel did not accept Ms Bayley's submissions that there had been a breach of Article 6 in your case.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct and impairment

The panel received written and oral submissions from both parties in respect of misconduct and impairment.

The panel also heard oral evidence from you under oath.

The panel heard and accepted the advice of the legal assessor. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Ronald Jack 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: Standards of conduct, performance and ethics for nurses and midwives 2008' (the 2008 Code) and 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the 2015 Code).

Charge 1.5

In respect of charge 1.5, the panel noted that you admitted the outstanding aspects of these charges following a submission of no case to answer.

The panel considered each individual patient within schedule 4 relating to this charge. It took into account that you admitted that you acted/practised outside the scope of your role, in that you on one or more occasions administered medication to adult patients/non-pregnant patients, without a prescription from a qualified medical prescriber. This potentially put patients at risk. The panel considered that its detailed analysis on this charge has already been clearly set out in its determination on the facts. The panel was satisfied that fellow registered practitioners would consider your actions to be deplorable. The panel determined that your actions at each individual charge were sufficiently serious to amount to misconduct and breached the following aspects of the 2008 Code and the 2015 Code which covers the period of the charges, specifically:

<u>The 2008 Code</u>

“The people in your care must be able to trust you with their health and wellbeing To justify that trust, you must:

• provide a high standard of practice and care at all times

61 You must uphold the reputation of your profession at all times”.

<u>The 2015 Code</u>

“18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

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”

Charge 1.9

The panel took into account that you admitted that you acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion accepted referrals for patients who were children/under the age of 18 and not pregnant as listed in schedule 8, except in relation to Child 19.

The panel considered each individual patient within schedule 8 relating to this charge. The panel viewed your behaviour as serious in as much as you had neither the competence nor the qualifications required to accept referrals for children under the age of 18 who were not pregnant, thereby putting these patients at potential risk of psychological and physical harm. The panel considered that its detailed analysis on this charge has already been clearly set out in its determination on the facts. The panel considered that fellow practitioners would consider your actions (individually) to be deplorable. The panel determined that this constitutes serious misconduct and breached the 2015 Code specifically:

“Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour'1 and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.4 take account of your own personal safety as well as the safety of people in your care
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"

Charge 1.10

The panel took into account that you admitted that you acted/practised outside the scope of your clinical competence/role, in that you on one or more occasion assessed/examined patients who were children/under the age of 18 and not pregnant, as listed in schedule 8 putting these patients at risk of harm.

The panel considered each individual patient within schedule 8 relating to this charge. The panel viewed your behaviour as serious in as much as that you had neither the competence nor the qualifications required to accept referrals for children under the age of 18 who were not pregnant, thereby putting these patients at potential risk of psychological and physical harm. The panel considered that its detailed analysis on this charge has already been clearly set out in its determination

on the facts. The panel considered that fellow practitioners would consider your actions (individually) to be deplorable. The panel determined that this constitutes serious misconduct and breached the 2015 Code specifically:

> *"Preserve safety*
> *You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour'1 and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.*
>
> *13 Recognise and work within the limits of your competence*
> *To achieve this, you must, as appropriate:*
> *13.2 make a timely referral to another practitioner when any action, care or treatment is required*
> *13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
> 13.4 take account of your own personal safety as well as the safety of people in your care
> *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"*

Charge 3

The panel considered that good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care.

Good record keeping has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability

• showing how decisions related to patient care were made
• supporting the delivery of services
• supporting effective clinical judgements and decisions
• supporting patient care and communications
• making continuity of care easier
• providing documentary evidence of services delivered
• promoting better communication and sharing of information between members of the multi-disciplinary team

Record keeping is a fundamental basic skill of a nursing and midwifery professional which is learned by student nurses and midwives at the outset of their career and is a core skill which should not be difficult to maintain.

The panel carefully considered each of the individual charges within charge 3. The evidence before the panel outlined that you were provided with patient clinical records from the administration department of the AWWC. If no patient records were available due to last minute attendance (a 'walk in' patient) there were Trust continuation sheets available within the clinic.

