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:	**Hazel Joy Williams**
NMC PIN	84H0477E
Part(s) of the register:	RM: Midwife: (8 September 1990) RN1: Adult nurse, level 1 (2 November 1987)
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)
Miss Williams:	Not present and not represented
Facts proved:	Charges 1b, 1c, 2, 3, 4, 5a, 5b, 5c, 6a, 6b(i), 6b(ii), 6b(iii), 6b(vi), 7, 9a, 10a, 10b, 10c, 10d, 10e, 11, 14a, 14b, 14c and 15
Facts not proved:	Charges 1a, 8, 9b, 12, 13a, 13b, 13c, 13d, 13e and 13f
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 Miss Williams was not in attendance and that, on 1 August 2024, the Notice of Hearing letter had been sent to what appeared to be a private email address of Miss Williams, rather than her registered email address. The panel was further informed that Miss Williams had provided the NMC with her private email address initially on 27 August 2020, again on 7 January 2022 and reiterated this email address on 9 February 2023.

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 Miss Williams's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Williams

The panel next considered whether it should proceed in the absence of Miss Williams. It had regard to Rule 21 and heard the submissions of Mr Bardill. He drew the panel's attention to an email sent by Ms Williams to the NMC dated 9 August 2024. Within this email she confirmed that she would not be attending the hearing and was content for the panel to proceed.

Mr Bardill submitted that Miss Williams was aware of these proceedings and had chosen not to attend. He submitted that there is a public interest in the expeditious disposal of this case. He further submitted that there had been no application made for an adjournment today and doing so would serve no purpose as there is no guarantee that adjourning would secure Miss Williams' attendance at a future date.

Mr Bardill invited the panel to continue in the absence of Miss Williams.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Williams. In reaching this decision, the panel has considered the submissions of Mr Bardill, the representations from Miss Williams, 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:

- Miss Williams had informed the NMC, in an email dated 9 August 2024, that she had received the Notice of Hearing and confirmed she was content for the hearing to proceed in her absence;
- No application for an adjournment has been made by Miss Williams;
- 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 were 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 Miss Williams in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Miss Williams 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 Miss Williams's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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 15.

The proposed amendment was to change the charges referenced. 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

15. Your conduct in respect of charges ~~14~~ **13** and ~~15~~ **14** above exposed patients to harm or neglect by fostering a poor culture.

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 Miss Williams 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, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

1. On 25 June 2019 being aware and/or having been made aware that Baby A was deteriorating shortly after birth,
   a. failed to recognise that Baby A was suffering from respiratory distress, and/or
   b. failed to escalate Baby A's condition to the neonatal team, and/or
   c. failed to communicate directly with Colleague B and/or the neonatal team of the need to immediately transfer Baby A.

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

3. On or around 25 June 2019 improperly encouraged Colleague A to change the condition of Baby A from ‘poor’ to ‘good’

4. On an unknown date between 25 and 28 June 2019 made incorrect retrospective entries into Patient A’s maternal records, in that you, added Baby A’s neonatal APGAR scores to change the scores recorded on Baby A’s Birth details.

5. On an unknown date between 28 August 2019 and 8 April 2021 made further retrospective entries in Patient A’s records in that you,
   a. added a fetal heart rate of 148 beats per minute timed at 18.00 to the partogram.
   b. changed the time from 18.20 to 18.23 hours to when Baby A was placed on the rescusitaire.
   c. changed the APGAR scores from 8 to 7 at 1 and 5 minutes on the partogram.

6. Your actions at charges 3-5 were dishonest in that you knew
   a. the retrospective entries were not true and/or
   b. you intended to mislead anyone reading Patient A’s record into believing that:
      i. Baby A’s condition at birth was ‘good’.
      ii. Baby A’s APGAR scores were incorrect on 25 June 2019.
      iii. You had listened to Baby A’s fetal heart rate at 18.00 hours.
      iv. Baby A’s condition deteriorated at a later time than originally recorded.

In relation to Patient B and Baby B

7. On 14 May 2020 as the allocated midwife, were aware or should have been aware from the medical records that Patient B was not suitable for midwifery-led care and taken the appropriate action by escalating to the hospital.

8. On 14 May 2020 between 1115 and 1210 hours failed to conduct fetal heart rate assessments every 5 minutes.

9. On one or more occasion on 14 May 2020 failed to transfer Patient B to obstetric care, in that you,
   a. failed to take into account Patient B's request to be transferred, on one or more occasions.
   b. when Baby B suffered fetal bradycardia and/or showed signs of distress.

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by

    a. activating the emergency bell, and/or
    b. informing Colleague C of the bradycardia on their attendance to assist, and/or
    c. asking for a category 1 ambulance, and/or
    d. informing Colleague D of the emergency on their attendance, and/or
    e. handing over to the receiving hospital that Baby B was bradycardic

11. Your actions at charges 8 to 10 above caused and/or contributed Baby B to lose a significant chance of survival.

12. On 14 May 2020 did not label Patient B's placenta accurately which prevented further examination.

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    a. discouraged the reporting of concerns; and/or

b. did not act on reported concerns, and/or
c. screened the bookings; and/or
d. encouraged unsuitable patients to choose the birth centre; and/or
e. delayed the transfer of patients to obstetric care; and/or
f. encouraged staff not to use the emergency bell.

14. On one or more occasions failed to cascade learning to colleagues in that you,
    a. did not update learning from serious incidents.
    b. did not embed the use of the NEWTT chart into practice.
    c. did not embed the SBAR handover process.

15. Your conduct in respect of charges 13 and 14 above exposed patients to harm or neglect by fostering a poor culture.

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 Miss Williams and Colleague B 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 Miss Williams and Colleague B. 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 was alleged that Miss Williams was responsible for Baby A's immediate postnatal care. It is the NMC's case that she failed to act quickly and accordingly when Baby A's respiratory distress was apparent and this delay contributed directly to Baby A's worsening condition and eventual death. It is also the NMC's case that Miss Williams did not maintain proper contemporaneous records during Baby A's deterioration. Miss Williams' notes were written retrospectively and did not accurately reflect the events as they unfolded and impacted the ability to provide timely care to Patient A and Baby A.

It was further alleged that Miss Williams' improper record keeping also impacted on the Trust investigations and their ability to try and ascertain what exactly had happened.

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 the NMC's case that Baby B's fetal heart rate was falling below 60 beats per minute. The NMC's witness will give evidence to say that this required immediate intervention.

It is the NMC's case that Baby B's mother, repeatedly requested transfer to an obstetric-led unit during labour, as she felt that her body was not coping with the labour. Miss Williams, who had taken over from Colleague B, ignored these requests, attempting alternative positions rather than ensuring the safety of the mother and baby by arranging a timely transfer. Baby B was born in poor condition requiring immediate resuscitation and transfer by ambulance. By the time the decision was made to transfer, Baby B's condition had already deteriorated significantly.

Baby B's condition was critical and was eventually transferred to the neonatal intensive care unit and remained there for three days before passing away due to complications arising from oxygen deprivation.

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 Miss Williams and Colleague B failed to follow the correct procedures for risk assessment and escalation.

There was a second referral that raised more broader cultural concerns. It is the NMC's case that Miss Williams encouraged a culture which was one of not reporting incidents, not escalating concerns and not transferring patients from the clinic to the place that patients needed to be. It is alleged that the reason this culture was fostered was to try and keep the numbers up in the clinic and essentially not lose patients.

Decision and reasons on application of no case to answer

Following the conclusion of the NMC's evidence the panel, of its own volition, invited submissions from Mr Bardill on the issues of whether or not there was no case to answer for charge 12.

12. On 14 May 2020 did not label Patient B's placenta accurately which prevented further examination.

Mr Bardill drew the panel's attention to the Management Investigation report dated 27 April 2021. It stated that Miss Williams was caring for Patient B and in the contemporaneous record, the placenta was delivered. He submitted that the placenta is within the management of Miss Williams.

Mr Bardill drew the panel's attention to another section within the report which cited the placenta was sent for histopathological examination, but the HSIB clinical panel was unable to review the results because it was difficult to ascertain if that placenta was the correct one. Two placenta's had been labelled with Patient B's details attached.

Mr Bardill submitted that because it was Miss Williams who delivered the placenta, it would be her responsibility to label it accurately.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor. This included the case of *R v Galbraith (1981) 73 Cr App R 124.* The panel considered Rule 24(7). This rule states:

> *24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*
>
> *(i) either upon the application of the registrant …*
>
> *the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.*

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

The NMC identified the evidence in support of this charge by noting inaccuracies surrounding the labelling the placenta of Patient B. The panel was of the view that these inaccuracies could be explored. Applying the first limb of *Galbraith*, the panel concluded that a reasonable panel, properly directed, could find this charge proved.

The panel determined that there is sufficient evidence that could support charge 12 as presented at this stage and, as such, it was not prepared, based on the evidence before it to determine, of its own volition, that there was no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on 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.

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

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 Miss Willliams was under a duty and whether she failed in her duty, was a matter for the panel.

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

Charge 1a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

1. On 25 June 2019 being aware and/or having been made aware that Baby A was deteriorating shortly after birth,
    a. failed to recognise that Baby A was suffering from respiratory distress, and/or

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, Miss Williams was aware that Baby A was deteriorating shortly after birth.

The panel reminded itself that when Baby A was born, Miss Williams, Colleague B, Patient A and her daughter was present in the room.

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 [Colleague B]."*

The following evidence was before the panel that supported her assessment.

The panel took account of Patient A's and Baby A's records written by Colleague B. At 18:17 Colleague B had written, *"Normal Birth…Patient A on all fours position cord unravelled"*. Later on at 18:23, changed from 18:20, Colleague B 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 Colleague B. 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" Colleague B 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 Colleague B 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.

The panel bore in mind that Miss Williams was in the room with Colleague B and handed over Baby A to her to take to the resuscitaire. In the panel's view, and in light of Colleague B's "Notes on resuscitation and state of baby" Miss Williams would have been completely aware of the condition of Baby A.

In light of the evidence above, the panel accepted that on 25 July 2019, Miss Williams was aware that Baby A was deteriorating shortly after birth.

