Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 – Friday 17 May 2024

Virtual Hearing

Name of Registrant:	Nothando Shereni
NMC PIN:	89A1287E
Part(s) of the register:	Registered Nurse – RN – March 1992 Registered Midwife – RM – March 1999
Relevant Location:	Hackney
Type of case:	Lack of competence
Panel members:	Gregory Hammond (Chair, Lay member) Laura Wallbank (Registrant member) Angela O'Brien (Registrant member)
Legal Assessor:	Andrew Young (7 – 14 May 2024) Charlotte Mitchell-Dunn (15 – 17 May 2024)
Hearings Coordinator:	Khadija Patwary Vicky Green (16 May 2024)
Nursing and Midwifery Council:	Represented by Lucie Danti, Case Presenter
Miss Shereni:	Not present and unrepresented
Facts proved:	Charges 1), 2), 3), 4) and 5) (except Schedule 1a)ii), Schedule 4a)ii), Schedule 5b)i), Schedule 5b)ii), part of Schedule 5b)iv) and Schedule 5b)vi))
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Shereni was not in attendance and that the Notice of Hearing letter had been sent to Miss Shereni's registered email address by secure email on 8 April 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Shereni

The panel next considered whether it should proceed in the absence of Miss Shereni. It had regard to Rule 21 and heard the submissions of Ms Danti who invited the panel to continue in the absence of Miss Shereni. She submitted Miss Shereni had voluntarily absented herself.

Ms Danti submitted that there had been no engagement at all by Miss Shereni with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Miss Shereni;
- Miss Shereni has not engaged with the NMC and has not responded to any of the emails or voicemails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses have been scheduled to give oral evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred from 2017 to 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Shereni in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Miss Shereni's registered email address. Miss Shereni will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The panel will also take into account the local written reflections produced by Miss Shereni and her written response to the internal disciplinary panel in relation to some of the allegations. Furthermore, the limited disadvantage is the consequence of Miss Shereni's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge (as amended)

That you, a Registered midwife failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 6 midwife in that you:

1) Failed to undertake medicines administration and/or management effectively, as set out in Schedule 1. **(proved)**

2) Failed to undertake observation effectively as set out in Schedule 2. **(proved)**

3) Failed to undertake escalation of clinical concerns effectively, as set out in Schedule 3. **(proved)**

4) Failed to undertake record keeping effectively, as set out in Schedule 4. **(proved)**

5) Failed to communicate effectively and/or treat people with adequate respect and/or compassion as set out in Schedule 5. **(proved)**

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

Schedule 1

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    i) Used unnecessary force to remove a cannula from Patient C. **(proved)**
    ii) Refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief. **(not proved)**

iii) Did not remove a catheter from Patient C until they had requested it be removed on multiple occasions. **(proved)**

iv) In the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients. **(proved)**

b) On an unknown date in March 2020, discharged Patient H with medication intended for another Patient and without their own required medication for blood pressure. **(proved)**

c) On or about 14 September 2020, did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift. **(proved)**

Schedule 2

a) In relation to home visits to Patient J in or around December 2017 did not check a third degree tear. **(proved)**

b) On 16 December 2018, while subject to an informal management plan, in relation to Baby D:

i) Did not carry out blood sugar level checks adequately or at all for a period of 12 hours. **(proved)**

ii) Did not carry out meconium observations adequately or at all for a period of 12 hours. **(proved)**

Schedule 3

a) On 29 December 2018, while subject to an informal management plan failed to escalate abnormal vital signs and/or NEWTT observations of Baby E. **(proved)**

b) Having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, did not complete that objective. **(proved)**

Schedule 4

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

i) Made only one entry in Patient C's notes and or checked their notes only once during a 12 hour shift. **(proved)**

ii) When Patient C explained to you that she had been advised not to take warfarin pending test results, became incorrectly recorded that Patient C 'refused' warfarin. **(not proved)**

b) As set out at Schedule 3 b) above, having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, did not complete that objective. **(proved)**

c) On 3 April 2020, signed Patient K's drug chart to record providing them with paracetamol and ibuprofen when you had not. **(proved)**

d) As set out at Schedule 1 c) above, On or about 14 September 2020, did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift. **(proved)**

Schedule 5

a) In relation to home visits to Patient J in or around December 2017:

i) Advised Patient J to supplement breast milk with formula contrary to their expressed wish. **(proved)**

ii) Did not introduce a student attending the visit with you. **(proved)**

iii) Did not effectively communicate your arrival time. **(proved)**

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

i) Criticised Patient C for being near a window and/or made no enquiry of them as to why they were near the window and/or explain to Patient C that they should not be feeling hot. **(not proved)**

ii) While Patient C was changing Baby C's nappy and dressing Baby C, criticised Patient C for the way she was dressing Baby C. **(not proved)**

iii) While Patient C was changing Baby C's nappy and dressing Baby C, took Baby C from Patient C and/or moved their sleeve over their cannula, in a rough manner. **(proved)**

iv) When Patient C explained to you that she had been advised not to take warfarin pending test results, became angry and/or incorrectly recorded that Patient C 'refused' warfarin. **(proved)**

v) Used unnecessary force to remove a cannula from Patient C. **(proved)**

vi) Refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief. **(not proved)**

vii) Did not remove a catheter from Patient C until they had requested it be removed on multiple occasions. **(proved)**

viii) In the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients. **(proved)**

ix) Displayed an unfriendly attitude to Person C. **(proved)**

c) In relation to Patient A, between 1 and 4 June 2020:

i) On Patient A arriving on Ward and requesting food, informed Patient A that there was no food for them on the ward and/or did not provide further information or indicate you would obtain food for them. **(proved)**

ii) On Patient A asking for painkillers stronger than paracetamol and ibuprofen, you responded that they could not without further explanation. **(proved)**

iii) Did not inform Patient A that there was a water tap and fruit available for patients and/or otherwise provide orientation to Patient A. **(proved)**

iv) When asked by Patient A and/or other Patients to turn off the light on the ward, responded by saying words to the effect that you were doing paperwork and would turn off the lights when you were ready. **(proved)**

v) On one or more occasions when Baby A was crying, woke Patient A by tapping them on the shoulder and/or pointed to Baby A, and/or went away without offering further assistance. **(proved)**

d) On or about 4 August 2020, commented on the breast anatomy of Patient L and/or did so loudly and/or in a bay where other people were present. **(proved)**

e) On an unknown date in September 2020 fed Baby M without first obtaining permission from Patient M. **(proved)**

f) Having been set performance management plan objectives on 9 October 2020 in relation to time management, prioritising skills and patient centred care, and communication, did not complete those objectives. **(proved)**

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Danti, on behalf of the NMC, to amend the wording of schedule 1)a)iv) and schedule 5)b)viii).

In relation to this schedule, Ms Danti referred the panel to Patient C's witness statement in which she referred to '*cannula*' not '*catheter*'. She also referred the panel to Patient C's complaint letter dated 7 October 2020 in which there was reference to '*cannula*' and not '*catheter*'. Ms Danti submitted that the proposed amendment was to replace the word '*catheter*' with '*cannula*' to correct a factual error and more accurately reflect the evidence. She submitted that this would be in the interests of justice and no prejudice would be caused to Miss Shereni by this amendment. Ms Danti submitted that Miss Shereni has

been provided with the above evidence which refers to cannulas and that the amendment will not make the charge more serious.

'Schedule 1

a) Between 8 and 10 December 2018, while subject to an informal management plan in relation to Patient C.

*iv) In the presence of Patient C, failed promptly and/or at all to remove ~~catheters~~ **cannulas** from one or more other Patients*

Schedule 5

b) Between 8 and 10 December 2018, while subject to an informal management plan in relation to Patient C.

*viii) In the presence of Patient C, failed promptly and/or at all to remove ~~catheters~~ **cannulas** from one or more other Patients'*

The panel heard a further application made by Ms Danti, on behalf of the NMC, to amend the wording of schedule 1)a)i) and schedule 5)b)v).

In relation to these schedules, Ms Danti referred the panel to Patient C's witness statement which refers to the manner in which the cannula was removed. However, Patient C's complaint letter dated 7 October 2020 also refers to how rough Miss Shereni was when administering medication via the cannula. Therefore, she submitted that this charge relates to how the cannula was handled in respect of Patient C. She submitted that this proposed amendment will not change the substance of the charge, or the facts alleged and does not make the charge more serious. Ms Danti submitted that the seriousness of the charge is the use of force whether that is by the administration of medication via the cannula or by the removal of the cannula, so the proposed amendment does not change the seriousness of this charge. She submitted that the proposed amendment would more accurately reflect the evidence.

‘Schedule 1

a) Between 8 and 10 December 2018, while subject to an informal management plan in relation to Patient C.

i) Used unnecessary force to remove a cannula from Patient C ***and/or to administer medication via a cannula to Patient C***

Schedule 5

b) Between 8 and 10 December 2018, while subject to an informal management plan in relation to Patient C.

v) Used unnecessary force to remove a cannula from Patient C ***and/or to administer medication via a cannula to Patient C’***

The panel heard a further application made by Ms Danti, on behalf of the NMC, to amend the wording of schedule 1)a), schedule 4)a) and schedule 5)b).

Ms Danti submitted that the proposed amendment should replace the year 2018 with 2019. She submitted this was a typographical error made in the course of drafting the charges. Ms Danti submitted that Patient C’s witness statement identifies the year she was at the Trust which was 2019. She referred the panel to Witness 1’s witness statement in which she sets out the year that Patient C was at the Trust which was 2019. Ms Danti submitted that the proposed amendment was to replace 2018 with 2019 to correct a factual error and more accurately reflect the evidence. She submitted that if the panel allowed this amendment this would be in the interests of justice and no prejudice would be caused to Miss Shereni. Ms Danti submitted that Miss Shereni has been provided with the above evidence which sets out the period of time and that the amendment will not make the charge more serious.

