Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 28 May 2024 – 14 June 2024
Wednesday, 9 October – Tuesday, 15 October 2024 (in camera)

Virtual Hearing

Name of Registrant:	**Ninette Priscilla Avotri**
NMC PIN:	70H0041E
Part(s) of the Register:	Nurses part of the Register Sub part 1 RN1: Adult nurse, level 1 (23 April 1975) Midwives part of the Register RM: Midwife (15 August 1977)
Relevant Location:	Harrow
Type of case:	Misconduct
Panel members:	Rachel Forster (Chair, Lay member) Carol Porteous (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	Angus Macpherson (28 May 2024 – 5 June 2024) Sean Hammond (6 June 2024 – 27 June 2024 9 – 11 October 2024) Paul Housego (14 – 15 October 2024)
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Ms Avotri:	Not present and not represented at the hearing
Midwife A:	Present and represented by Tope Adeyemi, instructed by Thompsons

Midwife B:	Present and represented by James Lloyd, instructed by Thompsons
Facts proved:	None
Facts not proved:	All charges
Fitness to practise:	N/A
Sanction:	N/A
Interim order:	N/A

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Avotri was not in attendance and that the Notice of Hearing letter had been sent to Ms Avotri's registered email address by secure email on 23 April 2024.

Further, the panel noted that the Notice of Hearing was also sent to Ms Avotri's representative on 23 April 2024.

Dr Joshi, 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 Ms Avotri's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Avotri 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 Ms Avotri

The panel next considered whether it should proceed in the absence of Ms Avotri. It had regard to Rule 21 and heard the submissions of Dr Joshi who invited the panel to continue in the absence of Ms Avotri. Dr Joshi directed the panel's attention to the bundle for the Proceeding in Absence, highlighting a specific letter dated 15 May 2024 from Ms Avotri's representative. The letter states, "*Ms Avotri will not attend the scheduled hearing."* Based on this communication, Dr Joshi submitted that both Ms Avotri and her representative are content for the proceedings to continue in their absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* 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 Ms Avotri. In reaching this decision, the panel has considered the submissions of Dr Joshi, the representations made on Ms Avotri's behalf, 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:

- No application for an adjournment has been made by Ms Avotri;

- Ms Avotri's representative has informed the NMC that they received the Notice of Hearing and that Ms Avotri had stated that she did not intend to attend the hearing;
- There is no reason to suppose that adjourning would secure Ms Avotri's attendance at some future date;
- Four witnesses are due to give live evidence. Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in disposal of the case after so long a delay.

There is some disadvantage to Ms Avotri in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give verbal 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 Ms Avotri deliberately having chosen not to exercise her right to be present or to give adequate instructions to enable lawyers to represent her.

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

Details of charge

That you a registered midwife, on 28 June 2019

1. During a verbal exchange with Patient A communicated inappropriately with them regarding their CTG in that you 'tutted' when the patient requested not to be attached to it

2. Did not update Patient A in relation to her request for a birthing ball

3. On checking Patient A between 01.00 to 03.00 did not fully explain matters to her

4. When Patient A requested pain relief in the form of gas and air, tutted which was inappropriate

5. Did not provide Patient A with an alternative to gas and air which was requested.

6. On carrying out a vaginal examination on Patient A at approximately 3am did not communicate with the patient

7. After carrying out a vaginal examination on Patient A at approximately 3am

a. did not communicate with the patient

b. sighed and walked off which was inappropriate

8. On moving Patient A to a wheelchair

a. did not respond to her when she advised that you that you were hurting her

b. used an incorrect moving and handling technique in that you dragged her to the wheelchair

9. When Patient A requested to be examined at approximately 5.45am to 6am , initially refused

10. Continued with a vaginal examination on Patient A despite the patient telling you to stop

11. Allowed Midwives A and/or B to forcefully restrain Patient A whilst you were carrying out the vaginal examination on Patient A which was inappropriate

12. On transferring Patient A to the delivery suite, did not communicate effectively with Patient A in that you did not explain to her

a. What stage of labour she was at

b. Why you were transferring her

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

Background

The case was heard as a joint case against Midwife A, Midwife B and Miss Avotri (referred to as Midwife C). This was joined at a case management hearing on 22 April 2024.

The NMC received a referral on 28 July 2020 from Patient A concerning Ms Avotri. During the events in question, Ms Avotri was employed as a bank midwife at Northwick Park, which is part of London North West University Healthcare NHS Trust (the Trust).

The alleged facts are as follows:

On 28 June 2019, Ms Avotri was assigned to Florence Ward (the Ward), a mixed high-risk antenatal and postnatal ward. Patient A, who was in the latent phase of labour, was admitted to the Ward due to previous obstetric history and ruptured amniotic membranes. Patient A was under Ms Avotri's care at that time.

Patient A requested a birthing ball for pain relief as contractions intensified, but Ms Avotri allegedly failed to provide one to Patient A. Additionally, Ms Avotri allegedly initiated the use of a Cardiotocograph (CTG) machine against Patient A's wishes and went against her birth plan.

Around 03:00, Patient A requested some additional pain relief. It is alleged that Ms Avotri tutted at Patient A and said that she could only have further pain relief once she was at 4cm dilated. Patient A then requested a vaginal examination to determine how advanced her labour was. Ms Avotri completed the vaginal examination with consent from Patient A. Following the examination, Ms Avotri allegedly ‘sighed and walked off’. The complaint from Patient A says that Ms Avotri failed to communicate with Patient A and left the bay. Patient

A says that she overheard Ms Avotri ‘talking and laughing’ about her to Ms Avotri’s midwifery colleagues at the midwives’ station.

Patient A says that she had to wait 20 minutes for Ms Avotri to return before finding out the result of the examination. Ms Avotri told patient A that she was 3cm dilated. At this point, Ms Avotri gave Patient A Entonox (gas and air) as pain relief.

Patient A’s sister arrived sometime between 03:00 and 04:00 to be her birth partner. Patient A’s sister noticed that Patient A still did not have a birthing ball and so she went to request one from the midwives at the midwives’ station. Ms Avotri was on her break and so Midwife A provided the birthing ball to Patient A.

At around 05:45, Ms Avotri, her midwifery colleagues Midwife A and Midwife B and Ms 1 heard loud screaming and pushing sounds coming from the bathroom and went to investigate. It was Patient A. Ms Avotri tried to gain entry to the bathroom but could not. After a couple of minutes had passed, it is alleged by Patient A that Ms Avotri ‘shoved’ the door open. Patient A was standing behind the door and so it is alleged that this hit her and caused pain to her side.

Ms Avotri attended to Patient A along with Midwife B. Ms Avotri allegedly inappropriately grabbed Patient A under her arms and together with Midwife B, dragged her to a wheelchair. This was said to result in Patient A hurting her foot on the wheelchair. After Patient A reached the wheelchair, she was taken back to her bed by Midwife A. It is alleged that Ms Avotri then watched as Midwife A and B used an incorrect manual handling technique to move Patient A back to her bed and forcefully pushed her down onto the bed. This allegedly caused Patient A pain, which Ms Avotri is said to have failed to acknowledge and/or failed to stop.

It is alleged that Patient A requested a vaginal examination to assess her progress, but Ms Avotri initially refused until Patient A informed her that she felt like ‘pushing’. Ms Avotri agreed to perform an examination on Patient A. During the examination, Patient A began

to have a contraction and allegedly asked Ms Avotri to stop carrying out the examination. Ms Avotri allegedly failed to stop at Patient A's request. She continued with the examination with the assistance of Midwives A and B who it is alleged were holding Patient A down on the bed to try to keep her still. Patient A's sister also said that she objected.

Following the vaginal examination, it was found that Patient A was in established labour and required transferring to Labour Ward.

Following the birth of her baby, Patient A put in a formal complaint regarding her treatment by Ms Avotri and her colleagues. A local investigation commenced, however Patient A's complaint was not upheld and no further action was taken other than to ask Ms Avotri to complete a reflection on the incident. This fact is added as background but was not relevant to the panel's decision. At the time that the formal complaint was made in July 2019, a referral to the NMC and Care Quality Commission (CQC) was also made by Patient A.

Application to redact Patient A's sister's witness statement

Ms Adeyemi on behalf of Midwife A and Mr Lloyd on behalf of Midwife B made an application to redact Patient A's sister's witness statement on that basis that it contained inadmissible opinion evidence.

Dr Joshi, on behalf of the NMC, objected to the application and submitted that the fact that the witness had expressed opinions was a matter that could be reflected in what weight the panel attached to that evidence.

The panel heard and accepted the advice of the legal assessor.

The panel noted that Patient A's sister, despite witnessing the incident firsthand, lacked a comprehensive understanding of the broader context, was a Student Midwife at the time of the incident and did not have knowledge of the Trust's policies at the time.