Th evidence before the panel was that:

- You routinely recorded your consultations in diaries which were not only out of date, but also the consultations did not reflect in those diaries the day or the month of the consultation accurately;
- The diaries routinely lacked detail in relation to the history of each patient;
- The reason for referral was often not recorded or inadequately recorded;
- The detail regarding what took place during the consultation was inadequately recorded and often had not content whatsoever;
- The detail of the treatment you provided was inadequately documented and the steps that had been put in place for follow up care (including EPR/outcome letters) was likewise inadequately recorded;
- You failed to record the purpose/reasons for prescribing antibiotics to patients;

- You failed to record the discussion of the illegality of FGM;
- You failed to record risk assessments;
- You failed to record safeguarding concerns.

The evidence before the panel was that your record keeping appeared to be chaotic.

The panel did not accept your evidence that the very broad statement *"All issues related to FGM discussed and well understood"* amounted to an adequate record to show you had carried out a risk assessment for FGM patients to the required standard.

The diary entries in evidence before the panel mirrored the audit findings in regards to patient clinical records. Further, the panel saw patient records in relation to Adult 19 and 35 and they are consistent with the finding of the audit in that they also demonstrated inadequate record keeping.

The panel determined that your conduct (at each individual charge) breached aspects of the Codes, specifically:

<u>The 2008 Code</u>

> *"42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been*
> *61 You must uphold the reputation of your profession at all times".*

<u>The 2015 Code</u>

> *"10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
10.5 take all steps to make sure that records are kept securely
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"

The panel accepted paragraph 16 of Ms Mustard's submissions which stated:

> *"On each occasion this occurred there was a risk that other professionals would not be able to sufficiently interpret or utilise the notes to be able to properly inform future care… this puts both the future practitioner and patient at risk because inaccurate or sub-standard advice may be given due to the picture of previous care being so unclear".*

Consequently, the panel determined that your failure to maintain adequate clinical records (individually) would be deemed as deplorable by fellow registered practitioners and was sufficiently serious to amount to misconduct.

Charge 5

The panel took into account that you admitted that you did not record the offer/confirmation of consent for FGM examinations/de-infibulation procedures in respect of Adult 19 and 35 and it found this charge proved in respect of the remaining patients in schedule 10.

The panel considered each individual patient within schedule 10 relating to this charge. The panel considered that your conduct breached aspects of the Codes, specifically:

The 2008 Code

"Keep clear and accurate records

42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

61 You must uphold the reputation of your profession at all times".

The 2015 Code

"4.2 make sure that you get properly informed consent and document it before carrying out any action

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

To achieve this, you must:

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

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"

The panel considered that, whilst you did not record consent, your evidence was that you always obtained consent. Furthermore, there is no evidence that any of the patients complained of having been examined without consent. Whilst the panel considered it was poor practice not to record consent, it determined that (individually or collectively) it was not so serious as to amount to misconduct.

Charge 6

The panel considered each individual patient within schedule 10 relating to this charge. The panel considered that your conduct breached aspects of the 2015 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"

The panel considered that, whilst you did not specifically record the offer/confirmation of a chaperone, your evidence was that you always had a chaperone with you or offered one. Furthermore, there is no evidence that any of these patients complained of having been examined without a chaperone. The panel determined (individually and collectively) that whilst it was poor practice not to record the offer/confirmation of a chaperone, it was not so serious as to amount to misconduct.

Charge 8

The panel carefully considered each of the individual charges within charge 8 in relation to Schedule 11.

It was clearly established at the facts stage that you had a duty to record/send GP outcome letter/follow up with the multidisciplinary team. The panel was of the view that the outcome letter/follow up constitutes an integral part of patient clinical care and is essential in providing professional colleagues with important clinical information.

The panel considered that your conduct breached aspects of the 2015 Code, specifically:

"*2.1 work in partnership with people to make sure you deliver care effectively*
3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
8 Work co-operatively
To achieve this, you must:
8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.6 share information to identify and reduce risk
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:
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
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"

Consequently, the panel determined that your failure in this regard would be deemed as deplorable (individually) by fellow registered practitioners and was sufficiently serious to amount to misconduct.

Charge 9

The panel carefully considered each of the individual charges within charge 9 in relation to Schedule 11.

It was clearly established at the facts stage that you had a duty to record/conduct follow up with the multidisciplinary team. The panel was of the view that such a record and follow up constitutes an integral part of patient clinical care and is essential in providing the patient with the opportunity to obtain the care required from professional colleagues.