‘Schedule 1

a) *Between 8 and 10 December ~~2018~~ **2019**, while subject to an informal management plan in relation to Patient C.*

Schedule 4

a) *Between 8 and 10 December ~~2018~~ **2019**, while subject to an informal management plan in relation to Patient C.*

Schedule 5

b) *Between 8 and 10 December ~~2018~~ **2019**, while subject to an informal management plan in relation to Patient C.’*

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 amendments, as applied for, were in the interest of justice in relation to schedule 1)a)iv), schedule 5)b)viii), schedule 1)a), schedule 4)a) and schedule 5)b). The panel was satisfied that there would be no prejudice to Miss Shereni and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

However, in relation to the proposed amendments applied for schedule 1)a)i) and schedule 5)b)v), the panel was of the view that by adding ‘*and/or to administer medication via a canula to Patient C’* the proposed amendment adds extra substance to the charge and appears to be inconsistent with the evidence. The panel determined that in the interests of justice and in the absence of Miss Shereni it would not be appropriate to allow the proposed amendments in relation to schedule 1)a)i) and schedule 5)b)v).

During the course of the hearing the panel spotted a number of typographical errors in the charges. Following consideration and submissions by Ms Danti, and confirmation of its powers from the legal assessor, the panel made the following additional editorial changes:

- Schedule 4)a)ii) – removed '*Patient C*' from the end of the sentence.
- Schedule 4)c) – removed '*a*' which did not need to be there.
- Schedule 5)a)i) – changed '*Patient H*' to '*Patient J*'.
- Schedule 5)a)iii) – removed the word '*to*' which did not need to be there.
- Schedule 5)b)ii) and Schedule 5b)iii) – changed all references from '*Baby D*' to '*Baby C*'.
- Schedule 5)b)iv) – removed '*Patient C*' from the end of the sentence.
- Schedule 5)c)i) – changed the word '*of*' to '*for*'.
- Schedule 5)c)iv) - changed the word '*of*' to '*off*'.

The panel considered that none of these changes would prejudice Miss Shereni on the basis that they were typographical in nature and made to reflect the evidence which was before the panel and sent to Miss Shereni.

Decision and reasons on application to admit Patient C's written statement

The panel heard an application made by Ms Danti under Rule 31 to allow the written statement of Patient C into evidence. She submitted that in respect of charge 1), charge 4) and charge 5), Patient C's evidence is not sole and decisive. Ms Danti submitted that the panel will have the benefit of written and oral evidence from Witness 1, Patient A and Witness 2. She further submitted that Patient C's husband (Person C) has also been scheduled to give oral evidence and he will speak to the majority of the charges which are in relation to Patient C.

Ms Danti submitted that Miss Shereni did not respond to the Case Management Form (CMF) and that there has been no challenge to the contents of the documents going into evidence. She submitted that there is no documentary evidence before the panel that would suggest Patient C had reason to fabricate her allegations. Ms Danti submitted that at no point has Miss Shereni suggested there were underlying tensions or a history with

Patient C, nor has Miss Shereni suggested any reason that Patient C would have to fabricate her evidence. Ms Danti submitted that the allegations in this case are serious and if found proved there could be adverse effects upon Miss Shereni's career.

Ms Danti referred the panel to a telephone log on 22 March 2024 between Patient C, Person C and the NMC case officer in which Patient C explained she is unable to give evidence in this hearing as she suffers from PTSD as a result of her experiences which include those that are the subject of the allegation. Ms Danti told the panel that Patient C further stated that she cannot re-live her experience in hospital and that she has spent the last four and half years going through therapy. She submitted that the NMC have made efforts to secure Patient C's attendance by offering her support during her oral evidence, but Patient C was not willing to go ahead as she was too traumatised by the events referred to in her letter of complaint to the Trust.

In the preparation of this hearing, the NMC had indicated to Miss Shereni in the CMF that it was the NMC's intention for Patient C to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Patient C, Miss Shereni made the decision not to attend this hearing. On this basis Ms Danti advanced the argument that there was no lack of fairness to Miss Shereni in allowing Patient C's written statement into evidence.

The panel accepted the advice of the legal assessor as regards admitting hearsay evidence, which was that the panel was entitled admit hearsay evidence under Rule 31 of the NMC (Fitness to Practise) Rules subject only to the requirements of relevance and fairness, but that the panel should consider carefully what weight to give to that evidence, if admitted. The panel was referred to the principles within the authority of *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel gave the application in regard to Patient C serious consideration and accepted that the matters being considered in relation to Miss Shereni's practice are serious. The panel noted that Patient C's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and was signed by her. The panel considered

whether Miss Shereni would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Patient C to that of a written statement.

The panel considered that as Miss Shereni had been provided with a copy of Patient C's statement and, as the panel had already determined that Miss Shereni had chosen to voluntarily absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel noted that Patient C's evidence was not sole and decisive in respect of most of the charges as Person C would give evidence to corroborate most of her evidence. The panel considered that there has been no suggestion or indication that Patient C has fabricated her evidence. In addition, the panel had the benefit of Miss Shereni's reflective statement about Patient C's complaint which did not contradict Patient C's allegations against her where she said she could remember the events.

The panel considered that any unfairness in this regard worked both ways in that the NMC would be deprived, as would be the panel, from reliance upon the live evidence of Patient C and the opportunity of questioning and probing her written testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel was also of the view that the NMC had offered all reasonable options to Patient C but, given the circumstances of her health condition and how it had developed from her experience at the Trust, her absence was understandable and reasonable.

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

Background

The charges arose whilst Miss Shereni was employed as a registered midwife at Homerton University Hospital NHS Foundation Trust (the Trust) from 1999 until her retirement in October 2021.

Miss Shereni was subject to the Trust's performance management process on three separate occasions in 2017, 2018-2019 and 2020-2021. It is alleged that Miss Shereni failed to show consistent or sustained improvement despite the first two competency plans being signed off successfully in 2017 and 2019.

The alleged areas of concern regarding Miss Shereni's competency are as follows:

- Medication administration errors;
- Inadequate observations/failure to escalate deteriorating patients;
- Inadequate record keeping; and
- Poor communication (rudeness/lack of compassion towards patients).

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Miss Shereni.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Band 8 Maternity Matron at the Trust at the time of the allegations;
- Person C: Husband of Patient C;
- Patient A: Patient at the Trust at the time of the allegations;
- Witness 2: Consultant Midwife at the Trust at the time of the allegations.

The panel also took into account the hearsay evidence of Patient C and the written evidence of Ms 1, who was the Practice Development Midwife at the Trust at the time of the allegations and whose evidence the NMC adduced as background material.

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

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

The panel considered each of the alleged failures as set out in Schedule 1 individually.

Schedule 1)a)i)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.
    i) Used unnecessary force to remove a cannula from Patient C.

In reaching this decision, the panel took into account Patient C's, Person C's and Witness 1's witness statements. It also took into account Witness 1's and Person C's oral evidence, Patient C's complaint letter dated 7 October 2020 and Miss Shereni's response

to the Trust regarding Patient C's complaint, which did not challenge the NMC's case on the facts. It further noted that Patient C's evidence on other matters was corroborated by other witnesses.

The panel also considered Patient C's witness statement in which she stated that "*Instead, Ms Shereni came to me and ripped my cannula out, really man-handling me, which felt like an act of punishment. I was left badly bruised from the removal of the tape and cannula. It also bled heavily following the removal*." While this evidence was hearsay, the panel noted that it was partially corroborated by Person C in his oral evidence in that he referred to Patient C having bruising in the affected area. As such, the panel considered that it would be able to attach weight to Patient C's evidence.

The panel also considered Witness 1's witness statement in which she stated that "*The incident happened in December 2019 but the patient only reported it in October 2020. [Patient C] clearly described Ms Shereni in their complaint. Patient satisfaction is very important as if they feel uncared for patients can lose trust and confidence in the midwife. This was exacerbated by Ms Shereni's alleged rudeness/ poor communication towards [Patient C] Communication is a vital skill for midwives, as per the NMC code of conduct…During the period of [Patient C] concerns whilst they were on Templar Ward (8 to 10 December 2019) Ms Shereni was off on 8 December 2019, worked a 12 hour shift on 9 December 2019 and had an 8 hour study day on 10 December 2019 (which is a non-clinical day in which Ms Shereni would not have seen patients)*." The panel further noted that Miss Shereni was on an informal management plan on the relevant dates as set out by Witness 1. The panel was of the view that Witness 1's evidence was reliable.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C Miss Shereni used unnecessary force to remove a cannula from Patient C.
In light of the above, the panel therefore finds Schedule 1)a)i) proved.

Schedule 1)a)ii)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    ii) Refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief.

In reaching this decision, the panel took into account Patient C's, Person C's and Witness 1's witness statements. It also took into account Witness 1's and Person C's oral evidence and Patient C's complaint letter dated 7 October 2020.

The panel considered Patient C's NMC witness statement in which she stated that "*Ms Shereni also refused to let me have pain killers aside from paracetamol, despite the anaesthesiologist earlier advising that I could have stronger pain relief – this happened on at least three occasions as far as I recall…*" In Patient C's complaint letter dated 7 October 2020 it states, "*I woke up in a lot of discomfort and requested the painkillers I'd been assured would be available, the head midwife (whose name I cannot remember) refused*." When questioned Witness 1 confirmed that the head midwife was not Miss Shereni.

The panel further considered Person C's witness statement in which he stated that "*We had been provided with a detailed explanation of what pain relief my wife would need from the surgery team, before we moved to the Ward. As such, it was not a case of my wife or I demanding stronger pain relief, above what Ms Shereni and the other midwives were providing (although I do not recall having specific concerns with any of the other midwives on the Ward), rather we were questioning something that had already been agreed, but we were being ignored. I ended up having to visit the delivery suite/theatre area to track down staff there who were fortunately still on shift, to get them to confirm and expedite the correct pain relief prescription. I do not feel that I should have had to do this, and that it reflects the lack of support we felt from Ms Shereni on the Ward (as above, I do not recall having concerns with any of the other midwives on the Ward). This failure to provide the pain relief that had been agreed resulted my wife's prolonged agony even more distressing, and unnecessary. The fact that I had to go above Ms Shereni to get my wife*

the pain relief she had previously been offered, and had been agreed to, remains a massive disappointment."