The panel then moved on to consider whether Miss Williams, being aware that Baby A was deteriorating 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 Miss Williams had a duty to recognise that Baby A was suffering from respiratory distress. The panel was satisfied that Miss Williams, as the senior 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 Miss Williams had failed in her duty to do so.

The panel took account of the aforementioned 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 indicates that Colleague B 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 Colleague B. It noted that under the heading "Notes on resuscitation and state of baby" Colleague B 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 reminded itself that Miss Williams was in the room as the senior midwife. Therefore she would have witnessed Colleague B providing “inflation breaths” to a newborn child within a short period of time from birth which would have indicated a recognition of issues with breathing.

The panel was of the view it was clear that Miss Williams was aware that Baby A was suffering from respiratory distress.

The panel therefore found this sub charge not proved.

Charge 1b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

1. On 25 June 2019 being aware and/or having been made aware that Baby A was deteriorating shortly after birth,
   b. failed to escalate Baby A’s condition to the neonatal team, and/or

This sub charge is found proved.

The panel had already established in charge 1a that Miss Williams was aware that Baby A was deteriorating shortly after birth. It now had to determine whether she had a duty to escalate 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” she provided. Under the heading “Summary of Conclusions” she stated “in respect of the care provided by Midwife Williams”,

"By 18:23 hours, when Baby A was noted to be 'struggling and pale', Midwife Williams should have promptly escalated concerns, including calling for additional support and arranging transfer of Baby A to a hospital with neonatal doctors for further evaluation and management."

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".*

All the midwives who gave evidence at this hearing and particularly Witness 2, in her oral evidence, stated that if you as a midwife identify something that another midwife does not, and there is a disagreement, you resolve it quicky and come to a joint decision to act in the best interests of the mother.

The panel was satisfied that having been aware that Baby A was deteriorating shortly after birth, Baby A's condition should have been escalated to the neonatal team. In light of this, the panel then went on to consider whether Miss Williams had failed in her duty to do so.

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 Miss Williams was present in the room and aware that Baby A was deteriorating shortly after birth. It also bore in mind that she would have been aware of the current status of Baby A and the treatment, namely the resuscitative measures, that was provided within her vicinity by Colleague B.

Therefore in the panel's view Miss Williams, as the band 7 senior midwife in the room in charge of the delivery of Baby A, given her advanced training, seniority and experience should have escalated Baby A's condition to the neonatal team shortly after birth or directed others to do so. However, there is no evidence before the panel to demonstrate that this was done.

The panel therefore found this sub charge proved.

Charge 1c

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

1. On 25 June 2019 being aware and/or having been made aware that Baby A was deteriorating shortly after birth,
    c. failed to communicate directly with Colleague B and/or the neonatal team of the need to immediately transfer Baby A.

This sub charge is found proved.

The panel had already established in charge 1a that Miss Williams was aware that Baby A was deteriorating shortly after birth. It now had to determine whether she had a duty to communicate directly with Colleague B and/or the neonatal team of the need to immediately transfer Baby A.

The panel bore in mind that Witness 4 in her written and oral evidence stated that Miss Williams had a duty to escalate Baby A's condition to the neonatal team. It was therefore satisfied that Miss Williams as the senior midwife in charge of the birth of Baby A had a

duty to communicate this need to Colleague B and the neonatal team. In light of this, the panel then went on to consider whether Miss Williams had failed in her duty to do so.

The panel took account of a transcript of a conversation with Patient A. With regards to the birth, Patient A stated that everything was fine and it sounded like Baby A had a lot of fluid in his airway and the midwives were trying to suction that out. She stated that they then passed Baby A back to her and took him back and tried for at least an hour to give him oxygen.

The panel noted that there did not appear to be any communication from Miss Williams to Colleague B or the neonatal team about the need to immediately transfer Baby A.

The panel was mindful that the comments of Patient A within the transcript amounted to hearsay because she had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of what Patient A had stated.

However, the panel took account of the written and oral evidence of Witness 2 and, in particular, the Management Investigation report for the Trust dated 27 April 2021 produced by Witness 2. Within this report is an interview with Colleague B. The "Summary of the key points" stated the following, *"[Colleague B] thought that the baby needed to be transferred but felt reassured by [Miss Williams]'s actions of weighing the baby."* The panel was of the view that this appeared to support what Patient A had stated in the transcript.

Additionally, within this Management Investigation report for the Trust dated 27 April 2021, Miss Williams was interviewed. She stated that she discussed with Colleague B that Baby A was not born in poor condition, but also stated earlier that when Baby A's condition changed she took Baby A to the resuscitaire.

Nevertheless, the panel bore in mind that within the clinical notes for Patient A, it stated that Baby A was born at 18:17 and taken to the resusitaire at 18:20, changed

retrospectively to 18:23. It could not find anything in the clinical notes to indicate any communication between Miss Williams and Colleague B pertaining to a risk assessment, what actions to take or for the need to immediately transfer Baby A shortly after birth.

The panel therefore found this sub-charge proved.

Charge 2

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

2. Your actions at charge 1 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 sub-charge 1b and 1c proved. Therefore, its consideration of this charge was only in respect of sub-charges 1b and 1c.

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 Williams",

> *"The delay in agreeing to initiate Baby A's transfer until 18:45 hours further underscored a lapse in timely intervention which, on the balance of probabilities, affected Baby A's survival chances and overall care outcomes."*

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. Her evidence

was from examination of medical notes that there was almost one and a half hours from recognition of a problem with Baby A to the subsequent transfer to the neonatal unit. Her evidence to the panel was that this delay could have significantly shortened Baby A's chances for 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 were Baby A transferred earlier. She stated that this chance was missed.

The panel accepted the evidence of Witness 4 and did not accept Miss Williams' account that Baby A was born in a condition that did not merit transfer.

The panel therefore found this charge proved.

Charge 3

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

3. On or around 25 June 2019 improperly encouraged Colleague A to change the condition of Baby A from 'poor' to 'good'

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 that supported her assessment.

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

The panel took account of the notes of an Interview between Witness 2 and Colleague B dated 11 December 2020. In response to a question about the retrospective entry, Colleague B stated that these were done three days later at the request of Miss Wiliams. Colleague B then stated that Miss Wiliams had told her that the APGAR scores were not correct and that Baby A was *“not in poor condition as he was born in good condition”.* Colleague B stated that she changed the record and *“over wrote “poor” with “good” on original document prior to transfer.”*

The panel was satisfied that Miss Williams encouraged Colleague B to change the condition of Baby A from ‘poor’ to ‘good’.

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. It noted that the assessment made by Colleague B at the time was that Baby A was born in poor condition. It also noted that there was evidence to support this assessment. It was of the view that it was improper for Miss Williams, as a band 7 senior midwife, to encourage Colleague B to subsequently change this assessment.

The panel did not accept Miss Williams’ account that Baby A was born in good condition.

The panel therefore found this charge proved.

Charge 4

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

4. On an unknown date between 25 and 28 June 2019 made incorrect retrospective entries into Patient A's maternal records, in that you, added Baby A's neonatal APGAR scores to change the scores recorded on Baby A's Birth details.

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. Under the heading "Chronology of events" she has stated the following occurred at 18:18: APGAR scores recorded as 8 [at 1 minute] on partogram by [Midwife] Williams and in contemporaneous notes as 5 [at 1 minute], 6 [at 5 minutes] and 7 at 10 minutes] (recorded differently in retrospective notes 3 days after birth as 7[[at 1 minute] and 7 [at 5 minutes] by [Colleague B])

The following evidence was before the panel that supported her assessment.

The panel took account of the "Details of Birth" form for Baby A, which had been signed by Colleague B. The panel bore in mind that this form would have been completed immediately after the birth of Baby A. The panel noted that Colleague B had contemporaneously recorded the APGAR score as 5 at 1 minute and 6 at 5 minutes, which suggested that Baby A was born in poor condition.

The panel took account of Patient A's partogram and noted that Miss Williams had recorded the APGAR score as 8 at 1 minute

The panel took account of Patient A's Clinical records dated 28 June 2019 which has been signed by Miss Williams. Within these records, Miss Williams has confirmed that the entries are a *"retrospective entry to my delivery on 25.6.19 for Patient A".* She also confirmed that she had assessed the APGARs as 7 at 1 minute and 7 at 5 minutes. The panel noted that these APGAR scores were different to the ones recorded by Colleague B and suggested that Baby A was infact born in better condition.

The panel considered that only Miss Williams and Colleague B were present at the birth of Baby A.

The panel considered the written and oral evidence of Witness 2 and in particular the Management Investigation report for the Trust dated 27 April 2021 produced by her. Within this report under the heading entitled "Analysis", Witness 2 took account of Patient A's clinical records and came to the following conclusion, *"In the Maternal Record [Miss Williams]'s has made a retrospective entry dated 28 June 2019 for the delivery on 25 June 2019 [Miss Williams]'s entry states that the APGARs were 7 at 1 minute and 7 at minutes."*

Additionally, within the same Investigation report, there is an interview with Miss Williams that was undertaken on 8 January 2021. From this interview Witness 2 recorded that Miss Williams stated that she had *"wrote a retrospective entry to correct the APGARs written by Colleague B".*

The panel was satisfied that Miss Williams had admitted that she had retrospectively changed Baby A's neonatal APGAR scores from the scores recorded on Baby A's "Details of Birth" form.

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. It also considered that Miss Williams retrospectively changed Colleague B's APGAR scores three days after Baby A was born, with the knowledge that Baby A had died. No evidence has been presented to the panel that supports Miss Williams' retrospective

changes or that Baby A was born in a better condition than that implied by the contemporaneous APGAR scores initially recorded by Colleague B.

The panel therefore determined that Miss Williams' retrospective entries were, more likely than not, incorrect.

The panel therefore found this charge proved.

Charge 5a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

5. On an unknown date between 28 August 2019 and 8 April 2021 made further retrospective entries in Patient A's records in that you,
   a. added a fetal heart rate of 148 beats per minute timed at 18.00 to the partogram.

This charge is found proved.