The panel considered that your conduct breached aspects of the Codes, specifically:

The 2008 Code

“28 You must make a referral to another practitioner when it is in the best interests of someone in your care

42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

61 You must uphold the reputation of your profession at all times”.

<u>The 2015 Code</u>

“2.1 work in partnership with people to make sure you deliver care effectively

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

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:

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

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

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”

Consequently, the panel determined that your failure in this regard would be deemed as deplorable (individually) by fellow registered practitioners and was sufficiently serious to amount to misconduct.

Charge 10

The panel carefully considered each of the individual charges within charge 10 including schedule 12.

This charge in essence relates to record keeping and therefore the issues highlighted in charge 3 are also applicable and important with regard to charge 10 and no useful purpose would be served by repeating them.

It was clearly established at the facts stage that you had a duty to record adequate details of patients' appointments/consultations including the points specified at a, b and c as detailed in the charge.

The requirements to risk assess patients within this group was identified and established in the Department of Health Guidance 2012. This was reviewed and updated in line with the new legal framework within the Department of Health Guidance 2015.

The panel determined that your failures (individually) as set out in the facts stage related to an integral part of patient clinical care which was essential in providing the patient with the opportunity to obtain the care required from professional colleagues. This placed patients at potential risk of harm.

The panel considered that your conduct breached aspects of the Codes, specifically:

The 2008 Code

"42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.
61 You must uphold the reputation of your profession at all times".

<u>The 2015 Code</u>

"3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
10.5 take all steps to make sure that records are kept securely
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"

Consequently, the panel determined that your failures (individually) in this regard would be deemed as deplorable by fellow registered practitioners and were sufficiently serious to amount to misconduct.

Charge 11

The panel carefully considered each of the individual charges within charge 11 including Schedule 13.

This charge in essence relates to record keeping and therefore the issues highlighted in charge 3 are also applicable and important with regard to charge 11 and no useful purpose would be served by repeating them.

It was clearly established at the facts stage that you had a duty to record the reason/origin of referral for patients in schedule 13.

The panel considered that your conduct breached aspects of the Codes, specifically:

<u>The 2008 Code</u>

> *"42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*
> *61 You must uphold the reputation of your profession at all times".*

<u>The 2015 Code</u>

> *"10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*
> *10.5 take all steps to make sure that records are kept securely*
> *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"

The panel determined that the clinical history is the starting point in the patient's journey and therefore important for a clinician to understand the reason for referral so they are able to adequately address the clinical reason for the attendance. This in the panel's view is different from the simple fact of who made the referral.

Consequently, the panel determined that your failures (individually) to record the reason for referral in this regard would be deemed as deplorable by fellow registered practitioners and were sufficiently serious to amount to misconduct. However, the failure to record the origin of referral although poor practice would not be so regarded.

Charge 12

The panel carefully considered each of the individual charges within charge 12 including Schedule 14.

This charge in essence relates to record keeping and therefore the issues highlighted in charge 3 are also applicable and important with regard to charge 12 and no useful purpose would be served by repeating them.

It was clearly established at the facts stage that you had a duty to record clinical consultations in the EPR/physical patient records for patients in schedule 14.

The panel considered that your conduct breached aspects of the Codes, specifically:

The 2008 Code

"42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

61 You must uphold the reputation of your profession at all times".

The 2015 Code

> *"10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*
> *10.5 take all steps to make sure that records are kept securely*
> *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"*

Consequently, the panel determined that your failures (individually) in this regard would be deemed as deplorable by fellow registered practitioners and were sufficiently serious to amount to misconduct.

Charge 17

The panel noted that you admitted this charge earlier in the hearing.

The panel accepted Witness 1's evidence that you should not have accepted the referral of Child 25 and should have referred her to a suitably qualified medical practitioner such as a paediatric gynaecologist or a specialist paediatric centre.

By accepting this referral instead of referring on to an appropriate qualified clinician you potentially could have caused delay in diagnosis and treatment and the unnecessary examination of a child.

The panel considered that your conduct breached aspects of the 2015 Code, specifically:

> *"1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *8 Work co-operatively*
> *To achieve this, you must:*
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *13 Recognise and work within the limits of your competence*
> *To achieve this, you must, as appropriate:*
> *13.2 make a timely referral to another practitioner when any action, care or treatment is required*
> *13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
> *16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training*
> *19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
> *To achieve this, you must:*
> *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses…*
> *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"*

Consequently, the panel determined that your failure in this regard would be deemed as deplorable by fellow registered practitioners and was sufficiently serious to amount to misconduct.