Regarding the references made in paragraphs 10 and 11 of Patient A's sister's witness statement on low-risk pregnancy and CTG, the panel considered that her lack of knowledge of the relevant policies at that Trust and her inexperience at the time of the alleged incidents meant that she did not have authority to put forward such opinions.

Concerning paragraph 17, where Patient A's sister speculated on Patient A's condition, the panel noted her lack of expertise and hands-on experience compared to the attending midwife. Additionally, her comments on manual handling practices and consent lacked credibility without direct knowledge of Trust policies at the time, leading the panel to dismiss them as irrelevant.

Paragraphs 20 to 42 were considered irrelevant and inadmissible as Patient A's sister's opinions exceeded the scope of her knowledge and were not supported by factual evidence or policy awareness. Patient A's sister was not an expert witness, and the role of a witness is to give evidence about facts. The opinion of Patient A's sister is not a matter for evidence.

The panel disregarded Patient A's sister's views on the seriousness of the conduct, as it is not her role to provide opinion about the seriousness of the conduct. That is the role of the panel in its determination.

The panel determined that at paragraph 44, where Patient A's sister commented on the outcome of the Trust's local investigation, was also irrelevant.

The panel determined to redact the inadmissible and irrelevant portions from her witness statement and provide a revised version to the involved parties.

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 Dr Joshi on behalf of the NMC, by Ms Adeyemi on behalf of Midwife A and by Mr Lloyd on behalf of Midwife B. The panel also took into account Ms Avotri's defence bundle.

The panel has drawn no adverse inference from the non-attendance of Ms Avotri.

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:

- Patient A
- Birth Partner/ Patient A's sister: Person A's birth partner
- Ms 1: Maternity Support Worker as at 28 June 2019
- Ms 2: Matron appointed to conduct the internal investigation

The panel also heard evidence from Midwife A and Midwife B under oath.

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 both the NMC and Ms Avotri.

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

Key documents

- Florence Ward plan
- Photograph of the bathroom
- Trust policies
- Email dated 23 August 2019 from Ms 2 to Patient A and birth partner
- Investigation Report
- Ms Avotri's (Midwife C) local statement and local statements made by Midwife A, Midwife B and Ms 1.
- Patient A's medical notes (incorporating antenatal and labour records)
- Work allocation book

Context – The Hospital and the Ward

The panel took into account Ms 2's witness statement, which states:

> *"Florence Ward ("the Ward") was a high risk Antenatal Ward and post-natal ward, and the staffing levels on the Ward during the day shift consist of four to five midwives, with many support workers such as neo-natal nurses and maternity assistants, and the night shifts consists of three midwives with support workers. The Birthing Centre is on the same floor, and depending on how busy the Birthing Centre is, as the midwives there provide 1:1 support, midwives from the Birthing Centre would often assist on other Wards, hence the staffing levels on the Wards can vary.*
>
> *During the night of 27 / 28 June 2019, the Antenatal Ward had a high number of induction procedures, and some patients from the Ward had to be transferred down to the Labour Ward. At that time, the staff on shift that night reported to the Matron of the Ward, when they came on shift, that the Ward had been very busy that night. This was also confirmed by the Matron during the investigation, and was a point that was confirmed to me as part of my evidence for the investigation."*

In her oral evidence Midwife A said there were several levels within the maternity unit – the bottom level, (level 4) is the delivery suite, assessment unit and a clinic. The upper floor, (level 5) has the neonatal unit and offices. Level 6 has the Florence Ward (the Ward), and on the opposite side is the birth centre and low risk ward. The Ward is an antenatal and post-natal high-risk ward.

The panel heard evidence from Ms 2 that the night in question was a busy night. The panel also heard that the Ward was appropriately staffed for this level of occupancy.

The panel also considered the allocation workbook which showed that there were 28 beds plus three separate single rooms furnished to a higher standard called “flower rooms”. All but two beds in the Ward were occupied that night. The panel was told that this Ward cared for women and their babies (neonates), including some neonates with conditions that required regular monitoring but did not require to be on the neonatal unit in a different part of the hospital, and also patients who had delivered by caesarean section (C-section). The panel also heard from Ms 2 that there were a high number of induction procedures on the Ward that night.

Patient A

The panel saw from the Allocation workbook that this was Patient A’s third pregnancy. She had had a previous C-section and a ‘Vaginal Birth After Caesarean Section’ (VBAC). This meant that Patient A was automatically classed as being at a higher risk.

The panel heard that Patient A wanted this birth to be different from her previous births and had specifically requested to be able to give birth in the Birth Centre. The panel noted that her doctors disagreed with this birth plan citing a small safety risk of a uterine rupture occurring due to the previous C-section. Patient A had therefore met with the senior Midwife JP during her antenatal period to further discuss her birth plan. The panel noted that Midwife JP acknowledged that her plan to give birth at the Birth Centre was Patient A’s choice.

The staff involved in Patient A's care

Initially, whilst Patient A was in the obstetric observation bay on the delivery ward, she was in the care of Midwife HM.

When she was transferred to the Ward, Patient A was under the overall care of Ms Avotri (Midwife C) with involvement of Midwife A, who was the coordinating midwife and bleep holder, and Midwife B.

Midwife B took over the care of Patient A from about 04:00 until 05:00 whilst Ms Avotri (Midwife C) was on a break. Midwife B continued to be involved in Patient A's care until Patient A was transferred back to the delivery suite at around 06:00. Ms 1 (HCA) was also involved in her care during her time on the Ward.

Patient A was transferred to the delivery suite at around 06:00 and from that time she was in the care of Midwife AP with involvement from Midwife HM.

Chronology of events on 28 / 29 June 2019

The panel saw a timeline prepared by Matron EJ on 22 July 2019 from Patient A's notes. It noted the following:

On 28 June 2019 at around 11:00, Patient A arrived at the Hospital at 39 weeks plus 5 days in her pregnancy for her regular midwife appointment. She had a history of spontaneous rupture of membranes (SROM) and reported at this appointment that she had some leaking.

At 11:55 Patient A was seen in triage where she was examined. It was confirmed that her membranes had ruptured but there was no room available on the Ward at that time. At 12:30 she went home and returned at around 15:00 where she waited in the obstetrics observation bay until 23:45. She was then transferred to the Ward where Ms Avotri

(Midwife C) took over her care. She remained on the Ward until 06:00 on 29 June 2019 when she was transferred to the delivery suite and Midwife AP took over her care. At 06:14 Patient A's baby was born.

The panel acknowledged the challenges faced by the Hospital due to it being at full capacity at that time. The panel also acknowledged that Patient A did not have a positive experience at the Hospital and that ultimately the birth plan that she had prepared with Midwife JP in her antenatal meeting was not followed. The birth of her third child did not go as she had planned, and it was a difficult and painful experience.

The panel noted that there were also a number of other incidents referred to in the evidence which did not form part of the allegations, but which nevertheless contributed to the negative experience that Patient A had at the Hospital. The panel will discuss those below before determining the allegations.

Patient A waited alone in the hospital for over eight hours, unsure of when exactly she was going to get a bed on the ward. She says that when she expressed a desire to go home, she was told that there were concerns for the wellbeing of her baby, which made her anxious. She says that the antenatal midwife she saw towards the end of her pregnancy told her she would be on duty when she went into labour, but in the event, this was not the case, and so Patient A was without even this familiar face.

Lack of birth partner

Patient A was told while in the obstetrics observation bay that she could not have a birth partner. This was not by Ms Avotri or by Midwives A or B.

Patient A said that when a bed became available and she was transferred to the Ward, she saw that another person did have a birth partner with them. She said that at that point she was confused and angry as she had been told that her birth partner was not allowed to come and support her.

The panel acknowledged that Patient A was alone and could have felt vulnerable and unsupported, but the panel noted that Patient A did not repeat her request for a birth partner to any member of staff on the Ward. The panel noted that she could have made a further request at that time for a birth partner to be present.

The panel later heard from Ms 2 that birth partners were not allowed to stay on the Ward until the woman was in established labour whereupon the birth partner could be called by either the woman or by the midwife for them to come in.

Call bell

The panel heard from Patient A that on arrival at her bed in the Ward, she had been told by Ms Avotri (Midwife C) not to use the call bell but to walk to the nurses' station if she needed any assistance. It noted that although this complaint was set out in her witness statement and oral evidence, no reference to this was made in her original letter of complaint, nor was it raised in the meeting she had with Midwife JP on 29 July 2019 which she attended with her sister. Ms 2 and Midwife A stated that this was not the Hospital policy. Midwife A and B both said in oral evidence that call bells were provided for all patients, and they were encouraged to use them. Ms Avotri made no mention of call bells in any of her evidence.

