Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 27 August– Tuesday 17 September 2024
Thursday 19 September - Tuesday, 24 September 2024

Virtual Hearing

Name of Registrant:	**Olubukola Bridget Ajana**
NMC PIN	07K0012O
Part(s) of the register:	Registered Midwife – November 2007
Relevant Location:	Barnet
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, Lay member) Hannah Harvey (Registrant member) Alyson Young (Lay member)
Legal Assessor:	Charles Conway (27 August – 17 September 2024) Andrew Lewis (19 September – 24 September 2024)
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Raj Joshi (Counsel), Case Presenter instructed by the Nursing and Midwifery Council (NMC) (27 August – 20 September 2024); and Assad Badruddin (23 – 24 September 2024)
Mrs Ajana:	Present and represented by Tope Adeyemi (Counsel) instructed by Thompsons Solicitors
No Case To Answer:	Charges 2e, 2f, 3c(i), 3c(ii), 3c(iii) and 3c(iv)
Facts proved:	Charges 1a, 1b, 1d(i), 1d(ii), 1e(i), 1e(ii), 1f(i), 1f(ii), 1f(iii), 1f(iv), 1g, 2a(i), 2a(ii), 2a(iii), 2b(i),

	2b(ii), 2b(iii), 2c(i), 2c(ii), 2d, 2g(i), 2g(ii), 2i), 3a(i), 3a(ii), 3b, 3d) 3e(i), 3e(ii) 3e(iii) 3e(iv), 3f, 3g(i), 3g(ii), 3h, Charge 4 in its entirety, Charge 5 in its entirety, Charge 6 in its entirety and Charge 7 in its entirety.
Facts not proved:	Charges 1c and 2h
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as read)

That you, a registered midwife, whilst working at Barnet Hospital;

1) On 27/28 June 2020;

a) Instructed Patient H that they could not stay in bed after their caesarean section.

b) Spoke to Patient H in an aggressive tone whilst requesting a blood sample, using words to the effect ‘no, it needs to be done now.’

c) One on or more occasion ignored Patient H’s call buzzer.

d) In response to discovering Patient H was crying used words to the effect;

i) ‘Why are you crying.’

ii) ‘You shouldn’t cry.’

e) After Patient H complained about the level of care being provided to her/that they wanted to go home;

i) Provided Patient H with a discharge form;

ii) Warned Patient H that if anything happened to their baby that it would be Patient H’s responsibility.

f) Failed to provide Patient H with adequate care in that you;

i) Left Patient H’s bed covered in blood;

ii) Failed to provide Patient H with pain relief;

iii) Failed to assist Patient H’s baby who was crying/hungry;

iv) Failed to change Patient H’s dirty pad.

g) Spoke to Colleague Z whilst referring to Patient H, using words to the effect ‘I am not looking after this Patient.’

2) On 23 October 2020;

a) After Patient E requested your assistance, to change their baby's nappy;

i) Refused to assist Patient E;

ii) Used words to the effect 'We aren't here to help you change nappies.';

iii) Used words to the effect 'Who do you thinks going to help you when you're at home.'

b) Spoke to Patient E in an aggressive tone, using words to the effect;

i) 'Stop pressing the call buzzer for assistance.';

ii) 'That the call buzzer is only for emergencies.';

iii) 'The baby is just windy.'

c) Whilst Patient E was trying to change her baby's nappy;

i) Pulled open the curtains;

ii) In an aggressive tone used words to the effect 'Why is your baby always crying.'

d) Took Patient E's baby into the corridor without asking for Patient E's consent.

e) Failed to identify that Patient E's baby had a tongue tie.

f) Inaccurately told Patient E that their baby did not have a tongue tie.

g) Spoke about Patient E using words to the effect;

i) 'I am not going to help her.';

ii) 'She keeps arguing with me.'

h) Did not administer pain medication to Patient E at appropriate times.

i) Spoke to Patient E in a patronising manner, using words to the effect 'babies don't just cry because they are hungry.'

3) On 27/28 October 2020;

a) When asked by Patient G about why there were was blood stains on her bed/linen, responded using words to the effect;

i) ‘Oh it’s nothing.’;

ii) ‘It’s been cleaned and laundered so they don’t need changing.’

b) Initially refused to change Patient G’s blood-stained bed linen.

c) Struggled/failed to fit a cannula to Patient G, in that you;

i) Made 4 attempts to fit the cannula;

ii) Caused bruising to Patient G’s arms/hands;

iii) Caused blood to spurt out of Patient G’s arms/hands;

iv) Called for another colleague to fit the cannula.

d) Refused to check Patient G’s dilation after they had arrived on the ward.

e) Whilst Patient G was in labour/suffering contractions, failed to;

i) Offer food;

ii) Offer water;

iii) Offer pain relief;

iv) Explain Patient G their options/choices.

f) Whilst Patient G was kneeling on the floor in pain, refused to check Patient G’s dilation.

g) Did not respond to Patient G’s call buzzer;

i) At all;

ii) In a timely manner.

h) Spoke to Patient G in an abrupt/rude manner when they were transferred to the delivery suite.

4) On 25/26 December 2020;

a) Shouted/spoke at Patient J using words to the effect;

i) ‘You should not use the call buzzer.’

ii) ‘You are wasting my time, other people on ward actually need me.’

iii) ‘You are taking time away.’

iv) ‘You should not use the call buzzer to ask how to change a nappy.’

b) Did not ensure that Patient J’s bedding was changed.

5) On 11/12 January 2021;

a) After Patient A underwent a caesarean section.

i) Asked Patient A why they had not stood up.

ii) Told Patient A that other women around her had stood up already.

b) After Patient A had used the call buzzer;

i) Threw Patient A’s curtain open;

ii) Shouted at Patient A, using words to the effect ‘You have to start changing your own nappies.’;

iii) Spoke to Patient A in an aggressive tone, using words to the effect ‘then you won’t go home today.’

c) Ignored Patient A whilst they were crying.

d) Failed to offer Patient A assistance whilst they were struggling to latch their baby onto their breast.

e) Did not send a colleague to check on Patient A.

6) On around 16/17 April 2021;

a) Spoke to one or more patients on ward using words to the effect;

i) ‘You don’t need to press the buzzer all the time.’

ii) ‘You must really feed your baby.’

b) On one or more occasion shouted at one or more patients on the ward.

c) After being asked by Patient F about blood in their baby’s nappy;

i) Rolled your eyes at Patient F;

ii) Ignored Patient F's question.

d) Responded to Patient F's pain medication requests in an aggressive/rude manner.

e) Did not provide Patient F pain medication in a timely manner.

7) On 28 April 2021;

a) Shouted across the ward, using words to the effect 'I am the midwife here, we are not here to look after your babies, you are the mums.'

b) After Patient I requested assistance in changing her baby, used words to the effect 'We are not here to look after your baby.'

c) Shouted/spoke at Patient I, using words to the effect;

i) 'You need to stop your baby crying.'

ii) 'I am not having a crying baby on my shift.'

iii) 'What are you going to do.'

iv) 'You need to stop your baby from crying.'

v) 'I can't tell you as people have made complaints when I have told them what to do.'

d) Removed Patient I's baby from their cot/Patient I without consent.

e) Held/lifted Patient I's baby with your arms wrapped around the baby's chest.

f) Shook Patient I's baby for approximately 5-10 seconds.

g) Without consent, squeezed Patient I's nipples.

h) Whilst/after squeezing Patient I's nipples, used words to the effect 'See you've got no milk, that's why he is crying, you need to give him formula.'