Charge 19

The panel noted that you admitted this charge earlier in the hearing.

The panel recognised that technically Child 29 (who was 17 years of age) was legally a child and therefore you should not have examined her but should instead have referred her on to a paediatric gynaecologist/special paediatric FGM centre/FGM child assessment provider.

Child 29 was technically within the legal framework deemed to be a child. However, the panel considered that a member of the public, and fellow registered practitioner in full knowledge of the circumstances would view your examination and assessment of an adolescent aged 17 in a significantly different light to that of a young child.

The panel considered that by examining and not referring the patient appropriately it constituted poor practice which would not necessarily be seen as deplorable by fellow registered professionals. The panel therefore concluded that this was not so serious as to amount to misconduct.

Charge 20

The panel took into account that you admitted that you did not record the offer/confirmation of consent for FGM assessments/examinations for one or more patients under the age of 18 who were not pregnant as listed in schedule 8.

The panel looked at each individual patient within schedule 8 relating to this charge apart from in relation to Child 19 which the panel found not proved. The panel considered that your conduct breached aspects of the 2015 Code, specifically:

> *"4.2 make sure that you get properly informed consent and document it before carrying out any action*
> *10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *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"*

The panel considered that whilst dealing with children, as opposed to adults, it is imperative to record consent for an examination or assessment of a child to protect both the clinician and the child.

Witness 1 gave evidence to the panel which included a number of relevant policies and procedures, such as GSTT's Safeguarding the Welfare of Children: Children in Need and Child Protection procedure which states *"Verbal consent must be obtained before performing intimate examinations… consent for all intimate procedures for all children must be recorded in the patient's notes"*.

Witness 1 stated:

> *"It is good record keeping practice to record consent because personal or intimate examinations can be misinterpreted by children and their families and in the event*

of false accusations it is important to have recorded that consent was obtained to protect a practitioner".

Consequently, the panel determined that your failures (individually) in this regard would be deemed as deplorable by fellow registered practitioners and were sufficiently serious to amount to misconduct.

Charge 21

The panel took into account that you admitted that you did not record the offer/confirmation of a chaperone for FGM assessments/examinations for one or more children/patients under the age of 18 who were not pregnant as listed in schedule 8.

The panel looked at each individual patient within schedule 8 relating to this charge apart from in relation to Child 19 which the panel found not proved. The panel considered that your conduct breached aspects of the 2015 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 records at the time or as soon as possible after an event, recording if the notes are written some time after the event
17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people
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"

The panel considered that whilst dealing with children as opposed to adults, it is imperative to record the offer/confirmation of a chaperone for an examination or

assessment of a child to protect both the clinician and the child. This is underpinned by local and national policies in place at the time of the charge, stating it is a mandatory requirement to record the offer/confirmation of a chaperone for an intimate examination.

Consequently, the panel determined that your failures (individually) in this regard would be deemed as deplorable by fellow registered practitioners and were sufficiently serious to amount to misconduct.

The panel found that your actions found proved at charges 1.5, 1.9, 1.10, 3 in its entirety, 8, 9, 10, 11 in respect of the reason for but not the origin of referral, 12, 17, 20, 21 fell seriously short of the conduct and standards expected of a nurse/midwife and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 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.'*

Nurses/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 nurses/midwives

with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

d) ...'

The panel found limbs a, b and c engaged in the *Grant* test. The panel finds that patients were potentially put at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing and midwifery professions and therefore brought its reputation into disrepute.

The panel has found misconduct in respect of 11 charges together with a further partial charge where misconduct was also found. The view of the panel was that it is fair and reasonable to break the charges down into three broad headings:

1. Administering medication to adult patients/non pregnant patients without a prescription…
2. Acting/practising outside the scope of your clinical role in relation to children…
3. Inadequacies in record keeping

The panel was mindful that the context within which these matters were brought before your regulator is significant and included the following matters:

<u>Professional</u>

- Overall lack of governance at the Trust in respect of your role and how it developed at the AWWC and no oversight to your registration status from 2013.
- Uncertainty regarding your job description/job title within your role as the FGM Specialist Midwife for the period of the charges.
- The majority of patients that came to the AWWC can be described as particularly vulnerable.

<u>Personal</u>

- Your personal responsibility to act within your scope of practice.
- Using your honorary title 'Doctor' in communication with professionals leading to possible confusion as to your medical qualifications.