Birthing ball

Patient A's notes showed that she had requested a pezzi ball (birthing ball) at 23:01 on obstetric observation bay. In Patient A's statement, she said that she made a further request for a birthing ball from the maternity assistant who transferred her to the Ward and at 01:00 she made a further request to Ms Avotri (Midwife C) who told her that there was not one available on the Ward but that she would go and find one for her. She did not actually receive a birthing ball until sometime after 04:00 when Midwife A delivered one to her.

Birth plan

The panel noted that Patient A had envisioned a birth experience at the birth centre for a more natural labour and birth, as discussed with Midwife JP. However, due to the birth centre being at full capacity, she was redirected to the Ward where Ms Avotri (Midwife C) took over her care. Patient A said that she informed Ms Avotri (Midwife C) that she had a birth plan in her pregnancy book which had been signed off by Midwife JP and that Ms Avotri (Midwife C) acknowledged the birth plan by saying *"oh, okay"* but did not bring it up again. Patient A did not feel that Ms Avotri (Midwife C) had read her birth plan or had taken account of it and said this made her feel unimportant.

It was with a background of these changes from her expectations that Patient A proceeded into established labour.

The allegations relate to the experience on the Ward with Midwives A, B and C between approximately 23:45 – 06:00.

Patient A's notes show that Ms Avotri (Midwife C) connected her to the CTG machine at approximately 01:30 and that shallow decelerations in the baby's heartbeat were recorded at 01:40. The patient notes record that observations and examinations were undertaken and recorded several times.

Patient A's letter of complaint refers to her repeatedly requesting gas and air to help with her pain but being informed by Ms Avotri (Midwife C) that she could not use it. Entonox (gas and air) was provided to Patient A at 03:10 for use during contractions.

Patient A also referred to hearing Midwife B and Ms Avotri (Midwife C) whispering to each other about her and laughing about her wanting gas and air and about the CTG monitoring. The panel heard considerable discussion in oral evidence about the likelihood of being able to hear from bed 6, midwives whispering and laughing at the nurses' station.

The panel was taken to a Ward plan drawn by Midwife A. Patient A was not aware of the full layout of the ward but did accept that she was in bed 6 and agreed the positioning of the showers on the opposite side of the corridor and the position of the nurses' station which she referred to as being 20 steps away. The panel also heard that there were double doors, two standalone rooms, a wall, a store cupboard and the matrons' office between Patient A's bed and the open plan nurses' station. Ms 1 and Ms 2 both agreed that it would not be possible to hear conversation at the nurses' station from bed 6. At a later point in Patient A's oral evidence, she stated that from her bed she was unable to hear a different conversation which took place at the nurses' station. The panel therefore determined that Patient A's recollection was unreliable with respect to this.

The panel heard that Patient A was in communication with her sister, a student midwife, throughout the evening by text message. At around 04:00 Ms Avotri (Midwife C) went on a break and Midwife B took over Patient A's care. Patient A's sister arrived during this time to act as her birth partner and was given immediate access to the Ward. Her sister told the panel that she had been studying into the night at the university library completing her dissertation which was due for submission shortly. She told the panel that it took her approximately 30 minutes to get to the Hospital on a night bus. She told the panel that having heard about her sister's contractions by text, she had come to act as Patient A's birth partner since Patient A's husband was at home looking after the other children.

Midwife A said that at approximately 04:00 when she was at the nurses' station, Patient A's sister came up to the desk and abruptly demanded a birthing ball saying that her sister has been asking for one for some time. Midwife A then went to source one and took it to Patient A with an apology which she says Patient A seemed to accept.

Patient A said that around 05:45 she went to the bathroom with her sister to relieve her bladder and take a shower. She said that she was standing behind the door of the bathroom, not able to move due to the pain and screaming in pain when Ms Avotri (Midwife C) knocked on the door and asked to come in. She said that the door was not locked and as her sister was in the bathroom with her, her sister would have unlocked the

door if it had been locked. She said that the midwives shoved the door without any warning or without any time for her to move away, hitting her on the right side and causing her pain.

The three midwives and the healthcare assistant give a different account. They all refer to them hearing screaming and pushing sounds coming from the bathroom whilst they were at the midwives station (reception) and all spontaneously without any discussion between them, rushed towards the bathroom to find out what was happening and provide assistance. On arrival, they say they found the door to be locked, they said that Ms Avotri (Midwife C) knocked on the door and asked for it to be opened and all refer to it taking up to a couple of minutes for the door to be opened by Patient A's sister. They saw the large Entonox cylinder was in the bathroom and all recall seeing Patient A standing fully clothed in the shower cubicle. The recollection of Patient A and her sister however, is that Patient A was standing by the door. All those involved agreed that the bathroom was small, although there was some variation in recollection of its layout.

Patient A was returned to her bed in a wheelchair where she was examined and found to be in established labour. She was transferred to the delivery suite in the wheelchair and her baby was born very soon afterwards.

The panel noted that the events with which the following allegations are concerned all took place over a very short period of time – a matter of minutes – and recognised that some of the events or actions which it heard described may have occurred concurrently or near concurrently but have, of necessity, been divided into discrete charges.

Charge 1)

That you a registered midwife, on 28 June 2019

1. During a verbal exchange with Patient A communicated inappropriately with them regarding their CTG in that you 'tutted' when the patient requested not to be attached to it

This charge is found NOT proved.

The panel primarily heard Patient A's account of the interaction with Midwife C, in which she alleged that Ms Avotri (Midwife C) insisted on continuous attachment to the CTG monitor despite Patient A expressing her desire to remain mobile. Patient A states:

> "*…Midwife C told me that I would need to be attached to the CTG machine, and I informed them that I did not want to be attached to the machine. Midwife C insisted for me to be attached to the CTG machine at all times to monitor the baby, and I informed Midwife C that I did not want to be attached to the CTG machine the entire time as I would like to be mobile. Upon this exchange, Midwife C became very annoyed at me, she tutted and said that the CTG machine is for the safety of my baby. I responded that I understand that, but it is my decision to be attached to the machine, and I will go back to being attached to the CTG machine when I feel more comfortable. Midwife C would not talk to me properly, and they would keep refusing what I would be saying to them."*

Ms Avotri (Midwife C) denied the allegations made by Patient A, stating:

> *"I maintain that I did my utmost to care for and support* [Patient A] *in accordance with NMC and Trust standards. As previously stated, I am saddened that* [Patient A] *feels that (in her words) 'I did not seem bothered by anything' she was saying to me, and that I 'brushed' her off and was 'dismissive'. I respect that all patients are entitled to their opinions, and I appreciate that individuals will have their own perceptions and interpretations of others' body language and verbal communications. However,* [Patient A's] *allegations are genuinely not my recollection of my behaviour, nor are they at all in keeping with my general conduct*

with patients or colleagues. It is not in my nature to 'tut' and 'sigh' at patient requests."

The panel recognised Midwife C's longstanding reputation as a professional midwife with no record of regulatory misconduct.

The panel noted that there was a lack of corroborating evidence regarding the alleged behaviour. The panel noted that no other witnesses reported any instance of Ms Avotri (Midwife C) displaying dismissive body language, such as tutting, during their interactions. When witnesses were questioned about any specific mannerisms of Ms Avotri that could have contributed to Patient A's interpretation, they were not able to recall any.

The panel recognised that Patient A had a difficult labour and that some of her experiences at the Hospital had not been optimal. She had clearly been in pain for much of the night and had been on her own for a significant amount of time. Patient A was using Entonox and was dealing with the pain of contractions up to the imminent birth of her baby. The panel found her to be confident and able to put her view across eloquently. However, the panel found inconsistencies in her evidence when compared with the evidence of other witnesses, and some of her recollection of events was, in the panel's view, mistaken. The panel found this to be understandable given her predicament at that time.

It was clear to the panel that Patient A was disappointed with her birth experience that night. The panel found that this may have influenced the way in which she had remembered the events of that night.

The panel also noted that Midwife C had a longstanding reputation as a midwife with no record of regulatory misconduct and decided that on the balance of probabilities, it was unlikely that she would have tutted in this way.

The panel therefore decided that the NMC has not provided sufficient evidence to prove this charge.

The panel therefore found charge 1) not proved.

Charge 2)

That you a registered midwife, on 28 June 2019

2. Did not update Patient A in relation to her request for a birthing ball

This charge is found NOT proved.