The panel considered Patient C's complaint dated 7 October 2020 in which she stated that "*Frequently, we had to chase her for pain relief…*" The panel noted, however, that there is no evidence to suggest that it was Miss Shereni who refused to provide Patient C with stronger pain relief. Person C's witness statement and Patient C's complaint letter dated 7 October 2020 both indicate that the stronger pain relief had to be chased up with the midwife on shift. However, the panel is of the view that repeated requests for strong pain relief not being responded to positively does not amount to a refusal by Miss Shereni.

It determined that, in the absence of any other evidence, it could not be satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds Schedule 1)a)ii) not proved.

Schedule 1)a)iii)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    iii) Did not remove a catheter from Patient C until they had requested it be removed on multiple occasions.

In reaching this decision, the panel took into account Patient C's and Person C's witness statements. It also took into account Person C's oral evidence, Patient C's complaint letter dated 7 October 2020 and Patient C's near-contemporaneous notes recorded shortly after the incident.

The panel considered Patient C's witness statement in which she stated that "*…One concern I remember was that I asked for my catheter to be removed, and after asking on multiple occasions Ms Shereni came and removed it. Whilst removing the catheter some urine spilt on the floor and Ms Shereni told me off for this…*"

The panel also considered Patient C's complaint letter dated 7 October 2020 in which she stated that "*When a doctor finally gave the go ahead for my catheter and cannula to be removed, I was made to wait for several hours. I asked Notello [sic] at least four times, and felt like I was being punished by her...*" Witness 1 confirmed in oral evidence that she had spoken to Patient C and verified that this was Miss Shereni but that Patient C had not known how to spell her name. The panel further considered Patient C's near-contemporaneous notes. The panel noted that Person C corroborated this in his oral evidence.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni did not remove a catheter from Patient C until they had requested it be removed on multiple occasions.

In light of the above, the panel therefore finds Schedule 1)a)iii) proved.

Schedule 1)a)iv)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    iv) In the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients.

In reaching this decision, the panel took into account Patient C's and Person C's witness statements. It also took into account Person C's oral evidence, Patient C's complaint letter

dated 7 October 2020 and Patient C's near-contemporaneous notes recorded soon after the incident.

The panel considered Patient C's witness statement in which she stated that *"During my time on the Ward I also witnessed Ms Shereni's poor behaviour towards other patients. I overheard other patients asking Ms Shereni for their cannulas to be removed, but Ms Shereni would, not assist, resulting in myself and others going to the Head Nurse to ask for them to be removed. In the end, I had to demand a doctor did it, who then instructed Ms Shereni to come and remove it."*

The panel noted that Person C corroborated this in his oral evidence. He told the panel that "*other patients raised concerns so I can't say if it was her blanket approach but for my wife it felt spiteful…*" or words to that effect.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni in the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients.

In light of the above, the panel therefore finds Schedule 1)a)iv) proved.

Schedule 1)b)

b) On an unknown date in March 2020, discharged Patient H with medication intended for another Patient and without their own required medication for blood pressure.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account Witness 1's email dated 17 April 2020.

The panel considered Witness 1's email dated 17 April 2020 in which she stated that "*Incident 2 – you gave a discharge folder to Patient H with the discharge / TTA letter of Patient S. You also gave the TTA medications of Patient S in SR5 to Patient H*."

The panel noted that this was corroborated by Witness 1 in her witness statement in which she stated that "*In March 2020 (I cannot recall the exact date) Ms Shereni was involved in a drug incident where a patient was provided with tablets to take home that were not theirs but intended for a COVID positive patient. At this time, we were trying to keep COVID patients' status confidential to prevent fear amongst the patients. The patient read the medication when they got home and rang us to say the medication (penicillin) was not issued in their name. This was also concerning as the patient may have been allergic to penicillin and may have taken the tablets by mistake, had they not noticed the error. The patient was supposed to have been provided with medication for high blood pressure, without which the patient may have had a stroke. As such, as well as being sent the wrong medication this patient did not receive their required blood pressure medication. I attach an email summarising this incident, dated 17 April 2020, as Exhibit "RS24…*"

On that basis, the panel was satisfied on the balance of probabilities that on an unknown date in March 2020, Miss Shereni discharged Patient H with medication intended for another Patient and without their own required medication for blood pressure.

In light of the above, the panel therefore finds Schedule 1)b) proved.

Schedule 1)c)

c) On or about 14 September 2020, did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account an Incident Investigation Form dated 14 September 2020, Miss Shereni's response to the 14 September 2020 incident and Patient I's drug chart.

The panel considered Witness 1's witness statement in which she stated that "*On 14 September 2020 a patient [Patient I] with high blood pressure was not given any of their prescribed blood pressure tablets by Ms Shereni during a 12 hour shift. The patient had*

pre-eclampsia and was prescribed Labetalol 3 times a day. The patient missed two doses during Ms Shereni's shift..." The panel noted that Witness 1 in her oral evidence told the panel that "*there was no way of knowing that and that the patient's blood pressure was quite raised which is why it was picked up…*" or words to that effect. It also noted that Witness 1 confirmed to the panel in her oral evidence that she had had sight of a clear version of Patient I's drug chart than that provided to the panel and could confirm that there was no record of the Labetalol being given to Patient I.

The panel further considered Miss Shereni's local response to the 14 September 2020 incident in which she stated "*I believe that I gave client her 09:30 medication but was not signed for. Duty of candour I have to put my hand up and say there is no signature on the drug chart.*"

On that basis, the panel was satisfied on the balance of probabilities that on or about 14 September 2020, Miss Shereni did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift.

In light of the above, the panel therefore finds Schedule 1)c) proved.

Charge 1)

1) Failed to undertake medicines administration and/or management effectively, as set out in Schedule 1.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement and oral evidence. It also took into account the Trust's Job Description for a Band 6 Experienced Midwife, The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code), v.3 of the Medicine Management for Midwives Policy and the alleged facts found proved in Schedule 1.

The panel considered the Trust's Job Description for a Band 6 Experienced Midwife and found that it was Miss Shereni's duty to "*ensure the safe administration and custody of drugs in accordance with the Safety of Medicines Act and the Trust Drugs Administration policy*."

The panel determined that Miss Shereni had a duty, in which she failed, as referenced in the following parts of the Code:

> ***"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***
>
> *To achieve this, you must:*
>
> *18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs."*

The panel noted that at the time of the incident the Medicine Management for Midwives Policy would have been v.2. However, there has been no change from v.2 to v.3, with which the panel was provided.

On that basis, the panel was satisfied that Miss Shereni failed to undertake medicines administration and/or management effectively, as set out in Schedule 1.

In light of the above, the panel therefore finds charge 1) proved.

The panel considered each of the alleged failures as set out in Schedule 2 individually.
Schedule 2)a)

a) In relation to home visits to Patient J in or around December 2017 did not check a third degree tear.

In reaching this decision, the panel took into account Witness 1's and Witness 2's witness statements and oral evidence. It also took into account an email outlining Patient J's complaint and summary of meeting – 23 April 2018.

The panel considered Witness 1's witness statement in which she stated that "*A complaint was received from [Patient J] on 13 April 2018, [Patient J] stated that Ms Shereni forgot a pen during both visits and insisted that she needed a black pen when [Patient J] offered a blue one. They stated Ms Shereni forgot a calculator to calculate the baby's weight loss and told [Patient J] that they should supplement breastfeeding with formula, which the patient did not want to do. [Patient J] further stated that Ms Shereni brought a student with them to the visit but failed to introduce the student, failed to check [Patient J] third degree tear and failed to communicate effectively so that [Patient J] had to wait at home for Ms Shereni's visit. [Patient J] also stated that Ms Shereni failed to arrange a birth reflections appointment they had said they would organize and that overall the experience was "extremely disappointing and frustrating". I did not speak to Ms Shereni about this concern, and do not know further details…*"

The panel also considered Witness 2's oral evidence as she told the panel that a "*third degree is a serious tear which could cause long term damage…*" or words to that effect.

The panel further considered the email outlining Patient J's complaint and summary of meeting in which it was stated by Patient J that "*I had a third degree tear and was quite upset about this. Nathando [sic] didn't ask me if I want her to have a look at it to see if it was healing. The other two midwives that visited (after Nathando) [sic] did ask and seemed surprised when I said that the first midwife hadn't*." The panel noted that it had no evidence to suggest that this was disputed by Miss Shereni.

On that basis, the panel was satisfied on the balance of probabilities that in relation to home visits to Patient J in or around December 2017, Miss Shereni did not check a third degree tear.

In light of the above, the panel therefore finds Schedule 2)a) proved.

Schedule 2)b)i) and Schedule 2)b)ii)

b) On 16 December 2018, while subject to an informal management plan, in relation to Baby D:
    i) Did not carry out blood sugar level checks adequately or at all for a period of 12 hours.
    ii) Did not carry out meconium observations adequately or at all for a period of 12 hours.

In reaching this decision, the panel took into account Witness 1's and Witness 2's witness statements and oral evidence. It also took into account an email which includes the confirmation of a Datix report dated 16 December 2018 and Miss Shereni's reflective statement received on 28 December 2018.

The panel considered the Datix notification dated 16 December 2018 in which it was stated that "*Came on to my night shift 16/12/18, no mec obs or prefeed BM's had been done for baby since the morning handover when I left my shift*."

The panel noted that Witness 1 in her oral evidence told the panel that she spoke to Patient D who confirmed Baby D's blood sugar was not taken.

