Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 4 September 2024 – Friday, 6 September 2024
Thursday, 12 September 2024 – Friday, 13 September 2024
Monday, 16 September 2024 – Friday, 20 September 2024
Tuesday, 24 September 2024 – Friday, 27 September 2024
Tuesday, 29 October 2024 – Thursday, 31 October 2024
Monday, 04 November 2024 – Tuesday, 5 November 2024
Wednesday, 06 November 2024

Virtual Hearing

Name of Registrant:	**Lisa Kay Land**
NMC PIN	08C0733E
Part(s) of the register:	RM: Midwife (17 September 2008)
Relevant Location:	Cheltenham
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Carol Porteous (Registrant member) Sabrina Sheikh (Lay member)
Legal Assessor:	Jayne Wheat (4 September 2024) Alain Gogarty (5 – 6 September 2024) Nigel Ingram (12,13, 16 – 20, 26 – 27 September 2024) Graeme Henderson (29-31 October 2024, 4-6 November 2024)
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter (4, 5, 6, 12, 13, 16-20, 26-27 September 2024) Represented by Rowena Wisniewska, Case Presenter (31 October 2024)

	Represented by Mohsin Malik, Case Presenter (4-6 November 2024)
Mrs Land:	Not present and not represented
Facts proved:	Charges 1b, 2, 3, 4, 5, 6, 7a, 7b, 8, 9, 10a, 10b, 11, 12, 13, 14a, 14b, 15a and 15b
Facts not proved:	Charges 1a
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Land was not in attendance and that the Notice of Hearing letter had been sent to Mrs Land's registered email address by secure email on 1 August 2024.

Mr Bardill, 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 allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Land'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 Mrs Land has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Land

The panel next considered whether it should proceed in the absence of Mrs Land. It had regard to Rule 21 and heard the submissions of Mr Bardill. He drew the panel's attention to an email sent by Mrs Land to the NMC dated 3 September 2024. Within this email she confirmed that she had withdrawn her interest from this case [PRIVATE].

Mr Bardill submitted that Mrs Land did not provide explicit permission for the panel to proceed in her absence. He submitted that the fact that Mrs Land stated that she had

withdrawn her interest in the case strongly suggested that if these proceedings were to be adjourned, she would not attend at a later date. He submitted that Mrs Land had voluntarily absented herself from these proceedings reminded the panel of the public interest of the expeditious disposal of this case.

Mr Bardill invited the panel to continue in the absence of Mrs Land.

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 Mrs Land. In reaching this decision, the panel has considered the submissions of Mr Bardill, the representations from Mrs Land, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Land had informed the NMC, in an email dated 3 September 2024, that she had received the Notice of Hearing and confirmed she had withdrawn her interest in the case;
- No application for an adjournment has been made by Mrs Land;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness had attended today to give live evidence, others are due to attend;

- 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 in 2019 and 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 Mrs Land in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Land at her registered address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Land'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 Mrs Land. The panel will draw no adverse inference from Mrs Land's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Bardill, on behalf of the NMC, to amend the wording of charge 1.

The proposed amendment was to change the date in the charge. It was submitted by Mr Bardill that the error was a typographical and proposed amendment would provide clarity and more accurately reflect the evidence.

Proposed Amendment

1. On 25 ~~July~~ **June** 2019 having concluded that Baby A was in a poor condition shortly after birth, in that you

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

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

Decision and reasons on application to amend the charge

The panel on its own volition invited submissions from Mr Bardill on its proposal to amend the wording of charge 1a.

The proposed amendment was to add the letter 'A' after the word 'Baby'. The panel was of the view that the error was typographical, and the proposed amendment would provide clarity and more accurately reflect the evidence.

Mr Bardill accepted the panel's proposal and had no objection to the amendment being made.

Proposed Amendment

1. On 25 June 2019 having concluded that Baby A was in a poor condition shortly after birth, in that you

a. failed to recognise that Baby **A** was suffering from respiratory distress.

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

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

Decision and reasons on application to amend the charge

During its deliberation on the facts, but prior to handing down on the facts, the panel had regard to charge 14a.

Charge 14(a) had to be read in conjunction with 13:

13. *On 14 July 2020 at Trust interview said 'I wrote blood-stained liquor++. This is not an accurate recollection of events, and I don't know why I wrote that' or words to that effect.*

14. *Your actions at charge 13 were dishonest in that*

    (a) you knew this information was correct and/or

The panel considered that Charge 14a contained an obvious typographical error. The panel determined that in order to bring a charge of dishonesty it would require to make findings that the information supplied at the interview, on 14 July 2020 was not correct. This drafting error probably occurred because the NMC were offering to prove that the

contemporaneous records were correct but what was said on 14 July 2020 was not correct.

The panel heard and accepted the advice of the Legal Assessor who referred to Rule 28 of the Rules.

- The panel could amend ‘at any stage before making its findings in fact’
- Since findings in fact had yet to be finalised and handed down it was still open for the panel to amend
- Before making any amendment the panel required to hear parties (in this case the NMC) on this issue
- The panel had the power to amend ‘unless having regard to the merits of the case and the fairness of the proceedings it could not be done without injustice

Proposed amendment

14. Your actions at charge 13 were dishonest in that

*(b) you knew this information was **in**correct and/or*

In light of this the panel reconvened and invited the case presenter to advise on the NMC’s position.

Ms Wisniewska, on behalf of the NMC, did not object to the proposed amendment.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there was a typographical error and there would be no prejudice to Mrs Land and no injustice would be caused to either party by the proposed

amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered midwife:

In relation to Baby A

1. On 25 June 2019 having concluded that Baby A was in a poor condition shortly after birth, in that you
   a. failed to recognise that Baby A was suffering from respiratory distress.
   b. failed to escalate, Baby A's condition immediately to Colleague A and/or the neonatal team.

2. Between 18.17 and 18.46 hours did not directly raise the issue of Baby A's condition to Colleague A and/or the neonatal team.

3. Between 18.46 and 19.04 did not call an ambulance for Baby A and/or failed to contact the neonatal team to arrange for Baby A's immediate transfer to hospital.

4. On 25 June 2019 failed to record contemporaneous notes in Baby A's records.

5. On an unknown date between 25 and 28 June 2019 retrospectively changed Baby A's birth details, to give the impression that the notes you had originally made in respect of Baby A's condition at birth had not been correct.

6. On or around 28 June 2019 made retrospective entries in Patient A's records, to give the impression that Baby A's original records as made by you, had not been correct.

7. And your actions at charges 4, and/or 5 and/or 6 were dishonest in that you:
    a. knew the retrospective entries were not true
    b. you intended to mislead anyone reading Baby A's birth details and/or Patient A's records as to the condition of Baby A shortly after birth.

8. Your actions at charges 1 to 3 above caused and/or contributed Baby A to lose a significant chance of survival.

    In relation to Patient B

9. Prior to 14 May 2020 as the named midwife, you should have been aware that Patient B was not suitable for midwifery- led care.

10. On 14 May 2020 did not escalate Patient B's condition and/or transfer Patient B to hospital, in light of
    a. the presence of blood-stained liquor++
    b. a low maternal temperature

11. Your actions at charges 9 and 10 above caused and/or contributed Baby B to lose a significant chance of survival.

12. On 14 May 2020 on one or more occasions recorded in Patient B's records there was blood-stained liquor

13. On 14 July 2020 at Trust interview said 'I wrote blood-stained liquor++. This is not an accurate recollection of events, and I don't know why I wrote that' or words to that effect.

14. Your actions at charge 13 were dishonest in that

    a. you knew this information was incorrect and/or

b. you intended to create misleading impression that there was no blood-stained liquor, when you knew there had been there.

15. On or before 26 March 2021, sent WhatsApp messages to Patient B
    a. without clinical justification and/or
    b. in breach of professional boundaries

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

Background

The NMC received an anonymous referral about midwives Mrs Land and Colleague A for allegedly being involved in the death of two babies, Baby A and Baby B, following intra partum care provided in a Stand-Alone Midwifery Led Unit in Cheltenham which is part of the Gloucestershire Hospitals Trust (the Trust). After an internal investigation, the NMC received a referral from the Trust which raised cultural concerns.

Baby A was born on 25 June 2019 at 18:17 and initially showed signs of respiratory distress and poor tone. It is the NMC's case that this is a clear indicator of neonatal distress. The mother of Baby A was considered a high-risk case, yet she remained at the Cheltenham Birth Unit, which lacked the necessary facilities to handle such complications. There was no immediate escalation or transfer to the obstetric led unit and Baby A's condition continued to deteriorate whilst under the care of Mrs Land and Colleague A. A transfer to the hospital for specialist neonatal care did not occur until 19:35.