The panel took into account the witness statement of Patient A, which states:

> *"At approximately 01:00, I asked Midwife C for a birthing ball, which I had also requested from the maternity assistant who transferred me to the ward. Midwife C informed me that they did not have a birthing ball on the Ward and that they would have to locate one for me. Midwife C did not seem very bothered by anything I was informing them of at the time, and when I told them that I had a birthing plan she informed me that she had not read it yet."*

Ms Avotri (Midwife C) denied these allegations. In her defence bundle, she states:

> *"*[Patient A] *states in paragraph 10 that at 1am she asked me for a birthing ball, that I agreed to go and look for one, and ultimately failed to provide this. Again, she has not stated this in her original complaint letter. You will note from my attached statement and my RCRF that I make no mention of a discussion of a birthing ball. This is because I have no recollection of any such discussion taking place. However, it is apparent that I did discuss pain management with* [Patient A] *at around 1am, which she declined. Although a birthing ball is an aid rather than pain*

relief, it would make no sense for me to be dismissive of [Patient A's] *repeated requests for a ball while being attentive to her pain."*

The panel took into account the Trust's investigation meeting with Ms Avotri (Midwife C) dated 10 September 2019. During this investigation, when asked if Patient A had requested a birthing ball at 04:00 or at any time before that, Ms Avotri (Midwife C) stated that no such request had been made.

Additionally, the panel considered Patient A's medical notes. It noted that the ward was full, most beds were occupied and that midwives were busy with patients. The notes indicated that a request for a birthing ball (referred to as a "pezzi ball") was first made at 23:01 by Patient A to Midwife HM on the delivery ward, with no further documentation of Patient A requesting it from Ms Avotri (Midwife C) throughout the night. The only recorded request for a ball occurred when Patient A's sister arrived at the ward around 04:00 and asked the reception for one, which was then provided by Midwife A.

The panel determined that the patient notes do not accord with Patient A's recollection. The panel also noted that Ms Avotri (Midwife C) strongly denies the allegation. As set out in charge 1), the panel had concerns about Patient A's recollection of the exact details and timelines given that she was tired, in pain and was in labour.

The panel therefore determined that charge 2) is found not proved.

Charge 3)

That you a registered midwife, on 28 June 2019

3. On checking Patient A between 01.00 to 03.00 did not fully explain matters to her

This charge is found NOT proved.

The panel noted that the charge is vaguely worded. The charge suggests, and the panel accepts that explanations were given by Ms Avotri during the specified time period. However, the NMC has not stipulated how these explanations were deficient, nor has it provided any evidence to support how Ms Avotri (Midwife C) failed to "fully explain matters" to Patient A.

The panel therefore the panel found charge 3) not proved.

Charges 4) and 5)

That you a registered midwife, on 28 June 2019

4. When Patient A requested pain relief in the form of gas and air, tutted which was inappropriate

5. Did not provide Patient A with an alternative to gas and air which was requested.

These charges are found NOT proved.

The panel considered these charges together.

The panel considered the charges that Ms Avotri (Midwife C) tutted when Patient A requested pain relief in the form of gas and air. It also considered the allegation that Ms Avotri (Midwife C) did not provide Patient A with an alternative to gas and air, a request outlined in Patient A's birthing plan.

The panel considered the evidence provided by both Patient A and Ms Avotri (Midwife C).

Patient A described feeling dismissed and stated that Ms Avotri (Midwife C) appeared unconcerned about her pain levels. In her witness statement, Patient A states:

"Between 01:00 and 03:00, Midwife C came to check on me five times, with each check-up lasting approximately five minutes…after the last check up before my

birthing partner arrived, Midwife C obtained the Entonox and pulled a chair up for me to sit on as I was having difficulty lying straight on my back on the bed, because of how much pain I was in.

"At around 03:00 my contractions were getting stronger, as a result I asked Midwife C if I could be put on gas and air as per my birthing plan. Midwife C was dismissive of me and my pain and informed me that I had to wait to be four centimetres dilated to be given gas and air. I asked Midwife C to examine me to see how many centimetres I was dilated, and they responded saying "okay" and informed me that they will go get the equipment, such as gloves, to carry out the examination. Upon my request for pain relief, Midwife C tutted when I asked for gas and air and they made me feel as if I was not in as much pain as I was describing. Midwife C also made me feel like they knew my pain better than I did."

Ms Avotri (Midwife C) categorically denied these allegations, asserting that she acted in accordance with professional standards throughout her care of Patient A. In her defence bundle, she states:

"I maintain that I did my utmost to care for and support [Patient A] *in accordance with NMC and Trust standards. As previously stated, I am saddened that* [Patient A] *feels that (in her words) 'I did not seem bothered by anything' she was saying to me, and that I 'brushed' her off and was 'dismissive'. I respect that all patients are entitled to their opinions, and I appreciate that individuals will have their own perceptions and interpretations of others' body language and verbal communications. However,* [Patient A's] *allegations are genuinely not my recollection of my behaviour, nor are they at all in keeping with my general conduct with patients or colleagues. It is not in my nature to 'tut' and 'sigh' at patient requests.*

I am confused by [Patient A's] *statements in paragraphs 12 and 13 (pages 26-27) regarding gas and air (Entonox). In paragraph 12,* [Patient A] *states that between 1-*

3am I checked on her 5 times and after the last check-up (which presumably would have been around 3am) I obtained Entonox (gas and air) and provided her with a chair to sit on because she was uncomfortable laying back.

In paragraph 13 (page 27), [Patient A] *begins by stating that around 3am her contractions were getting stronger so she requested gas and air which I refused and explained that she could not receive this until she was 4cm dilated. I am unclear as to why she states in paragraph 12 that I obtained gas and air but in paragraph 13 states that I refused to give it to her. According to my attached statement (page 2),* [Patient A's] *pain did increase, and she requested pain relief at 2:50am. In response, I conducted appropriate observations and then the vaginal examination at 3am at which time I determined that she was 3cm dilated. My attached statement also states that this was followed by a discussion where 'analgesia with benefits and side effects were explained and accepted' and 'Entonox was provided as requested.' My attached statement also confirms that* [Patient A] *was indeed uncomfortable laying back and that I provided her with a chair, which is consistent with her comments in paragraph 12."*

The panel considered Midwife C's response dated 6 July 2019 to Patient A's letter of complaint to the Trust, which indicates that some time before 01:15, Midwife C:

"Returned to [Patient A] *and with consent, curtains drawn for privacy and dignity, I performed full observations and checks including Temperature, Pulse B/P, Respiration Abdominal palpation including fundal height measurements, observing liquor and auscultation of fetal heart over 60 sec with Sonicaid. Her contractions were mild every 5 mins and she did not appeared to be distressed….I discussed pain relief available, including Codydramol orally, Gas & Air (Entonox) and Pethidine injection. All forms of analgesia were declined…"*

Ms Avotri (Midwife C) also says:

> *"*[Patient A] *became more distressed with contractions and requested pain relief at approximately 02:50. To ensure my Client was in established labour, Consented maternal pulse and fetal heart auscultation was done followed by Vaginal examination at 03:00. She was 3cms dilated…At this point I continued to offer reassurance…I rediscussed analgesia available with benefits and side effects were explained and accepted. Entonox was provided as requested…"*

The panel noted that Patient A's medical notes show that Entonox was provided at 03:10.

The panel considered Midwife C's detailed account, emphasising her commitment to patient care. She stated that appropriate checks were made throughout the night, and it was established that Patient A was only 3cm dilated at the time when she requested, and was given, Entonox. Ms Avotri (Midwife C) stated that she recalled discussing various pain relief options, which Patient A subsequently declined.

The panel recognised that Patient A had a difficult labour and that some of her experiences at the Hospital had not been optimal. She had clearly been in pain for much of the night and had been on her own for a significant amount of time. Patient A was using Entonox and was dealing with the pain of contractions up to the imminent birth of her baby. The panel found her to be confident and able to put her view across eloquently. However, the panel found inconsistencies in her evidence when compared with the evidence of other witnesses and some of her recollection of events was, in the panel's view, mistaken. For example, Patient A says that she was told she could not have Entonox until she was four centimetres dilated. However, Patient A's medical notes confirmed that she was three centimetres dilated when the Entonox was provided. Patient A's statement also says in one paragraph that Ms Avotri (Midwife C) obtained Entonox for her, while in the next paragraph, she claims that her request for Entonox was refused.

The panel found this confused recollection to be understandable given her predicament at that time. The panel decided that Patient A was an honest witness but that her recollection of exactly what had happened was unreliable. The panel reminded itself that honest

witnesses can be mistaken as a result of memories being fluid and malleable and sometimes tainted by negative experiences or influenced by the accounts of others. The panel also reminded itself that memories can change over time especially when a memory is recalled multiple times.

Patient A was disappointed with her birth experience. The panel found that this may have influenced the way in which she had remembered the events of that night.