The panel also considered Miss Shereni's reflective statement in which she stated that "*Three clients were discharged and I received three new clients and their families. I later received three clients within a short space of time. This process interrupted my normal routine on check with the nursery nurse how the observations were. Problems identified I failed to check whether observations were being carried out and getting the result of the Blood sugar. On reflecting on this incident I am going to be checking more often with the nursery nurse whether the observations and blood sugars' are being carried out. The nursery nurse appears to escalate any abnormal result directly to the doctor. Therefore it is difficult to keep up to date while you are being occupied by the new admissions. As the registered midwife I am accountable to my employer and NMC to provide high standard of*

care to all clients who need midwifery services. I am also responsible for making sure clients in my care are safe. All babies need a care plan and feeding plan to ensure that all observations are not missed…" and "As the trained nurse in the bay I am accountable for my actions and or omission. As the midwife in charge of client I have to provide effective communication skills when working with others. The duty of candour is to acknowledge that mistakes were made and have an action plan to apply what I have learned from this situation. Looking back at this situation I have identified areas to develop further making sure that all observations are carried out by going through all the client list in a systematic way and checking with the client and the nursery nurse. I should have escalated concerns to the neonatal doctor and sister in charge of the ward. As the senior nurse I should have completed the incident form instead of giving it to junior staff."

The panel had regard to the undated and unsigned local reflective statement provided to the Trust. The panel noted that Miss Shereni made admissions to failings on her part in respect of ensuring that blood sugar level checks and observations were being carried out.

On that basis, the panel was satisfied on the balance of probabilities that on 16 December 2018, while subject to an informal management plan, in relation to Baby D, Miss Shereni, did not carry out blood sugar level checks adequately or at all for a period of 12 hours and did not carry out meconium observations adequately or at all for a period of 12 hours.

In light of the above, the panel therefore finds Schedule 2)b)i) and Schedule 2)b)ii) proved.

Charge 2)

2) Failed to undertake observation effectively as set out in Schedule 2.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and 2's witness statements and oral evidence. It also took into account the Trust's Job Description for a Band 6 Experienced Midwife, The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and the alleged facts found proved in Schedule 2.

The panel had regard to Witness 1's oral evidence in which she told the panel that "*a midwife has three options, number one delegate tasks and ask other staff member if it had been done, two delegate task and check yourself that it had been done or third option which is to carry out the task yourself…*" or words to that effect.

The panel considered the Trust's Job Description for a Band 6 Experienced Midwife and found that it was Miss Shereni's duty to "*work with neonatologists in the provision of care to the newborn as appropriate*" and to "*ensure the needs of women are accurately assessed and appropriately met*."

The panel determined that Miss Shereni had a duty, in which she failed, as referenced in following parts of the Code:

> ***"3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> *To achieve this, you must:*
>
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> ***11 Be accountable for your decisions to delegate tasks and duties to other people***
>
> *To achieve this, you must:*
>
> *11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard*
>
> ***13 Recognise and work within the limits of your competence***

To achieve this, you must, as appropriate:
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care"

On that basis, the panel was satisfied Miss Shereni failed to undertake observation effectively as set out in Schedule 2.

In light of the above, the panel therefore finds charge 2) proved.

The panel considered each of the alleged failures as set out in Schedule 3 individually.
Schedule 3)a)

a) On 29 December 2018, while subject to an informal management plan failed to escalate abnormal vital signs and/or NEWTT observations of Baby E.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account Miss Shereni's undated reflective statement regarding Baby E and an Incident Investigation Form dated 29 December 2018.

The panel considered Miss Shereni's undated reflective statement regarding Baby E in which she stated that "*I did not escalate for the neonatologist to come and review baby regarding risk factors that the mother was gestational diabetic militates and diet controlled and no medication, The BMS were persistently low during the night and I did not escalate that the baby needed to be reviewed. From the observation and looking at the baby did not appear unwell to me, I was speaking to the neonatal doctor the other day and she told me about the new policy on reluctant to feed babies. It was an oversight on my part not to escalate the baby's low blood sugars to the doctor. I should have done a post feed BM within the hour of the pre-feed reading of 2.3 mmols. The first reading done was 2.5 which is borderline / should have escalated to the doctor*."

Witness 1 verified to the panel in her oral evidence that this was a reflective statement from Miss Shereni.

The panel also considered the Incident Investigation Form dated 29 December 2018 in which it was stated that "*Unplanned transfer to SCBU.-Baby born by emcs at 15:18 on… PROM of 25hrs, mat GDM), baby had 8 x Bm's done - only 2 had been within normal range, (2 were below 2.0), NEWTT score had been 1 on 3 occasions. None of the above had been escalated to The neonatal doctors. At NIPE check(24hrs old) feed chart and obs seen, baby tachypnoei (70-30), 02 sats 93%, tinge jaundice*."

On that basis, the panel was satisfied on the balance of probabilities that on 29 December 2018, while subject to an informal management plan, Miss Shereni failed to escalate abnormal vital signs and/or NEWTT observations of Baby E.

In light of the above, the panel therefore finds Schedule 3)a) proved.

Schedule 3)b)

b) Having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, did not complete that objective.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account Witness 1's letter regarding re-commencement of performance management dated 7 September 2020 and a letter to Miss Shereni dated 25 October 2021.

The panel considered Witness 1's witness statement in which she stated that "*Performance management was re-started in September 2020 for Ms Shereni due to the ongoing complaints received about them and the fact there had been no sustained improvement following the completion of their formal competency plan. Ms Shereni had been through an informal and a formal performance management plan (as well as a previous informal plan when working in the community) during which they received a lot of support and training and there was no improvement in their performance. I understood Ms Shereni to be a liability to patients from a safety and conduct perspective, I felt they were*

putting patients at risk and patient expectations would not be met as Ms Shereni did not seem to be able to work autonomously as expected within the NMC code of conduct for a Senior Midwife…" and " From 7 October 2020 to 14 March 2021, Ms Shereni was allocated to work in a non-patient facing/non clinical supernumerary role. There were no clear set targets or objectives set whilst senior management and Human resources decided the next steps and to ensure the safety of patients and Ms Shereni."

The Trust's letter to Miss Shereni dated 25 October 2021 set out their assessment of her "*failure to meet the objectives set during the formal monitoring period and…failure to sustain the expected level of performance*", specifically: "*4. Failure to demonstrate excellent documentation and escalation skills using SBAR*."

On that basis, the panel was satisfied on the balance of probabilities that having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, Miss Shereni did not complete that objective.

In light of the above, the panel therefore finds Schedule 3)b) proved.

Charge 3)

3) Failed to undertake escalation of clinical concerns effectively, as set out in Schedule 3.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and 2's witness statements and oral evidence. It also took into account the Trust's Job Description for a Band 6 Experienced Midwife, The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and the alleged facts found proved in Schedule 3.

The panel considered the Trust's Job Description for a Band 6 Experienced Midwife and found that it was Miss Shereni's duty to "*where deviations from the normal occur refer to a*

doctor or other senior practitioner in accordance with the midwife's responsibilities and sphere of practice."

The panel determined that Miss Shereni had a duty, in which she failed, as referenced in the following parts of the Code:

> ***"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"*

On that basis, the panel was satisfied that Miss Shereni failed to undertake escalation of clinical concerns effectively, as set out in Schedule 3.

In light of the above, the panel therefore finds charge 3) proved.

The panel considered each of the alleged failures as set out in Schedule 4 individually.

Schedule 4)a)i)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.
    i) Made only one entry in Patient C's notes and or checked their notes only once during a 12 hour shift.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account Miss Shereni's responses to Patient C's complaint and Patient C's notes and drug chart.

The panel considered Witness 1's witness statement in which she stated that "*there were also concerns with Ms Shereni's record-keeping in respect of this patient. On review of [Patient C] notes there is only one (retrospective) entry by Ms Shereni at 18:58 on 9 December 2019, which Ms Shereni notes was written in retrospect due to them dealing with a sick baby*."

The panel reviewed screenshots of parts of Patient C's electronic records and noted that it had not been provided with any screenshots of the records prior to 18:58 on 9 December 2019. However, Witness 1 confirmed in her oral evidence that the allegation as set out was accurately described.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni made only one entry in Patient C's notes and or checked their notes only once during a 12 hour shift.

In light of the above, the panel therefore finds Schedule 4)a)i) proved.

Schedule 4)a)ii)

a) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    ii) When Patient C explained to you that she had been advised not to take warfarin pending test results, became incorrectly recorded that Patient C 'refused' warfarin.

In reaching this decision, the panel took into account Patient C's witness statement. It also took into account Person C's witness statement and oral evidence and Patient C's complaint letter dated 7 October 2020.

The panel considered Witness 1's witness statement in which she stated that "*After the doctor left, but I had not yet received the blood test result, Ms Shereni came to my bay and tried to give me warfarin. Ms Shereni had the medication with her and demanded I expose my stomach for the injection. I explained to Ms Shereni that I was waiting on test results from the doctor before having the warfarin. In response, Ms Shereni got annoyed and stormed off. I cannot recall her exact words but I do remember her huffing and storming off through the curtains. Later that night, when preparing for discharge I asked about the test results and warfarin and was told that the medication for discharge had not been ordered. Whilst this was being sorted saw a copy of my notes which included an*

entry by Ms Shereni that I had refused my medication (the warfarin), when this was not the case, I was just waiting for the blood test to be sure I could take it and was not refusing it outright. I am unsure as to exactly which notes/records this entry was in. This felt passive aggressive, and resulted in delays in my discharge as it meant the correct medication had not been ordered, as staff were under the impression I had refused medication."

The panel had regard to Person C's oral evidence in which he told the panel that "*she did technically refuse it as she wanted to wait for the blood results and there was a good reason…*" or words to that effect.

The panel determined that, in the absence of any other evidence, it could not be satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, when Patient C explained to Miss Shereni that she had been advised not to take warfarin pending test results it became incorrectly recorded that Patient C 'refused' warfarin.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds Schedule 4)a)ii) not proved.

Schedule 4)b)

b) As set out at Schedule 3 b) above, having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, did not complete that objective.

In reaching this decision, the panel took into account the evidence considered from Schedule 3)b). The panel found Schedule 3)b) proved. It determined that, as set out at Schedule 3)b) above, having been set a performance management plan objective on 9 October 2020 in relation to documentation and escalation, Miss Shereni did not complete that objective.

In light of the above, the panel therefore finds Schedule 4)b) proved.

Schedule 4)c)

c) On 3 April 2020, signed Patient K's drug chart to record providing them with paracetamol and ibuprofen when you had not.

In reaching this decision, the panel took into account Witness 1's email dated 17 April 2020 and a Datix report made by Miss Shereni regarding the 3 April 2020 incident.