Baby A tragically died at 05:25 the next morning. The death certificate recorded Baby A's death as a result of severe Hypoxic ischemic, severe metabolic acidosis and massive feto maternal haemorrhage.

It is the NMC's case that the mother of Baby A, Patient A, had multiple risk factors that warranted a transfer to an obstetric-led unit. Despite this, Mrs Land allowed the mother to remain at the Cheltenham Birth Unit.

It is the NMC's case that Mrs Land made retrospective changes to the records, altering Baby A's condition at birth from "poor" to "good" in her notes. This is a significant breach of the NMC Code's requirement to maintain accurate and contemporaneous records.

Baby B was born on 14 May 2020 at 13:31. During labour, Baby B's mother, Patient B was shown to have blood stained liquor that was observed at about 03:50. It is also recorded that Patient B's temperature fell below normal levels on three occasions. It is the NMC's case that this required intervention.

It is alleged that Mrs Land failed to transfer Patient B, even though her presenting symptoms before Baby B was born merited this transfer.

It is the NMC's case that Mrs Land failed to transfer Patient B despite two separate recordings of blood stained liquor and three recording of low maternal temperature, despite no action being taken to actually escalate the care. It is alleged that that both Mrs Land and Colleague A failed to follow the correct procedures for both risk assessment and escalation.

The Healthcare Safety Investigation Branch (HSIB) reports for both incidents emphasise that both mothers should have been transferred to an obstetric-led unit. The HSIB identified that Mrs Land and Colleague A failed to follow the correct procedures for risk assessment and escalation.

Decision and reasons on facts

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

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

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

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

- Colleague D: Community Midwife at the Trust;
- Witness 1: At the relevant time, the Divisional Director of Quality and Nursing for the Women and Children's Division and Chief Midwife at the Trust;
- Witness 2: Deputy Director of Quality and Programme Director Nursing and Midwifery Excellence and Registered Midwife;
- Witness 3: At the relevant time, Maternity Investigator employed by the Healthcare Safety Investigation Branch (HSIB);
- Colleague C: At the relevant time, Registered Midwife;
- Patient B: Mother of Baby B;
- Person B: Father of Baby B;

- Witness 4: A midwifery medico legal expert witness;

- Witness 5: Registered Midwife at the Trust.

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. Whilst sitting in camera the panel was invited to assess the evidence of the expert evidence in light of the *Supreme Court case of Kennedy v Cordia Services [2016] UKSC 6*.

The panel was reminded that experts can and often do give evidence of fact as well as opinion evidence. An expert witness, like any non-expert witness, can give evidence of what he or she has observed if it is relevant to the issues to be decided. In this case her evidence contained a detailed analysis of evidential material and provided evidence of what she considered the factual position to be. It was open for the panel to consider whether or not the factual basis was based on the evidence before it and whether there was any evidence that would contradict her assumptions.

Unlike other witnesses, an expert witness may also give evidence based on his or her knowledge and experience of a subject matter, drawing on the work of others, such as the findings of published research or the pooled knowledge of a team of people with whom he or she works.

When providing an opinion the expert witness should state the facts or assumption upon which his or her opinion is based. They should not omit to consider material facts which could detract from their concluded opinion.

When providing an opinion on what a competent midwife was expected to do the panel had to be satisfied that the factual basis for the situation the midwife was said to have

found herself in was set up on an evidential basis. It was also relevant to consider the evidence of other members of the midwifery profession and their views on what the duties of a midwife were in such a situation.

The decision of what the factual situation was, whether Mrs Land was under a duty and whether she failed in her duty, was a matter for the panel.

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

Charge 1a

That you, a registered midwife:

In relation to Baby A

1. On 25 June 2019 having concluded that Baby A was in a poor condition shortly after birth, in that you
   a. failed to recognise that Baby A was suffering from respiratory distress.

This sub charge is found not proved.

In order to find this sub-charge proved, the panel had to be satisfied that on 25 June 2019, Mrs Land concluded that Baby A was in poor condition shortly after birth.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her, a registered midwife with 14 years clinical experience within both hospital and community settings and a midwifery medico legal expert witness. Within her report, under the heading "Synopsis" she stated:

> *"Around 6 minutes after birth (times adjusted in the notes from 18:20 hours to 18:23 hours), Baby A was noted to be exhibiting signs of 'struggling', including having a*

pale colour, increased respiratory effort, and poor tone, prompting his removal to the resuscitaire for assessment by Midwife Land."

The panel took account of Patient A's and Baby A's records written by Mrs Land. At 18:17 Mrs Land had written, *"Normal Birth…Patient A on all fours position cord unravelled"*. Later on at 18:23, changed from 18:20, Mrs Land had written, "*Baby on resus for assessment as appears to be struggling + pale".*

The panel also took account of the "Details of Birth" form for Baby A, which had been signed by Mrs Land. The panel bore in mind that this form would have been completed after the birth of Baby A. Under the heading "Notes on resuscitation and state of baby" Mrs Land had stated *"Baby born in poor condition initially followed by Mec stained liquor ++ No drugs during labour. Floppy = slight response to tactile situation becoming worse by 1 min…"* The panel noted that "poor" appeared to have been changed to "good". It further noted that Mrs Land had recorded the apgar score as 5 at 1 minute and 6 at 5 minutes. This was also an indication that Baby A was in poor condition shortly after birth.

The panel bore in mind that Witness 2 in her oral evidence stated that the contemporaneous records written shortly after the event are likely to be the most accurate.

In light of the evidence above, the panel accepted that on 25 July 2019, Mrs Land had concluded that Baby A was in a poor condition shortly after birth.

The panel then moved on to consider whether Mrs Land, having already concluded that Baby A was in a poor condition shortly after birth, had failed to recognise that Baby A was suffering from respiratory distress. In order to find this proved, the panel had to be satisfied first that Mrs Land had a duty to recognise that Baby A was suffering from respiratory distress.

The panel was satisfied that Mrs Land, as the midwife in charge who was present during the birth of Baby A had a duty recognise that Baby A was suffering from respiratory

distress. In light of this, the panel then went on to consider whether Mrs Land had failed in her duty to do so.

The panel took account of the Expert Witness Report. Within this report, Witness 4 under the heading “Chronology of events” had stated that at 18:20, which she acknowledged was changed retrospectively to 18:23, *“Midwives concerned as Baby A appeared pale in colour with increased work of breathing”*

The panel noted that the Expert Witness Report indicated that Mrs Land had recognised that Baby A had issues with breathing.

The panel took account of the contemporaneous “Details of Birth” form for Baby A, which had been signed by Mrs Land. It noted that under the heading “Notes on resuscitation and state of baby” Mrs Land had further stated *“…Floppy + slight response to tactile situation becoming worse by 1 min. Tactile stimulation + inflation beaths given following 5 good chest rises…”*

The panel was of the view that from the notes from the “Details of Birth” form, Mrs Land providing “inflation breaths” to a newborn child within a short period of time from birth indicated a recognition of issues with breathing.

The panel also took account of an email, dated 14 October 2019, sent by the Risk Manager for Obstetrics and Gynaecology of the Trust to Witness 1 and Mrs Land. This email was a summary of a meeting that had occurred between them on 12 July 2019. The email appeared to clarify the notes made on the “Details of Birth” form. It stated:

> *“The birth notes written by Lisa were discussed…She said that she should not have written them, as [Colleague A] was caring for the baby during this time and that she did not make an assessment of the baby until he was 6 minutes old. At this point she said that the baby was showing signs of [Respiratory distress syndrome] so she started some resuscitative measures.”*

The panel was of the view it was clear that Mrs Land was aware that shortly after birth, Baby A was suffering from respiratory distress.

The panel therefore found this sub charge not proved.

Charge 1b

That you, a registered midwife:

In relation to Baby A

1. On 25 July 2019 having concluded that Baby A was in a poor condition shortly after birth, in that you
   b. failed to escalate, Baby A's condition immediately to Colleague A and/or the neonatal team.

This sub charge is found proved (for Colleague A not neonatal team).