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

Decision and reasons on application for hearing to be held partly in private

At the outset of the hearing, Ms Adeyemi made a request on your behalf, that this case be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Joshi, on behalf of the Nursing and Midwifery Council (NMC), did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised [PRIVATE].

Application to adduce the full Lactation Consultant's Report (Day 1)

Ms Adeyemi made an initial application that the hearsay argument in relation to the Lactation Consultant's Report which the NMC seek to adduce and propose to explore with Patient E, should be heard now rather than later, and certainly before Patient E is called to give evidence on 10 September 2024. She submitted that Patient E''s statement was made in 2022 and as such, the NMC has had ample time to prepare their case and make enquiries beforehand.

Ms Adeyemi invited the panel to refuse the application to adduce the hearsay evidence on the basis that it would cause significant unfairness to you.

Mr Joshi made no specific application. He told the panel that enquiries had been made by the NMC beforehand in relation to the Lactation Consultant's Report and had been served on the instructing solicitors in November 2022. He told the panel that they did not respond to any of the documentation. He submitted that the NMC were first alerted

this morning by Ms Adeyemi that the matter of the Lactation Consultant's Report was an issue.

Mr Joshi submitted that he considered that it is fair for the NMC to investigate the source of the Lactation Consultant's Report.

The panel determined that if Mr Joshi intends on making an application that it is deferred until Monday 9 September 2024 before Patient E attends to give evidence on Tuesday 10 September 2024.

Decision and reasons on application to admit the witness statement of Person 1 as hearsay evidence (Day 1)

The panel heard an application made by Mr Joshi under Rule 31, to allow the written statement and corresponding exhibits of Person 1 into evidence. He submitted that Person 1's written statement is directly relevant to evidence in the charges in relation to Patient F and that she is not a reluctant witness but unable to give evidence [PRIVATE]. [PRIVATE].

Mr Joshi referred the panel to NMC guidance on Evidence reference DMA-6.

Ms Adeyemi opposed the application. She provided the panel with written submissions and made reference to it in oral submissions. She submitted that it would be unfair to admit the hearsay evidence.

[PRIVATE]. Ms Adeyemi submitted that there is no explanation as to why in the circumstances Person 1 cannot give evidence. She submitted that arrangements could be made during the hearing, for example breaks [PRIVATE].

Ms Adeyemi highlighted a phone note dated 21 May 2024. She submitted that the reason given [PRIVATE], is not a good reason to decline to attend. She submitted that Person 1 is a professional witness (a midwife) who provides significant evidence

against another individual whose career is on the line. She submitted that in these circumstances the reason given for not attending is not a good enough reason.

Ms Adeyemi submitted that there has been no prior notice of Person 1's non-attendance, and it is not satisfactory that the hearsay bundle was only received today saying that she could not attend. She submitted that prior notice should be provided so that it gives the defence an opportunity to properly anticipate the evidence that is or is not going to be marshalled to make representations. She submitted that Person 1's evidence goes to the core of an allegation that is very serious in which the NMC would seek your removal from the register.

The panel heard and accepted the legal assessor's advice on the matters it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The panel was referred to guidance DMA-6 and the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), *El Karout v NMC* [2019] EWHC 28 (Admin).

The panel was of the view that the evidence produced by Person 1 was directly relevant to charge 6, however she was not a direct witness to the alleged incidents and was reporting what Patient F had told her about the complaint. The panel determined that Person 1's evidence is not the sole or decisive evidence, as it has been provided with the witness statement of Patient F who is due to attend to give evidence on the matter.

The panel considered whether Person 1 had provided sufficient reasons for not attending the hearing to give evidence. The panel determined that [PRIVATE] is not in and of itself a sufficient reason for not attending, absent any other reason. It considered the nature and extent of the charges and noted that you deny all charges. The panel determined that the charges are so serious that it could potentially result in adverse findings against you. The panel determined that it would be unfair to you if you were not able to cross examine Person 1 on their evidence.

The panel considered that you did not have any prior notice that Person 1 was not going to attend to give evidence. The panel determined that it was a basic principle of fairness that you have notice of Mr Joshi's application and given the opportunity to factor this into any defence you chose to present to the panel.

The panel determined it would be unfair to you to accept into evidence the written statement of Person 1.

In these circumstances the panel refused the application.

Application for Witness 9 (Patient H) to not be in-camera and seen by you when giving evidence (Day 8)

The panel heard an application made by Mr Joshi under Rule 23 for special measures to be allowed in relation to Witness 9. He submitted that Witness 9 does not wish to be seen by you when she is giving evidence. He referred the panel to Witness 9's witness statement in which she outlines the effect that the alleged incident has had on her. He submitted that during the preliminary discussion with Witness 9 accompanied by the NMC witness liaison officer earlier she said that she is still traumatised by the events which allegedly took place.

Mr Joshi referred the panel to the NMC guidance CMT-12 'Supporting people to give evidence in hearings', and highlighted paragraph 7, which reads:

> *'Using screens or setting up the room or virtual hearing in a way that the person giving evidence feels most comfortable and can give evidence effectively.'*

Mr Joshi submitted that in practical terms it would mean you joining the hearing via audio as opposed to being on screen in view whilst Witness 9 gives her evidence. He submitted that it is fair, as you can dial in and still be represented by Ms Adeyemi who can see Witness 9.

Mr Joshi invited the panel to grant the application.

Ms Adeyemi took further instructions. Upon her return she opposed the application. She submitted that it is unfair and Rule 23 does not apply. She submitted that there are high stakes for you in terms of the proposed sanction.

Ms Adeyemi referred the panel to Article 6 of the Human Rights Act 1998. She submitted that it is a basic human right for individuals to have a fair trial. She submitted that whilst it may sound dramatic, she reminded the panel that the NMC are seeking the ultimate sanction of a striking off order in your case. She submitted that with your assistance, you are trying your hardest to defend yourself.

Ms Adeyemi submitted that it would be wholly unfair and inappropriate to jeopardise your right to a fair trial and in circumstances where Patient H, who makes approximately eleven allegations and cannot be seen by you, jeopardises fairness to you.

Ms Adeyemi submitted that these alleged incidents occurred in some instances from 2020 and if you saw Patient H you may be able to place her and possibly put some further context in your mind about the allegations.

She submitted that it is especially important for this witness because we have no separate complaint letter from her and it is not clear if this is in fact the individual Colleague Z spoke to.

Ms Adeyemi referred the panel to Rule 23. She submitted that there are some instances where a registrant's rights can be compromised in order to protect the rights of vulnerable witnesses through the adoption of special measures, but they do not arise in this particular instance.

Ms Adeyemi submitted that she is not seeking to minimise the difficulties Patient H may have had, but simply asserting trauma without any evidence to substantiate a diagnosis does not establish that they were indeed traumatised as there are different degrees of

trauma. She submitted that we do not have any medical evidence showing the extent to which this trauma is asserted.