The panel took account of Patient A's partogram, however it noted that it was not legible enough for the panel to ascertain whether or not Miss Williams had retrospectively added a fetal heart rate of 148 beats per minute timed at 18.00.

The panel considered the written and oral evidence of Witness 2 and in particular the Management Investigation report for the Trust dated 27 May 2021 produced by her. Under the sub-heading entitled "Analysis", Witness 2 had stated the following, *"The investigator went to check the original records, including the Partogram, on 8 April 2021 and an*

additional fetal heart recording had been added in to the records after the time the scanned copy of the records was made."

Further, there was a table within the Investigation report which demonstrated the Fetal heart auscultation and where they were recorded. Next to "18:00", the Witness 2 had written the following, *"At 18:05 the [Fetal heartrate] was recorded at 148bpm (pre VE) and 140bpm (post VE)."* The panel then noted that under the date "8 April 2021", Witness 2 had written the following, *"148 addition added to the record".*

The panel considered that it could rely on Witness 2's interpretation of the clinical records. It also noted that Witness 2 within her Investigation report stated the following, *"[Patient A] and [Baby A] records were scanned by the legal team on 28 August 2019. This means that any amendments made to the original records were made after this time."* It bore in mind that Witness 2's interview with Miss Williams had occurred on 8 April 2021 and this is when the retrospective entries were noticed and brought to Miss Williams' attention.

The panel noted that later in the investigation report, Witness 2 stated the following, *"The investigator is critical that an addition to the record has been made on the partogram of a fetal heart of 148 beats/per minute."*

The panel also noted that later in the investigation report, Witness 2 stated the following, *"[Miss Williams] stated that she must have changed the partogram as that too had her signature and the reason for the change."*

In light of the above, the panel was satisfied that on an unknown date between 28 August 2019 (after the date the legal team had scanned the records) and 8 April 2021, Miss Williams made further retrospective entries in Patient A's records in that she had added a fetal heart rate of 148 beats per minute timed at 18.00 to the partogram.

The panel therefore found this sub charge proved.

Charge 5b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

5. On an unknown date between 28 August 2019 and 8 April 2021 made further retrospective entries in Patient A's records in that you,
    b. changed the time from 18.20 to 18.23 hours to when Baby A was placed on the rescusitaire.

This sub charge is found proved.

The panel considered the written and oral evidence of Witness 2 and in particular the Management Investigation report for the Trust dated 27 May 2021 produced by her. Under the sub-heading entitled "Analysis" Witness 2 had recorded the following, *"In the scanned copy of the maternal notes (contemporaneous record) the time the baby was recorded on the rescuscitaire (resus) was 18:20."* The panel took account of the scanned copy of Patient A and Baby A's patient record that was in the Investigation report which confirmed what Witness 2 had recorded. The time of 18:20 was recorded as being the time Baby A was taken to the rescuscitaire.

Witness 2 in the report continued, *"On 28 June 2019 [Miss Williams] made a retrospective entry on 25 June 2019. The retrospective entry was made to correct record keeping procedures as it was dated on the date the entry was made and it was clear which date the entry related to."*

The panel took account of the scanned copy of Patient A and Baby A's patient record which showed that 18:20 had been crossed out and 18:23 was written instead.

Witness 2 in the report continued, *"On 8 April 2021, the investigator went to check the original records and noted that an amendment had been made to the records since the scanned copy of the records that had been made. After the scanned copy was made on 28 August 2019 [Miss Williams] had added in a single line that crosses through the time at 18:20 and the time of 18:23 been added. There is a * and then "see retrospective entry timings incorrect" and this entry has been signed by [Miss Williams] but there is no date."* It continued*, "At interview with [Miss Williams] on 21 April 2021 [Miss Williams] stated that she must have made these changes as they are signed by her"*.

The panel accepted Witness 2's interpretation of the clinical records. It bore in mind that Witness 2 had stated within her aforementioned investigation report that Patient A and Baby A's records were scanned by the legal team on 28 August 2019. This meant that the amendments made to the original records were made after this time. It bore in mind that Witness 2's interview with Miss Williams had occurred in April 2021 and this is when the retrospective entries were noticed and brought to Miss Williams' attention. The panel accepted the evidence that Miss Williams admitted during interview that she had made the retrospective changes.

In light of the above, the panel was satisfied that on an unknown date between 28 August 2019 (after the date the legal team had scanned the records) and 8 April 2021 Miss Williams made further retrospective entries which changed the time from 18.20 to 18.23 hours to when Baby A was placed on the rescusitaire.

The panel therefore found this sub charge proved.

Charge 5c

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

5. On an unknown date between 28 August 2019 and 8 April 2021 made further retrospective entries in Patient A's records in that you,
    c. changed the APGAR scores from 8 to 7 at 1 and 5 minutes on the partogram.

This sub charge is found proved.

The panel considered the written and oral evidence of Witness 2 and in particular the Management Investigation report for the Trust dated 27 May 2021 produced by her. Within this report, under the sub-heading entitled "Partogram", Witness 2 stated, "In the scanned copy of the records (scanned 28 August 2019) [Miss Williams] has written in her contemporaneous record on the partogram page that the APGAR was 8 at 1 minute…" Witness 2 accepted within the report that this entry was difficult to read.

Witness 2 continued "*The investigator on 8 April 2021 observed that the original APGAR score had been scrubbed out and an addition had been made to the record. Incorrect processes had been used to amend the record retrospectively as the previous record could now not be read. The amendment is difficult to read and appears to record the APGARs at 7 at 1 min and then It is difficult to read (?7 at 5) and looks like [Miss Williams]'s signature and a date recorded of 8/8/2019 (this is also unclear) and the record now states amended after retrospective review."*

The panel noted that later in the investigation report, Witness 2 stated the following, *"[Miss Williams] stated that she must have changed the partogram as that too had her signature and the reason for the and the reason or the change".*

The panel accepted Witness 2's interpretation of the clinical records. The panel bore in mind that Witness 2 had stated within her investigation report that Patient A and Baby A's records were scanned by the legal team on 28 August 2019. This meant that the amendments made to the original records were made after this time. It bore in mind that

Witness 2's interview with Miss Williams had occurred in April 2021 and this is when the retrospective entries were brought to Miss Williams' attention.

In light of the above, the panel was satisfied that on an unknown date between 28 August 2019 and 8 April 2021 Miss Williams retrospectively changed the APGAR scores from 8 to 7 at 1 and 5 minutes on the partogram.

The panel therefore found this sub charge proved.

Charge 6a, 6b(i), 6b(ii), 6b(iii), 6b(vi)

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Baby A and Patient A

6. Your actions at charges 3-5 were dishonest in that you knew
    a. the retrospective entries were not true and/or
    b. you intended to mislead anyone reading Patient A's record into believing that:
        i. Baby A's condition at birth was 'good'.
        ii. Baby A's APGAR scores were incorrect on 25 June 2019.
        iii. You had listened to Baby A's fetal heart rate at 18.00 hours.
        iv. Baby A's condition deteriorated at a later time than originally recorded.

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.

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 Miss Williams' 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 3, 4 and all of 5 proved. In its consideration of finding charges 6a, and 6b as a whole proved, it reminded itself of the timeline of events.

Baby A was born on 25 June 2019 at 18:17. Colleague B originally recorded that Baby was born in "poor condition" on the "Details of birth" form. However, the panel found that on or around 25 June 2019, Miss Williams improperly encouraged Colleague B to change the condition of Baby A from 'poor' to 'good'. The panel reminded itself that within the "Management Investigation for Gloucestershire Hospitals NHS Foundation Trust" Witness 2 documented that, at interview, Colleague B stated that "*she wrote this entry at the request of her line manager [Miss Williams].*"

On 25 June 2019, Colleague B had contemporaneously recorded Baby A's APGAR scores as 5 at 1 minute and 6 at 5 minutes. This supported the entry that Baby A was born in "poor condition" on the "Details of birth" form. However, the panel found that sometime between 25 and 28 June 2019, Miss Williams had made incorrect retrospective entries into Patient A's maternal records. Within Patient A's clinical records dated 28 June 2019, which has been signed by Miss Williams, she had assessed the APGARs as 7 at 1 minute and 7 at 5 minutes. Miss Williams had also confirmed that these entries were made retrospectively.

The panel accepted Witness 2's written and oral evidence that Patient A and Baby A's records were scanned by the legal team on 28 August 2019. Following this, between 28 August 2019 and 8 April 2021, Miss Williams had added a fetal heart rate, changed the time from 18.20 to 18.23 hours to when Baby A was placed on the rescusitaire and changed the APGAR scores from 8 to 7 at 1 and 5 minutes on the partogram.

In assessing Miss Williams' state of mind, the panel considered that she would have known that Baby A had passed away when she made each of the retrospective entries starting on 28 June 2019. The panel considered that as a result, she ought to have known that she should not have amended the clinical records in such circumstances.

Nevertheless, Miss Williams made retrospective entries recounting events days and then again months later with no medical evidence to support them and this was likely to mislead any reader of the records.

Further, the panel had no evidence before it to suggest that Miss Williams informed the trust of the subsequent retrospective entries she had made sometime between 28 August 2019 and 8 April 2021. These alterations to the records would not have been discovered but for the fact that the legal team had made photocopies of the original clinical records and the subsequent entries were only discovered after comparing photocopies with the originals. They were then brought to the attention of Miss Williams in an interview in April 2021 and it was only at that time that she admitted what she had done.

Additionally, the panel noted that the retrospective entries made gave the impression that Baby A was born in better condition than what was originally recorded at the material time. It was of the view that ordinary decent people, would consider that the retrospective entries were done with an intention to mislead.

The panel concluded that on the balance of probabilities Miss Williams' actions in relation to charges 3, 4 and 5 based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67,* were dishonest.

The panel therefore found these sub charges proved.

Charge 7

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

7. On 14 May 2020 as the allocated midwife, were aware or should have been aware from the medical records that Patient B was not suitable for midwifery-led care and taken the appropriate action by escalating to the hospital.

This sub charge is found proved.