The panel had already established in charge 1a that Mrs Land had concluded that Baby A was in a poor condition shortly after birth. It now had to determine whether she had a duty to escalate Baby A's condition immediately to Colleague A and/or the neonatal team.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Under the heading "Summary of Conclusions" she stated "in respect of the care provided by Midwife Land",

> *"A competent Band 6 midwife working in a standalone birthing unit is expected to swiftly recognise and interpret critical conditions in newborns, promptly escalate concerns to senior staff and arrange timely transfer to an appropriate setting for neonatal care."*

Witness 1 provided the panel with a copy of Trust Guideline Immediate Care of The Newborn A1093 issued in February 2019. It stated that in section 6.1 that you should, *"Call for help early if you feel you need it".*

The panel was satisfied that having concluded that Baby A was in a poor condition shortly after birth, Baby A's condition should have been escalated to Colleague A and/or the neonatal team. In light of this, the panel then went on to consider whether Mrs Land had failed in her duty to do so.

The panel took account of the Expert Witness Report provided by Witness 4. Within her report, Witness 4 provided a chronology of events and stated that at 18:17, *"Baby born (documented as 'poor' condition and corrected to 'good' condition retrospectively), cord around neck and shoulders, unwound at birth"*. Then at 18:20, changed to 18:23 retrospectively, *"Baby A assessed on resuscitaire, floppy tone – stimulated and given inflation breaths with mask and T-piece."* Then at 18:27, *"5 x inflation breaths given…"* and at 18:28, *"30 seconds of ventilation breaths given."*

The panel bore in mind that it had been established that Baby A was born in poor condition and Mrs Land would have been aware of this as it was documented within Patient A and Baby A's clinical records. It was of the view that Colleague A was also present in the room when Baby A was born and therefore would have been aware of the current status of Baby A and the treatment, namely the resuscitative measures, that was provided within her vicinity. Therefore, there would be no need for Mrs Land to escalate Baby A's condition to Colleague A.

However, the panel was of the view that Baby A's condition should have been escalated to the neonatal team. The panel had no evidence before it that Mrs Land escalated Baby A's condition to the neonatal team shortly after Baby A was born. This appears from medical records to have been done sometime after 19:00, 37 minutes after Baby A was born.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF) and had indicated in her local interview that whilst she had concerns, she was reassured by her senior colleague and therefore had not referred to the neonatal team.

The panel accepted the evidence of Witness 4 and was satisfied that the evidence provided by Witness 1 corroborated Witness 4's evidence. Both of these witnesses were of the opinion that in these circumstances Mrs Land was under an obligation to escalate her professional concerns, notwithstanding the fact that a senior colleague was in the room.

The panel therefore found this sub charge proved only in respect of Mrs Land's failure to escalate Baby A's condition to the neonatal team.

Charge 2

That you, a registered midwife:

In relation to Baby A

2. Between 18.17 and 18.46 hours did not directly raise the issue of Baby A's condition to Colleague A and/or the neonatal team.

This sub charge is found proved.

The panel had already established that Colleague A was in the room with Mrs Land when Baby A was born, so there would not have been a need to raise the issue of Baby A's condition. Colleague A should have already been aware.

The panel moved on to consider whether Mrs Land, between 18.17 and 18.46 hours, raised the issue of Baby A's condition to the neonatal team.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, Witness 4 provided a chronology of events. It had already taken account of the events documented between 18:17 and 18:28 in charge 1b, namely that Baby A was born in poor condition and the subsequent resuscitative measures that had taken place. Between 18:30 and 18:45, there was no record of Mrs Land raising the issue of Baby A's condition to the neonatal team. At 18:45 Witness 4's report records, *"Baby A showing signs of respiratory distress…Discussion between midwives and decision made that Baby A needed transfer to the hospital for a neonatal review (28 minutes since birth)"* However the call to the ambulance was not made until 19:04.

The panel took account of the contemporaneous notes made by Mrs Land in respect of the care provided to Patient A and Baby A. The panel could not find any record of Mrs Land raising the issue of Baby A's condition to the neonatal team or instructing somebody else to.

The panel also took account of the oral and written evidence of Witness 2 and in particular the "Management Investigation for Gloucestershire Hospitals NHS Foundation Trust" she produced. Within this report Mrs Land was interviewed and the summary of this stated the following:

> *"[Mrs Land] stated that she asked [Colleague A] to review the baby and she was not given a signal by [Colleague A] that the baby needed to be transferred.*
>
> *[Mrs Land] thought that the baby needed to be transferred but felt reassured by [Colleague A]'s actions of weighing the baby*
> *…*
> *[Mrs Land] stated that the baby was noted to have RDS [respiratory distress syndrome] and then the decision was made to transfer the baby at approx.18:45."*

It was clear to the panel that Mrs Land, between 18:17 and 18:46 did not directly raise the issues of Baby A's condition to the neonatal team.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4 and was satisfied that the evidence provided by Witness 2 corroborated Witness 4's evidence. Both of these witnesses were of the opinion that in these circumstances Mrs Land was under an obligation to escalate her professional concerns, notwithstanding the fact that a senior colleague was in the room.

The panel was therefore satisfied that between 18:17 and 18:46 Mrs Land did not directly raise the issue of Baby A's condition to the neonatal team.

The panel therefore found this sub charge proved.

Charge 3

That you, a registered midwife:

In relation to Baby A

3. Between 18.46 and 19.04 did not call an ambulance for Baby A and/or failed to contact the neonatal team to arrange for Baby A's immediate transfer to hospital.

This charge is found proved.

The panel had already established in sub-charge 1b that Mrs Land had a duty to escalate Baby A's condition to the neonatal team. It was of the view that as the midwife in charge of Baby A, this extended to contacting the neonatal team to arrange for Baby A's immediate

transfer to hospital. It moved onto consider whether Mrs Land failed in her duty to do so and/or if she called an ambulance for Baby A between 18:46 and 19:04.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, Witness 4 provided a chronology of events. At 18:45 Witness 4's report records, *"Baby A showing signs of respiratory distress…Discussion between midwives and decision made that Baby A needed transfer to the hospital for a neonatal review (28 minutes since birth)"* However, according to Witness 4's chronology the call to the ambulance was not made until 19:04.

There is no record as to why at 18:45, after the decision had been made that Baby A needed to be transferred, this was not actioned.

The panel took account of the paramedic records which indicated that on 25 June 2019, at 19:04 there was a called made from the Trust in relation to Baby A.

The panel took account of the contemporaneous notes made by Mrs Land in respect of the care provided to Patient A and Baby A. The panel could not find any record of Mrs Land, between 18:46 and 19:04 calling an ambulance for Baby A and/or contacting the neonatal team to arrange for Baby A's immediate transfer to hospital.

The panel bore in mind that Mrs Land denied the charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4. Witness 4 was of the opinion that in these circumstances Mrs Land was under an obligation to escalate her professional concerns, notwithstanding the fact that a senior colleague was in the room.

The panel was therefore satisfied that between 18.46 and 19.04 Mrs Land did not call an ambulance for Baby A and/or failed to contact the neonatal team to arrange for Baby A's immediate transfer to hospital.

The panel therefore found this charge proved.

Charge 4

That you, a registered midwife:

In relation to Baby A

4. On 25 June 2019 failed to record contemporaneous notes in Baby A's records.

This sub charge is found proved.

In order to find this proved, the panel had to be satisfied first that Mrs Land had a duty to record contemporaneous notes in Baby A's records.

Witness 4, in her oral evidence stated that upon delivery of a baby the midwife would be writing notes in respect of all aspects of care up to and including the time the baby is transferred from care. The panel noted that this was supported by all the other midwifes who were witnesses at this hearing.

The panel was therefore satisfied that Mrs Land, as the midwife in charge who was present during the birth of Baby A had a duty to record contemporaneous notes in Baby A's records. In light of this, the panel then went on to consider whether Mrs Land had failed in her duty to do so.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, Witness 4 and in response to the question *"What risks did Midwife Land assess for ?"* she answered, *"Due to very limited contemporaneous documentation, there is no evidence to suggest that other factors…were considered."* Later on within the report, Witness 4 stated, *"In my opinion, a*

competent Band 6 midwife should be capable of:… Accurately and contemporaneously measure and document neonatal observations and clinical notes to demonstrate they have recognised the risks and what actions are being taken."

Witness 4, in her oral evidence stated that if a midwife was occupied and unable to physically write down notes, the midwife could call for what she called a "third person scribe". She stated that a midwife would call for a third person to take over the note writing particularly in neonatal resuscitation.

The panel noted it had limited contemporaneous documentation pertaining to the care provided to Patient A and Baby A.