Ms Adeyemi further submitted that it is neither fair or practical given the factual matrix of this particular case, for you to hear evidence from Patient H, that makes such extensive allegations, and for you not to see what they look like..

Ms Adeyemi invited the panel not to allow the application.

The panel accepted the advice of the legal assessor who referred it to the NMC guidance CMT-12 paragraph 7.

The panel carefully considered the application. It bore in mind the guidance in CMT-12 paragraph 7, and the need to support witnesses to be as comfortable as possible when giving evidence. The panel determined that it would be fair for Witness 9 to give evidence without her camera on and that you would join the hearing via audio in order to facilitate the hearing proceeding in the manner applied for.

The panel granted the application however due to technical difficulties this was not possible, accordingly, the panel suggested to the parties that the fairest solution would be for Witness 9 to dial in and give evidence by telephone and for you to join the hearing as normal., This suggestion was acceptable by both parties.

Application to adduce evidence referred to in Witness 5's witness statement (Day 9)

The panel heard an application made by Mr Joshi under Rule 31 to adduce the patient records referred to in Witness 5's witness statement. Mr Joshi submitted that Witness 5 in her witness statement says:

> *'[Witness 11] reported that the Midwife had not been named in Patient G's complaint however, it was clear given the dates and having checked the electronic patient records that the Midwife had provided their care...'*

Mr Joshi submitted that Witness 11 has confirmed that the patient records are available and can be accessed and further, it contains information which verifies and identifies which midwife was on duty on the various dates in relation to the patients, as set out in the charges at the material times.

Mr Joshi submitted that one of the main issues to arise throughout these proceedings is the issue of identification of the midwife. He submitted that your case is that you do not remember whether you were on duty or not, and even if you were, you would not have behaved in manner set out in the charges, and therefore it may well have been another midwife.

Mr Joshi referred the panel to the guidance on 'Evidence' DMA-6 and the case of *PSA v (1) NMC (2) Jozi* [2015] EWHC 764 (Admin). He submitted that the patient records are relevant, in the overarching duty of public protection and is also in the public interest for Witness 11 to obtain those records. Further, he submitted that it is also the responsibility of the panel to ask the NMC to obtain further evidence if it is concerned there are gaps in the evidence which will prevent it from properly performing their function.

Mr Joshi submitted that for the above reasons, it is therefore fair and relevant to admit the patient records into evidence.

Ms Adeyemi opposed the application.

She submitted that it would be unfair to you to allow the patient records into evidence. She submitted that it is well recognised that individuals defending themselves against allegations, especially when the desire is to strike them off, do not have the resources that organisations such as the NMC or the Hospital have to defend themselves. She submitted that the best they can do is have a good idea of what the evidence being presented is and try and organise themselves and marshall a defence. And that is what you are trying to do with her assistance.

Ms Adeyemi submitted that in the event that this evidence is allowed, '*where will it end'*. She submitted that the panel has already heard from nine of the witnesses and the patient records would be evidence that ordinarily questions would be asked to these witnesses. However, the patients to whom they relate to have already given evidence and you therefore have not had the opportunity speak to those witnesses. She submitted that it does not provide you with the opportunity to properly put forward a defence.

Ms Adeyemi submitted that it appears that the NMC is going on an endless expedition to obtain evidence and putting it forward as and when, which places you in a very difficult situation, which is not fair. She further submitted that it goes against your right to a proper and fair hearing.

Ms Adeyemi invited the panel not to allow Witness 11 to provide patient records the day before she gives her evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He also referred the panel to the guidance on evidence Reference DMA-6.

The panel carefully considered the application. It determined that the extra clarification from the patient records would be of assistance to the panel. The panel was of the view that it could also assist you in knowing whether or not you were on duty at the relevant times to corroborate and support your evidence. The panel made it clear that it was only interested in seeing whether you were on duty or not.

In these circumstances, the panel determined that it would be fair and relevant to grant the application and it would give what weight it deemed appropriate once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application of no case to answer (Day 12)

The panel considered an application from Ms Adeyemi that there is no case to answer in respect of charges 1c, 1f(i), 1f(ii), 1f(iii), 1f(iv), 2e, 2f, 2h, 3a(i), 3a(ii), 3b, 3c(i), 3c(ii), 3c(iii), 3c(iv), 3g(i) and 3g(ii). This application was made under Rule 24(7). Ms Adeyemi referred the panel to the test set out in the case of *R v Galbraith* (1981) 73 Cr App R 124 that should be applied in this particular context. The first limb of the test is if there is no evidence to find a charge proved, the charge would fail. The second limb of the test is if there is some evidence but it is of a tenuous nature because of weakness and vagueness, or because it is inconsistent with other evidence, a panel properly directed could not find the charge(s) proved. Ms Adeyemi submitted that both limbs are engaged in this case.

Ms Adeyemi submitted that the overarching concern is whether or not you are the individual complained of in this case. She submitted that the NMC's evidence in this case as to the identity of who the midwife was in each of these allegations, is essentially that it must have been you. She submitted that the foundation of your name being implemented or implicated is not based on reliable or credible evidence, but on a series of assumptions.

Ms Adeyemi referred the panel to the patient records provided by Witness 11. She submitted that the actual patient records were not provided, instead we were presented with Witness 11's record of what she saw in the patient records. She submitted that no details of actual care or assistance was provided and the only name she actually provides is yours; everyone else is abbreviated. She submitted that you provided assistance to some of the patients set out in the allegations however the mere inclusion of your name in the records is not of itself evidence of any wrongdoing or that you are the individual the patients are referring to.

Charges 1c, 1f(i), 1f(ii), 1f(iii)

In relation to Patient H, Ms Adeyemi submitted that she is complaining of a midwife she met on the morning of 27 June 2024. She submitted that your documentary evidence and that of Witness 11 show that you were not working on that day. She submitted that it cannot be suggested that there is some sort of overlap in regards to that particular

day. Ms Adeyemi submitted that as with other witnesses, Witness 11 has simply got it mixed up.

Ms Adeyemi submitted that Witness 11 provides nothing else by way of description other than that the midwife was a black woman who was bigger.

Ms Adeyemi submitted that there is no case to answer in relation to these charges.

Charges 2e, 2f, 2h

In relation to Patient E, Ms Adeyemi submitted that firstly the allegation is based on an assumption that the baby had a diagnosis of a tongue tie; and secondly even if they did, that the symptoms of tongue tied were clearly discernible from other symptoms on 23 October 2020. She submitted that there is no evidence to support either of those propositions.

Ms Adeyemi submitted that there is no evidence to show that Patient E is a medical practitioner and it appears that she asked for a check to be undertaken because she did not know herself what the position was. She submitted that it is far from clear what the symptoms of tongue tie are, when exactly it manifests, and whether they can look like other conditions that babies experience.

Ms Adeyemi submitted that there is no admissible evidence to substantiate Charge 2f and without such information, there's no evidence to show a failure or an inaccurate diagnosis.