The panel found that the NMC has not provided sufficient evidence to prove the charges of inappropriate behaviour or failure to provide requested alternatives.

The panel therefore found charges 4) and 5) not proved.

Charge 6)

That you a registered midwife, on 28 June 2019

6. On carrying out a vaginal examination on Patient A at approximately 3am did not communicate with the patient

This charge is found NOT proved.

The panel took into account Patient A's witness statement, which states:

> *"I asked Midwife C to examine me to see how many centimetres I was dilated, and they responded by saying "okay" and informed me that they will go get the equipment, such as gloves, to carry out the examination…*
>
> *At 03:00, upon my request, Midwife C then carried out the examination but did not communicate with me at all before, during or after the examination. It is an intimate examination for which I was not able to prepare myself for, and Midwife C did not put me at ease or make me feel comfortable, as compared to my previous*

experiences where the midwife would put a lot of care into the examination and communicate with me throughout. Moreover, Midwife C did not inform me after the examination that I was four centimetres dilated. From my previous birthing experiences, the midwife would always ask me if it is okay to go ahead with an examination before undertaking the procedure. However, at this time I did not expect Midwife C to ask me before performing the examination, as I had been the one to request them to undertake it. Consequently, Midwife C gave me the usual instructions to carry out, for a vaginal examination, and I was able to prepare myself."

The panel considered the original complaint letter from Patient A dated 2 July 2019, which states:

"At 03:00am a vaginal examination had been done with my consent. After completion, [Colleague C] walked straight out of the room. There was no exchange of words and I felt like I had been violated as there was no care or compassion or even an acknowledgment of the examination. 20 minutes later I was informed I was 3cm dilated."

Ms Avotri (Midwife C) denied the allegations. In her defence bundle, she states:

"In her original complaint letter, [Patient A] *states that I conducted a vaginal examination at 3am and there was 'no exchange of words' as I 'walked straight out of the room' only telling her 20 minutes later that she was 3cm.* [Patient A] *repeats this allegation similarly in paragraphs 14-16 (page 27-28) of her statement. However, when I review paragraph 12 and my attached statement, I cannot see when or how this 20-minute delay could have taken place. The reason I did the vaginal examination in the first place was in response to her request for pain relief. Does it seem logical that I would conduct the examination, say nothing at all, and leave the room for 20 minutes knowing that* [Patient A] *was in pain and in need of relief?*

> *In truth, I told* [Patient A] *immediately that she was 3cm and I can recall that she was disappointed because she wasn't further along; this is documented in my statement (page 2). Furthermore, even though it is my practice to inform women immediately, in my experience the first thing women say when I examine them is, 'How far along am I?' before I even get a chance to tell them. [Patient A] complained that I did not say anything, but it appears from paragraph 14 that she didn't ask immediately either, which I would expect her to do. I cannot imagine any woman staying silent as I walked out of the door immediately after a vaginal examination.*

The panel identified inconsistencies in Patient A's account and concluded that effective communication pertaining to consent was indeed established prior to the vaginal examination. The panel found it implausible that Ms Avotri (Midwife C) would not convey the results of the examination immediately after having done it nor that Patient A would not have sought clarification after the examination by Ms Avotri given that she had initially requested it.

For the same reasons as previously noted, the panel decided that Patient A was an honest witness but that her recollection of exactly what had happened was unreliable. The panel reminded itself that honest witnesses can be mistaken as a result of memories being fluid and malleable and sometimes tainted by negative experiences or influenced by the accounts of others. The panel also reminded itself that memories can change over time especially when a memory is recalled multiple times.

The panel noted that Patient A stood by her statement, even when presented with clear evidence to the contrary, showing an unwillingness to accept that she may have misremembered.

Patient A was disappointed with her birth experience. The panel found that this may have influenced the way in which she had remembered the events of that night.

Therefore, the panel favoured the consistent account provided by Midwife C, which stated that she had informed Patient A of her dilation status immediately after the examination and had noted Patient A's disappointment that she had not progressed further in her labour.

On the balance of probabilities, the panel determined that the NMC has not discharged the burden of proving the allegation

The panel therefore found charge 6) not proved.

Charge 7a)

That you a registered midwife, on 28 June 2019

7. After carrying out a vaginal examination on Patient A at approximately 3am
a. did not communicate with the patient

This charge is found NOT proved.

The panel considered the original complaint letter from Patient A dated 2 July 2019, which states:

"At 03:00am a vaginal examination had been done with my consent. After completion, [Colleague C] walked straight out of the room. There was no exchange of words and I felt like I had been violated as there was no care or compassion or even an acknowledgment of the examination. 20 minutes later I was informed I was 3cm dilated."

The panel also considered Ms Avotri's (Midwife C's) defence bundle, which states:

'In truth, I told [Patient A] *immediately that she was 3cm and I can recall that she was disappointed because she wasn't further along; this is documented in my statement (page 2). Furthermore, even though it is my practice to inform women immediately, in my experience the first thing women say when I examine them is, 'How far along am I?' before I even get a chance to tell them*. [Patient A] *complained that I did not say anything, but it appears from paragraph 14 that she didn't ask immediately either, which I would expect her to do. I cannot imagine any woman staying silent as I walked out of the door immediately after a vaginal examination.'*

The panel considered Midwife C's response dated 6 July 2019 to Patient A's letter of complaint to the Trust, which states:

"[Patient A] *became more distressed with contractions and requested pain relief at approximately 02:50. To ensure my Client was in established labour, Consented maternal pulse and fetal heart auscultation was done followed by Vaginal examination at 03:00. She was 3cms dilated…At this point I continued to offer reassurance…I rediscussed analgesia available with benefits and side effects were explained and accepted. Entonox was provided as requested…"*

The panel also reviewed Patient A's medical notes and found a clear timeline indicating that consent was given at 03:00 for the vaginal examination. At 03:10, the medical notes record that the CTG was discontinued and that the importance of continuous CTG monitoring was explained by Midwife C. Furthermore, it indicates that Entonox was administered at that time, suggesting active communication between Ms Avotri and Patient A regarding Patient A's care.

Given the evidence presented, the panel determined that communication did occur between Ms Avotri (Midwife C) and Patient A at approximately 03:00.

The panel acknowledged Patient A's difficult labour experiences including prolonged pain and isolation during her stay. While Patient A articulated her views confidently, the panel identified discrepancies when comparing Patient A's evidence with that of other witnesses. The panel found some of her recollections as mistaken, likely influenced by the intensity of her experience.

Patient A was considered an honest witness; however, the panel concluded that her specific recollection of events was unreliable. The panel acknowledged that even honest witnesses can misremember details, especially when shaped by distressing experiences or the influence of others' accounts.

The panel therefore preferred the account of Midwife C, so that on the balance of probabilities the NMC has not discharged the burden of proving the allegation

The panel therefore found charge 7a) not proved.

Charge 7b

That you a registered midwife, on 28 June 2019

7. After carrying out a vaginal examination on Patient A at approximately 3am
b. sighed and walked off which was inappropriate

This charge is found NOT proved.

The panel took into account Patient A's statement, which states :

"After carrying out the examination, Midwife C sighed and walked off. They did not communicate with me, and I heard them talk about me to the other midwives at reception which included Midwife A and Midwife B. During this time I was still in the bed, however I was close enough to hear what was being said as I have said the

location of reception was not very far from my bed. I heard Midwife C say that I had asked them for gas and air, that I did not seem to be four centimetres dilated as they had just examined me, or in much pain. I then heard Midwife C laugh at me, alongside the other midwives which included Midwife A and Midwife B, and I felt lonely as I was by myself with no support. At the time there was no one else in the bay, and Midwife C had just performed an examination on me, which is how I realised that they were laughing at me."

Ms Avotri (Midwife C) denied the allegation, stating in her defence bundle:

"I maintain that I did my utmost to care for and support [Patient A] *in accordance with NMC and Trust standards. As previously stated, I am saddened that* [Patient A] *feels that (in her words) 'I did not seem bothered by anything' she was saying to me, and that I 'brushed' her off and was 'dismissive'. I respect that all patients are entitled to their opinions, and I appreciate that individuals will have their own perceptions and interpretations of others' body language and verbal communications. However,* [Patient A's] *allegations are genuinely not my recollection of my behaviour, nor are they at all in keeping with my general conduct with patients or colleagues. It is not in my nature to 'tut' and 'sigh' at patient requests….*

I further reiterate that a busy ward is an environment that I am very familiar with and am accustomed to working in. There was no situation that I was presented with while caring for Mrs Aktar that I had not dealt with before in my extensive career as a midwife. As such, there would be no reason for me to express annoyance, frustration, or irritation in the form of 'tutting' or 'sighing' towards [Patient A] *in response to any request she made."*

Furthermore, Patient A also referred to hearing Midwife B and Ms Avotri (Midwife C) whispering to each other at the reception (midwives' station) about her and laughing about her wanting gas and air and about the CTG monitoring. The panel heard considerable

discussion in oral evidence about the likelihood of Patient A being able to hear from bed 6, midwives whispering to each other and laughing at the midwives' station. The panel was taken to a Ward plan drawn by Midwife A. Patient A was not aware of the full layout of the ward but did accept that she was in bed 6 and agreed the positioning of the showers on the opposite side of the corridor and the position of the midwives' station which she referred to as being 20 steps away. The panel also heard that there were double doors, two standalone rooms, a wall, a store cupboard and the matrons' office between Patient A's bed and the open plan midwives' station. Ms 1 and Ms 2 both agreed that it would not be possible to hear conversation at the midwives' station from bed 6. Furthermore, at a later point in Patient A's oral evidence, she stated that from her bed she was unable to hear a different conversation which took place at the midwives' station.