The panel also took account of the oral and written evidence of Witness 2 and in particular the "Management Investigation for Gloucestershire Hospitals NHS Foundation Trust" she produced. Under the heading "2.0 Record keeping standards – Details of Birth Record", there is a sub-heading entitled "Analysis" it is stated:

> *From [Colleague A]'s records [Mrs Land] entered the room at 18:15 as second midwife. [Mrs Land] completed the "Details of Birth" form and this was [Mrs Land]'s contemporaneous record of events. [Mrs Land] confirmed that this was completed at the time/ as soon as possible after the event.*

The panel noted that the "Details of Birth" form appeared to be the only contemporaneous notes for Baby A. It took account of the fact that Mrs Land had annotated on the form, *"See retrospective report re[garding] incorrect completion of this form".*

The panel noted that all the other records appeared to have been written retrospectively. It noted that within the clinical records for Patient A an entry, dated 28 June 2019, stated *"Retrospective entry of Baby A due to Rushed documentation for neonatal transfer for respiratory distress, timing errors made"* The panel bore in mind that it had noted that Mrs Land had retrospectively changed the times from 18:20 to 18:23 in Baby A's records.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel determined, from the evidence presented, that as the midwife in charge of the care of Baby A, Mrs Land had responsibility to record contemporaneous notes within the records or ensure a scribe was present to do so.

The panel was therefore satisfied that on 25 June 2019, Mrs Land failed to record contemporaneous notes in Baby A's records.

The panel therefore found this charge proved.

Charge 5

That you, a registered midwife:

In relation to Baby A

5. On an unknown date between 25 and 28 June 2019 retrospectively changed Baby A's birth details, to give the impression that the notes you had originally made in respect of Baby A's condition at birth had not been correct.

This sub charge is found proved.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, Witness 4 provided a chronology of events. Witness 4 had documented that at 18:17, *"Baby born (documented as 'poor' condition and corrected to 'good' condition retrospectively), cord around neck and shoulders, unwound at birth."*

The following evidence was before the panel and supported Witness 4's opinion.

The panel took account of the "Details of Birth" form. It noted that under the heading "Notes on resuscitation and state of baby", Mrs Land had documented that Baby A was born in "poor" condition, but it had seemingly been changed to "good". It also noted that Mrs Land had annotated the following on the form, "*See retrospective report re[garding] incorrect completion of this form".*

The panel also noted that on the same "Details of Birth" form Mrs Land had recorded the Apgar scores as 5 at 1 minute and 6 at 5 minutes. However, Witness 4 in her Expert Witness Report stated that Mrs Land recorded this differently in retrospective notes three days after birth as 7 at 1 minute and 7 at 5 minutes.

The panel also took account of the oral and written evidence of Witness 2 and in particular the "Management Investigation for Gloucestershire Hospitals NHS Foundation Trust" she produced. Within this report there is a picture of the entry made by Mrs Land on the "Details of Birth" form and Witness 2 has documented the following in response:

> *"[Mrs Land]'s wrote a retrospective entry this was written 3 days after the event (28 June 2019). [Mrs Land] stated at interview that she wrote this entry at the request of her line manager [Colleague A]. [Mrs Land] stated at interview she wrote this whole entry without the Neonatal Records and just with the maternal records."*

The panel also took account of the Interview notes of Witness 2 and Mrs Land dated 11 December 2020. When Mrs Land was asked about the retrospective entry, Mrs Land stated that she did this *"3 days later"* and was asked by Colleague A to the to write a retrospective entry. Mrs Land stated that Colleague A had told her that the *"baby was not in poor condition as he was born in good condition"* so Mrs Land changed the record. Mrs Land stated that she *"over wrote "poor" with "good" on original document prior to transfer"*.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4 and was also satisfied that the evidence provided by Witness 2 corroborated Witness 4's evidence.

The panel determined that the changes made by Mrs Land gave the impression that Baby A was born in better condition than he actually was.

The panel was therefore satisfied that Mrs Land retrospectively changed Baby A's birth details, to give the impression that the notes she had originally made in respect of Baby A's condition at birth had not been correct.

The panel therefore found this charge proved.

Charge 6

That you, a registered midwife:

In relation to Baby A

6. On or around 28 June 2019 made retrospective entries in Patient A's records, to give the impression that Baby A's original records as made by you, had not been correct.

This charge is found proved.

The panel took account of the Clinical record for Patient A. In an entry dated 28 June 2019 it was stated, *"Retrospective entry of Baby A due to Rushed documentation for neonatal transfer for respiratory distress, timing errors made"* The panel noted that Mrs Land had signed this entry. The panel further noted that there are five pages of retrospective entries

from Mrs Land with multiple time stamps to chronicle the birth of Baby A and the care that was provided.

The panel noted that Mrs Land, on 25 June 2019, had originally documented at 18:20, changed to 18:23, "*Baby on resus for assessment as appears to be struggling + pale".* However, on her retrospective notes on 28 June 2019 she had written, *"I completed an initial assessment of Baby A on the resucitaire at request of [Colleague A] – Baby pink, H/R good regular @ 130bpm, baby respirations regular but grunting…"*
The panel also noted that at 18:50 of the retrospective records, Mrs Land had recorded, *"Baby back to Patient A for skin to skin as stable…"* however, the panel noted that Mrs Land had recorded this occurring much earlier in the contemporaneous notes.

Additionally, on the retrospective notes, Mrs Land at 18:23 stated, *"…Apgar @ 5 given by [Colleague A] 7."* However, the panel noted that Mrs Land had recorded Baby A's apgar as a 6 at 5 minutes. It appeared to the panel that Mrs Land was now stating that Colleague A had recorded the apgar score.

Within the retrospective notes, it appeared that Mrs Land documented mistakes she stated she made during the contemporaneous notes on 25 June 2019. In the panel's view this gave the impression that the original records were incorrect, and the retrospective records gave a clear indication of what was correct in respect of timings, the care provided, the condition of Baby A and the actions carried out by Mrs Land and her colleagues.

The panel therefore found this charge proved.

Charge 7a

That you, a registered midwife:

In relation to Baby A

7. And your actions at charges 4, and/or 5 and/or 6 were dishonest in that you:
    a. knew the retrospective entries were not true

This sub charge is found proved.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67.* It had to now ascertain (subjectively) what Mrs Land's actual state of knowledge or belief was to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary decent people.

The panel bore in mind that it had already found charges 4, 5 and 6 proved.

In assessing Mrs Land's state of mind at the time it considered that Mrs Land, in an interview with Witness 2, stated that she was told to make these changes at the request of Colleague A who had told her that the baby was not born in poor condition as he was born in good condition. Mrs Land also stated Colleague A had recorded the apgar scores.

However, the panel was of the view that just because Colleague A had told Mrs Land that she made an error regarding the condition of Baby A, did not necessarily mean that it was true.

The panel also noted that Mrs Land stated, in her retrospective notes, that these entries were due to "rushed documentation for respiratory distress" and "timing errors made".

However, the panel noted that the notes appeared to reflect significant moments that had not been documented in her original chronology of care provided or the contemporaneous notes in the "Details of Birth" form. The panel was of the view that it was highly unlikely that Mrs Land would be able to provide the level of detail in retrospective notes, made three days after, unless she made contemporaneous notes at the time. However, the panel had already found that she did not do this.

The panel was of the view that Mrs Land ought to have known that her retrospective entries were not true. It considered that the contemporaneous notes she made at the time outlined what occurred at the material time. However, her retrospective entries made on 25 June 2019 and 28 June 2019 did not contain information that was supported with any evidence at the concerning time.

The panel concluded that on the balance of probabilities Mrs Land's actions in relation to charges 4, 5 and 6 based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67,* were dishonest because she knew the retrospective entries were not true.

The panel therefore found this sub charge proved.

Charge 7b

That you, a registered midwife:

In relation to Baby A

7. And your actions at charges 4, and/or 5 and/or 6 were dishonest in that you:
    b. you intended to mislead anyone reading Baby A's birth details and/or Patient A's records as to the condition of Baby A shortly after birth.

This sub charge is found proved.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* established in charge 7a.

The panel reminded itself that the retrospective changes Mrs Land had made with regards to charge 5 namely changing Baby A's condition from "Poor" to "Good" and the apgar scores from 5 at 1 minute and 6 at 5 minutes to 7 at 1 minute and 7 at 5 minutes.

The panel also bore in mind that, with regards to charge 6, it appeared that Mrs Land, three days after Baby A had died, appeared to reflect significant moments that had not been documented in her original chronology of care provided or the contemporaneous notes in the "Details of Birth" form.

The panel noted that these changes gave the impression that Baby A was in a better condition after birth than what he was at the material time. It was of the view that ordinary decent people, would consider that changing contemporaneous notes demonstrating that a baby was in poor condition to show that same baby in good condition was done, in the circumstances outlined, with an intention to mislead.