The panel took account of Patient B's clinical records. Within the records, on 14 May 2020 at 07:48, Colleague B had recorded the following, *"Care handed over to [Miss Williams] intro's made".* The panel was satisfied that Miss Williams from this time was in charge of Patient B's care.

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, she cited the risks identified by Colleague B. She stated that Colleague B had observed blood-stained liquor and this was noted multiple times. She stated that *"At 03:50, the antenatal notes recorded 'blood-stained liquor ++'".* She further stated that, *"This observation was repeated in the intrapartum notes and documented again at 06:10 hours"*

Witness 4, in her Expert Witness Report also stated that, *"Patient B's temperature was consistently below the expected range: 35.7°C at 00:05 hours, and 35.9 °C at 02:30 hours, 03:40 hours, and 04:45 hours"*

The panel also noted that Witness 4, in her Expert Witness Report, that *"upon observing a heavily blooded stained show and blood-stained liquor following SROM"* and *"upon noting sustained low maternal temperature"* would have been an appropriate time to escalate.

Witness 4 continued, *"Upon receiving Patient B into her care, a competent Band 7 midwife would be expected to conduct a thorough assessment to identify and manage potential risks throughout the labour and delivery process. Patient B presented with a history of an episode of antepartum haemorrhage (APH) and reduced fetal movements (RFM) at 34+2 weeks, blood stained liquor and low maternal temperature during labour."*

In the case of Midwife Williams, it is evident from the Trust investigation that she did not meet expected standards. When taking over care of Patient B from [Colleague B], she failed to review Patient B's complete medical history and the intrapartum notes documenting instances of blood-stained liquor and maternal temperature abnormalities earlier in labour."

The panel also noted that "fresh eyes" had been documented on Patient B's clinical records. The panel took account of the notes of an Interview with Miss Williams, dated 14 December 2020 undertaken by Witness 2. Witness 2 had documented the following, *"[Miss Williams] felt that she had a good handover from [Colleague B] so did not read through entire notes as she felt it more important to form a relationship. [Witness 2] asked what fresh eyes is – do [observations], check notes ensure correct pathway but did not read notes."*

The panel noted that "fresh eyes" would indicate that Miss Williams would familiarize herself with Patient B's clinical notes to see what had been documented and what care had been provided. However, it was clear that she did not do this.

The panel accepted that it may have been difficult for Miss Williams to read fully about the ante-natal care provided. However, it was of the view that she ought to have at least read about the care Patient B had been provided whilst on the birth unit. Had Miss Williams

done this, she would have seen the two instances of bloodstained liquor and the three instances of low maternal temperatures. This would have informed her that Patient B was not suitable for midwifery-led care and taken the appropriate action by escalating to the hospital.

The panel therefore found this charge proved.

Charge 8

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

8. On 14 May 2020 between 1115 and 1210 hours failed to conduct fetal heart rate assessments every 5 minutes.

This charge is found not proved.

In order to find this proved, the panel had to be satisfied first that Miss Williams on 14 May 2020 had a duty to conduct fetal heart rate assessments every 5 minutes in relation to Patient B and Baby B. The panel bore in mind that in charge 7 Colleague B on 14 May 2020 at 07:48, had recorded the following, *"Care handed over to [Miss Williams] intro's made".* The panel was satisfied that Miss Williams, as the senior midwife in charge who had taken over for care of Patient B and, subsequently Baby B, and was present during the birth of Baby B had a duty to conduct fetal heart rate assessments every 5 minutes. In light of this, the panel then went on to consider whether Miss Williams had failed in her duty to do so.

The panel took account of the Healthcare Safety Investigation Branch (HSIB) report dated November 2020. Under the heading entitled “5.3.3 Practice of intermittent auscultation”, the following has been stated:

> *“When performed in line with national guidance (NICE 2017), [intermittent auscultation] is conducted at least every 15 minutes in the first stage of established labour, increasing to at least every five minutes, or after each contraction, in the second stage of labour.”*

The panel also bore in mind that a description of the second stage of labour is mentioned within the aforementioned HSIB report, under the heading “5.3.4 Transition to second stage of labour”. It stated that NICE (2014) described the second stage of labour as, *“expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix”*

The panel took account of the partogram of Patient B. It noted that the fetal heart rate assessments were being conducted every 15 minutes up until 12:10. At that point they were then assessed at every 5 minutes.

In considering the NICE 2017 guidelines and the partogram the panel noted that to find this charge proved, it would have to be satisfied that Patient B was in the second stage of labour between 11:15 and 12:10. Then, and only then, would Miss Williams have failed in her duty to conduct fetal heart rate assessments every 5 minutes.

The panel reminded itself that it is for the NMC to prove the charge. It noted that the NMC appeared to rely on the oral and written evidence provided by Witness 4. Within her report in a section entitled “Fetal wellbeing concerns”, she stated:

> *“There were times that the [fetal heart rate] was not auscultated in line with local and national guidelines, for example every 5 minutes after the second stage of labour was thought to have commenced.”*

In response to panel questions, Witness 4 was presented with Patient B's partogram. She stated that the second stage of labour is confirmed when the mother undergoes a vaginal examination to confirm cervical dilatation.

The panel asked Witness 4 how a midwife would know when to go from assessing the fetal heart rate from every 15 minutes in the first stage of labour to every 5 minutes in the second stage of labour. Witness 4 stated that it would be difficult to determine this because not every mother would have undergone a vaginal examination. She also stated that it would be down to the clinical judgement of the midwife on when the second stage starts. Witness 4 conceded that it would not be unreasonable to say that the second stage started at 12:15 where she stated that it appeared the second stage fetal heart observations were commenced at this point. Witness 4 also stated that the vaginal examination was undertaken at 12:45 which would have confirmed cervical dilatation.

The panel was of the view that the NMC's evidence falls short of satisfying the panel that Patient B was in the second stage of labour between 11:15 and 12:10. It noted that Witness 4, in her expert report, stated that Patient B may have been in the second stage of labour between 11:15 and 12:10, however in her oral evidence she conceded that this may have been a wrong assessment on her part.

The panel noted that Witness 2 was also shown Patient B's partogram. In response to panel questions, her interpretation of the partogram was that it was not the second stage of labour between 11:15 and 12:10 so therefore fetal heart rate only needed to be conducted every 15 minutes during these times.

The panel therefore found this charge not proved.

Charge 9a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

9. On one or more occasion on 14 May 2020 failed to transfer Patient B to obstetric care, in that you,
a. failed to take into account Patient B's request to be transferred, on one or more occasions.

This sub charge is found proved.

In order to find this sub charge proved, the panel had to be satisfied first that Miss Williams had a duty to transfer Patient B to obstetric care when Patient B requested to be transferred on one or more occasions.

The panel was satisfied that Miss Williams, as the senior midwife in charge who was present during the birth of Baby B had a duty to take into account a request from Patient B to transfer her to obstetric led care when she requested to be transferred. In light of this, the panel then went on to consider whether Miss Williams 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 she had recorded the following, *"Non-Compliance with Patient Wishes: Ignoring Patient B's request for transfer to a higher-level care facility highlights a failure to respect patient autonomy and preferences, which is a key aspect of midwifery care."*

The panel bore in mind that the opinion of Witness 4 was supported by the oral evidence of the other midwives who gave evidence. They all shared the same sentiment, namely that the mother's wishes must be adhered to.

The panel was satisfied that Miss Williams, as the senior midwife in charge who was present had a duty to transfer Patient B to obstetric care when Patient B requested this. In light of this, the panel then went on to consider whether Miss Williams had failed in her duty to do so.

Patient B in her witness statement described how she asked to be transferred to Gloucester obstetric ward multiple times during labour when she was in Miss Williams care. She stated that her requests were at 11:00, midday and 13:00.

In her Witness statement, Person B stated that when she had asked at around 11:00, Miss Williams said she wanted to try some oils. Person B stated that Miss Williams did not ask if this was ok with her.

When Person B asked at midday because she was *"struggling so much"*, Miss Williams said she had heard Person B, but Miss Williams wanted her to try one more position.

Person B stated that when she had asked at 13:00, Miss Williams told another midwife in the room at that point to call an ambulance but by that time it was too late as labour was progressing, and Miss Williams could see Baby B's head.

Patient B reiterated this in her oral evidence.

Person B, the partner of Patient B, in his oral evidence supported Patient B's evidence and stated that she had asked several times to be transferred.

The panel took account of the clinical notes for Patient B. It noted that the following had been recorded at 13:00, *"Patient B exhausted would like to be transferred".* At 13:08, the following had also been recorded, *"NB Ambulance called".*

Additionally, the panel took account of the Management Investigation report for the Trust dated 27 April 2021 provided by Witness 2. Within this report, the following had been quoted from the HSIB report, *"Because the Mother was feeling exhausted, she requested to be transferred to the obstetric led unit at the Trust 13 hours after her arrival on the BC and an ambulance was called to transfer her. Before the Mother could be transferred, the Baby's heart rate decelerated down to 100 beats per minute (bpm), recovering to within the expected range, before decelerating down again to 80 bpm. This did not recover (known as a bradycardia) and, as the Baby's head was advancing."*

The panel noted that the Patient B's clinical notes and the Management Investigation report for the Trust supported the evidence of Patient B. It also noted that an ambulance was called at 13:08.

Witness 2 in her witness statement also supported Patient B's evidence. In her witness statement she stated *"[Miss Williams] should have transferred the mother when she initially requested to be transferred at 11am because she was exhausted".*

The panel also bore in mind that Witness 4, in her oral evidence stated that that during labour, a mother may request to be transferred, and you would agree to this but inform them you want to try something else while the transfer is being arranged. She also stated that if the alternative method of care works in assisting the mother, then the transfer ambulance can be cancelled. However, she stated that a midwife would not ignore the request to be transferred.

The oral evidence the panel had heard from the midwives who gave evidence at his hearing supported Witness 4's opinion. Additionally, in Miss Williams' local statement regarding the incident, she stated that at 13:00 Patient B requested to be transferred. She

stated that *"Although there had been progress in the 2nd stage of labour the woman's wishes should be acknowledged and respected therefore the transfer process was instigated".* Despite this, Miss Williams did not appear to acknowledge this when Patient B requested to be transferred at 11:00 and at midday.