In relation to charge 2h, Ms Adeyemi submitted that in order to find this charge proved, the panel first needs to have evidence of the relevant times for administering the pain medication, and that you were the sole person responsible for providing Patient E with it. She submitted that no such evidence has been provided.

Ms Adeyemi submitted that the panel heard evidence on the working culture on the Ward and that they worked as a team. She submitted that it cannot be said that one

midwife was solely responsible for ensuring that the patient had the pain relief and further, it cannot be said what the relevant times were. She submitted that no prescription or records have been provided to show that Patient E was supposed to receive pain relief at a particular time. Ms Adeyemi further submitted that there is no clear evidence as to what is tantamount to '*appropriate'* in the circumstances.

Ms Adeyemi submitted that there is no case to answer in relation to these charges.

Charges 3a(i), 3a(ii)

Ms Adeyemi submitted that in oral evidence Patient G told the panel that she dealt with a number of healthcare practitioners and she had a number of concerns about her general treatment while she was at the Hospital on the Ward. However there is no real evidence as to who this conversation was with.

Charge 3b

Ms Adeyemi referred the panel to the local Witness Investigation Meeting notes of 12 August 2021. She submitted that in Witness 11's interview with Witness 5, it was not at that stage prepared to conclude that the issue relating to the bed linen could be attributed to you. She submitted that now three years later there is no further evidence that implicates you.

Charges 3c(i), 3c(ii), 3c(iii), 3c(iv)

Ms Adeyemi submitted that in 2021, Witness 11 stated that the cannula complaint specifically did not relate to you. In her original complaint letter Patient G made it clear that this was something that concerned '*nurses'* and she did differentiate between the terms. Referring to nurses at one stage and now mentioning '*midwives'*. In her evidence, she stated that it was two white nurses who were involved in fitting the cannula and not the black woman who she was unhappy with in regards to other matters and no evidence from any other source that this is a matter that could possibly

have anything to do with you.

Charge 3g(i) and 3g(ii)

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Ms Adeyemi submitted that Patient G's evidence is that somebody did attend, but not quickly enough. She submitted that if it is as alleged, that this is attributed to you, there is no evidence to show that it was your responsibility alone to respond to the buzzer, and that in the context of the shift the response was not timely.

She submitted that the panel has no evidence of what other work was going on, whether there were any emergencies nor the capacity of other staff. She submitted that without this information, the panel does not have any evidence before it to support the allegation that a response was not timely.

Ms Adeyemi submitted that the burden of proof rests with the NMC and they have been given much leeway and opportunity to provide all the evidence that they could possibly gather and all they have provided is what they have provided to the panel.

Ms Adeyemi submitted that there is no case to answer in relation to these charges.

In these circumstances, Ms Adeyemi submitted that in relation to charges 1c, 1f(i), 1f(ii), 1f(iii), 1f(iv), 2e, 2f, 2h, 3a(i), 3a(ii), 3b, 3c(i), 3c(ii), 3c(iii), 3c(iv), 3b, 3c, 3g(i) and 3g(ii) there is no case to answer.

Mr Joshi made broad submissions in relation to each of the no case to answer submissions made by Ms Adeyemi.

In response to the application in relation to you being the midwife identified, Mr Joshi submitted that on any spelling of your name, whether it is spelled 'B-u-k-i' or 'B-o-o-k-i-e', or in some other way, every patient has put forward the same name or a different spelling of the same name. He submitted that it is not only identification of you by name, and referred the panel to the rotas submitted by Witness 11's and to Appendix 12 as exhibited by Witness 5, places you as the midwife on duty who cared for Patient

H. He submitted that in relation to charge 1c to suggest that the responsibility to answer the buzzer was also for other midwives is simply not accurate.

In relation to the generic issue submitted that you not remember whether you were on duty on particular occasions. Mr Joshi told the panel that the difficulty with that submission is in the similarity of the allegations and it is clear that you are the midwife referred to and identified variously in terms of spelling as ‘B-u-k-i’ or ‘B-o-o-k-i-e’, or another iteration of the spelling of your name.

Mr Joshi further submitted that another generic matter is that it has been put that it could have been the responsibility of a number of individuals, and secondly, this ‘*failure to*’ in the charges means that it was in accordance with a particular standard. He submitted that the particular standard is what would be expected of a reasonable midwife and if a buzzer is going off, a reasonable midwife would answer it because it is not only part of the training and part of the Code, but also professional responsibility. The fact is, it was you, the specific midwife who did not deal with it.

He submitted that Patient E was asked how was it that she recognised you and she said it was as a result, maybe of a name badge as she was in close proximity. Patient E stated that the other two midwives were white and this particular midwife that was the subject of the complaint was black.

Mr Joshi submitted that the term ‘*failures’* as described in charges 1f(i) – 1f(iv), 2e, 2f and 2h are simply standards that would be expected of any midwife, and particularly when one considers that you are a midwife of considerable experience. He submitted that a member of the public would think that a bed left covered in blood in these circumstances was quite frankly a failure on behalf of any midwife.

Mr Joshi submitted that in terms of the conduct, what has been described is various abuse or otherwise. He submitted that witnesses, whilst they were not talking in terms of the words that were said, it was the attitude, the manner in which the words were said and the tone that was adopted.

Mr Joshi submitted that each patient in this case has stated in evidence that they had a similar experience with you.

In response to the application in relation to charges 2e, 2f, 2h, Mr Joshi submitted that any midwife would know what is expected of them. He reiterated that the term '*failures'* as described in charges 1f(i) – 1f(iv) are quite simply standards that would be expected of any midwife, and particularly when one considers that you are a midwife of considerable experience, especially in the circumstances that have been outlined by each one of these patients.

Mr Joshi submitted that when the panel goes through each and every one of allegations in these charges, and considers each allegation separately, and looking at them context, there is a case to answer in relation to each.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

Decision and reasons on submissions of no case to answer

In reaching its decision, the panel made an assessment of all the evidence that had been presented at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts of charges 1c, 1f(i), 1f(ii), 1f(iii), 1f(iv), 2e, 2f, 2h, 3a(i), 3a(ii), 3b, 3c(i), 3c(ii), 3c(iii), 3c(iv), 3g(i) and 3g(ii) proved on the balance of probabilities, and whether you have a case to answer in respect of these charges.

The panel took account of the submissions made by both parties and accepted the advice of the legal assessor who referred the panel to the case of *Galbraith*.

The panel first considered the overarching matter of identification in relation to you and had regard to the test in the case in *Galbraith* as set out as follows:

- *If there is no evidence that the crime alleged has been committed by the*

defendant, there is no difficulty. The judge will of course stop the case

- *The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence*

- *Taken at its highest a panel properly directed could not find the charge(s) proved*.

The panel considered the evidence in relation to the identification. The panel was of the view that in relation to the majority of the charges the witnesses had actually identified you by name (several variations of your name) in their complaint letters or could provide a description of you compared to the other midwives that they experienced at the time of the incidents. The panel determined that in all of the charges sufficient evidence had been presented relating to identification.

The panel also had sight of the internal local investigation provided in evidence by Witness 5 and the work conducted to identify you as the relevant registrant. The panel had regard to the rosters that showed you were on duty and the evidence from Witness 11 which showed you caring for the majority of the witnesses at the material times.