The other midwives denied any whispering or laughing about Patient A. They all referred to the night being very busy, with all beds but two occupied with several inductions and post c-sections on that ward. The panel was aware it was a high risk antenatal and post-natal ward.

The panel recognised that Patient A had a difficult labour and that some of her experiences at the Hospital had not been optimal. She had clearly been in pain for much of the night and had been on her own for a significant amount of time. Patient A was using Entonox and was dealing with the pain of contractions up to the imminent birth of her baby. The panel found her to be confident and able to put her view across eloquently. However, the panel found inconsistencies in her evidence when compared with the evidence of other witnesses, and some of her recollection of events was, in the panel's view, mistaken. The panel found this to be understandable given her predicament at that time.

The panel decided that Patient A was an honest witness but that her recollection of exactly what had happened was unreliable. The panel reminded itself that honest witnesses can be mistaken as a result of memories being fluid and malleable and sometimes tainted by negative experiences or influenced by the accounts of others. The panel also reminded

itself that memories can change over time especially when a memory is recalled multiple times.

The panel noted that Patient A stood by her statement, even when presented with clear evidence to the contrary, showing an unwillingness to accept that she may have misremembered. For example, Patient A and her sister were insistent that she had not been changed into a hospital gown prior to being taken to the delivery ward. However, the panel heard evidence from Ms 1 and from Midwife B that she had been cleaned up and changed prior to being taken to the delivery ward and the panel also noted a statement from the receiving Midwife HM on the delivery ward which stated that she remembered cleaning and changing Patient A's hospital gown as she was soiled. This indicates that Patient A had already been changed into a hospital gown prior to her arrival on the delivery ward.

Patient A was disappointed with her birth experience. The panel found that this may have influenced the way in which she had remembered the events of that night. The panel therefore determined that Patient A's recollection was unreliable.

The panel also noted that Ms Avotri (Midwife C) had a longstanding reputation as a midwife with no record of regulatory misconduct and decided that on the balance of probabilities, it was unlikely that she would have sighed and walked off in this way.

On the balance of probabilities, the panel determined that the NMC has not discharged the burden of proving the allegation

The panel therefore found charge 7b) not proved.

Charge 8a)

That you a registered midwife, on 28 June 2019

8. On moving Patient A to a wheelchair

a. did not respond to her when she advised that you that you were hurting her

This charge is found NOT proved.

The panel considered Patient A's witness statement, where she described hitting her foot on the wheelchair while being moved by the midwives. She said that she felt unheard and in pain, and that the midwives did not examine her foot despite her saying that she had notified the midwives that she had hurt it:

> *"Whilst they were moving me to the wheelchair I hit my foot quite hard on the wheel of the chair as Midwife B and Midwife C were dragging me from the top half of my body and due to my contractions my feet could not move quick enough. I informed Midwife B and Midwife C, whilst they were moving me to the wheelchair, that they were hurting me in moving me, and that I had hurt my foot and that it was painful. However none of the midwives present registered or listened to what I was saying and moved me back to the bed. I felt like a ragdoll as they would just move me very drastically, without informing or communicating beforehand. They also did not examine my foot despite me telling them that I had hurt it. I was then taken back to the bed area in the wheelchair by Midwife A, and I recall seeing a Maternity Assistant at the time accompanying us…"*

Patient A's sister's witness statement states:

> "*Midwife C then informed Person A that they needed to get back to their bed and Midwife C and Midwife A moved Person A by holding them from under their arms, from the bathroom to a wheelchair, whilst Midwife B was by the wheelchair. Person A was having a contraction at that time, and as a result of that as well as how compact the entrance of the bathroom was, they almost tripped up on the wheelchair, and stubbed their toe, as they were being forcefully sat down on it."*

In oral evidence Patient A's sister said, *"I don't even think she noticed she had hit her foot…I don't think she told anyone and I didn't tell anyone".* The panel noted that Patient A's sister conceded that there would have been no way for any person present to know that Patient A had hurt her toe, in her words, *"unless they saw".*

Midwife C does not make any mention of touching Patient A at all. She says that Midwife B was leading Patient A who was walking to the chair herself. Midwife C said that she did not see any inappropriate force from her colleagues, and she did not witness any tripping which would have caused Patient A to hurt herself. Midwives A and B both confirmed that Patient A got into the wheelchair by herself and that nobody touched her due to the presence of faeces.

The panel took into account Ms 1's witness statement, which states:

> *"Once Midwife A arrived at the bathroom with the wheelchair, Midwife B then assisted Patient A to the wheelchair, as the patient was mobile, so Midwife B provided support to Patient A. I did not witness any concerns in the manual handling of Patient A from the bathroom to the wheelchair. Patient A was moved back to the bay. Patient A kept apologising as they were covered in faeces, and Midwife B told them not to worry and to stop apologising…"*

Ms 1 confirms in her interview notes on 5 July 2019 as well as in her statement that Midwife C had no involvement in escorting Patient A out of the bathroom to the wheelchair. She says "*Midwife C moved the Entonox from Patient A's mouth as the Entonox had a long tube and Midwife C did not want Patient A to fall over it, they came out of the bathroom to drop the Entonox outside and requested for me to fetch clean linen."*

The panel considered the evidence submitted by Ms Avotri (Midwife C) and of Midwives A and B, along with the healthcare assistant, Ms 1, who stated that they were unaware of Patient A's complaint about her foot injury. As they were not aware of any injury, they could not acknowledge or examine or treat it.

The panel noted that Patient A's witness statement was the sole evidence provided by the NMC indicating that there had been communication about a foot injury or pain at that time. Contrary to this account, all other witnesses present did not recall Patient A disclosing such an injury. The oral evidence from witnesses emphasised the standard practice of initiating a DATIX report for any patient injuries during transfers. Notably, the patient notes maintained by the midwives and subsequent staff did not document any injury or assessment pertaining to Patient A's foot.

Consequently, based on the evidence before it, the panel found charge 8a) not proved.

Charge 8b)

That you a registered midwife, on 28 June 2019

8. On moving Patient A to a wheelchair

b. used an incorrect moving and handling technique in that you dragged her to the wheelchair

This charge is found NOT proved.

Having found that Ms Avotri (Midwife C) was not involved in helping Patient A to the wheelchair and did not touch her at all, there was no need to consider whether she used an incorrect moving and handling technique.

Therefore, the panel found 8b) not proved.

Charge 9)

That you a registered midwife, on 28 June 2019

9. When Patient A requested to be examined at approximately 5.45am to 6am , initially refused

This charge is found NOT proved.

The panel took into account Patient A's statement, which states:

> *"When I returned to the bed area, at around 06:00, I was experiencing a break in between my contractions and I asked Midwife C to examine me as I could feel my body telling me to push to deliver my baby. Midwife C initially refused to examine me until I informed them that I felt like pushing as they had just recently conducted an examination on me, and I told Midwife C that I think I am now further along."*

The panel also considered the interview notes with Midwife C and Ms 2:

> *"Ms Avotri said, "When she sat down, I communicated that when she gets on the bed I will see how much she has opened. I had done a previous examination on* [Patient A]*. The trolley was by the door (already had sterile gloves and pad"*
>
> *Ms 2 asked, "When you told* [Patient A] *you were going to examine her, did she understand? Was she disoriented?"*
>
> *Ms Avotri responded, "She didn't seem disoriented. I felt she understood at that time."*

The allegation is that Ms Avotri "initially refused" to examine Patient A vaginally. The evidence was that a vaginal examination was undertaken as soon as Patient A was back on her bed. There was no earlier opportunity to examine Patient A before she was back on the bed as she was in a wheelchair being transported back from the shower room. Patient A confirmed under cross-examination that it would have taken less than one minute to go from the shower room to the bed in a wheelchair. Therefore, the examination was undertaken at the earliest opportunity after the request. Accordingly, there can have been no "initial refusal" to examine Patient A.