The panel accepted the evidence of Patient B and Person B. In the panel's judgment, Miss Williams appeared to ignore Patient B's request to be transferred, on one or more occasions, namely at 11:00 and at midday.

The panel therefore found this sub charge proved.

Charge 9b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

9. On one or more occasion on 14 May 2020 failed to transfer Patient B to obstetric care, in that you,
   b. when Baby B suffered fetal bradycardia and/or showed signs of distress.

This sub charge is found not 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 she had recorded the following, *"Observation: Midwife Williams documented changes in the fetal heart rate, including episodes of bradycardia and varying heart rates prior to birth. Notably, there was a fetal heart rate of 100bpm, recovering briefly to 140bpm, but then showing bradycardia at 80bpm shortly before Baby B was born."* She also reported, with regards to the risk this

posed was, *“Irregular fetal heart rates are indicative of fetal distress, potentially due to hypoxia or other underlying issues.”*

The panel took account to the “Second Stage Partogram” within Patient B’s clinical notes. It noted that it appeared to support Witness 4’s analysis, namely that the fetal heart rate had been recorded as approximately 160 bpm at 13:15 to 100 bpm at 13:20, and then approximately 90 bpm at 13:20. It also noted that Miss Williams had annotated “bradycardia” where the fetal heart rate is recorded as approximately 90 bpm at 13:20.

However, the panel then took account of the clinical notes of Patient B. At 13:08, the following had been recorded, *“NB Ambulance called”.* This is supported by the Management Investigation report for the Trust dated 27 May 2021 undertaken by Witness 2. Within this report, there is a chronology of what had occurred on 14 May 2020. The panel noted that, according to this chronology, an ambulance had been called at 13:08.

The panel was of the view that Miss Williams had not failed in her duty to transfer Patient B to obstetric care when when Baby B suffered fetal bradycardia and/or showed signs of distress. It noted that while the fetal heart rate had dropped to approximately 100 bpm at 13:20, which according to Witness 4’s report was, “*followed by a bradycardia, raising concerns about potential fetal distress”*, the transfer via ambulance had already been arranged at 13:08.

The panel therefore found this sub charge not proved.

Charge 10a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by
    a. activating the emergency bell, and/or

This sub charge is found proved.

The panel bore in mind that in its consideration of charge 9b, Miss Williams had identified a fetal bradycardia at 13:20. It now had to determine whether or not, upon this identification, Miss Williams alerted colleagues to the emergency by activating the emergency bell.

The panel took account of the chronology of events in relation to this charge. In Patient B's clinical notes, it stated that at 13:00, Patient B was exhausted and requested to be transferred. At 13:08 the ambulance was called. At 13:10, it stated that a second midwife was called via the maternity care assistant. At 13:28, the clinical notes stated, *"called for midwife help in view of bradycardia."* This was Colleague C.

The panel took account of Colleague C's retrospective notes written on 21 May 2020. The panel noted that these were the most contemporaneous patient notes it had outside of the ones written by Miss Williams. At 13:28, Colleague C stated that she *"Answered call bell to Athena room".*

Colleague C in her local statement written on 24 November 2020, stated that at 13:05, the maternity care assistant *"came into the little office to inform me that [Miss Williams] was planning to transfer Patient B over to Gloucestershire Royal Hospital".*

The panel bore in mind that there was a discrepancy with the times provided by Colleague C. However, it was satisfied that she was the midwife called into the as described in Patient B's clinical notes.

The panel bore in mind that Colleague D in her oral evidence stated that the emergency bell would be used for any maternal emergency where you need *"more hands than you already have"*. She stated that it would be similar to a fire alarm as it is heard throughout the birthing unit and you would expect everybody to attend to where the emergency was.

With this in mind, the panel noted that Colleague C in her oral evidence stated that when she was called, she did not know what she was walking into. Additionally, Colleague C in her witness statement stated, *"At this point I wasn't even aware of the bradycardia as [Miss Williams] hadn't mentioned it.*

The panel was of the view that there did not appear to be a sense of urgency surrounding the incident. It also reminded itself that Colleague C, in her contemporaneous retrospective patient notes dated 21 May 2020, stated that she responded to a "call bell". She also confirmed this in her oral evidence.

Witness 2 who investigated the incident, in her witness statement stated that the *"emergency buzzer was not used by [Miss Williams] instead she used the normal call bell that is not used for emergencies".*

The panel was of the view that the lack of urgency and the fact that only Colleague C was called and entered the room suggests that the emergency bell was not activated.

However, the panel bore in mind that it had heard evidence that indicated that the emergency bell had been turned off at the birthing unit or was not used at all.

Colleague C in her oral evidence stated that she had mentioned her concerns about the lack of an emergency bell going off for Patient B's deliver, she stated that she had been notified that the emergency bell had been disconnected. She stated that the rationale behind this was not explained to her. She also stated that Miss Williams had wanted to create a *"home from home environment"* and not have the emergency bells going off.

This apparent culture of not using the emergency bell was reflected in Colleague D's witness statement. She stated that everyone was confused as to why they did not know a serious incident had happened with regards to the passing of Baby A in June 2019. She stated that she had told the Risk Manager and Deputy Director of her concerns and they *"found out that the Emergency Bells had been turned off, so even if people had been using them they wouldn't actually call anyone."*

The panel was of the view that once a fetal bradycardia was identified, the appropriate procedure would be to use the emergency bell. The panel bore in mind that there was evidence to suggest that the emergency bell at the birthing unit was not working. However, on a purely factual basis, the panel was satisfied that Miss Williams had not activated the emergency bell.

The panel therefore found this sub charge proved.

Charge 10b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by
    b. informing Colleague C of the bradycardia on their attendance to assist, and/or

This sub charge is found proved.

The panel bore in mind that in its consideration of charge 10a, it noted that it was the maternity care assistant who was relaying information to Colleague C from Miss Williams during the incident. This would have been before Colleague C entered the room.

The panel took account of an interview with the maternity care assistant undertaken by Witness 2. The maternity care assistant stated that Miss Williams had asked her to call the delivery suite to inform them that they were transferring Patient B over to them because of a failure to progress. Later in the interview, the maternity care assistant stated that she was asked by Miss Williams to call for a slow ambulance. She stated that the call handler had asked her if this was an obstetric emergency. The maternity care assistant asked Colleague C and was told to say that it was otherwise there would have been a four hour wait. She stated that when the ambulance crew arrived she entered the room and saw Patient B in the Lithotomy position pushing and she went to support Patient B. She stated that she saw Miss Williams push the call bell and that is when Colleague C enter the room.

The panel noted that at this stage, the maternity care assistant has not been told of an emergency situation relating to a fetal bradycardia. Additionally, she has not relayed any such information to Colleague C.

The panel was mindful that this amounted to hearsay. The maternity care assistant had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no way to test the veracity of this.

However, the panel bore in mind that her account appeared to be supported by the evidence of Colleague C. Colleague C in her witness statement stated:

> *"At 13:05…Maternity Care Assistant, came into the office to inform me that [Miss Williams] was planning to transfer the Mother to Gloucester Royal Hospital and wanted a 'slow ambulance'. I said there was no such thing and that a transfer required an immediate response.*

…

The paramedics arrived and I was waiting outside the room with them when I was called in to assist. [Miss Williams] sent the paramedics away when they attempted to enter the room. [Miss Williams] asked me to listen to the fetal heartrate which I did and thought it was possibly 80bpm but I was not convinced this was fetal as the Mother had another contraction at this point. The sonicaid to listen to the heartrate wasn't immediately available so it seemed [Miss Williams] hadn't been following guidance that when there is a bradycardia you must listen in. At this point I wasn't aware of the bradycardia as [Miss Williams] hadn't mentioned it."

The panel noted that this was consistent with the contemporaneous notes of Colleague C regarding the incident which was written on 21 May 2020. At 13:29, Colleague C stated that, "*[Miss Williams requests consultation of [Fetal Heart]. Difficult to locate…unable to confirm maternal pulse as contraction started".*

Colleague C reiterated this in her oral evidence. She stated that when she was called, she did not know what she was walking into. She stated that she walked into the room on a normal call bell thinking Patient B was about to deliver or to assist with tea and toast for Patient B. She stated that when she did not expect any kind of emergency. She stated that when she entered the room, Patient B was lying on the bed being supported by Person B. She stated that she was told by Miss Williams that Patient B was exhausted and the plan was to give her diamorphine. She stated that there was no indication that there was an emergency.

The panel took account of the local statement of Miss Williams. She stated that at 13:00, Patient B was exhausted and requested to be transferred as she did not have the strength to push anymore. She also stated that the maternity care assistant was asked to organise transfer and call delivery suite to inform the delivery suite of the plans to transfer. She stated that the reasons for transfer was delay in second stage due to lack of contractions and maternal request.

The panel noted that this appeared to support the account of the maternity care assistant and confirmed that the transfer process was because Patient B requested it and not because of the fetal bradycardia. However later in her statement, she stated that at 13:25 the fetal heart rate auscultated at 80bpm with no recovery. The panel bore in mind that this was the identification of the bradycardia. Miss Williams stated that when Colleague C entered the room, she explained the bradycardia and asked Colleague C to auscultate the fetal heart rate.

The panel bore in mind that this is at odds with the account of Colleague C who stated that she did not know what she was walking into when she entered the room and was not aware of any bradycardia.

The panel accepted evidence of Colleague C and was satisfied that her account was supported by her witness statement, her oral evidence and contemporaneous documentary evidence. Her evidence was as also supported by the account of the maternity care assistant. The panel preferred the evidence of Colleague C over Miss Williams' explanation.

The panel therefore concluded that upon identifying a fetal bradycardia, Miss Williams did not alert Colleagues to the emergency by informing Colleague C of the bradycardia on their attendance to assist.

The panel therefore found this sub charge proved.

Charge 10c

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by
    c. asking for a category 1 ambulance, and/or

This sub charge is found proved.