The panel determined that in each case there is sufficient evidence that a properly directed panel could come to a conclusion on the balance of probabilities, that the midwife in question is you. Moreover, the panel did not consider the evidence of identification to be tenuous.

Charge 1c

The panel had regard to your local statement in which you state that you were not on duty on 27 June 2020. It took into account that Patient H said that she met you on the morning of 27 June 2020 the day after she gave birth to her baby. The panel also had regard to the rosters provided by Witness 11 which place you on shift on the day shift duty on 28 June 2024 and also caring for Patient H on this day. This also corresponds with the evidence of Witness 6 who sent a contemporaneous email on the evening of

28 June 2024 following her interaction with Patient H earlier that day.

The panel therefore determined that whilst there are some inconsistencies in the dates of the incidents there is sufficient evidence to support a case to answer in relation to charge 1c.

Proceeding.

Charges 1f(i), 1f(ii), 1f(iii), 1f(iv)

The panel had regard to the evidence of Witness 6 and was of the view that she has no reason to fabricate her account of events and did not find her evidence tenuous.

The panel therefore determined that there is a case to answer in relation to charges 1f(i), 1f(ii), 1f(iii) and 1f(iv).

Proceeding.

Charges 2e, 2f,

The panel was of the view that the full Lactation Consultant's Report was not provided in evidence. The panel therefore determined that there is no evidence to substantiate the first part of the *Galbraith* test and further no evidence from the Patient E in relation to these charges.

Accordingly, the panel determined that there is no case to answer in respect of charges 2e and 2f.

No case to answer.

Charge 2h

The panel had regard to Patient E's witness statement. It noted that she did not receive pain relief when needed and was in a lot of pain. The panel had regard to the various contemporaneous text messages sent from Patient E to her husband. The panel also had sight of Patient E's complaint letter dated 3 February 2021 in which she states she was unable to get out of bed without being in severe pain.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, determined that there is a case to answer in relation to charge 2h.

Proceeding.

Charges 3a (i), 3a(ii) and 3b,

The panel had regard to the witness statement of Patient G, which states:

> *'I noticed that there were blood stains on the bedding of the bed I had been allocated which I assumed would be clean for me. I asked the Midwife why there were blood stains and their initial reaction was 'oh its nothing, it's been cleaned and laundered so they don't need changing. I said that they clearly had not been changed but the Midwife continued and refused to change the bedding. I had to ask about three time and refused to get into a dirty bed until they finally requested for the night porter to come and change the bedding'.*

The panel had regard to Patient G's evidence that she was not asking you personally to change the bed linen rather she was asking you to make arrangements to facilitate it being changed. The panel determined that Patient G was adamant in her assertion and her evidence was clear.

The panel was of the view that it would consider whether it was your responsibility to change Patient G's bed linen at the fact finding stage.
The panel was of the view that there is sufficient evidence to support the charges at this stage and determined that there was a case to answer in relation to them.

Proceeding.

Charges 3c(i), 3c(ii), 3c(iii), and 3c(iv)

The panel had regard to Patient G's oral evidence where she gives a completely different description of the midwife who struggled/failed to fit a cannula. Patient G stated

> *'I remember that the two nurses here attempted to fit the cannula. They were both white.'*

The panel was of the view that, taking account of all the evidence before it, there was no evidence to support 3c(i), 3c(ii), 3c(iii) and 3c(iv).

The panel therefore determined that there is no case to answer in relation to them.

No case to answer.

Charge 3g

The panel considered Patient G's witness statement and heard some evidence in relation to the buzzer not being answered. The panel was of the view that Patient G was clear in her evidence of her description of you and that it was you who was caring for her at the time. The panel was of the view that it was your responsibility to answer the buzzer.

The panel was of the view that there has been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Proceeding.

Background

You were referred to the NMC on 12 December 2021 by the Head of Midwifery and Gynaecology Nursing at the Royal Free London NHS Foundation Trust (the Trust). The charges arose whilst you were employed by the Trust as a Band 6 registered midwife, working at Barnet Hospital (the Hospital) on the Victoria Ward (the Ward). You joined the Trust with 12 years of post-registration experience and commenced your employment with the Trust on 10 June 2019.

It is alleged that between 5 April 2020 and 29 April 2021, the Trust received a number of complaints from patients in relation to your alleged attitudinal conduct, namely rudeness and lack of appropriate care. Similar complaints were made by colleagues.

There are numerous complaints from a variety of sources: six from patients directly that followed themes around consent, behaviours, shaking/inappropriate contact with babies; lack of kindness/empathy; dismissive attitude; aggression, and the impact of behaviour described by some patients.

A local investigation commenced on 28 May 2021 and the matter proceeded to a disciplinary hearing, when you were dismissed on the grounds of gross misconduct on 10 December 2021. You submitted an appeal on 31 March 2022 in relation to your dismissal from the Trust. The appeal was heard on 6 April 2022 and a decision was made not to uphold the original decision to dismiss you. Consequently, on 30 May 2022 you were reinstated by the Trust and are currently working as a Band 6 Midwife on the Antenatal / Postnatal Ward clinic.

The regulatory concerns are allegedly: failure to treat people with dignity and respect; and failure to provide an adequate standard of care.

You refute all of the allegations made against you.

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 Joshi on behalf of the NMC and those made by Ms Adeyemi on your behalf.

The panel also took into account the NMC guidance on evidence DMA-6.

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

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

- Witness 1: Patient F, postpartum patient at the Hospital on the Ward at the material time
- Witness 2: Patient G, antenatal patient at the Hospital on the Ward at the material time
- Witness 3: Patient I, postpartum patient at the Hospital on the Ward at the material time
- Witness 4: Patient J, postpartum patient at the Hospital on the Ward at the material time
- Witness 5: Registered nurse / Lead nurse for practice development / Local investigating officer, at the

	Hospital on the Ward at the material time
• Witness 6:	Senior midwife at the Hospital on the Ward at the material time
• Witness 7:	Patient A, postpartum patient at the Hospital on the Ward at the material time
• Witness 8:	(Joint) Interim Group Director of Midwifery and Head of Midwifery and Gynaecology nursing at the Hospital at the material time
• Witness 9:	Patient H, postpartum patient at the Hospital on the Ward at the material time
• Witness 10:	Patient E, postpartum patient at the Hospital on the Ward at the material time
• Witness 11:	Registered Midwife / Maternity Matron at the Hospital on the Ward at the material time

The panel also heard evidence from you 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 you.

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

Identification of midwife

In relation to all of the charges the panel was satisfied on the balance of probabilities that you were the midwife on duty involved in the alleged incidents.

The panel saw evidence that you were rostered at the time of all of the incidents and that you were allocated as the midwife for the majority of the patients at the relevant times. The panel also heard evidence that you were named as '*Bucky'*, '*Bookie'* and '*Bukky'* or similar sounding names.

Charge 1a

1) On 27/28 June 2020;

a) Instructed Patient H that they could not stay in bed after their caesarean section.