The panel considered Witness 1's email dated 17 April 2020 in which she stated, "*Incident 1 – On Friday April 3rd, you recorded in error on EPR that you gave a patient oral analgesic in C bay when you were working in A / B bay*."

The panel also considered Miss Shereni's Datix report regarding the 3 April 2020 incident in which she stated "*I signed the drug chart for a client in C bay in error and failed to positively identify the client confirming the information on the identity bracelet. I was not giving women in C bay medication therefore I opened the drug chart in error and signed it I presumed that this was my client*."

On that basis, the panel was satisfied on the balance of probabilities that on 3 April 2020, Miss Shereni signed Patient K's drug chart to record providing them with paracetamol and ibuprofen when she had not.

In light of the above, the panel therefore finds Schedule 4)c) proved.

Schedule 4)d)

a) As set out at Schedule 1 c) above, On or about 14 September 2020, did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift.

In reaching this decision, the panel took into account the evidence considered at Schedule 1)c). The panel found Schedule 1)c) proved. It determined that, as set out at Schedule 1)c) above, on or about 14 September 2020, Miss Shereni did not administer and/or record administering Labetalol to Patient I on two occasions throughout a 12 hour shift.

In light of the above, the panel therefore finds Schedule 4)d) proved.

Charge 4)

4) Failed to undertake record keeping effectively, as set out in Schedule 4.

This charge is found proved.

In reaching this decision, the panel took into account the Trust's Job Description for a Band 6 Experienced Midwife, The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and the alleged facts found proved in Schedule 4.

The panel determined that Miss Shereni had a duty, in which she failed, as referenced in the following parts of the 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"*

The panel considered the Trust's Job Description for a Band 6 Experienced Midwife and found that it was Miss Shereni's duty to:

- '*Maintain an effective and safe communication system amongst all staff grounds working within the maternity services, in order to achieve a positive working environment; and*
- *Take responsibility for maintaining written and electronic patient records relating to client care in accordance with NMC rules and code of practice and local guidelines*.'

On that basis, the panel was satisfied that Miss Shereni failed to undertake record keeping effectively, as set out in Schedule 4.

In light of the above, the panel therefore finds charge 4) proved.

The panel considered each of the alleged failures as set out in Schedule 5 individually.

Schedule 5)a)i)

a) In relation to home visits to Patient J in or around December 2017:
    i) Advised Patient J to supplement breast milk with formula contrary to their expressed wish.

In reaching this decision, the panel took into account Patient J's complaint dated 13 April 2018.

The panel considered Patient J's complaint dated 13 April 2018 in which she stated that *"After we worked out that [Baby J] had lost more than a certain amount of her birth weight she told me I needed to supplement her with formula. My milk had come in that day so I had loads of milk and I told her this but she still told me to supplement with formula. She didn't seem to understand my argument that I had a lot of milk but only as of that day.*

Future midwives and a lactation consultant that I spoke to thought that supplementation wasn't required."

On that basis, the panel was satisfied on the balance of probabilities in relation to home visits to Patient J in or around December 2017, that Miss Shereni advised Patient J to supplement breast milk with formula contrary to their expressed wish.

In light of the above, the panel therefore finds Schedule 5)a)i) proved.

Schedule 5)a)ii)

a) In relation to home visits to Patient J in or around December 2017:
    ii) Did not introduce a student attending the visit with you.

In reaching this decision, the panel took into account Witness 1's and Witness 2's witness statements and oral evidence. It also took into account Patient J's complaint dated 13 April 2018.
The panel considered Witness 1's witness statement in which she stated that "*Ms Shereni brought a student with them to the visit but failed to introduce the student…*"

The panel also considered Witness 2's witness statement in which she stated that "*The patient was also unhappy on one occasion Ms Shereni brought a student with them who they did not introduce.*" This was corroborated by Witness 2's oral evidence in which she told the panel that "*Student should have been introduced and role of student explained to the mother*" or words to that effect.

The panel further considered Patient J's complaint dated 13 April 2018 in which she stated that "*The second time she visited she brought a student with her but didn't introduce the student, I had to introduce myself to the student and ask her who she was. This is highly unprofessional*."

On that basis, the panel was satisfied on the balance of probabilities in relation to home visits to Patient J in or around December 2017, that Miss Shereni did not introduce a student attending the visit with her.

In light of the above, the panel therefore finds Schedule 5)a)ii) proved.

Schedule 5)a)iii)

a) In relation to home visits to Patient J in or around December 2017:

iii) Did not effectively communicate your arrival time.

In reaching this decision, the panel took into account Witness 1's and Witness 2's witness statements and oral evidence. It also took into account Patient J's complaint dated 13 April 2018.

The panel considered Witness 2's witness statement in which she stated that "*On one occasion Ms Shereni also left the patient a message, to which the patient tried to call back to get an idea of the time of the planned visit but had to stay in all day…*" This was corroborated by Witness 2's oral evidence in which she told the panel that "*communication about time constraints can be quite challenging for midwives as you sometimes don't know when you will arrive but there needs to be communication between midwife and mother generally best to say morning or afternoon rather than a precise time…midwife should have responded to messages and an alternative phone number should have been provided…*" or words to that effect.

The panel also considered Patient J's complaint dated 13 April 2018 in which she stated that "*On the days of her visits she would call in the morning, leave a message to say she was coming that day (no time) and when I tried to phone her back she wouldn't answer. This meant I was stuck at home all day not knowing when she would come. I told her this and asked her to tell me what time she was coming (at least morning or afternoon) so I wouldn't be trapped at home all day. She didn't seem to get the message.*

On that basis, the panel was satisfied on the balance of probabilities in relation to home visits to Patient J in or around December 2017, that Miss Shereni did not effectively communicate her arrival time.

In light of the above, the panel therefore finds Schedule 5)a)iii) proved.

Schedule 5)b)i)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.
    i) Criticised Patient C for being near a window and/or made no enquiry of them as to why they were near the window and/or explain to Patient C that they should not be feeling hot.

In reaching this decision, the panel took into account Patient C's witness statement.

The panel considered Patient C's witness statement in which she stated that "*The first time I remember meeting Ms Shereni was, I believe, the day of my daughter's birth, after I had been moved to the Ward (8 December 2019). When I was first moved I met a different midwife who had been lovely. I remember I was really hot at that point, which I now believe was a sign of sepsis, so asked to be in a bed next to the window, with my daughter also going next to the window. As it was December it was very cold by the window. After the change of shift I met Ms Shereni for the first time as they came over to me. My first memory is Ms Shereni approaching me telling me off for being near a window with my daughter as it was too cold, then taking my daughter in their cot and moving them to the other side of my bed, away from the window. At no point did they explain that I should not be feeling as hot as I was, or ask why I wanted to be in such a cold area of the Ward. I do not remember Ms Shereni saying anything else after this, just feeling told off.*"

The panel found that this was not corroborated by Patient C's near-contemporaneous notes, nor her complaint letter dated 7 October 2020.

Person C made his witness statement almost three years after the event and this allegation is not mentioned in Patient C's complaint letter or in any other contemporaneous evidence.

The panel determined that, in the absence of any other evidence, it could not be satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni criticised Patient C for being near a window and/or made no enquiry of them as to why they were near the window and/or explain to Patient C that they should not be feeling hot.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds Schedule 5)b)i) not proved.

Schedule 5)b)ii)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.
    ii) While Patient C was changing Baby C's nappy and dressing Baby C, criticised Patient C for the way she was dressing Baby C.

In reaching this decision, the panel took into account Patient C's witness statement.

The panel considered Patient C's witness statement in which she stated that "*I had not changed a nappy and dressed a baby before and when Ms Shereni came over, instead of helping she proceeded to tell me off for not dressing my daughter properly…*"

The panel found that this was not corroborated by Patient C's near-contemporaneous notes, nor her complaint letter dated 7 October 2020.

The panel determined that, in the absence of any other evidence, it could not be satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, while Patient C was changing Baby C's nappy and dressing Baby C, Miss Shereni criticised Patient C for the way she was dressing Baby C.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds Schedule 5)b)ii) not proved.

Schedule 5)b)iii)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    iii) While Patient C was changing Baby C's nappy and dressing Baby C, took Baby C from Patient C and/or moved their sleeve over their cannula, in a rough manner.

In reaching this decision, the panel took into account Patient C's witness statement. It also took into account Person C's witness statement and oral evidence.

The panel considered Patient C's witness statement in which she stated that "*Ms Shereni came over, instead of helping she proceeded to tell me off for not dressing my daughter properly, grabbed her from me and yanked her sleeve over her cannula. I found this very distressing, seeing my daughter in pain and Ms Shereni handling her in a rough manner, yanking the sleeve over the cannula. I recall thinking this was not the care I expected from a midwife who was supposed to be supporting me*."

The panel noted that this was corroborated by Person C in his oral evidence as he told the panel that "*it was bad enough to watch my wife being handled roughly but my new daughter it triggered a primal instinct in me to protect her…*" or words to that effect.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, while Patient C was changing Baby C's nappy and dressing Baby C, Miss Shereni took Baby C from Patient C and/or moved their sleeve over their cannula, in a rough manner.

In light of the above, the panel therefore finds Schedule 5)b)iii) proved.

Schedule 5)b)iv)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

    iv) When Patient C explained to you that she had been advised not to take warfarin pending test results, became angry and/or incorrectly recorded that Patient C 'refused' warfarin.

In reaching this decision, the panel took into account Patient C's witness statement. It also took into account Person C's witness statement and oral evidence and Patient C's complaint letter dated 7 October 2020.

In respect of the first part of this allegation '*When Patient C explained to you that she had been advised not to take warfarin pending test results, became angry*…' The panel considered Witness 1's witness statement in which she stated that "*After the doctor left, but I had not yet received the blood test result, Ms Shereni came to my bay and tried to give me warfarin. Ms Shereni had the medication with her and demanded I expose my stomach for the injection. I explained to Ms Shereni that I was waiting on test results from the doctor before having the warfarin. In response, Ms Shereni got annoyed and stormed off. I cannot recall her exact words but I do remember her huffing and storming off through the curtains. Later that night, when preparing for discharge I asked about the test results and warfarin and was told that the medication for discharge had not been ordered...*"

The panel had regard to Person C's oral evidence in which he told the panel that "*I tried not to assume bad intend but it felt spiteful*" or words to that effect.