The panel bore in mind that in its consideration of charge 10b, it had taken account of the interview of the maternity care assistant produced by Witness 2. She stated that she was asked by Miss Williams to call for a *"slow ambulance"* because of *"a failure to progress."* The maternity care assistant stated that she was asked by the call handler if this was an obstetric emergency. She asked Colleague C and was told by Colleague C to say that it was otherwise there would be a four-hour delay.

The panel bore in mind that this was hearsay and neither attended to give evidence at this hearing nor provided a formal witness statement. However, her account was supported by Colleague C's witness statement. She stated that the maternity care assistant, *"came into the office to inform me that [Miss Williams] was planning to transfer the Mother to Gloucester Royal Hospital and wanted a 'slow ambulance'. I said there was no such thing and that a transfer required an immediate response."*

The panel also took account of the local statement of Miss Williams who stated that the reasons for transfer was delay in second stage due to lack of contractions and maternal request.

The panel noted that there was no evidence before the panel to suggest that Miss Williams had called for a category 1 ambulance. It appeared to the panel that Miss Williams had asked the maternity care assistant for a *"slow ambulance"* and this was never upgraded to a category 1 ambulance upon identifying a fetal bradycardia or at any stage of labour.

The panel therefore found this sub charge proved.

Charge 10d

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by

    d. informing Colleague D of the emergency on their attendance, and/or

This sub charge is found proved.

Colleague D in her witness statement stated:

"I was eating my lunch at the computer…A Maternity Support Worker…came in and said help was needed in a patient room. I got up straight away to go but I wasn't really sure what to expect. I clicked my fingers to get [Another Community Midwives]'s attention whilst she was on the phone, so she knew where I was going and that she might need to help.

After I left the office, I walked round the corner to the room and knocked on the door out of habit. I then pulled the curtain slightly across and saw [Miss Williams] directly in front of me. She told me to calm down and said everything was fine, that she just needed sutures… When I turned round, I realised the placenta was still in the Mother and there was no active blood loss coming from the episiotomy, so it seemed early to be preparing for suturing. Hazel told me I had given her the wrong sutures so I turned back round to get the right ones.

At this point, Hazel asked me to check if we could get some blankets warmed, as

Baby B might need transferring. This is when I looked over at the resuscitaire and noticed midwife [Colleague C] and a paramedic doing chest compressions."

Colleague D reiterated this in her oral evidence. She stated that she was being told that there was a flat baby compromise and expecting to be asked to either help with resuscitation or to organise transfer. She then stated that Colleague C had asked her to assist with resuscitation. She stated that Colleague C gave her a brief handover of where she was with resuscitation.

The panel took account of the local statement of Miss Williams regarding the incident on 14 May 2020. She stated that Colleague D and the other community midwife referenced in Colleague D's witness statement, arrived and that only Colleague D stayed and assisted with resuscitation.

The panel noted that Miss Williams did not indicate that she had informed Colleague D of the emergency regarding the fetal bradycardia. It also noted that Colleague D in her witness statement or her oral evidence did not say that Miss Williams had informed her of the emergency situation regarding the fetal bradycardia. Both statements appeared to be consistent with each other.

The panel accepted the evidence of Colleague D and preferred the evidence of Colleague D over the account given by Miss Williams.

The panel therefore concluded that upon identifying a fetal bradycardia, Miss Williams did not alert Colleagues to the emergency by informing Colleague D of the emergency on their attendance.

The panel therefore found this sub charge proved.

Charge 10e

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

10. On 14 May 2020 on identifying a fetal bradycardia did not alert Colleagues to the emergency by
    e. handing over to the receiving hospital that Baby B was bradycardic

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. She cited what would be expected of competent midwife during the waiting period for transfer. She stated, *"Ensure all medical notes are thorough and complete, and utilise an SBAR tool for an effective handover to hospital clinicians"*

Witness 4 in her oral evidence stated that the SBAR (Situation, Background, Assessment and Recommendations) was a standard tool was not just used for maternity but across medicine. She stated that this is for when you are handing over to clinicians, you can very clearly and succinctly explain what the problem is. She stated that this could be done whilst waiting for transfer.

Colleague D in her Witness statement stated:

> *"The handover should have come from the midwife who was looking after mum or had the most knowledge of her pregnancy, labour, birth history. In this case it was [Miss Williams] who was both. For every handover, even during an escalation situation the Trust handover should have been used. This had changed in the*

September 2019 (relaunched in July 2020) from RSVP to SBAR but neither were used. No information was provided. SBAR...You need to handover everything such as observations, what is happening and what needs to happen next. You should document the information you are handing over or the care you are taking over. We need to make sure that there is a clear history of who we are looking after."

The panel took account of the hospital records. Within these records, there was no indication of a handover regarding what care had been provided to Patient B and Baby B nor any indication of any clinical notes being handed over including the partogram.

The panel also took account of Miss Williams' local statement which confirmed that she had written the patient notes retrospectively and therefore they would not have been available to handover to the receiving hospital.

The panel bore in mind that in its consideration of charges 10b and 10d it had concluded that neither Colleague C nor Colleague D were informed of the fetal bradycardia emergency upon entering the room.

The panel bore in mind that as the Senior Midwife in charge of the care of Patient B, and of the birthing unit, there would have been an expectation for her to communicate to fellow professionals of the state of Patient B and the state Baby B before transfer or to ensure that it was done.

However, there was no evidence before the panel that upon identifying a fetal bradycardia, Miss Williams handed over to the receiving hospital that Baby B was bradycardic. There is no evidence before the panel that this was done by way of an SBAR, a transfer of the clinical notes or by way of a telephone call.

The panel therefore found this sub charge proved.

Charge 11

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

11. Your actions at charges 8 to 10 above caused and/or contributed Baby B to lose a significant chance of survival.

This sub charge is found proved.

The panel bore in mind that it had only found charges 9a, and 10a, 10b, 10c, 10d and 10e proved. Therefore, it would only consider whether Miss Williams actions, in relation to these charges, caused and/or contributed Baby B to lose a significant chance of survival.

The panel bore in mind that it had found that Miss Williams had failed to take into account Patient B's request to be transferred on multiple occasions. Additionally, upon identifying a fetal bradycardia, Miss Williams did not alert colleagues to the emergency by activating the emergency bell, informing Colleague C or Colleague D of the bradycardia when they attended to assist; asking for a category 1 ambulance; or providing a handover to the receiving hospital that Baby B was bradycardic.

The panel took account of the written and oral evidence of Witness 4 and in particular the "Expert Witness Report" provided by her, which stated:

> *"A competent Band 7 midwife would be expected to promptly escalate care when indicated by clinical signs or patient preferences, ensuring timely interventions to optimise maternal and fetal outcomes."*

On the evidence presented to the panel, it was clear that Miss Williams delay in the transfer of Patient B prevented obstetric led care being instigated at the earliest available

opportunity. The panel was satisfied that Miss Williams' actions, in relation to charges 9a, and 10b, 10c, 10d and 10e, caused and/or contributed Baby B to lose a significant chance of survival.

The panel was of the view that, since the emergency bell was not active, the fact that she did not activate it could not have caused or contributed to a loss of chance for Baby B to survive.

The panel therefore found this charge proved for 9a, 10b, 10c, 10d and 10e.

Charge 12

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

12. On 14 May 2020 did not label Patient B's placenta accurately which prevented further examination.

This charge is found not proved.

The panel took account of the evidence the NMC were relying on to prove this charge.

The panel noted that there is a record of the placenta being delivered by Miss Williams in Patient B's clinical records.

The panel also took account of the oral and written evidence of Witness 2 and in particular the Management Investigation report for the Trust dated 27 April 2021 produced by her. Within this report, the following had been quoted from the HSIB report, "*The Mother's placenta was sent for histopathological examination. The HSIB clinical panel was unable*

to review the results as it is not clear how it was ascertained that the placenta was the correct one as two placentas had been sent to the laboratory with the Mother's details attached."

The panel also noted that there was no further information about this within Witness 2's witness statement, nor did she address this in her oral evidence.

The panel reminded itself that it is for the NMC to prove the charge. It noted that the NMC had not provided the panel with evidence of; who sent the placenta's to the laboratory; how the placenta's were labelled or whether or not they were labelled by Miss Williams. It reminded itself that the NMC relied solely on the record in Patient B's clinical records and the quote in the Management Investigation report from Witness 2. It noted that neither are sufficient to demonstrate that Miss Williams did not label Patient B's placenta accurately which prevented further examination.

This charge is not supported by any other evidence before the panel.

The panel therefore found this charge not proved.

Charge 13a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    a. discouraged the reporting of concerns; and/or

This sub charge is found not proved.

The panel noted that there appeared to be a general culture of discouragement at the birth centre. It bore in mind that Patient B, in her witness statement, stated that at her first antenatal class, she could recall two mothers mentioning that they did not want to give birth at the birth centre and wanted to go to Gloucester. She stated that staff appeared to ignore them after this.

Colleague D in her witness statement stated:

> *"I did experience issues at the Trust, including with [Miss Williams]. [Miss Williams] was the Clinical Lead midwife and was also involved with the incident in May 2020. I had problems with how she dealt with issues and with her practice…As a community midwife, I was not completely sure where everything was kept on the birth unit, as things would move…. [Miss Williams] had said she would look into the issues I reported but I never heard anything about it. She was just dismissive about me reporting it and I felt belittled by her."*

Colleague D reiterated this in her oral evidence.

The panel turned to the stem of the charge. It was of the view that whilst discouraging the reporting of concerns would put patients at risk of harm, there was no evidence that Miss Williams fostered this culture with a view to keeping birthing numbers up. The panel heard opinion evidence from Colleague D and Witness 2 that this was the reason for the culture. These allegations were not put to Miss Williams and there was no evidence to suggest that the culture was anything other than problems created by the fact that there were two units, effectively, in competition.

The panel noted that audits completed by Witness 1 had not revealed evidence of any improper practice being done in order to maintain numbers in the birth centre.

The panel therefore found this sub charge not proved.

Charge 13b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    b. did not act on reported concerns, and/or

This sub charge is found not proved.