Therefore, the panel concluded that Midwife C did not initially refuse to examine Patient A but rather communicated her intention to perform the examination at the appropriate time.

The panel therefore found charge 9) not proved.

Charge 10)

> *That you a registered midwife, on 28 June 2019*
> *10. Continued with a vaginal examination on Patient A despite the patient telling you to stop*

This charge is found NOT proved.

The panel noted that Patient A was in significant pain, experiencing regular contractions, and had requested a vaginal examination from Midwife C. Midwife B was standing beside the bed and Ms Avotri (Midwife C) was standing at the end of the bed ready to do the examination. Patient A's sister was standing on the opposite side of the bed from Midwife B. Midwife A was also present. Patient A described feeling vulnerable and unable to fully compose herself due to the intense pain of labour. She mentioned being on the verge of a contraction, using gas and air for relief, and feeling the urge to push. Patient A indicated that she believed she could communicate between contractions.

The panel took into account Patient A's witness statement, which states:

> *"Midwife C then began to examine me as I was being held down in the bed by Midwife A and Midwife B, however as I was having another contraction at the time I asked Midwife C to stop because I am having a contraction. During the height of a contraction, you are in too much pain to communicate, however prior to Midwife C conducting the examination, I was experiencing a break in my contractions and I was clear headed enough to inform Midwife C to wait to undertake the procedure."*

In Midwife B's statement to the NMC, she states:

> *"I categorically deny this allegation. During the internal examination at no point did Patient A verbally or non-verbally communicate for the examination to be stopped. At no point did her body language suggest otherwise, or that she was in discomfort or wanted the examination to be stopped. If this was the case, I would have challenged the midwife performing the examination and informed them to stop as per section 3.4 of the NMC Code of conduct."*

In Patient A's sister's oral evidence, she said that while on the bed Patient A was very vocal about her pain, but she did not state that Patient A was speaking. She said that while in the bathroom that she knew Patient A was having a contraction as Patient A was so vocal. Given that Patient A had been heard screaming in the shower, the panel understood that describing Patient A as very vocal did not mean that she was clearly verbalising her pain, but rather that she was screaming. The panel also noted that Patient A's sister reported that earlier she could not communicate properly with her sister because of delayed responses expected from someone in pain. She said that Patient A was responsive, but the response time changed with the pain.

Ms Avotri (Midwife C) in her written defence said that there was clear communication between her and Patient A leading up to the vaginal examination and emphasised that her recollection is that Patient A did not say anything to her during the examination nor did she express any objections during the process. She says that the concern was only raised towards the end of the examination when Patient A's sister shouted at Ms Avotri (Midwife C) when she was withdrawing her hand. Ms Avotri (Midwife C) states:

> *"It was my understanding that* [Patient A] *and I had been communicating well with each leading to the third examination. There had been no confusion between us regarding consent and examinations. The only suggestion of this arose when* [Patient A's] *birthing partner shouted at me as I was withdrawing my hand following*

the third examination by exclaiming, 'Why did you do the examination without her permission?!' I was so taken aback by her aggression that I didn't reply to her. It was [Midwife A] *who interjected and replied, 'Didn't you hear her say that she was going to examine her?' I focused my attention on* [Patient A] *and advised her that she was 5cm.* [Patient A] *did not say anything during this exchange; there was nothing about her aspect that led me to believe that she was unhappy with being examined or that she felt violated."*

The panel took into account the minutes from the Trust investigation meeting of 10 September 2019 with Midwife C which states: "'*Did the Birthing Partner say anything?'* [Midwife C] responded: *'No I was just about finished. I was taking my fingers out and at this point the Birthing Partner shouted, "Why did you do the examination without permission?"*

The panel took into account Midwife A's statement as requested by Matron EJ in response to a complaint regarding events that occurred on 28 June 2019, which states:

"With curtains drawn to maintain privacy and dignity and with [Patient A] *in bed with consent a vaginal examination was performed by* [Midwife C]*, we stood by to offer support and I remember clearly that the patient was not touched by myself,* [Midwife B] *or* [Ms 1] *as we were not wearing gloves at this stage and as the client was covered in faeces. I offered verbal encouragement and reassurance to keep her calm and relaxed for the vaginal examination to be performed…"*

The panel took into account the investigation meeting notes dated 2 September 2019, which states: "[Ms 2] – do you recall either one of them requesting for the examination to be stopped? Midwife A responded: *'No, only that the birthing partner had interjected during the examination. The patient never interjected to stop.'*

On the face of it, the interjection by Patient A's sister appeared to the panel to be evidence that Patient A had either not consented at all, or had withdrawn consent, but an

examination nevertheless went ahead. However, the panel had doubts about the reliability and credibility of the evidence provided by Patient A's sister. The panel noted that Patient A's sister described her difficulties with seeing Patient A in pain and how she herself felt a bit flustered, young and scared. The panel understood that this was a difficult situation for her to be in, but her description of her state of mind at the time cast doubts for the panel on the reliability of her recollection.

Furthermore, the panel had heard from Midwives A, B and Ms 1 and the written evidence of Midwife C, that Patient A's sister had been "*rude",* "*patronising"* and some of her actions were unhelpful throughout her time on the ward. The panel noted the following:

- Patient A's sister assisted Patient A to go to the bathroom with an Entonox cylinder, an action which clearly worried the midwives and Ms 2 as it was contrary to good practise as the Entonox cylinder should remain next to the bed for health and safety reasons.

- Patient A had described her sister as arguing with Midwife A and Ms Avotri (Midwife C).

- The panel heard that she took two to three minutes to open the bathroom door and asked unnecessary questions before letting any midwives in.

- The panel noted that the midwives had referred to Patient A's sister as being a disruptive rather than a helpful presence.

The panel accepted the consistent evidence of the midwives and Ms 1 about Patient A's sister's disruptive behaviour.

It was of concern to the panel that Patient A's sister showed very limited understanding of the reality of the situation, the need for urgency or the potential risks of certain actions despite her midwifery training. Midwife A and Midwife C gave evidence that Patient A's

sister told staff at the Hospital on arrival that she was a midwife, although the panel heard from Patient A's sister that she was at that time a student midwife in her final year of midwifery training.

The panel noted that there were other inconsistencies in Patient A's sister's evidence which caused the panel to doubt her recollection and thus her credibility as a witness. Some examples include:

- Patient A and her sister were insistent that she had not been changed into a hospital gown prior to being taken to the delivery ward. However, the panel heard evidence from Ms 1 and from Midwife B that she had been cleaned up and changed prior to being taken to the delivery ward and the panel also noted a statement from the receiving Midwife HM on the delivery ward which stated that she remembered cleaning and changing Patient A's hospital gown as she was soiled. This shows that Patient A had already been changed into a hospital gown prior to her arrival on the delivery ward.

- Patient A's sister in her statement says that "*Person A's contractions were very frequent…Person A was already attached to the CTG when I arrived, and no one came to check on the CTG machine whilst I was there…"*

  However, the panel noted that in Patient A's hospital notes that the CTG was checked on three occasions between 03:00 and 05:25. In oral evidence of Midwife B the panel heard that she had readjusted the CTG and on the last occasion said that Patient A's sister had *"screamed at her"* to take her sister off the CTG. This shows that Patient A's sister was present when Midwife B was adjusting the CTG and therefore this throws further doubt onto her recollection of exactly what happened at that time.

- Patient A's sister told the panel that Patient A was very modest, saying Patient A would never be undressed in front of her. However, when cross-examined about

Patient A having a wet nightie that needed to be changed, she told the panel that If anyone had changed Patient A, it would have been her, not a support worker or a midwife.

- Patient A's sister also said that Patient A would not have wanted to empty her bowels when her sister was present. However, Patient A's sister also told the panel that she had not only accompanied Patient A to the bathroom to empty her bowels but had stayed with her.

As a result, the panel found Patient A's sister's recollection to be inconsistent and therefore unreliable. The panel considered that by the time Patient A's sister wrote her statement and subsequently gave evidence she may, with the benefit of hindsight and having gained further experience as a midwife since the incident, have been selective and lacked candour in her evidence.

The panel noted Midwife C's written evidence where she states that Patient A's sister may have made a complaint about the examination taking place without consent to *"deflect from her involvement in the bathroom incident."* The panel therefore considered that this was a further reason to treat Patient A's sister's evidence with caution.

The panel noted that the interjection by Patient A's sister only came at the end of the examination and that the timing of this interjection was confirmed by Midwives A, B and C, and Ms 1 who were present. It was only Patient A who said that she asked Midwife C to stop.