The panel had regard to Patient H's witness statement and oral evidence. In her witness statement she says *'...I also mentioned how I was in so much pain and could not get up'*. The panel also heard in oral evidence Patient H state that you told her that she was *'...not supposed to be in the bed and that you should get up'.*

The panel noted that in your local investigation meeting you stated that you have no recollection of this incident and you repeated the same in your oral evidence. The panel rejected your explanation and accepted the evidence of Patient H.

The panel finds the charge proved.

Charge 1b

b) Spoke to Patient H in an aggressive tone whilst requesting a blood sample, using words to the effect ‘no, it needs to be done now.’

The panel considered Patient H’s evidence and determined that it had no evidence put before it to disbelieve what she said. The panel had regard to Patient H’s witness statement in which she states:

> *‘The Midwife said that they needed to take some of my blood but at the time they asked I was breastfeeding my baby, so I said not right now. The midwife was ‘no, it needs to be done now’ in an aggressive tone and so I let them.’*

The panel determined that Patient H was clear in her evidence that you were aggressive when you spoke to her.

The panel finds this charge proved.

Charge 1c

c) One on or more occasion ignored Patient H’s call buzzer.

The panel had regard to the witness statement of Patient H which states:

‘I called the buzzer a few times and the Midwife did not come to see me and if they did it took around 30 minutes’.

...

‘I kept calling the buzzer but no one came to see me so I had to get up and go outside the bay to ask for help’.

The panel considered Witness 6's evidence that midwives would help each other out in a busy period. The panel was of the view that it is unknown what you were doing, who you were caring for or where you were at the time of this alleged incident.

In considering this charge, the panel accepted the evidence that the buzzer was called and unanswered, however it found on the balance of probabilities there was insufficient evidence for it to conclude that it was going off and you made an intentional decision to ignore it.

The panel finds this charge NOT proved.

Charges 1d(i) and 1d(ii)

d) In response to discovering Patient H was crying used words to the effect;

i) 'Why are you crying.'

ii) 'You shouldn't cry.'

The panel referred to Patient H's witness statement that it took thirty minutes for the buzzer to be answered, and that she was in so much pain when you came into her bay and said these words to her. The panel determined that in the absence of any evidence to the contrary, it finds this charge proved.

The panel finds this charge proved.

Charges 1e (i) and 1e(ii)

e) After Patient H complained about the level of care being provided to her/that they wanted to go home;

i) Provided Patient H with a discharge form;

ii) Warned Patient H that if anything happened to their baby that it would be Patient H's responsibility.

The panel had regard to the witness statement and oral evidence of Patient H:

> *'...the Midwife walked off and came back with a form. The Midwife said I need to sign the form if I wanted to go home, but if something happened to my baby I would be responsible'*

The panel was of the view that it had no reason to doubt Patient H's evidence especially as she expressed to you that she wanted to go home. It determined that on the balance of probabilities this charge is proved.

The panel therefore finds this charge proved.

Charges 1f(i), 1f(ii), 1f(iii) and 1f(iv)

1f) Failed to provide Patient H with adequate care in that you;

i) Left Patient H's bed covered in blood;

ii) Failed to provide Patient H with pain relief;

iii) Failed to assist Patient H's baby who was crying/hungry;

iv) Failed to change Patient H's dirty pad.

The panel considered the contemporaneous email about the incident from Witness 6's evidence of 28 June 2020:

> *'I regret to inform you of an incident I had on Sunday 28th June. The above named patient [..] was being cared for by m/w Booky (Ajana Olubukola) at approximately midday and said m/w came to me an reported that the patient said she "no longer" want her to look after her.*
> *I went to the side room patient sobbing, very upset. Felt that m/w had been*

rude to her. I settled [...] and took over her care and she appeared to be much better for the rest of the shift'.

The panel also had regard to her witness statement which states:

'I went and saw Patient H and they were in tears, rigid with pain and unable to move. The bed was covered in blood and Patient H's baby was crying'.

'*Patient H's baby was also screaming and hungry so I ensured they were fed and content.'*

'I gave Patient H some pain relief, washed them and changed their pad'.

In oral evidence, Witness 6 stated that it needed doing and it took about thirty minutes and that it was not difficult.

Based on the evidence provided by Witness 6 and in the absence of any evidence to the contrary, the panel is satisfied on the balance of probabilities that you failed to provide adequate care to Patient H as set out in the sub-charges.

The panel therefore finds this charge proved.

Charge 1g

1g) Spoke to Colleague Z whilst referring to Patient H, using words to the effect 'I am not looking after this Patient.'

The panel had regard to Patient H's witness statement and the contemporaneous email from Colleague Z dated 28 June 2020.

The panel was satisfied that there is sufficient evidence before it to find this charge proved.

The panel finds this charge proved.

The panel determined that Colleague Z wrote the email dated 28 June 2020 on the same day as the incident happened. The panel determined that Colleague Z was a credible witness and provided reliable evidence. The panel acknowledged that there were some inconsistencies between the evidence provided by Patient H and Colleague Z but those inconsistencies were not material to its findings. It was of the view that the email was a strong contemporaneous record reporting the matter and it noted Colleague Z's responses in the local investigation.

The panel was also of the view that Patient H gave clear evidence noting that she made a complaint at the time and determined that it had no reason to disbelieve her.

The panel had sight of your account given in the internal Investigation Meeting of 14 July 2020. You stated that you could not recall the incidents and had not done the things alleged as it was not your practice.

In oral evidence when it was put to you about the conversation you had with Colleague Z, you denied the conversation occurred or that Colleague Z is mistaken. The panel rejected your evidence and accepted the evidence of Patient H and Colleague Z.

Charges 2a(i), 2a(ii) and 2a(iii)

2) On 23 October 2020;

a) After Patient E requested your assistance, to change their baby's nappy;

i) Refused to assist Patient E;

ii) Used words to the effect ‘We aren’t here to help you change nappies.’;

iii) Used words to the effect ‘Who do you thinks going to help you when you’re at home.’

In reaching this decision, the panel took into account Patient E’s witness statement and oral evidence. The panel considered that she gave clear evidence that she did not receive the assistance she had asked for and needed.

> *‘I realised that my baby’s nappy had not been changed for about four hours so I called the buzzer for help. The Midwife came in and said ‘we aren’t here to help you change nappies. Who do you thing is going to help you when you’re home’.*

The panel determined that Patient E articulated the incidents clearly in her oral evidence and referred the panel to the text messages she sent to her husband in real time, which included:

> *‘Asked for help with the nappy change as haven’t done one and got told to basically do it myself’ 22.51*
>
> *‘I said can you watch and let me know if im doing it right and she said no she had to go’ 22.51*

The panel was of the view that Patient E was a credible witness. She was clear that she had asked for assistance needed and did not receive it. The panel determined that it had no reason to disbelieve her.

The panel therefore finds this charge proved.

Charges 2b(i), 2b(ii) and 2b(iii)

b) Spoke to Patient E in an aggressive tone, using words to the effect;

i) ‘Stop pressing the call buzzer for assistance.’;

ii) ‘That the call buzzer is only for emergencies.’;

iii) ‘The baby is just windy.’