Regarding insight, the panel took into account all of the evidence before it during this hearing including your witness statement, reflective account and oral evidence together with the submissions made on your behalf.

In relation to point 1 above, the panel heard submissions made by Ms Bayley which highlighted your acceptance of the administering medication charge as outlined below:

> *"Comfort accepts entirely that she should never had administered medication without a prescription and made admissions to these allegations. She did so at the time wrongly believing that the use of lidocaine and voltarol in deinfibulation procedures fell within the statutory exemptions for midwives. Comfort agrees that it was her responsibility to be aware of the legalities of the exemptions and is genuinely remorseful for her error".*
>
> *"Comfort believed that, as a midwife, she was entitled to use the drug in her practice. This was never challenged. It is not clear that Comfort or the Trust were aware that the drug should not have been used under midwifery exemptions. It was never raised with her in training or supervisions, nor by [Witness 5], who had some oversight of the service as the clinical lead".*

On that basis, the panel was satisfied that you have demonstrated sufficient insight into your conduct in respect of point 1 and you would handle the situation differently in the future.

In relation to point 2, the panel noted the submissions made on your behalf in relation to examination and assessment of children and your admissions. Extracts from the written submissions are set out below:

> *"Comfort accepts entirely that she should not have accepted referrals for or examined children and has made admissions to these allegations. She did so believing it to be part of her role. Having considered the guidance and the Code of Conduct, alongside*

the evidence presented in the case and following reflective discussions with other professionals, Comfort agrees that she did not have the necessary training, qualifications and skills to assess children and should not have done so".

"...Comfort has considered these allegations from the viewpoints of the children, their families, her colleagues and in relation to the potential impact on the midwifery profession. She has demonstrated a significant degree of insight into what she did wrong, why it was wrong and what she would do in future and why".

The panel heard conflicting evidence in relation to your role as it evolved at the Trust from 1997. The panel was not provided with your job description for the period of the charges as it could not be established accurately which job description was applicable at the time. However, the panel did see your job descriptions over the years when you were at the Trust which did include reference to women and girls. The panel noted that the job description for your replacement when you retired in the job summary stated *"The FGM specialist midwife will be responsible for clinical care for women and girls referred through women's services who have undergone female genital mutilation".*

The panel was of the view that the governance in place at the time of the charges was not adequate in terms of overseeing your role. Your line manager informed the panel that she had not, for the duration of the time that she had supervised you, seen you in a clinical setting within the AWWC. There were a variety of reporting mechanisms within the Trust to the executive board. There was no evidence that there was robust supervision or appraisals of you during your time as the FGM specialist midwife.

The panel heard evidence from witnesses which set out your personal accountability for working within your competence/role.

On that basis, the panel was satisfied that you have demonstrated sufficient insight into your conduct in respect of point 2 and you made it clear that you would not operate outside of your competence/role in the future.

In respect of point 3, the panel considered that the failures were wide ranging and encompassed a significant number of allegations found proved which amounted to misconduct.

In submissions made on your behalf, you accepted that your records were not adequate at times.

The panel agreed with the submissions made by Ms Mustard on behalf of the NMC in respect of your inadequate record keeping. In particular:

> *"Furthermore, whilst it was indicated from the outset that the Registrant accepted some elements of poor record keeping her eventual admissions on this topic were 'equivocal' and crucially did not accept a failure to maintain adequate clinical records (the stem). Whilst she now appears to accept this failure that she failed to maintain adequate clinical record's this is only since the panel have found as such at the facts stage".*

There was a lack of oversight by the Trust in respect of your role, in particular the panel saw no evidence of auditing of your records within the AWWC apart from the audit conducted during the Trust's investigation. Throughout the time covered by the charges, your role in the AWWC appears to have been completely devoid of any adequate and necessary supervisory oversight.

However, the panel was of the view that as a senior and experienced midwife your own personal professional duty should have ensured that your record keeping was to the necessary standard. The factors that you raised in your evidence regarding the external workplace pressures cannot excuse your record keeping failures, which were significant both in number and extent.

The panel considered the factors set out in the case of *Cohen*. It was satisfied that the misconduct in relation to all three points highlighted above is capable of being addressed.

Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

The panel took into account all of the evidence in the case, including but not limited to your lengthy reflective statement, evidence of training, testimonials, oral evidence and submissions made on your behalf.