The panel concluded that on the balance of probabilities Mrs Land's actions in relation to charges 4, 5 and 6 based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67,* were dishonest in that she intended to mislead anyone reading Baby A's birth details and/or Patient A's records as to the condition of Baby A shortly after birth.

The panel therefore found this sub charge proved.

Charge 8

That you, a registered midwife:

In relation to Baby A

8. Your actions at charges 1 to 3 above caused and/or contributed Baby A to lose a significant chance of survival.

This sub charge is found proved.

The panel reminded itself that it had only found charges 1b, 2 and 3 proved. Therefore, its consideration of this charge was only in respect of sub-charge 1b, charges 2 and 3.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, there is a section where she provides her opinion from the documentary evidence available. She came to the following conclusion:

> *"Between 18:23 and 18:44 hours, Midwife Land did not initiate Baby A's earlier transfer despite recognising concerns over his condition and beginning resuscitative measures. This failure to act promptly during a critical period underscores a significant lapse in recognising and responding to an unwell neonate. It falls well below the expected standards for a competent Band 6 midwife, on balance affecting Baby A's chances of survival."*

Witness 4 reiterated this in her oral evidence. She stated that the quicker you can get to a unit that had neonatal care facilities the quicker causes can be reversed. She stated that there was almost an hour and a half from recognition of there being a problem to Baby A actually getting to then neonatal unit that could have been significantly shortened to improve Baby A's chances of survival. She stated that she could not say for certain that Baby A would have survived but there was a chance that the causes could be reversed. She stated that this chance was missed.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4 and determined that her actions caused and/or contributed Baby A to lose a significant chance of survival.

The panel therefore found this charge proved.

Charge 9

That you, a registered midwife:

In relation to Patient B

9. Prior to 14 May 2020 as the named midwife, you should have been aware that Patient B was not suitable for midwifery- led care.

This charge is found proved.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, there is a section entitled "Summary of Conclusions" where she stated:

> *"Midwife Land, as an experienced Band 6 midwife, should have conducted a comprehensive risk assessment upon receiving Patient B into her care. This assessment is crucial to ensure the wellbeing of both mother and baby throughout the maternity journey…*
>
> *At 34+2 weeks, Patient B experienced a minor unprovoked antepartum haemorrhage (APH) and an episode of reduced fetal movements (RFM), requiring a reassessment of her risk status according to Trust and NICE guidelines. However, there was no documented recognition by Midwife Land of an increased risk profile during subsequent interactions, such as a birth preferences discussion, either later in the pregnancy or upon admission to the standalone birth unit."*

The panel bore in mind that within the Expert Witness Report, there is an entry which documents the “Triage assessment at the obstetric maternity unit” at “34+2” weeks . Under this heading reads the following: *“Presented with small vaginal bleed which started at 34+1 weeks ‘not enough to fill a small sanitary towel’ and reduced fetal movements (RFM)”*

Witness 4 in her Expert Witness Report continued, *“When booking Patient B for maternity care, no risks were identified by Midwife Land (as there were none) and Patient B was appropriately booked on a midwifery-led pathway of care (without needing obstetric oversight during pregnancy at that time).”*

The panel took account of Patient B’s clinical records and saw that there had been no risk assessment undertaken by Mrs Land. It noted that there were five subsequent follow up appointments at the Aveta Birth centre. Mrs Land had not undertaken a risk assessment at any of these follow up appointments.

The panel took account of the “Antenatal Risk Assessment” form completed by Mrs Land within Patient B’s clinical records. It noted that risk assessments were undertaken by Mrs Land on 14 October 2019 at booking and 17 April 2020 at 36 weeks. Mrs Land had ticked a box entitled “Healthy nulliparous pathway” on both occasions.

The panel particularly noted the following within the Expert Witness Report, “*At 34+2 weeks, Patient B experienced a minor unprovoked antepartum haemorrhage (APH) and an episode of reduced fetal movements (RFM). This meant she may not have continued to be suitable for the low-risk pathway (according to Trust and NICE guidelines) and an individualised risk assessment was required before planning for her to birth on the standalone unit and continue on the low-risk midwifery-led pathway.”*

The panel accepted the evidence from Witness 4 who stated that at 34+2 weeks, Patient B had *“experienced a minor unprovoked antepartum haemorrhage”* which warranted a risk assessment. It took account of the HSIB report which stated that Patient B should not

have been risk assessed as suitable for the birth centre as she had experienced an antepartum haemorrhage. It noted that had a risk assessment been undertaken, this would have determined whether Patient B was suitable for midwifery-led care. This was not done.

The panel noted that there was evidence before the panel to support the NMC's case, namely that Patient B was not suitable for midwifery-led care. The midwives who gave evidence at this hearing said that a risk assessment would have informed them as to whether Patient B was suitable.

The panel bore in mind that Witness 4 stated that a risk assessment was required to determine whether Patient B would have been suitable for midwifery-led care after experiencing an antepartum haemorrhage. As the named midwife Mrs Land had a responsibility to carry out a risk assessment for Patient B at every contact she had with her. When Mrs Land carried out subsequent risk assessments, after 34+2 weeks, being aware of Patient B experiencing an antepartum haemorrhage, she should have realised that she was unsuitable for midwifery-led care.

The panel therefore found this charge proved.

Charge 10a

That you, a registered midwife:

In relation to Patient B

10. On 14 May 2020 did not escalate Patient B's condition and/or transfer Patient B to hospital, in light of
    a. the presence of blood-stained liquor++

This sub charge is found proved.

Colleague C in her witness statement stated:

> *"I have had the opportunity since the incident to review the Mother's notes and noted that there was bloodstained fluids documented at around 3am and 6am whilst [Mrs Land] was caring for her.*
>
> *Lisa documented in the Mother's notes twice that she had bloodstained liquor (amniotic fluid). These were missed opportunities to transfer her to the high-risk unit at Gloucester Royal Hospital at 3am and 6am… It is standard procedure to transfer when waters are bloodstained and two missed opportunities to do this is life threatening."*

The panel took account of Patient B's clinical notes. It noted that on 14 May 2020, Mrs Land had made two entries where she recorded that there was "bloodstained liquor". At 03:50 she had recorded "Blood stained Liquor" and 06:10 she recorded "Blood stained Liquor +".

The panel also noted that the entry of 03:50 is supported on Patient B's partogram where Mrs Land had recorded "bloodstained" next to "Liquor".

Person B in his oral evidence recalled having witnessed blood staining. Once on the sheets and another running down the leg of Patient B. He stated he had to change the sheets twice and described the blood as a "nosebleed colour".

This is supported by the Management Investigation report for the Trust produced by Witness 2, dated 27 May 2021. Within this report there is an extract of an email sent by the Director of Midwifery to Witness 2 after she met with Patient B and Person B. It stated that during the conversation, *"Person B stated that he had removed pads from under Patient B and that they were bloodstained"*. It further stated that Person B saved them to

show Mrs Land and described the colour as “fresh red blood like when you have a nose bleed.”

The panel took account of the Interview notes with Mrs Land dated 14 July 2020. In this interview Mrs Land stated, *“Mum went to bathroom and gave her a sanitary pad. Inco pad on bed clear liquor seen, lots of mucoid bloody show with pink liquor. Contractions more regular. At that point I wrote blood stained liquor ++. This is not an accurate recollection of events and don’t know why I wrote this.”*

In light of the evidence above, the panel was satisfied that despite Mrs Land’s denial in her interview, there was the presence of blood-stained liquor. The panel then considered whether in light of the presence of blood stained liquor, Mrs Land had a duty to escalate Patient B’s condition and/or transfer Patient B to hospital.

The panel took account of the Expert Witness Report where Witness 4 noted the risks identified by Mrs Land. She stated:

> *“Although Midwife Land noted the presence of blood-stained liquor, there is no evidence that this was identified as a significant risk factor. The documentation indicates recognition of the symptom but no subsequent action or escalation, such as transfer to the obstetric unit or detailed handover to the incoming midwife, [Colleague A].”*

Additionally, within the Expert Witness Report it described occasions when it would be have been appropriate to escalate care to another health professional. It is stated:

> *“Upon observing a heavily blooded stained show and blood-stained liquor following SROM, which could signal uterine bleeding from placental abruption and lead to fetal distress”*

In her oral evidence, Witness 4 stated that at this stage transfer would have been recommended.