The panel had regard to the witness statement of Patient E which states:

> *‘I pressed the buzzer a few time and no one would come and help me. There was a time where I pressed the buzzer and the Midwife told me know to press it because I was disturbing the other patients and that the buzzer was only for emergencies. It was the middle of night , I was exhausted and this really threw me off’.*

In Patient E’s complaint letter dated 3 February 2021, Patient E states that you told her:

> ‘*In a patronising way the baby was not hungry (and that “They don’t just cry because they are hungry”) She then aggressively told me the baby was ‘just windy’ and when I questioned whether this was correct I was aggressively told that she was ‘Qualified’ and I should “Stop arguing”, which made me feel extremely stupid’*

The panel finds that Patient E was clear and concise in her oral evidence and that she was a credible and reliable witness. The panel determined that it could find no evidence to show why she would be mistaken in her evidence.

The panel therefore finds this charge proved.

Charge 2c(i) and 2c(ii)

c) Whilst Patient E was trying to change her baby's nappy;

i) Pulled open the curtains;

ii) In an aggressive tone used words to the effect 'Why is your baby always crying.'

In reaching this decision, the panel took into account of Patient E's witness statement:

> *'The curtains were closed around my bed, and the Midwife pull the curtains open and said 'why is your baby always crying'. I said 'she is not always crying, I am changing her nappy'*

The panel also took account of the descriptive letter of the complaint of 3 February 2021 in which Patient E states that she was:

> *'Asked aggressively by Bookie "Why is your baby always crying?" when I was unable to stand and change my baby's nappy quickly enough – bearing in mind I had a csection around ten hours earlier and had nerve damage in my foot, swollen feet and a numb right leg preventing me from walking'.*

The panel determined that in terms of identifying you as being on duty on 23 October 2020, the panel noted that you were rostered on the night duty on this date and that Patient E names you as '*Bookie'* in her complaint letter.

The panel therefore finds this charge proved.

Charge 2d

d) Took Patient E's baby into the corridor without asking for Patient E's consent.

In reaching this decision, the panel took into account Patient E's witness statement:

> *'The curtain around the bed was closed so I could not see where they took my baby. I did not have the energy or strength to question the Midwife at the time, but now I would say what are you doing. The Midwife and my baby were out of sight for 30 seconds'.*

As above, the panel determined that it could find no evidence to show that Patient E would be mistaken in their evidence.

The panel finds this charge proved.

Charges 2g(i) and 2g(ii)

g) Spoke about Patient E using words to the effect;

i) 'I am not going to help her.';

ii) 'She keeps arguing with me.'

In reaching its decision the panel considered Patient E's witness statement which states:

> *'I heard the Midwife in the corridor say to another midwife, 'I'm not going to help her, she keeps arguing with me' about me wanting help with by baby's feeding. The Midwife had no compassion'.*

It took account of Patient E's complaint letter dated 3 February 2021.

The panel accepted the evidence of Patient E and determined that it could find no evidence that Patient E was mistaken in their account.

The panel finds this charge proved.

Charge 2h

h) Did not administer pain medication to Patient E at appropriate times.

In reaching its decision, the panel took into account that Patient E states that at one point her medication was brought late and on another occasion it was brought early. The panel determined that there is no evidence to corroborate from the patient records that show the frequency of the medication, or what the appropriate times were. The panel did not have Patient E's care plan before it.

The panel had regard to Patient E's text messages to her husband which states

> *'I asked when my pain meds were due and she got me pain medicine. [emoji] one overdue and one 30 mins early' 04.40*

The panel determined that in the absence of any evidence to show that Patient E would know what the appropriate times are, the panel determined that NMC has not discharged their burden of proof in relation to this charge.

This panel finds this charge not proved.

Charge 2i

i) Spoke to Patient E in a patronising manner, using words to the effect 'babies don't just cry because they are hungry.'

In reaching its decision the panel considered Patient E's witness statement which states that you spoke to her:

> *'In a patronising way the baby was not hungry (and that "They don't just cry because they are hungry")'*

It also took account of Patient E's complaint letter dated 3 February 2021.

As above, the panel determined that it could find no evidence to show that Patient E would be mistaken in their evidence.

This charge is found proved.

The panel found Patient E to be a credible and reliable witness. Patient E explained in her evidence she was still traumatised from the events and finds it difficult to talk about it. The panel determined that it could find no reason to dispute her evidence.

The panel noted that in your local investigation interview, you stated *'I don't have recollection of this, of being aggressive to any patient'*

The panel rejected your evidence and accepted Patient E's evidence.

Charge 3a(i), 3a(ii), 3b, 3d, 3e(i), 3e(ii), 3e(iii), 3e(iv), 3f, 3g(i), 3g(ii) and 3h

3) On 27/28 October 2020;

a) When asked by Patient G about why there were was blood stains on her bed/linen, responded using words to the effect;

i) '*Oh it's nothing.*';

ii) '*It's been cleaned and laundered so they don't need changing.*'

b) Initially refused to change Patient G's blood-stained bed linen.

In reaching its decision the panel had regard to Patient G's witness statement and (undated) complaint letter raised with the Hospital.

In her witness statement, she states:

> *'I asked the Midwife why there were blood stains and their initial reaction was 'oh its nothing, it's been cleaned and laundered so they don't need changing'*

And in her complaint letter:

> *On arrival, I was provided a bay on the ward. I immediately noticed that the bedding was unclean with what appeared to be bloodstains and other bodily fluids. I asked for them to be changed and was told that 'they were clean....straight from the laundry...it's normal for there to be stains'.*

d) Refused to check Patient G's dilation after they had arrived on the ward.

In Patient G's witness statement she states:

> *'The Midwife told me that because my waters had already broken, they could not check how dilated I was because of the risk of infection.*

In Patient G's complaint letter she states:

> *'The Midwife left me on the floor, again refusing to examine me to check how dilated I was.'*

e) Whilst Patient G was in labour/suffering contractions, failed to;

i) Offer food;

ii) Offer water;

iii) Offer pain relief;

iv) Explain Patient G their options/choices.

f) Whilst Patient G was kneeling on the floor in pain, refused to check Patient G's dilation.

In reaching this decision the panel had regard to Patient G's witness statement:

> *'I was kneeling of the floor in front of the chair at this point (with the belt still attached) trying to alleviate the pain. I was not offered pain relief, food or water. My choices were not explained to me. The Midwife left me on the floor.'*

And Patient G's complaint letter:

> *'I could not reach my bag to get any food and in total, I did not eat anything for 12 hours because I did not have the opportunity to, after I was transferred from the Ward for delivery.'*

g) Did not respond to Patient G's call buzzer;

i) At all;

ii) In a timely manner.

In reaching this decision the panel had regard to Patient G's witness statement:

> *'I pressed the called buzzer a few time whilst on the Ward and either no one would come and see me or it would take around 30 – 45 minutes for a response. The curtains were closed and I felt totally alone.'*

The panel had regard to the response you gave in the local Investigation Meeting which was you have no recollection of these events.

The panel was of the view that you should have responded to the buzzer and did not do so. Patient G was pregnant, in labour and in pain. The panel determined that you had a duty to check up on her and on the balance of probabilities, it finds this charges proved.

h) Spoke to Patient G in an abrupt/rude manner when they were transferred to the delivery suite.