Colleague D in her witness statement stated:

> *"There was also an incident where I had a patient who needed a new born examination done before 72 hours. I hadn't done the training as of yet at the time, so I phoned up the Birth Unit to see if someone could help, as no one on the community team had the capacity. I was informed by [Miss Williams] she would do it. They told me to bring the patient up to the Birth Unit but when I did by [Miss Williams] just looked at me when I walked in and said she couldn't do it now because something had come up and walked off."*

Colleague D reiterated this in her oral evidence

The panel turned to the stem of the charge and took account of its reasons set out in charge 13a above. Whilst the panel accepts that Miss Williams, on occasion, did not act on reported concerns in a manner which could have put patients at risk of harm, there is no evidence before the panel to indicate that this was done to keep birth numbers up at the birth centre.

The panel therefore found this sub charge not proved.

Charge 13c

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    c. screened the bookings; and/or

This sub charge is found not proved.

Colleague D in her witness statement stated:

> *"Both [Miss Williams] and [Colleague B] wanted to screen all new bookings before the community midwives, as they wanted to allocate more multiparous women to the continuity teams caseloads, to increase the number of births on the unit. This is despite this meaning these women would not be cared for by their previous community midwife or not actually wanting to go to Cheltenham for their birth. As with the 36 week assessment checks, I was told by [Miss Williams] if a woman was low risk they would be able to persuade them to come to Cheltenham, even if they preferred to go to Gloucester. [Miss Williams] told me not long after I started working as a community midwife that I should refer my 36 week checks to the birth unit midwives to complete so they could persuade any low risk women to go there and not Gloucester."*

Colleague D reiterated this in her oral evidence

The panel turned to the stem of the charge and took account of its reasons set out in charge 13a above. Whilst the panel accepts that Miss Williams, on occasion, screened the bookings, there is no evidence before the panel to indicate that this was done in a manner which put patients at risk of harm or to keep birth numbers up at the birth centre.

The panel therefore found this sub charge not proved.

Charge 13d

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    d. encouraged unsuitable patients to choose the birth centre; and/or

This sub charge is found not proved.

Colleague D in her witness statement stated:

> *"In my opinion, it is all about the numbers for the birth unit and some of the staff there…We were also told that our continuity framework was not about continuity with the midwives but with the Birth Unit, which encouraged people not to transfer mothers and babies. The focus was just totally on the numbers and who the women were was irrelevant. The Trust wanted to keep the numbers down and wanted 'normal' births."*

The panel turned to the stem of the charge and took account of its reasons set out in charge 13a above. It noted that this was the only evidence before the panel in support of the charge was from Colleague D. It noted that this may suggest that Miss Williams encouraged patients to use the birthing centre. However, there is no evidence before the panel that would demonstrate that the patients Miss Williams encouraged were unsuitable at the material time, put patients at risk of harm or done to keep birth numbers up at the birth centre.

The panel therefore found this sub charge not proved.

Charge 13e

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    e. delayed the transfer of patients to obstetric care; and/or

This sub charge is found not proved.

The panel took account of its findings in charge 1b, where it found that Miss Williams did not escalate Baby A's condition to the neonatal team.

The panel took account of its findings in charge 9a where it found that Miss Williams ignored Patient B's request to be transferred, on one or more occasions, namely at 11:00 and at midday.

The panel was of the view that these incidents demonstrated that Miss Williams delayed the transfer of patients to obstetric care.

The panel turned to the stem of the charge and took account of its reasons set out in charge 13a above. While it accepted that Miss Williams actions in delaying the transfer of Patient B and Baby B, and Patient A and Baby A put them at a risk of harm, it was not satisfied that this was done to keep birth numbers up at the birth centre.

There were no other examples before the panel of Miss Williams delaying the transfer of patients to obstetric care.

The panel therefore found this sub charge not proved.

Charge 13f

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

13. On one or more occasions acted in a manner that put patients at risk of harm to keep birth numbers up at the birth centre, in that you,
    f. encouraged staff not to use the emergency bell

This sub charge is found not proved.

Witness 3 in her witness statement stated:

> *"Staff also explained that emergency call bells were not used as staff had been told "we are home from home, and they wouldn't be used in the home". Staff have raised concerns that this is a recurring theme."*

This was reflected in the letter Witness 3 wrote to Witness 1 dated 16 July 2020 in relation to the investigation into the Trust following the passing of Baby B.

The evidence of Witness 3 appears to be supported by Patient B. Patient B in her witness statement stated:

> *"During my labour, the midwives didn't raise the alarm or ring the emergency bell. The justification for this was that they didn't want to scare other mums on the ward, but I believe any mother would understand the need for an emergency bell."*

The panel was of the view that these incidents demonstrated that Miss Williams encouraged staff not to use the emergency bell.

The panel turned to the stem of the charge and took account of its reasons set out in charge 13a above. The panel noted that while Miss Williams' actions may have put patients at risk of harm, there was no evidence to demonstrate that her actions were done to keep birth numbers up at the birth centre.

The panel therefore found this sub charge not proved.

Charge 14a

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

14. On one or more occasions failed to cascade learning to colleagues in that you,
    a. did not update learning from serious incidents.

This sub charge is found proved.

In order to find this proved, the panel had to be satisfied first that Miss Williams had a duty to cascade learning to colleagues.

Witness 1 in her witness statement stated:

> *"[Miss Williams] was a band 7 midwife who took an active role in supporting policy development and the delivery of the mandatory training programme for the Trusts midwives, leading skills drills."*

The panel was satisfied that Miss Williams, as the senior Band 7 midwife had a duty cascade learning to colleagues. In light of this, the panel then went on to consider whether Miss Williams had failed in her duty to do so by not updating learning from a serious incident. The panel bore in mind that the serious incident was the passing of Baby A on 26 June 2019.

Witness 1 in her witness statement stated that there was an audit of record keeping of maternal notes and learning points and areas for improvement were identified in the retrospective record keeping audit of maternal notes in 2019/20 and these were shared within mandatory training. She stated that in the subsequent audits, individual practitioners were identified, and these findings were fed back by the incoming Band 7 team leaders.

The panel noted that Miss Williams, as a Senior Band 7 Midwife responsible for mandatory training, was involved in the incident that resulted in the death of Baby A. It was of the view that when this occurred, Miss Williams should have disclosed what occurred to other midwives so that they could learn from this. However, the panel bore in mind that Colleague C and Colleague D in their oral evidence both stated that they knew nothing about what actually occurred regarding Baby A and Patient A.

The panel was of the view that on this occasion Miss Williams, as a Senior Band 7 Midwife responsible for mandatory training, failed to cascade learning by not updating learning from serious incidents.

The panel also took account of the “Interim Report of the High Level Review of Aveta Birth Centre” dated 11 September 2020 referred to by Witness 1 in her witness statement. Under the sub-heading entitled "Staff Engagement and communication” it stated that, “L*earning from incidents was not consistently disseminated to staff within the Birth Centre”.* The report cites and example where following a Coroner’s Prevention of Future Death Report all birth areas including the Aveta Birth Centre Lead, Miss Williams, received communication in August and November 2019 pertaining to the requirement to keep placentae for 24 hours. However, according to the report, the birth centre were freezing placentae. The report stated that this would make them unable to *be sent for histological examination following adverse outcome for baby.”*

The panel was of the view that on this occasion Miss Williams, as a Senior Band 7 Midwife responsible for mandatory training, failed to cascade learning, on this occasion, the need to keep placentae for 24 hours, to colleagues by not updating learning from serious incidents.

The panel therefore found this sub charge proved.

Charge 14b

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

14. On one or more occasions failed to cascade learning to colleagues in that you,
    b. did not embed the use of the NEWTT chart into practice.

This sub charge is found proved.

The panel had already established in charge 14a that Miss Williams had a duty to cascade learning to colleagues. It now had to determine if she failed in her duty to do so by not embedding the use of the NEWTT chart into practice.

Witness 1 in her witness statement stated that she had a meeting in July 2019 with Miss Williams and the Risk Manager for obstetrics and gynaecology. Witness 1 stated that Miss Williams that the use of a Newborn Early Warning Trigger and Track (NEWTT) score chart would have highlighted the need for escalation in relation to Baby A sooner.

Witness 1 in her witness statement referred to the "Trust Guideline Immediate Care of the Newborn A1093" which stated, *"Observations performed or required due to risk factor/s must be documented on a Newborn Early Warning Trigger and Track (NEWTT) chart and continued for a minimum of 12 hours after the initial risk factor has resolved or neonatal review has been undertaken and plan for ongoing care is in place."*

Witness 1 in her witness statement then stated that the HSIB investigation found that at that at the time of the incident *"the NEWTT chart was not embedded in practice in the Aveta Midwifery Led Unit".* She also stated that, *"…after the incident in 2019 it was clear that the use of the NEWTT was not consistent".*

The panel was of the view that on this occasion Miss Williams, as a Senior Band 7 Midwife, failed to cascade learning to colleagues by ensuring that the use of the NEWTT chart was embedded into practice.

The panel therefore found this sub charge proved.

Charge 14c

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

14. On one or more occasions failed to cascade learning to colleagues in that you,
    c. did not embed the SBAR handover process

This sub charge is found proved.

The panel had already established in charge 14a that Miss Williams had a duty to cascade learning to colleagues. It now had to determine if she failed in her duty to do so by not embedding the SBAR handover process.

Colleague D in her witness statement stated referred to the incident involving Baby B. She stated that the handover should have come from the midwife who was looking after mum or had the most knowledge of her pregnancy, labour, birth history. She stated that this would have been Miss Williams. She stated that the Trust Handover had changed in September 2019 from RSVP to SBAR (Situation, Background Assessment and Recommendations) but neither were used.