The panel acknowledged that Patient A may well have vocalised something while having the vaginal examination, but that did not mean that it was clear to the staff around that she was withdrawing consent and wanted the examination to stop. It was clear to the panel that Patient A was in pain, felt the urge to push and was vocal. However, the panel determined that Patient A did not articulate her feelings in a clear enough way for you to

understand. The fact that no one else present heard her communicate further confirms this finding.

Furthermore, the panel determined that the fact that Patient A's sister had only intervened at the end of the examination and had said that consent had not been provided at all, was evidence that Patient A's views were not articulated clearly at the time to her either.

The panel concluded that Patient A had not communicated her wishes clearly to anyone before or during the examination.

It was against this backdrop and in light of the evidence set out above and the inconsistencies in Patient A's sister's evidence highlighted, that the panel determined that her evidence was not reliable and preferred the account of the midwives.

The panel therefore found charge 10) not proved.

Charge 11)

> *That you a registered midwife, on 28 June 2019*
> *11. Allowed Midwives A and/or B to forcefully restrain Patient A whilst you were carrying out the vaginal examination on Patient A which was inappropriate*

This charge is found NOT proved.

The panel took into account the witness statement of Patient A, which states:

> *"Midwife C then began to examine me as I was being held down in the bed by Midwife A and Midwife B, however as I was having another contraction at the time I asked Midwife C to stop because I was having a contraction…*

Midwife C was aware of my pain and contraction at the time as they could see my face scrunching up in pain, and I was taking in the gas and air very frequently. I was in a lot of pain at that time and I felt Midwife C touch the head of my baby during the examination. I was putting my knees together in pain and moved to my side to try and manage my contraction, and I was in disbelief that Midwife C was still carrying on with the examination…

.... During this examination, Midwife B was next to Midwife C beside my bed and held my legs down…"

The panel also took into account Patient A's letter of complaint to the Trust dated 2 July 2019, which details the events:

"At 06:00 I was moved to the bed in the bay. The three midwives were being physically aggressive in their manner. I was aware that [Midwife C] *would need to do a vaginal examination at some point.* [Midwife A] *and* [Midwife B] *would not let me labour during contractions how I wanted to, and instead they were very forceful and physically aggressive. They literally held me down onto the bed using unnecessary force…"*

The panel also took into account Patient A's sister's witness statement which states:

"During this, Midwife A was holding down Person A by their shoulders to stop them from moving on the bed and to have them lie flat on their back."

In cross examination Patient A's sister said that her sister was moving when on the bed but not so much as to be worried that she would fall off the bed. The panel felt this was inconsistent with the idea of Patient A being forcibly held down on the bed. These changes in details and inconsistencies raised doubts about the reliability of Patient A's sister's recollection on this point.

In cross examination, Patient A said that she recalled that Midwife B had her hand on Patient A's arms in between her elbow and her wrist but later she said that during the examination Midwife B was holding her legs with her knees dropped.

Midwife C was undertaking the vaginal examination which she believed she had consent to do and she makes no reference to any forceful restraint of Patient A by either of the other midwives in attendance. It is her case that this did not happen. Midwife C *states "I did not witness* [Patient A] *being held down during contractions"*. In response to a question in her interview as to whether she saw anyone touch Patient A, Midwife C said *"I saw nobody touch her because she had faeces on her."*

The panel found that there were many discrepancies in Patient A's evidence which the panel found understandable given that she was in labour with regular contractions and was taking Entonox very frequently, although she denied this when cross examined. Accordingly, the panel found her evidence on the detail of exactly what had happened at this time to be unreliable.

The panel carefully considered the accounts provided by Midwife A and Midwife B, asserting that neither Midwife A nor Midwife B touched Patient A at all due to her being contaminated with faeces and them not having the appropriate protective gloves and apron at that time. Midwife A and Midwife B both offered verbal support instead.

The panel accepted that Midwives A and B did not collude and did not touch Patient A. In coming to this conclusion, the panel deliberated over the submission by the NMC that the three midwives and Ms 1 may have colluded in order to produce a single consistent story, but it dismissed this for the following reasons:

The panel found Ms 1 to be independent – no allegations were made against her, she was consistent in her evidence and told the panel that if she had seen anything of concern happening, she would have stepped in to intervene.

Midwife C was a bank midwife working occasionally on the Ward and she did not work on the Ward again. Midwife B did not work on the Ward after this incident and moved to another hospital. Midwife A continued at the Trust.

The panel heard that the midwives did not know each other socially, had cooperated with the Trust investigation but had provided their initial statements individually, initially without access to other documents but from their own memory. Midwife A and Midwife B denied, on oath, speaking to each other about the case either at the time or subsequently. They were all midwives of previous good character with no other regulatory concerns and with positive testimonials and some with awards to their names.

The panel was persuaded that the consistency of their accounts was not as a result of collusion but rather because this was in fact what had happened. There were some minor details which differed, but they were willing to say when they did not remember, were fair in their assessment and all showed care and compassion and empathy with the situation that Patient A found herself in.

As a result, the panel preferred the evidence of the midwives and Ms 1 over the evidence of Patient A and Patient A's sister.

Consequently, the panel found charge 11) not proved.

Charges 12a) and 12b)

That you a registered midwife, on 28 June 2019

12. On transferring Patient A to the delivery suite, did not communicate effectively with Patient A in that you did not explain to her

a. What stage of labour she was at

b. Why you were transferring her

These charges are found NOT proved.

The panel considered these charges together.

The panel took into account Patient A's witness statement, which states:

> *'…Ran down the corridor, with me in the chair, to the lift. I asked Midwife C where they were taking me and they informed that they were taking me to the Labour Ward.'*

The panel also took into account the letter of complaint dated 2 July 2019 which states:

> *"I was told I was 5cm dilated, however within 1 minute I was downstairs in the labour ward. I was rushed aggressively and forcefully moved to the wheelchair by all three midwives. This opens the question to the fact that if I was only 5cm why I was rushed downstairs so quickly? Why wasn't I given time to contain and prepare myself for birth?"*

The panel noted that while Patient A expressed feeling rushed, it noted that she did receive information regarding her transfer to the delivery ward.

The panel took into account local statement of Midwife B dated 5 September 2019, which states:

> *"once the examination was complete, she was informed she was 5cm dilated and that she needed to be transferred to delivery suite. At that instant [Midwife A] left the room to inform the delivery suite of the situation and to obtain a room for [Patient A] to be transferred. Whilst* [Midwife A] *was doing that,* [Patient A] *was informed that she was going to be transferred to delivery suite. I then proceeded to clean her legs to maintain her dignity whilst being transferred down as I did not want different patient and families to see the faeces on her. I also provided her with a new gown which I helped her to wear and informed her to assist herself to the*

wheelchair when ready. Whilst she was on the wheelchair [Patient A] *proceeded to make involuntary pushing but the vertex was not visible, however we could feel delivery would be imminent due to her being multiparous and VBAC woman."*

The panel also took into account Ms 1's witness statement, which states:

"Once Midwife C conducted the examination, they informed Patient A that they are ready to go down to the delivery ward; I cannot recall if Midwife C then informed Midwife A to contact the delivery ward to inform and prepare for Patient A's arrival, and Midwife B helped Patient A to the wheelchair and Midwife C transferred Patient A to the delivery ward."

The panel recognised that the entire process occurred within a condensed timeframe of approximately 20 minutes, from Patient A leaving the bathroom to her delivery at 06:14.

The panel recognised that this entire process unfolded within a short window of approximately 20 minutes—from the moment Patient A left the bathroom, underwent examination, and was moved to the delivery ward, to the necessary cleaning and changing, culminating in the birth of her baby at 06:14. This brief timeframe likely contributed to significant stress for Patient A. The panel also noted that the rapid progression of events suggests a high level of urgency due to Patient A being multiparous and undergoing a VBAC, which inherently carries a heightened risk of uterine rupture. It was clear that there was good reason for Midwives A, B and C to conclude that Patient A was not a suitable candidate for the birthing centre or delivery on Florence Ward. Thus, the delivery ward was the most appropriate environment for Patient A's care, which is why the midwives acted with such a sense of urgency.

Having considered the evidence, the panel determined that there were numerous instances of effective communication directed towards Patient A regarding her transfer to the delivery ward, particularly concerning her cervical dilation.

Consequently, the panel determined that charges 12a) and 12b) were found not proved.

Having found none of the charges proved in this case the case will proceed no further.

The panel's determination will not be published on the NMC's website. If Ms Avotri would like the NMC to publish the panel's determination Ms Avotri must contact her NMC case officer to arrange for this to be done.

The panel's determination will be confirmed to Ms Avotri in writing.

That concludes this hearing.