The panel also took account of the oral and written evidence of Witness 2 and in particular the Management Investigation for the Trust date 27 April 2021 she produced. Within this report the causes of blood stained liquor is described. It then stated, *"The HSIB investigation team learned from staff that usual practice is to escalate any blood-stained liquor to the obstetric team."*

The panel also noted that this was corroborated by all the midwives who provided evidence at this hearing. It is also reflected in the 2017 National Institute for Health and Care Excellence (NICE) guidelines.

The panel was satisfied that Mrs Land had a duty to escalate Patient B's condition and/or transfer Patient B to hospital, in light of the presence of blood-stained liquor. The panel turned to the stem of the charge to determine whether or not she failed in this duty.

There was no evidence before the panel to demonstrate that Mrs Land had escalated Patient B's condition and/or transfer Patient B to hospital in light of the presence of blood-stained liquor.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4, Colleague C, Person B and Witness 2. Given the presence of blood-stained liquor, Mrs Land did not escalate Patient B's condition and/or transfer her to hospital.

The panel therefore found this sub charge proved.

Charge 10b

That you, a registered midwife:

In relation to Patient B

10. On 14 May 2020 did not escalate Patient B's condition and/or transfer Patient B to hospital, in light of
    b. a low maternal temperature

This sub charge is found proved.

The panel took account of the oral and written evidence of Witness 2 and in particular Management Investigation for the Trust date 27 April 2021 produced by her. Within this report it references the fact that the Maternal temperature was recorded less than 36°C on three occasions. It then stated, *"The Maternal Sepsis guidelines define that there are possible signs of sepsis when there is a temperature of less than <36 °C."*

The panel also took account of Patient B's clinical notes. It noted that on 14 May 2020, Mrs Land had recorded low maternal temperatures on several occasions. At 00:05 she had recorded "Temp 35.7", at 2:30 "Temp 35.9", at 03:40 and 3:50 she recorded "35.9".

In light of this evidence, the panel was satisfied that there was a low maternal temperature. The panel then considered whether in light of the low maternal temperature, Mrs Land had a duty to escalate Patient B's condition and/or transfer Patient B to hospital.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her and noted the risks identified by Mrs Land. She stated:

"Midwife Land documented the low temperatures but did not comment on it as a

specific risk factor. The subsequent Trust investigation revealed that Midwife Land was unaware that a low temperature could be a risk factor for sepsis. This suggests a lack of awareness about the implications of hypothermia and potential sepsis risk."

Additionally, within the Expert Witness Report it stated:

"Additionally, Patient B's temperature was noted to be consistently low on three occasions and measured between 35.7 – 35.9°C, which is below the normal range. According to local guidelines, this deviation should have triggered closer monitoring and consideration for obstetric-led care if the parameters remained abnormal, which was not recognised by Midwife Land.…"

The panel was satisfied that Mrs Land had a duty to escalate Patient B's condition and/or transfer Patient B to hospital, in light of the low maternal temperature. The panel turned to the stem of the charge to determine whether or not she failed in this duty.

There was no evidence before the panel to demonstrate that Mrs Land had escalated Patient B's condition and/or transfer Patient B to hospital in light of the presence of the low maternal temperature.

The panel took account of the interview notes with Mrs Land dated 11 December 2020 undertaken by Witness 2. Mrs Land is recorded as stating that the temperature on admission for Patient B was 35.7°C but was not concerned about this. She stated that she did not feel the temperature needed discussion or transfer. However, she stated that upon reading and reflection she now understands "cold sepsis" having not heard of it before.

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel accepted the evidence of Witness 4 and Witness 2. It also noted Mrs Land's responses within the aforementioned interview notes.

The panel therefore found this sub charge proved.

Charge 11

That you, a registered midwife:

In relation to Patient B

11. Your actions at charges 9 and 10 above caused and/or contributed Baby B to lose a significant chance of survival.

This charge is found proved.

The panel reminded itself that it had found charge 9 and charges 10a and 10b proved.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her. Within her report, there is a section where she provides her opinion on the standards expected of a Band 6 midwife. She came to the following conclusion:

> *"'At 34+2 weeks, Patient B experienced a minor unprovoked antepartum haemorrhage (APH) and an episode of reduced fetal movements (RFM). This meant she may not have continued to be suitable for the low-risk pathway (according to Trust and NICE guidelines) and an individualised risk assessment was required before planning for her to birth on the standalone unit and continue on the low-risk midwifery-led pathway.*
> *…*

Given the nature of the missed risks – particularly concerning signs like blood-stained liquor – it is reasonable to expect a competent Band 6 midwife to have identified and acted upon these indicators promptly.

…

The impact of Midwife Land failing to identify the risks that were evident in the care of Patient B was likely to have been:

Delayed or inadequate interventions – failing to recognise risks like blood-stained liquor after SROM or persistent low maternal temperature meant essential actions such as continuous fetal monitoring to rule out fetal distress or deterioration of maternal condition were not undertaken, which on the balance of probabilities, led to the poor outcome for Baby B."

The panel bore in mind that Mrs Land denied the sub-charge in her returned case management form (CMF).

The panel heard evidence from Witness 4 that obstetric led care and access to specialist care and/or equipment was not available at the birth centre. On the evidence presented to the panel it was clear that Mrs Land's delay in the referral of Patient B prevented obstetric led care being instigated at the earliest available opportunity.

The panel was satisfied that Mrs Land's actions in relation to charges 9 and 10 determined that Patient B was unsuitable for midwifery-led care. Given the presence of blood-stained liquor and low maternal temperature, she did not escalate, make a referral to obstetric led care caused and or contributed to Baby B losing a significant chance of survival.

The panel therefore found this charge proved.

Charge 12

That you, a registered midwife:

In relation to Patient B

12. On 14 May 2020 on one or more occasions recorded in Patient B's records there was blood-stained liquor

These charges are found proved.

The panel took account of Patient B's clinical notes. It noted that on 14 May 2020, Mrs Land had made two entries where she recorded that there was "bloodstained liquor". At 03:50 she had recorded "Blood stained Liquor" and 06:10 she recorded "Blood stained Liquor +".

The panel bore in mind that Mrs Land admitted this charge in her returned case management form (CMF).

The panel therefore found this charge proved.

Charge 13

That you, a registered midwife:

In relation to Patient B

13. On 14 July 2020 at Trust interview said 'I wrote blood-stained liquor++. This is not an accurate recollection of events, and I don't know why I wrote that' or words to that effect.

This sub charge is found proved.

The panel took account of the Interview notes with Mrs Land dated 14 July 2020. In this interview Mrs Land stated, *"Mum went to bathroom and gave her a sanitary pad. Inco pad on bed clear liquor seen, lots of mucoid bloody show with pink liquor. Contractions more regular. At that point I wrote blood stained liquor ++. This is not an accurate recollection of events and don't know why I wrote this."*

The panel bore in mind that Mrs Land admitted this charge in her returned case management form (CMF).

The panel therefore found this charge proved.

Charge 14a

That you, a registered midwife:

In relation to Patient B

14. Your actions at charge 13 were dishonest in that
    a. you knew this information was incorrect and/or
    b. you intended to create misleading impression that there was no blood-stained liquor, when you knew there had been there.

These sub-charges are both found proved

The panel considered each of these sub-charges separately but as the evidence in relation to each was broadly similar it dealt with them under one heading.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* established in charge 7a.

The panel reminded itself that in finding charge 13 proved, it noted that Mrs Land had recorded “bloodstained liquor” on two occasions within Patient B’s records and at Trust interview, On 14 July 2020, said ‘I wrote blood-stained liquor++. This is not an accurate recollection of events, and I don’t know why I wrote that’.

The panel also took account of the evidence of Colleague C. In her witness statement she stated that Mrs Land had documented on two occasions that Patient B had bloodstained liquor. She also stated that she had confronted Mrs Land about why nothing had been done, namely transferring Patient B to the high-risk unit. In her oral evidence, she clearly recalled this and stated that Mrs Land was distraught after the incident and stated that Mrs Land had said she had identified the bloodstained liquor and wished she would have initiated a transfer.

Colleague C also supported the evidence of the presence of bloodstained liquor in a text message she had sent to Colleague D regarding the incident. The panel considered this to be a note of the conversation Colleague C had with Mrs Land, albeit being relayed to another colleague. It noted that this text message stated that Mrs Land started crying, made a reference to bloodstained and “partial abruption”. Additionally, it stated that Mrs Land wished she had transferred Patient B.

The panel determined that Mrs Land had contemporaneously and correctly recorded that she had identified blood-stained liquor.