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, under the heading "Actions Expected for Baby A's Care" she stated, *"Reasonable actions at this stage would include thorough clinical observations, temperature management, and ensuring a comprehensive handover to hospital staff using structured communication tools like SBAR."*

Later in her report, Witness 4 also stated, *"On receiving Patient B into their care, I would expect it would be reasonable for a competent Band 7 midwife to take a detailed handover using a structured tool such as SBAR from the outgoing midwife and read/review the*

antenatal and intrapartum notes themselves to assess for existing or evolving risks, considering the history and current presentation of Patient B…"

The panel bore in mind that Colleague D in her witness statement stated that SBAR was not used. She stated:

> *"For every handover, even during an escalation situation the Trust handover should have been used. This had changed in the September 2019 (relaunched in July 2020) from RSVP to SBAR but neither were used. No information was provided".*

This was supported by the evidence of Colleague C and Witness 2.

The panel was of the view that on this occasion Miss Williams, as a Senior Band 7 Midwife responsible for mandatory training, failed to cascade learning, on this occasion, by embedding the SBAR handover process.

The panel therefore found this sub charge proved.

Charge 15

That you, a registered midwife, whilst working as clinical lead at the Aveta Birth Centre, a midwifery-led unit

In relation to Patient B and Baby B

15. Your conduct in respect of charges 13 and 14 above exposed patients to harm or neglect by fostering a poor culture.

This sub charge is found proved.

The panel bore in mind that it had only found charges 14a, 14b and 14c, proved. Therefore, it would only consider whether Miss Williams actions, in relation to these charges, exposed patients to harm or neglect by fostering a poor culture.

The panel noted it had found that Miss Willaims had, on one or more occasions, failed to cascade learning to colleagues when she did not update learning from serious incidents; did not embed the use of the NEWTT chart into practice and did not embed the SBAR handover process.

The panel noted that the above relates fundamental aspects of care and demonstrates a poor culture at the Birth Unit. It was of the view that a band 7 senior midwife conducting herself in this way as found proved would expose patients to harm or neglect by virtue of this poor culture.

The panel therefore found this charge proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Williams' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Malik, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. He 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 having insufficient or non-existent handovers and not correctly reading patient notes meant that risk factors were missed more than once unnecessarily. He submitted that this meant that Patient B remained in the wrong place for her birth; therefore, when the complications arose, the situation could not be as effectively dealt with.

Mr Malik submitted that the failure to transfer Patient B in a timely manner and ignoring her request for transfer caused an unacceptable delay and inflicted direct harm and suffering on the patient.

Mr Malik submitted that the inappropriate, inaccurate, and dishonest record-keeping, or lack thereof, compounds the charges' seriousness. He submitted that the patients and their babies, as well as fellow colleagues, were directly harmed and placed at risk of further harm on multiple occasions by Miss Williams.

Mr Malik submitted that there are serious attitudinal issues which grounded many of her actions or omissions. He cited examples including the deliberate ignoring of patient wishes, the lack of any recognition of the need to cascade learning, the lack of proper perusal of patient notes, or the lack of communication with colleagues. He submitted that Miss Williams' attitudinal issues are deep-seated, and exacerbated by the lack of any real reflection, recognition or remorse.

Mr Malik submitted that Miss Williams' 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 Miss Williams' 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 Miss Williams 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 Miss Williams 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 Miss Williams' fitness to practice currently impaired on both public protection and public interest grounds.

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

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

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

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

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

10.3 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

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

To achieve this, you must:

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

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…

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 to appropriately escalate the care or condition of patients/babies;
- Failure to provide appropriate care/carry out proper assessments;
- Ignoring patient requests about their care;
- Failure to recognise patient risks/risk factors appropriately;
- Failure to keep appropriate patient notes;
- Failure to carry out important non-clinical responsibilities;
- Dishonesty and a lack of candour; and
- Causing direct harm to patients/babies or exposing them to harm.

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 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 Miss Williams failed to escalate Baby A's condition to the neonatal team or communicate the need to transfer Baby A to the neonatal team contributed to Baby A losing a significant chance of survival.

The panel also bore in mind that Miss Williams had failed to take requests from Patient B to be transferred to obstetric care, or to communicate with colleagues to the emergency

upon identifying a fetal bradycardia and that these contributed to Baby B losing a significant chance of survival.

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

Additionally, the panel noted that Miss Williams tried to cover up her actions of Patient A and Baby A with inaccurate and dishonest record keeping.

The panel considered Miss Williams' actions did fall short of the conduct and standards expected of a midwife and were serious departures from the standards, amounting to misconduct.

The panel also considered Miss Williams' failure to cascade learning to colleagues to be serious as it increased the risk of harm to patients due to staff not being up to date with procedures surrounding aspects of care.

The panel bore in mind that in relation to charge 10a, it had heard evidence that indicated that the emergency bell had been turned off at the birthing unit or was not used at all. It was of the view that while Miss Williams did not press the emergency bell, there appeared to be a culture of not doing so at the birthing unit.

While the panel found this charge proved, given the circumstances of the emergency bell not working, the panel did not find this amounted to serious misconduct.

In light of the above the panel determined that the charges found proved, with the exception of charge 10a, individually 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 approved by Mrs Justice Cox in the case of *CHRE v NMC and Grant* in paragraph 76

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

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 Miss Williams' 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 Miss Williams failed to escalate Baby A's condition to the neonatal team or communicate the need to transfer Baby A and failed to

take a request from Patient B to be transferred to obstetric care. This, as the panel found, caused both Baby A and Baby B to lose a significant chance for survival and both babies died.

The panel determined that Miss Williams' 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 Miss Williams attempt to cover up her actions with inaccurate and dishonest record keeping 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 Miss Williams' 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 Miss Williams' 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 Miss Williams had provided evidence of insight and remorse.

Regarding insight, the panel noted that the only communication it had from Miss Williams was an email dated 9 August 2024 which stated that she would not be attending these proceedings.

The panel had no evidence before it of any insight or remorse from Miss Williams. 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 Miss Williams 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 addressed. 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 Miss Williams 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 Miss Williams 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 Miss Williams had strengthened her practice, in the areas of concern identified by the panel, Miss Williams 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 Miss Williams' fitness to practise was not found to be impaired and therefore public confidence in the midwifery profession would be undermined if Miss Williams were allowed to practice unrestricted.

For all the above reasons the panel concluded that Miss Williams' 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 Miss Williams off the register. The effect of this order is that the NMC register will show that Miss Williams 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 Miss Williams that it would seek the imposition of a striking off order if it found Miss Williams'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 took the panel through the aggravating factors he considered to be applicable in this case. He submitted that there are no mitigating features applicable in this case.

Mr Malik submitted that this case is too serious for taking no action or a caution order. He submitted that conduct such as dishonesty, making retrospective changes to patient notes, not communicating adequately with colleagues within the birthing centre or at the hospital was likely to undermine the confidence the public has in the midwifery profession.

Mr Malik submitted that the imposition of a caution order would be insufficient to protect the public or mark the seriousness of the misconduct in this case. He submitted that this case was not at the lower end of the spectrum of impairment. He also submitted that the concerns have been repeated on two occasions with fatal outcomes, and there has been no insight from Miss Williams.

With regards to a conditions of practice order, Mr Malik submitted that there is evidence of direct harm and potential risk to harm to patients as a result of Miss Williams misconduct. He submitted that Miss Williams demonstrated a pattern of sustained dishonest behaviour which was linked to her professional practice.

Mr Malik submitted that conditions of practice order would not be appropriate as there are no areas of Miss Williams' practice in need of assessment or training. He submitted that the issue in this case is more fundamental as Miss Williams is someone who lied. He

submitted that the matter is therefore too serous and there are no workable conditions that could be formulated to deal with the regulatory concerns.

With regards to a suspension order, Mr Malik submitted that the concerns raised are serious and highlight a deep-seated attitudinal issue. He reminded the panel that it had found no evidence of any insight in relation to the serious misconduct and that Miss Williams was liable to repeat her actions in the future. He submitted that a suspension order is not appropriate as the conduct in this case is incompatible with continued registration.

Mr Malik submitted that the nature and seriousness of Miss Williams' misconduct call into question her integrity and professionalism. He submitted that trust and confidence in the profession can only be maintained by the imposition of a striking off order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Miss Williams was a senior midwife in a position of trust;
- Sustained dishonesty directly related to her clinical practice;
- No insight into failings;
- No remorse;

- No remediation;
- A pattern of repeated misconduct over a period of time
- 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*
> - *misuse of power*
> - *vulnerable victims*
> - *…*
> - *direct risk to people receiving care*
> - *premeditated, systematic or longstanding deception"*

The panel found that Mrs Williams had covered up her misconduct when things went wrong. It bore in mind that it had found that Miss Williams had made incorrect retrospective entries onto Patient A's clinical notes on multiple occasions. The panel found the dishonesty to be at the higher end of the scale.

The panel also noted that her conduct was a misuse of power considering that she was one of the senior managers at the birthing unit. It bore in mind that there were vulnerable victims in this case, namely Baby A and Baby B.

Additionally, there was direct risk to people receiving care. Miss Williams failed to escalate Baby A's condition to the neonatal team or communicate the need to transfer Baby A and failed to take a request from Patient B to be transferred to obstetric care. 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 Miss Williams had instructed Colleague B to make incorrect retrospective changes to the clinical notes of Patient A and Baby A on 25 June 2019. Miss Williams then made further incorrect retrospective changes three days later. Miss Williams then made further incorrect retrospective changes between 28 August 2019 and 8 April 2021 which she did not disclose to anybody particularly at the Trust interview. In the panel's view this was premeditated and systematic. Whilst it did not consider Miss Williams' dishonesty to be longstanding, it was repeated deception over a significant period of time.

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 Miss Williams' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Williams' 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 Miss Williams'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 Miss Williams 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 Miss Williams' 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 Miss Williams' 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 Miss Williams' 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 Miss Williams' misconduct was not a single instance. It occurred over a period of time and was repeated. There was evidence of deep-seated attitudinal problems. Miss Williams' 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 Miss Williams 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 Miss Williams's actions is fundamentally incompatible with Miss Williams 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?*

Miss Williams' 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 Miss Williams 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 Miss Williams' misconduct was too serious and 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 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 Miss Williams'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 also 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 Miss Williams 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 Miss Williams' 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 Miss Williams is sent the decision of this hearing in writing.

That concludes this determination.