In relation to the first part of this allegation the panel finds this proved.

In respect of the second part of this allegation '*When Patient C explained to you that she had been advised not to take warfarin pending test results,…and/or incorrectly recorded that Patient C 'refused' warfarin*' the panel took into account the evidence considered from Schedule 4)a)ii) and finds the second part of this allegation not proved.

In light of the above, the panel therefore finds the first part of the allegation in Schedule 5)b)iv) proved and the second part of Schedule 5)b)iv) not proved.

Schedule 5)b)v)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

v) Used unnecessary force to remove a cannula from Patient C.

In reaching this decision, the panel took into account the evidence considered from Schedule 1)a)i). The panel found Schedule 1)a)i) proved. It determined that on the balance of probabilities between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni used unnecessary force to remove a cannula from Patient C.

In light of the above, the panel therefore finds Schedule 5)b)v) proved.

Schedule 5)b)vi)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

vi) Refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief.

In reaching this decision, the panel took into account the evidence considered from Schedule 1)a)ii). The panel found Schedule 1)a)ii) not proved. It determined that it was not satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni refused pain medication other than paracetamol to Patient C on one or more occasions, when an anaesthesiologist had permitted stronger pain relief.

In light of the above, the panel therefore finds Schedule 5)b)vi) not proved.

Schedule 5)b)vii)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

vii) Did not remove a catheter from Patient C until they had requested it be removed on multiple occasions.

In reaching this decision, the panel took into account the evidence considered from Schedule 1)a)iii). The panel found Schedule 1)a)iii) proved. It determined that on the balance of probabilities between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni did not remove a catheter from Patient C until they had requested it be removed on multiple occasions.

In light of the above, the panel therefore finds Schedule 5)b)vii) proved.

Schedule 5)b)viii)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

viii)In the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients.

In reaching this decision, the panel took into account the evidence considered from Schedule 1)a)iv). The panel found Schedule 1)a)iv) proved. It determined that on the balance of probabilities between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni in the presence of Patient C, failed promptly and/or at all to remove cannulas from one or more other Patients.

In light of the above, the panel therefore finds Schedule 5)b)viii) proved.

Schedule 5)b)ix)

b) Between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C.

ix) Displayed an unfriendly attitude to Person C.

In reaching this decision, the panel took into account Person C's witness statement and oral evidence.

The panel considered Person C's witness statement in which he stated that "*I remember in every situation whilst at the Hospital I tried to see the situation from the midwives' point of view, as I understand that it is a tough job, and if someone is unpleasant in a moment I accepted they may have been burnt out or having a difficult day. However, despite this, recall thinking that Ms Shereni was so unpleasant that someone like her should not be in that role. Whilst I will make some allowances for the difficulty of the job, if your job is caring for new mothers, the behaviour demonstrated by Ms Shereni is outright wrong…In addition to Ms Shereni's behaviour towards my wife and me, I also recall finding them to be forceful with our daughter when handling her. I understand that midwives know what they are doing, but I could not shake the feeling that Ms Shereni was using a large amount of force with a small baby who had a large cannula in her arm, and it seemed harsh. I remember being upset when seeing this, but do not think I raised it with anyone…Overall, I found Ms Shereni's behaviour towards my wife, daughter and I to be subpar. Every interaction seemed to be problematic, and we were consistently met with an unfriendly and uncaring response from Ms Shereni when asking for any help or assistance. Even now, nearly three years on, I can still connect to the feeling of discomfort I experienced every time Ms Shereni was present. My elation of being a new father would be replaced by worry, slight confusion and a mixture of anger and fear*."

The panel noted that this was corroborated by Person C in his oral evidence in which he told the panel that "*registrants conduct made us always on edge when in her orbit or vicinity what then followed was that at every opportunity there was spite, or malice or unpleasantness on the part of the registrant…by the time we left we felt that it was a horrible experience and we felt that we would not be safe until we got home*" or words to that effect.

On that basis, the panel was satisfied on the balance of probabilities that between 8 and 10 December 2019, while subject to an informal management plan in relation to Patient C, Miss Shereni displayed an unfriendly attitude to Person C.

In light of the above, the panel therefore finds Schedule 5)b)ix) proved.

Schedule 5)c)i)

c) In relation to Patient A, between 1 and 4 June 2020:

    i) On Patient A arriving on Ward and requesting food, informed Patient A that there was no food for them on the ward and/or did not provide further information or indicate you would obtain food for them.

In reaching this decision, the panel took into account Patient A's witness statement and oral evidence. It also took into account Patient A's complaint dated 23 June 2020 and Miss Shereni's response to Patient A's complaint dated 10 July 2020.

The panel considered Patient A's witness statement in which she stated that "*When I arrived on the Ward I was very hungry as all day I had only had a cheese sandwich, and shared some jam on toast with my husband. I therefore asked Ms Shereni, as soon as I arrived, if I could get something to eat. Ms Shereni, in a very plain and almost annoyed way, responded that they did not have any food for me on the Ward. The manner in which this response was delivered shocked me, as I felt like Ms Shereni was responding as if I had asked for a three course meal. I remember bursting into tears as I was feeling very ill, due to the complications I had experienced during birth, and needed some energy. I do not remember details, but think after asking Ms Shereni they left and I heard a conversation outside the Ward where Ms Shereni, and others I do not know, were saying wanted something to eat and to see what they had. I was eventually bought another sandwich, I do not recall by who*."

The panel also considered Patient A's complaint dated 23 June 2020 in which she stated that "*I was kept in recovery until 10pm after the birth, at which point I was moved to Templar. I'd been given a cheese sandwich and some jam on toast in recovery, but by the evening I was ready for a meal, especially since I'd lost so much blood. I asked if I could have something to eat and was told blunty 'We have no food for you here'. I started crying*

because I had just said bye to my husband and was overwhelmed and really hungry and the midwife walked away. In the end I was given another cheese sandwich, which was better than nothing, but I was amazed that there was nothing more available outside of meal times for women that have been through either long labours or operations."

The panel noted that this was corroborated by Patient A in her oral evidence and found that she was a reliable witness.

The panel further considered Miss Shereni's response to Patient A's complaint dated 10 July 2020 in which she stated, "*There was no hot meal for her on the ward only a cheese sandwich*."

On that basis, the panel was satisfied on the balance of probabilities that in relation to Patient A, between 1 and 4 June 2020, Miss Shereni on Patient A arriving on Ward and requesting food, informed Patient A that there was no food for them on the ward and/or did not provide further information or indicate you would obtain food for them.

In light of the above, the panel therefore finds Schedule 5)c)i) proved.

Schedule 5)c)ii)

c) In relation to Patient A, between 1 and 4 June 2020:
    ii) On Patient A asking for painkillers stronger than paracetamol and ibuprofen, you responded that they could not without further explanation.

In reaching this decision, the panel took into account Patient A's witness statement and oral evidence. It also took into account Patient A's complaint dated 23 June 2020 and Miss Shereni's response to Patient A's complaint dated 10 July 2020.

The panel considered Patient A's complaint dated 23 June 2020 in which she stated that "*I then asked for painkillers (in recovery I'd had ibuprofen and paracetamol and they told me to ask if I needed something stronger) and the same midwife said in wuite [sic] an admonishing way that she could only give me paracetamol*."

The panel noted that this was corroborated by Patient A in her oral evidence in which she told the panel that "*no explanation was given that there was a reason I couldn't have more pain relief, communication is key explanation would've helped and reduced the anxiety of the situation. I almost felt like I child I just needed someone to tell me it was okay*…" or words to that effect.

The panel further considered Miss Shereni's response to Patient A's complaint dated 10 July 2020 in which she stated, "*I acknowledge client felt that she was not supported and was only offered paracetamol for pain relief. Pain is what the client says it is. Working with clients in order to manage their pain by movement and taking regular analgesia for a short time. I have reflected on this complaint and learned that were high emotion is involved we need to show empathy by using some the clients own words. To show that the client has been heard and to see how we can move forward, by asking open. To find out why the client felt disappointed with her care and did not want other women going through the same situation*."

On that basis, the panel was satisfied on the balance of probabilities that, between 1 and 4 June 2020, when Patient A asked for painkillers stronger than paracetamol and ibuprofen, Miss Shereni responded that she could not provide them without giving further explanation.

In light of the above, the panel therefore finds Schedule 5)c)ii) proved.

Schedule 5)c)iii)

c) In relation to Patient A, between 1 and 4 June 2020:

    iii) Did not inform Patient A that there was a water tap and fruit available for patients and/or otherwise provide orientation to Patient A.

In reaching this decision, the panel took into account Patient A's witness statement and oral evidence.

The panel looked at this allegation as a whole.

The panel considered Patient A's witness statement in which she stated that "*After being admitted to the Ward I never received any orientation, with my first interactions being with Ms Shereni in relation to the food and painkillers. On either the second or third day, I cannot remember which, another midwife on the day shift was doing my observations and said my heart rate was high as I was dehydrated, saying I needed to drink more water. I explained to this midwife that I was just drinking what was brought to me, and it was only at this point that I was shown there was a tap available for patients to use, as well as fruit for patients to help themselves to*."

The panel noted that this was corroborated by Patient A in her oral evidence and found her to be a reliable witness.

On that basis, the panel was satisfied on the balance of probabilities that in relation to Patient A, between 1 and 4 June 2020, Miss Shereni did not inform Patient A that there was a water tap and fruit available for patients and/or otherwise provide orientation to Patient A.

In light of the above, the panel therefore finds Schedule 5)c)iii) proved.

Schedule 5)c)iv)

c) In relation to Patient A, between 1 and 4 June 2020:
    iv) When asked by Patient A and/or other Patients to turn off the light on the ward, responded by saying words to the effect that you were doing paperwork and would turn off the lights when you were ready.