In considering Mrs Land’s state of mind at the time of commenting on these entries at a later interview, the panel determined that there appeared to be no other reason for making these entries other than that it was clear that she did believe that there was bloodstained liquor present at the material time and knew this information was correct.

The panel was of the view that for Mrs Land to then say during the interview on 14 July 2020 (after being aware that Baby B had died), that the entries pertaining to bloodstained

liquor were inaccurate was a dishonest act and would be considered dishonest by the standards of ordinary decent people.

The panel concluded that on the balance of probabilities Mrs Land's actions in relation to charge 13 based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67,* were dishonest she knew this information was incorrect and intended to create a misleading impression that there was no blood-stained liquor, when she knew there had been.

The panel therefore found both these sub-charges proved

Charge 15a

That you, a registered midwife:

In relation to Patient B

15. On or before 26 March 2021, sent WhatsApp messages to Patient B
    a. without clinical justification and/or
    b. in breach of professional boundaries

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each was broadly similar it dealt with them under one heading.

Patient B in her witness statement stated that Mrs Land had messaged her to see how she was. She stated that she did tell Mrs Land that she may want to have met up with her in the future but after realising that Mrs Land *"had done things wrong and never really wanted to see her again as I was just to upset."* She stated that she did not know why Mrs

Land thought it was a good idea to send her a message and stated that it *“filled me with anger”.*

The panel saw a screenshot of the WhatsApp messages Mrs Land had sent to Patient B on 26 March 2021. Upon reading the WhatsApp messages, the panel noted that there was nothing of a clinical nature in these messages. There was no further clinical care being provided by Mrs Land and no clinical justification for Mrs Land contacting Patient B.

With regards to sub-charge 15b, the panel took account of evidence of Patient B who had stated that the WhatsApp messages were causing her distress having been sent on the anniversary of Baby B’s death. She stated that she did not think it was a professional thing to do for a midwife who had previously been in charge of her care. Additionally, in Patient B’s oral evidence, she stated that she had to contact her solicitor to get in contact with Mrs Land and ask her to stop contacting her.

Witness 1 in a letter to Patient B apologised for Mrs Land’s messages. She also stated in her oral evidence that sending WhatsApp messages to a patient was something she would not do and stated that it was unprofessional.

The panel considered the messages and determined that there was no clinical justification for Mrs Land to contact Patient B after care had concluded and therefore the messages were in breach of professional boundaries.

The panel therefore found these sub-charges proved.

Fitness to practise

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

The panel, in reaching its decision, 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.

Submissions on misconduct

Mr Malik, on behalf of the NMC referred the panel to the case *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Malik invited the panel to take the view that the facts found proved involved both positive actions and omissions while on shift carrying out clinical duties. He submitted that the misconduct relates to behaviour not directly linked to clinical practice. He also submitted that the conduct found proved does amount to sufficient serious misconduct.

Mr Malik submitted that the consequences of incorrectly assessing Patient A, missing essential risk factors, and incorrectly allocating her were such that Patient A's access to care was unacceptably delayed. He also submitted that the failure to escalate and the inappropriate and inaccurate record-keeping, or lack thereof, compounds the seriousness of these charges. He submitted that where records are not kept, are kept inaccurately or

inappropriately, or are kept/changed dishonestly, this taints the chain of information on which colleagues who are trying to implement care rely.

Mr Malik submitted that this gives rise to the risk that problems with the patient are not addressed at the first opportunity, that colleagues make fatal errors, or that the patient is put at risk of deterioration and, subsequently, harm. He submitted that this is precisely what has taken place, and as such, both colleagues, the patients and their babies were harmed and placed at risk of further harm.

Mr Malik submitted there are some attitudinal issues, not only owing to the lack of any real reflection, recognition or remorse, but owing to the inappropriate traversing of professional boundaries in sending messages to Patient B. He reminded the panel of the evidence of Patient B who stated that these messages caused great distress and upset, and thus further harm.

Mr Malik submitted that Mrs Land's actions do amount to sufficiently serious misconduct.

Mr Malik referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where Mrs Land's actions amounted to misconduct.

Submissions on impairment

Mr Malik 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.

Mr Malik referred the panel to the NMC guidance entitled, "*Insight and Strengthened Practice"* and *'Has the concern been addressed?'.*

Mr Malik submitted that Mrs Land has not shown any insight or reflection, and therefore, there is no evidence before the panel of any steps she may have taken to address the underlying concerns.

Mr Malik submitted that while Mrs Land had yet to explain her conduct, she has had ample opportunity to do so. He submitted that this is significant to the question of ongoing risk to patients and the public.

Mr Malik submitted that deep-seated attitudinal issues towards staff and patients, combined with a lack of honesty in the context of no evidence of remediation, demonstrate a serious ongoing risk to patient safety.

Mr Malik submitted that the concerns have not been addressed and likely cannot be. He submitted that the panel may think that without proper remediation, there remains a real risk to patient safety and of repetition. He submitted that it is the NMC's position that the risk of repetition is increased in the absence of insight, remorse, responsibility or remediation.

Mr Malik submitted that the same pattern of behaviour has been repeated more than once, even after concerns or issues had been raised or identified. He submitted that the risk to patient safety is clear, current, and ongoing.

Mr Malik invited the panel to find Mrs Land's fitness to practice currently impaired on the grounds of public protection and public interest.

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

Decision and reasons on misconduct

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

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

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

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

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

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

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

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…

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It bore in mind that the areas of concern related to:

- Failures to communicate and escalate the care or condition of patients/babies;
- Failure to recognise patient risks/risk factors appropriately
- Failure to keep contemporaneous notes as appropriate
- Dishonesty and a lack of candour
- A breach of professional boundaries
- Causing direct harm to a patient/baby

The panel took account of the NMC Guidance entitled *"How we determine seriousness"* (reference FTP-3) which stated:

> *"Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*
>
> - *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care…"*

The panel was of the view that the acts or omissions highlighted in the concerns raised are serious. It noted that these acts or omissions placed vulnerable patients, namely a mother and her child, at significant risk of harm. It also noted that when these acts or omissions occurred in relation to Patient A and Baby A in 2019, similar conduct occurred the following year in relation to Patient B and Baby B.

The panel bore in mind that it had found Mrs Land failed to escalate Baby A's condition to the neonatal team having concluded that Baby A was in poor condition shortly after birth. Additionally, Mrs Land did not escalate Patient B's condition or transfer Patient B in light of the presence of bloodstained liquor or a low maternal temperature.

The panel bore in mind that both acts or omissions contributed to Baby A and Baby B losing a significant chance of survival.

The panel was of the view that these omissions were fundamental basic midwifery care and Mrs Land did not take the necessary action to increase the chances of survival for Baby A or Baby B.

The panel also bore in mind that there were two instances of dishonesty, nearly a year apart, with inaccurate and dishonest record keeping in relation to both Patient A and Baby A and Patient B and Baby B.

The panel also considered sending messages to Patient B without clinical justification to be serious and a breach of professional boundaries.

In light of the above the panel determined that the charges found proved amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

Having made findings of past misconduct the panel then went on to consider the issue of current impairment.

In this regard the panel considered the test of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

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

The panel began by considering whether these limbs were engaged with regard to the past. The panel determined that limbs a, b, c and d were engaged by Mrs Land's misconduct with regard to the past.

The panel found that Patient A, Baby A, Patient B and Baby B were all put at an unwarranted risk of harm. It bore in mind that Mrs Land failed to escalate Baby A's condition to the neonatal team having concluded that Baby A was in poor condition shortly after birth. Additionally, Mrs Land did not escalate Patient B's condition or transfer Patient B in light of the presence of bloodstained liquor or a low maternal temperature. This, as the panel found, caused both Baby A and Baby B to lose a significant chance of survival and both babies died.

The panel determined that Mrs Land's misconduct had breached fundamental tenets of the midwifery profession, particularly in relation to not transferring Baby A or Patient B which the panel considered to be fundamental basic midwifery care. Further, the panel considered Mrs Land's attempt to cover up her actions with inaccurate and dishonest record keeping on two occasions to be a breach of the fundamental tenets of the midwifery profession and therefore brought its reputation into disrepute. It was of the view that such acts or omissions could discourage members of the public to seek midwifery services at a birthing unit.

The panel was satisfied that confidence in the midwifery profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel recognised that it must make an assessment of Mrs Land's fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether she would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in Mrs Land's nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Mrs Land had provided evidence of insight and remorse.

Regarding insight the panel noted that Mrs Land within her CMF admitted charges 12 and 13, but had denied the rest of the charges and denied that her fitness to practice was impaired by reason of her misconduct. It recognised her right to contest the charges.