The panel was reassured by your reflections and oral evidence that you have considered carefully and extensively the deficiencies in your practice which have been identified during this hearing. The panel was aware that as you had not worked clinically in the last seven years there was no test to show that your deficiencies had been addressed. However, the panel was reassured by your detailed explanations as to how you would work differently in the future and would not allow your working environment to negatively impact on your performance.

The panel was of the view that having gone through a rigorous regulatory process for the last seven years, in which you have fully engaged, you have clearly learned the necessary lessons and developed sufficient insight to ensure that the risk of repetition is now minimal.

The panel therefore decided that a finding of impairment on the grounds of public protection is not required for all three points raised by the panel.

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 not required in relation to the administering medication to adult patient/non pregnant patients without a prescription..

The panel determined that a finding of impairment on public interest grounds is required in respect of your misconduct in relation to examining and assessing children and inadequate record keeping. The misconduct is so serious due to the potential risk of harm to patients. Your conduct was over a substantial period of time with a significant amount of evidence in relation to the deficiencies in your practice.

The panel reached this conclusion notwithstanding giving you full credit for the fact that this case has taken some seven years to reach this stage of proceedings and what Ms Bayley has appropriately referred to in her submissions as "the legacy of [your] life's work".

The panel was satisfied that a reasonable, well-informed member of the public would expect nothing less than such a finding of current impairment on public interest grounds, notwithstanding the length of time the proceedings have taken and the personal and financial impact this may have caused.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

The panel received written and oral submissions from both parties in respect of sanction.

Ms Mustard submitted that the proportionate sanction in the circumstances of this case is a suspension order for 6 months. The NMC's position is that a review prior to expiry of such an order is not necessary.

Ms Bayley invited the panel to take no further action. In the alternative, she invited the panel to impose a caution order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a sustained period of time involving particularly vulnerable patients including children.
- Conduct which potentially put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- You made some early admissions.
- Evidence you have developed sufficient insight and taken steps to address the concerns.
- Contextual factors. An ineffective governance structure, a lack of oversight and supervision of your developing role within the AWWC.
- You have been professionally recognised for your advocacy on behalf of women and families who are victims of FGM both nationally and internationally. You have helped raise the awareness of FGM nationally and internationally.

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. The panel took full account of the submissions of Ms Bayley on your behalf, but was satisfied that some form of restriction on your practice was necessary.

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel determined that a conditions of practice order is not suitable nor workable in this case. It concluded that you have addressed the concerns and there is no current risk to the public in relation to your clinical practice. In these circumstances there are no practicable conditions which can be formulated. In any event, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case.

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

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

The panel determined that this was not a single instance but a course of conduct which was repeated over a sustained period. However, the panel saw no evidence that you have repeated the misconduct since these events, and it saw no evidence of harmful deep-seated personality or attitudinal problems. The panel has seen numerous testimonials speaking to your good character and professional standing. It also took account of your career of over 35 years with no evidence of any complaints in relation to your work. The panel was satisfied that you had developed sufficient insight into your misconduct and, given the rigorous regulatory process you have been subject to, it considered the risk of repetition to be low.

The panel carefully considered the public interest balance between returning a registered midwife with valuable skills and experience to safe practice and the need to uphold public confidence in the profession and maintain professional standards. The panel concluded that the public interest in this case outweighed the interests in returning you to practice without a period of restriction to mark the seriousness of your case.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be wholly disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

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

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

The panel determined that a suspension order for a period of 6 months was appropriate and proportionate in this case to mark the seriousness of the misconduct.

In accordance with Article 29 (8A) of the Order, the panel has decided to exercise its discretionary power and determine that a review of the substantive order is not necessary,

given the panel’s finding that your fitness to practise is impaired solely on public interest grounds.

The panel was satisfied that the suspension order will satisfy the public interest in this case and will maintain public confidence in the profession(s) as well as the NMC as the regulator. Further, the substantive order will declare and uphold proper professional standards. Accordingly, the suspension order will expire, without review.

This decision will be confirmed to you in writing.

Interim order

The panel was informed by Ms Mustard that the NMC would not be seeking the imposition of an interim order to cover the appeal period. She submitted that it is a matter for the panel whether it considers an interim order is necessary.

Ms Bayley submitted that given that the bar is high for the imposition of an interim order for a public interest only case, an interim order is not necessary.

The panel accepted the advice of the legal assessor.

In all the circumstances, the panel decided not to impose an interim order.

That concludes this determination.