In reaching this decision, the panel took into account Patient A's witness statement and oral evidence.

The panel considered Patient A's witness statement in which she stated that "*On the second night of my admission to the Ward Ms Shereni was working again. All of the*

patients on the Ward, including me, were tired so we asked Ms Shereni to turn the light off. Ms Shereni responded saying no as they were doing their paperwork, and that they would turn the lights off when they were ready."

The panel also considered Patient A's oral evidence in which she told the panel that "*one mother asked for the light to be switched off. Other mothers joined in and said its 1:30am. The registrant replied I am doing paper work I will turn the light off when I am finished*" or words to that effect.

On that basis, the panel was satisfied on the balance of probabilities that in relation to Patient A, between 1 and 4 June 2020, when asked by Patient A and/or other Patients to turn off the light on the ward, Miss Shereni responded by saying words to the effect that she was doing paperwork and would turn off the lights when she was ready.
In light of the above, the panel therefore finds Schedule 5)c)iv) proved.

Schedule 5)c)v)

c) In relation to Patient A, between 1 and 4 June 2020:
    v) On one or more occasions when Baby A was crying, woke Patient A by tapping them on the shoulder and/or pointed to Baby A, and/or went away without offering further assistance.

In reaching this decision, the panel took into account Patient A's witness statement and oral evidence.

The panel considered Patient A's witness statement in which she stated that "*My final concern, specifically in relation to Ms Shereni, was that if I fell asleep and my son was crying, and I did not wake immediately, Ms Shereni would wake me by tapping my shoulder or foot, point to my son which I took to suggest I needed to deal with it, and then leave without any assistance. I already felt nervous about not knowing what to do with a newborn baby, and this did not make me feel any better, it just made me feel more vulnerable. Prior to going in to have my son I was nervous about what would do when no one was able to help me with the baby, as I knew I was having abdominal surgery, and*

everyone had reassured me that the midwives and other staff would be there for that. This led to me feeling like I couldn't ask for help."

The panel also considered Patient A's oral evidence in which she told the panel that "*because it was so loud on the ward. I had ear plugs in and my son had woken up and I was strongly tapped on the foot by the registrant and jolted awake. The registrant just pointed at the cot and walked away. This compounded my feeling of uselessness as I had ongoing for the first few days*..." or words to that effect.

The panel considered that it was unclear whether it was Patient A's foot or her shoulder that was tapped by Miss Shereni. However, either way Miss Shereni had tapped Patient A.

On that basis, the panel was satisfied on the balance of probabilities that in relation to Patient A, between 1 and 4 June 2020, on one or more occasions when Baby A was crying, Miss Shereni woke Patient A by tapping them on the shoulder and/or pointed to Baby A, and/or went away without offering further assistance.

In light of the above, the panel therefore finds Schedule 5)c)v) proved.

Schedule 5)d)

d) On or about 4 August 2020, commented on the breast anatomy of Patient L and/or did so loudly and/or in a bay where other people were present.

In reaching this decision, the panel took into account the Trust's Incident Investigation Form dated 10 August 2020 and Miss Shereni's response to the 4 August 2020 incident.

The panel considered the Trust's Incident Investigation Form dated 10 August 2020 in which it was stated that "*Midwife shouted across the ward that I had to go give feeding support to another client as she has very flap nipples*."

The panel noted that Miss Shereni in her written response to the Trust about the 4 August 2020 incident said she does not remember this incident.

On that basis, the panel was satisfied on the balance of probabilities that on or about 4 August 2020, commented on the breast anatomy of Patient L and/or did so loudly and/or in a bay where other people were present.

In light of the above, the panel therefore finds Schedule 5)d) proved.

Schedule 5)e)

e) On an unknown date in September 2020 fed Baby M without first obtaining permission from Patient M.

In reaching this decision, the panel took into account Witness 2's witness statement and oral evidence. It also took into account Miss Shereni's local reflective statement dated 7 October 2020.

The panel considered Witness 2's witness statement in which she referred the panel to Miss Shereni's reflective statement in relation to an incident in September 2020 where Miss Shereni did not support a mothers wish to breastfeed.

The panel noted Miss Shereni's words in the local reflective statement dated 7 October 2020 as follows: "*I am sorry that the client felt that I did not ask permission before feeding baby. The doctor stated that the mother had agreed to give baby formula. In future I am going to check with client that she agreed with the doctor to give formula*."

Witness 2 in her oral evidence told the panel that even if a doctor reports that a woman has given consent the midwife has a responsibility to check this and that she understands what she has consented to.

On that basis, the panel was satisfied on the balance of probabilities that on an unknown date in September 2020 Miss Shereni fed Baby M without first obtaining permission from Patient M.

In light of the above, the panel therefore finds Schedule 5)e) proved.

Schedule 5)f)

f) Having been set performance management plan objectives on 9 October 2020 in relation to time management, prioritising skills and patient centred care, and communication, did not complete those objectives.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account the Trust's letter to Miss Shereni dated 25 October 2021.

The panel considered Witness 1's witness statement in which she stated that "*Performance management was re-started in September 2020 for Ms Shereni due to the ongoing complaints received about them and the fact there had been no sustained improvement following the completion of their formal competency plan. Ms Shereni had been through an informal and a formal performance management plan (as well as a previous informal plan when working in the community) during which they received a lot of support and training and there was no improvement in their performance. I understood Ms Shereni to be a liability to patients from a safety and conduct perspective, I felt they were putting patients at risk and patient expectations would not be met as Ms Shereni did not seem to be able to work autonomously as expected within the NMC code of conduct for a Senior Midwife. I attach the correspondence confirming the plan to recommence performance management, dated 7 September 2020…*"

The panel also considered the Trust's letter to Mrs Shereni dated 25 October 2021 setting out their assessment of her "*failure to meet the objectives set during the formal monitoring period and…failure to sustain the expected level of performance*", specifically:

"2. Timekeeping.
3. Effective MDT communication and prioritising skills using SBAR…
6. Increased number of complaints from patients and staff."

On that basis, the panel was satisfied on the balance of probabilities that, having been set performance management plan objectives on 9 October 2020 in relation to time

management, prioritising skills and patient centred care, and communication Miss Shereni did not complete those objectives.

In light of the above, the panel therefore finds Schedule 5)f) proved.

Charge 5)

5) Failed to communicate effectively and/or treat people with adequate respect and/or compassion as set out in Schedule 5.

This charge is found proved.

In reaching this decision, the panel took into account the Trust's Job Description for a Band 6 Experienced Midwife, The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and the alleged facts found proved in Schedule 5.

The panel determined that Miss Shereni had a duty, in which she failed, as referenced in the following parts of the Code:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

7 Communicate clearly

To achieve this, you must:

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

20 Uphold the reputation of your profession at all times

To achieve this, you must:
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel considered the Trust's Job Description for a Band 6 Experienced Midwife and found that it was Miss Shereni's duty to:

- *'Have due regard for the individual needs of women and their families in an environment, which promotes women centred care*
- *Maintain a good rapport with women and visitors to the unit and facilitate this approach amongst all staff within your area of responsibility; and*
- *Maintain an effective and safe communication system amongst all staff groups working within the maternity services, in order to achieve a positive working environment'*

The panel determined that Miss Shereni had a responsibility to communicate effectively and treat people with adequate respect and compassion, and on the basis of the facts found proved in Schedule 5, it was satisfied that Miss Shereni failed to communicate effectively and/or treat people with adequate respect and/or compassion.
In light of the above, the panel therefore finds charge 5) proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and, if so, whether Miss Shereni's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

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

Ms Danti invited the panel to take the view that the facts found proved amount to a lack of competence.
Ms Danti identified the specific, relevant standards where in her submission, Miss Shereni's actions breached *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'* (the Code) and amounted to a lack of competence. Ms

Danti submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that Miss Shereni was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

Ms Danti submitted that Miss Shereni was, systematically, made aware of the issues around her competence. She submitted that there is evidence that Miss Shereni was subject to repeated processes and the measures that were put in place to assist her to address the issues in her practice. Ms Danti submitted that there is evidence that Miss Shereni was subject to rigorous, formal and informal assessments during the relevant time.

Ms Danti submitted that the facts found proved show that Miss Shereni's competence at the time was below the standard expected of a band 6 registered midwife and the charges found proved amounted to lack of competence.

Submissions on impairment

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

Ms Danti submitted that despite ample support being provided to her, Miss Shereni made repeated errors from December 2017 until 2020 when she was removed from clinical duties. Ms Danti submitted that there is an obvious risk of harm to patients and provided a number of examples of when Miss Shereni's actions caused actual physical and emotional

harm and when they had the potential to cause physical and emotional harm to mothers and their newborn babies.

Ms Danti referred the panel to a number of reflective statements provided by Miss Shereni locally. Ms Danti submitted that Miss Shereni appeared to attempt to provide excuses and did not appreciate the gravity of her actions. She submitted that there is no evidence of genuine remorse or insight into the impact of her actions.

Ms Danti submitted that there is no evidence that Miss Shereni has remediated her lack of competence or strengthened her practice. She submitted that Miss Shereni indicated that she retired in October 2021.

Ms Danti submitted that taking all factors into consideration, a finding of impairment is required on public protection grounds, given the ongoing risk of repetition and risk of harm to patients. She submitted that the public interest is also engaged in this case given the wide-ranging nature and consequences of Miss Shereni's lack of competence. Ms Danti submitted that a well-informed member of the public would expect a finding of impairment to maintain confidence in the profession and to uphold proper professional standards.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included:

- *General Medical Council v Meadow* [2007] QB 462 (Admin);
- *Holton v General Medical Council* [2006] EWHC 2960;
- *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin);
- *R (Vali) v General Optical Council* [2011] EWHC 310 (Admin);
- *Cheatle v General Medical Council* [2009] EWHC 645 (Admin);
- *Cohen v General Medical Council* [2008] EWHC 581 (Admin);
- *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin);
- *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin);
- *Yeong v General Medical Council* [2009] EWHC 1923 (Admin); and
- Dame Janet Smiths test in the 5th Shipman Report.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, it found that Miss Shereni had breached the following standards:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

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

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

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

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

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

7 Communicate clearly

To achieve this, you must:

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's

personal and health needs 11 Professional standards of practice and behaviour for nurses, midwives and nursing associates. All standards apply within your professional scope of practice.