The panel noted that whilst Mrs Land accepted charge 12, namely that on one or more occasions she had recorded in Patient B's records there was bloodstained liquor, this was a factual charge. It was clear in Patient B's records that Mrs Land had bloodstained liquor.

However, it particularly noted that in charge 13, which occurred a month later at a Trust interview, when presented with Patient B's records Mrs Land stated that this was not an accurate recollection of events and stated that she did not know why she wrote it.

The panel was of the view that this did not demonstrate insight into these charges. Additionally for Mrs Land to dispute the reasons for recording bloodstained liquor despite

clear evidence to the contrary, in the panel's view, appeared to demonstrate some attitudinal concerns.

The panel had no evidence before it of any insight or remorse from Mrs Land. It did not have any recognition or acknowledgement of the impact her conduct had on Patient A or Patient B, their families, colleagues or the midwifery profession.

In light of the above, the panel determined that it had no evidence Mrs Land had any insight in relation to her serious misconduct.

The panel was satisfied that some aspects of the misconduct in this case are capable of being remediated. It particularly noted that certain aspects around clinical care were capable of being remediated. It also bore in mind that misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However, in the panel's judgment, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all relevant in considering the risk of repetition, as is the nature and duration of the dishonesty itself.

Therefore, the panel carefully considered there was no evidence before it that would assist in determining whether Mrs Land has taken steps to strengthen her practice. In the absence of evidence of insight or strengthened practice there was no evidence that the concerns had been remedied to date. The panel noted that it had no evidence before it of any action taken by Mrs Land to acknowledge, address or remedy the concerns identified in relation to the matters in this hearing, or the attitudinal issues which appear to underpin them.

The panel is of the view that in the absence of insight, remorse and evidence that Mrs Land had strengthened her practice, in the areas of concern identified by the panel, Mrs Land was liable to repeat her actions in the future. It followed that the panel determined that all four limbs of *Grant* were engaged with regard to the future.

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

The panel was satisfied that, having regard to the nature of the misconduct and lack of competence in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if Mrs Land's fitness to practise was not found to be impaired and therefore public confidence in the midwifery profession would be undermined if Mrs Land were allowed to practice unrestricted.

For all the above reasons the panel concluded that Mrs Land fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Sanction

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

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

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 1 August 2024, the NMC had advised Mrs Land that it would seek the imposition of a striking off order if it found Mrs Land's fitness to practise currently impaired.

Mr Malik submitted that the most appropriate and proportionate sanction in this case is a striking off order.

Mr Malik submitted that this case is too serious for taking no action or a caution order. He submitted that this is because dishonesty is a serious matter. He also submitted that a caution order would be insufficient to protect the public or mark the seriousness of the misconduct in this case. Mr Malik reminded the panel that the concerns have been repeated on two occasions with fatal outcomes and there has been no insight from Mrs Land.

With regards to conditions of practice, Mr Malik submitted that there is evidence of direct harm and potential risk of harm to patients as a result of Mrs Land's misconduct. He also submitted that there were two instances of dishonesty nearly a year apart, with inaccurate and dishonest record keeping in relation to both Patient A and Baby A and Patient B and Baby B. He reminded the panel that dishonesty is a type of concern that is difficult to remediate.

Mr Malik reminded the panel that it had had no evidence before it of any action taken by Mrs Land to acknowledge, address, or remedy the concerns identified or the attitudinal issues. He submitted that Mrs Land is someone who has lied and attempted to cover up her actions with inaccurate and dishonest record keeping. He submitted that conditions of practice order would not be appropriate as there are no areas of practice in need of assessment or training.

With regards to a suspension order, Mr Malik submitted that Mrs Lands actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. He submitted that Mrs

Land had shown no insight. He reminded the panel that dishonesty charges were found proved and the acts or omissions placed vulnerable patients, namely a mother and her child, at significant risk of harm.

Mr Malik submitted that the concerns in this case do raise fundamental concerns about Mrs Land's honesty, trustworthiness and professionalism. He submitted that the concerns are difficult to address and put right and constitute a serious breach of nursing standards.

Mr Malik submitted that a striking off order is the appropriate sanction. He submitted that public confidence in the profession can only be maintained by removing Mrs Land from the NMC Register. He submitted that findings in this case demonstrate that Mrs Land's actions were serious. He submitted that to allow Mrs Land to continue practising would undermine public confidence in the profession and the NMC as a regulatory body.

Decision and reasons on sanction

Having found Mrs Land'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:

- Repeated dishonesty occurring on two separate occasions;
- No insight into failings
- No remediation;
- No remorse;
- A pattern of repeated misconduct;
- Attitudinal concerns;

- Conduct which put patients at risk of actual harm and caused or contributed to the patients losing a significant chance of survival.

The panel was of the view that there were no mitigating features applicable to this case.

The panel took account of the NMC guidance entitled, "Considering sanctions for serious cases" (Reference: SAN-2). Under the sub-heading entitled "Cases involving dishonesty" it stated:

> *"Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
> - *…*
> - *vulnerable victims*
> - *…*
> - *direct risk to people receiving care*
> - *…"*

The panel found that Mrs Land had covered up her misconduct when things went wrong. The panel considered that when providing midwifery care to vulnerable patients during pregnancy and, subsequently their vulnerable babies, there is an expectation that patient records are accurate and not retrospectively amended incorrectly.

The panel also bore in mind that Mrs Land repeated the same misconduct a year later with regards to entries made in patient records which she subsequently stated were incorrect at a Trust interview. It found that this created a misleading impression for anybody looking at the patient record.

The panel noted that Mrs Land was junior to Colleague A and Colleague A had influenced Mrs Land to make incorrect retrospective entries. However, it was of the view that as a registered midwife who had been on the NMC register since 2008, Mrs Land ought to have known better and adhered to the NMC Code.

The panel found the dishonesty to be at the higher end of the scale.

The panel bore in mind that there were vulnerable victims in this case, namely Baby A and Baby B. The panel also found that there was a direct risk to people receiving care. Mrs Land failed to escalate Baby A's condition to the neonatal team having concluded that Baby A was in poor condition shortly after birth. Additionally, Mrs Land did not escalate Patient B's condition or transfer Patient B in light of the presence of bloodstained liquor or a low maternal temperature. This caused both Baby A and Baby B to lose a significant chance of survival and both babies died.

The panel bore in mind that Mrs Land made incorrect retrospective changes to the clinical notes of Patient A and Baby A. Then a year later with regards to the patient records of Patient B created a misleading impression for anybody looking at Patient B's records. Whilst it did not consider Mrs Land's dishonesty to be longstanding, it was repeated deception occurring on two separate occasions.

The panel bore this in mind as it went on to consider sanctions.

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

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

The panel next considered whether placing conditions of practice on Mrs Land's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. Whilst conditions of practice could be formulated to address some of the clinical failings identified, the panel bore in mind that it had no evidence from Mrs Land to demonstrate a willingness to undergo re-training to address the failing in her clinical practice.

Additionally, the panel was of the view that the dishonesty identified in this case was not something that can be addressed through retraining. The panel concluded that placing conditions on Mrs Land's registration would not adequately address the seriousness of this case, would not protect the public nor meet the public interest.

The panel has no evidence before it of Mrs Land's willingness to undertake training or comply with conditions of practice. Therefore, there are no practicable or workable conditions that could be formulated in these circumstances. Furthermore, the panel concluded that the placing of conditions on Mrs Land's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel was of the view that Mrs Land's misconduct was not a single instance. It occurred over a period of time and was repeated. It also bore in mind that the dishonesty identified was repeated and there was evidence of deep-seated attitudinal problems. Mrs Land's actions in relation to Patient A and Baby A were repeated a year later with Patient B and Baby B. The panel bore in mind that Mrs Land had no insight and poses a significant risk of repeating the conduct found proved.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Land's actions is fundamentally incompatible with Mrs Land remaining on the register.

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

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

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

Mrs Land's actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with her remaining on the register. It bore in mind that the acts and omissions of Mrs Land contributed Baby A and Baby B losing a significant chance of survival. Additionally, this was compounded by the inappropriate, inaccurate, and dishonest record-keeping.

The panel was of the view that the findings in this particular case demonstrate that Mrs Land's misconduct was too serious to allow her to continue practising and that it would undermine public confidence in the profession and in the NMC as a regulatory body if she were permitted to remain on the register.

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

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

This will be confirmed to Mrs Land in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik. Given the panel's findings in relation to sanction he submitted that only an interim suspension order for a period of 18 months will be appropriate. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.