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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

To achieve this, you must:

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

24 Respond to any complaints made against you professionally

To achieve this, you must:
24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice'

The panel bore in mind, when reaching its decision, that Miss Shereni should be judged by the standard that was applicable to the post to which Miss Shereni had been appointed and the work she was carrying out.
Taking into account its findings on the facts, the panel concluded that Miss Shereni lacked competence and her practice was below the standard expected of a band 6 registered midwife.

The panel had regard to the NMC Guidance on *'Lack of Competence'* (Reference: FTP-2b Last Updated: 14/04/2021) and noted the following:

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

The panel was of the view that Miss Shereni's professional performance was of an unacceptably low standard which placed patients at risk. The panel found that there was evidence of Miss Shereni performing at an unacceptably low standard over a sustained period of approximately three years. The panel was satisfied that it had been presented with evidence of a fair sample of Miss Shereni's work which demonstrated wide ranging and repeated errors over a significant period of time.

In all the circumstances, the panel determined that Miss Sherena's performance demonstrated a lack of knowledge, skill and judgement and amounted to a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of her lack of competence, Miss Shereni's fitness to practise is currently impaired.

In reaching this decision, the panel had regard to the NMC Guidance on Fitness to Practise (Last updated: 27 March 2023) in which the following is stated:

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *...'*

The panel found limbs a, b and c were engaged in this case.

The panel found that patients were put at an unwarranted risk of harm and several patients were caused actual physical and emotional harm as a result of Miss Shereni's lack of competence, and others were put at risk. Midwives are expected to demonstrate safe and effective practice and the panel determined that Miss Shereni's lack of competence breached fundamental tenets of the profession and brought the profession into disrepute.

The panel considered whether Miss Shereni's lack of competence was capable of remediation. The panel was mindful of the repeated errors made by Miss Shereni, despite her being subject to a number of formal and informal management plans from October 2017 until December 2020. Competence and clinical concerns can usually be addressed by retraining and are generally considered to be remediable. However, given the persistent, repeated and serious nature of the errors made by Miss Shereni over a significant period of time whilst receiving additional support, the panel determined that the lack of competence identified in this case would be difficult to remediate.

The panel had sight of a number of reflective statements made by Miss Shereni at a local level, following the incidents that formed the basis of the charges. The panel found that Miss Shereni's reflections were inadequate; she failed to appreciate the impact of her actions on patients and their babies, and the harm caused or potential harm she could have caused. The panel was of the view that in these local reflections, Miss Shereni did not demonstrate any remorse or reflect on how she would act differently in the future to address the concerns. The panel noted that Miss Shereni has not engaged with the NMC or provided any recent reflection. The panel found that Miss Shereni's level of insight was insufficient and that she lacked remorse.

The panel noted that in Miss Shereni's response to the local Statement of Case she stated the following:

> *'In my 22 years at Homerton I experienced structural inequalities that have had an important impact on my working life. There have been constant micro-aggressions (those brief everyday exchanges that sent denigrating messages to people of colour because they belong to a minority group).'*

When hearing oral evidence at the facts stage, the panel put Miss Shereni's allegations of discrimination to Witness 1 and Witness 2.

Witness 1 told the panel that she had worked in the NHS for 34 years and that she had worked in the Trust for more than 25 years. Witness 1 said that this is the first time that she has had to take a registrant to a Trust capability panel. Witness 1 said that there are

lots of complaints in maternity but that they are generally not repeated. She said that most registrants want to learn and do not repeat mistakes. However, Witness 1 told the panel that Miss Shereni was a *"repeat offender"*. Witness 1 went on to tell the panel that despite all of the support given to Miss Shereni, she was not learning, not improving, and continued to put patients at risk.

Witness 2 told the panel that Miss Shereni raised the issue of discrimination at the hearing at which the HR representative was from a minority background. Witness 2 said that the issue of discrimination and Miss Shereni's statement that she felt she was treated unfairly were considered carefully. Witness 2 told the panel that Miss Shereni may have thought that she was treated unfairly as she was taken off clinical duties when others were not. Witness 2 said that Miss Shereni was taken off clinical duties because she had been involved in several incidents of a similar nature. Witness 2 also said that Miss Shereni's colleagues were not taken off clinical duties because they had reflected and learnt and had not been involved in any further incidents. Witness 2 said that there was a very diverse midwifery and patient population at the Trust.

The panel was satisfied that there was no evidence before it to conclude that Miss Shereni was subject to discrimination or unfair treatment at the Trust.

The panel considered whether Miss Shereni has taken steps to address her lack of competence and strengthen her practice. The panel had no evidence of strengthened practice and it noted that Miss Shereni has indicated that she has retired in October 2021.

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

In accordance with the NMC Guidance in determining fitness to practise, the panel considered whether Miss Shereni is capable of practising kindly, safely and effectively. The panel determined that, having found that Miss Shereni's actions amounted to a lack of competence and that there is a risk of repetition, she is not currently capable of kind, safe and effective practise.

Given Miss Shereni's lack of insight into her lack of competence, and that there is no evidence of strengthened practice, the panel determined that there is a risk of repetition and a consequent risk of harm to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel was of the view that a fully informed member of the public would be concerned to hear that a registered midwife, through lack of competence over a significant period of time, caused harm to multiple patients and placed multiple patients at a risk of harm despite receiving additional support. The panel therefore determined that a finding of impairment on public interest grounds is also required.

Having regard to all of the above, the panel determined that Miss Shereni's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with a review prior to expiry. The effect of this order is that the NMC register will show that Miss Shereni's 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

Ms Danti submitted that the NMC seeks a 12-month suspension order with review. She submitted that the panel may consider the following aggravating features which included Miss Shereni's lack of insight, Miss Shereni's lack of regret and a lack of evidence of any strengthening of her practice. Ms Danti submitted that Miss Shereni's failings in this case constituted a pattern of repeated incidents occurring on multiple occasions over a prolonged period of time and that there were multiple periods where significant support was put in place by the Trust. She submitted that, despite this, there was no improvement in Miss Shereni's practice. Ms Danti submitted that Miss Shereni has not engaged with these proceedings and that there is no evidence of mitigation in this case.

Ms Danti submitted that Miss Shereni has failed to demonstrate her competence in a wide range of areas of practice over a sustained period. She submitted that Miss Shereni presents a continuing risk to patients and the public interest. Ms Danti submitted that taking no action in this case would not be appropriate.

Ms Danti submitted that a caution order would be the least restrictive sanction, but considering Miss Shereni's lack of competence, the ongoing risk to the public and also public interest, a caution order would not be appropriate. She submitted that there is no evidence of Miss Shereni's insight, remorse or improvement in her practice. Ms Danti submitted a conditions of practice order would also not be appropriate as it would not address the widespread concerns identified. She submitted that Miss Shereni has not been able to practise autonomously or safely, for a long period of time, despite multiple instances of support from the Trust. Therefore, Ms Danti submitted that a suspension order of 12 months with a review is the appropriate sanction in this case.

Ms Danti submitted that a suspension order would protect patients and members of the public from harm and maintain confidence in the nursing profession and the NMC as a regulator. She submitted that a suspension order of 12 months with a review would provide time for Miss Shereni to develop her insight and to consider how to address the issues in her practice.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Miss Shereni's lack of insight or remorse into her failings;
- A pattern of repeated incidents and wide-ranging failures over a period of time;
- A risk of harm, and actual harm caused, to mothers and their newborn babies; and
- A lack of engagement with the NMC.

The panel was not able to identify any mitigating features in this case.

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

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

The panel next considered whether placing conditions of practice on Miss Shereni's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel determined that there are no practicable or workable conditions that could be formulated that would protect patients, given the widespread failings in this case. The panel noted that Miss Shereni has not engaged with the NMC proceedings, nor does it have any evidence before it to suggest that she will comply with a conditions of practice order if imposed. The panel further noted that it does not have any information before it about whether Miss Shereni is retired, or if she is working, or whether she has any intentions of working as a midwife in the future. The found that, despite her being supported by the Trust, Miss Shereni's competence had not improved to an acceptable standard.

The panel further considered that it had not seen any evidence before it to demonstrate that Miss Shereni is capable of safe and effective practice, and that patients would be in direct or indirect risk of harm even were it to impose conditions of practice. It noted that despite several periods of informal and formal periods of support from the Trust, Miss Shereni had not demonstrated sustained improvement in her competence.

Furthermore, the panel concluded that placing conditions of practice on Miss Shereni's registration would not adequately address the seriousness of this case and would not address the public interest issues identified.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel determined that there were multiple instances of failures over a long period of time and, as Miss Shereni has not engaged with the NMC, it had not been provided with any evidence of her insight, remorse or strengthening of her practice. The panel therefore considered the SG which states that suspension order may be appropriate where some of the following factors are apparent:

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case there would be a risk to patient safety even if Miss Shereni were allowed to practise with conditions. The panel noted that a striking-off order was not an available sanction for it to consider today.

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 may cause Miss Shereni. However, this is outweighed by the need to protect the public and the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the wide-ranging nature of Miss Shereni's lack of competence.

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

Any future panel reviewing this case would be assisted by:

- Miss Shereni's engagement with the NMC;
- A statement from Miss Shereni which outlines her intentions for the future;
- Evidence of reflection to demonstrate Miss Shereni's insight and re-training.

Interim order

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

Submissions on interim order

The panel considered the submissions made by Ms Danti that an interim suspension order should be made to cover the appeal period. She submitted that an interim order is necessary to protect the public and in the public interest. She invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public and in the public interest. The panel had regard to the seriousness of the lack of competence and the reasons set out in its decision for the substantive order in reaching

the decision to impose an interim order. It concluded that not to impose an interim suspension order would be inconsistent with its earlier findings.
Therefore, the panel made an interim suspension order for a period of 18 months to cover the appeal period.

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

This will be confirmed to Miss Shereni in writing.

That concludes this determination.