The panel had regard to Patient G's witness statement:

> *'At around 06:00 on 28 October 2021, it had been 24 hours since my waters broke. For this reason, I was sent over to the delivery suite because they needed to get my baby out...The Midwife's tone switched instantly and in an abrupt and rude manner they said this is to be the case'*

The panel noted that in cross-examination you stated that you did not recall this incident and would not have behaved in this manner.

The panel also determined that Patient G to be a credible, reliable and honest witness whose treatment was not how it should have been.

The panel therefore determined on the balance of probabilities, charges 3a(i), 3a(ii), 3b, 3d) 3e(i), 3e(ii) 3e(iii) 3e(iv), 3f, 3g(i), 3g(ii) and 3h proved.

Charge 4a(i), 4a(ii), 4a(iii) and 4a(iv)

4) On 25/26 December 2020;

a) Shouted/spoke at Patient J using words to the effect;

i) '*You should not use the call buzzer*.'

ii) '*You are wasting my time, other people on ward actually need me*.'

iii) '*You are taking time away.*'

iv) '*You should not use the call buzzer to ask how to change a nappy.*'

In reaching this decision, the panel took account of witness J's witness statement and oral evidence. The panel noted that Patient J stated in her oral evidence exactly how she felt, is exactly as she stated in her witness statement.

The panel took account of Patient J's witness statement:

> *'No one had changed my bin or bedding so there were nappies and sanitary towels overflowing in the bin and bloody stained bedding. I had not even been given a chance to shower.'*

Patient J also witnessed you shouting at other patients and felt that you lacked compassion.

In the local Investigation Meeting, your response to the allegation was that you do not have any recollection of being aggressive to any patient. In your live evidence, you again said that you had no recollection of this incident.

The panel was of the view that Patient J was a credible and reliable witness and accepted her evidence.

The panel therefore finds this charge proved in its entirety.

Charges 5a(i), 5a(ii), 5b(i), 5b(ii), 5b(iii), 5c, 5d, and 5e

5) On 11/12 January 2021;

a) After Patient A underwent a caesarean section.

i) Asked Patient A why they had not stood up.

ii) Told Patient A that other women around her had stood up already.

The panel had regard to Patient A's witness statement:

> *'It had only been around nine hours since I had the caesarean and I remember the Midwife asking me if I had stood up yet. This was my first interaction with the Midwife; there was no introduction. I responded that I had not stood up as I had just had major abdominal surgery. The Midwife said it had been nine hours and there were other women around me who were up. I felt like I was being shamed so I stood up and I was in agony ...'*

b) After Patient A had used the call buzzer;

i) Threw Patient A's curtain open;

ii) Shouted at Patient A, using words to the effect '*You have to start changing your own nappies.*';

iii) Spoke to Patient A in an aggressive tone, using words to the effect '*then you won't go home today.*'

The panel had regard to Patient A's witness statement where she states that you threw open the curtains and shouted *'you have to start changing your own nappies'.* She further states '*The Midwife was incredibly unkind with her words and tone, making me feel shamed and unworthy. I tried to explain my pain and that I was unable to safely move my baby, to which she aggressively said "then you won't go home today"...'*

c) Ignored Patient A whilst they were crying.

d) Failed to offer Patient A assistance whilst they were struggling to latch their baby onto their breast.

e) Did not send a colleague to check on Patient A.

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

The panel had regard to the patient records which confirms that you cared for Patient A. Patient A's complaint letter of 31 January 2021 also identifies you as named '*Bucky',* a name you acknowledge you were known by.

The panel noted that your response in the Internal Investigation Meeting was that you have no recollection of being present at this incident. During your live evidence you reiterated that you had no recollection but also if anything did happen, you would not have behaved in the manner as alleged in the charges.

The panel determined that Patient A was very clear in her evidence and further, that her witness statement mirrors her complaint letter.

The panel was satisfied that there was sufficient evidence to find this charge proved in its entirety.

The panel finds this charge proved in its entirety.

Charges 6a(i), 6a(ii), 6b, 6c(i), 6c(ii), 6d and 6e

6) On around 16/17 April 2021;

a) Spoke to one or more patients on ward using words to the effect;

i) '*You don't need to press the buzzer all the time*.'

ii) '*You must really feed your baby.*'

In reaching this decision, the panel took account of Patient F's witness statement and complaint letter.

In Patient F's witness statement she states:

I also heard the Midwife shouting at other patients on the Ward. On one occasion, a lady was having a difficult time and their baby was crying a lot. The Midwife came to the and I overheard them say 'you really must feed your baby'.

In oral evidence Patient F said that she believed it was you who she spoke to when you said '*You don't need to press the buzzer all the time*.' Patient F said that the voice was distinct from any others and it was abrasive and aggressive in tone.

b) On one or more occasion shouted at one or more patients on the ward.

c) After being asked by Patient F about blood in their baby's nappy;

i) Rolled your eyes at Patient F;

ii) Ignored Patient F's question.

In Patient F's witness statement states that *'The Midwife rolled their eyes at me as if I had asked a stupid question'.* Patient F said in oral evidence that the only reason a colleague of yours responded to her is because you ignored her.

d) Responded to Patient F's pain medication requests in an aggressive/rude manner.

e) Did not provide Patient F pain medication in a timely manner.

The panel had no details or evidence on what constitutes a timely manner. In her witness statement she expressed that '*Whenever I asked, the Midwife's tone was awful, they were aggressive, rude and insensitive'.* The panel was of the view that there was no reason for Patient F to fabricate her evidence. The panel also noted that that Patient F said the same in her initial complaint.

The panel therefore determined on the balance of probabilities that this charge is found proved in its entirety.

Charges 7a, 7b, 7c(i), 7c(ii), 7c(iii), 7c(iv), 7c(v), 7d, 7e, 7f and 7g

7) On 28 April 2021;

a) Shouted across the ward, using words to the effect *'I am the midwife here, we are not here to look after your babies, you are the mums.*'

b) After Patient I requested assistance in changing her baby, used words to the effect '*We are not here to look after your baby.*'

In reaching this decision, the panel took into account of Patient I's witness statement:

> *'All the curtains were shut so I could not see the other women in the bay and the Midwife said 'I am the midwife here, we are not here to look after your babies, you are the mums. The Midwife then came into my bay and shouted at me 'we are not here to look after your baby...'.*

c) Shouted/spoke at Patient I, using words to the effect;

i) '*You need to stop your baby crying.*'

ii) '*I am not having a crying baby on my shift.*'

iii) '*What are you going to do.*'

iv) '*You need to stop your baby from crying.*'

v) '*I can't tell you as people have made complaints when I have told them what to do.*'

Patient I's witness statement states:

> *'The Midwife was waving her arms around and shouting 'you need to stop your baby crying...The Midwife kept shouting at me 'what are you going to do?'...'you need to stop your baby from crying'...'I asked the Midwife what did they wasn't me to do and they said 'I can't tell you as people have made complaints when I have told them what to do'*

d) Removed Patient I's baby from their cot/Patient I without consent.

e) Held/lifted Patient I's baby with your arms wrapped around the baby's chest.

f) Shook Patient I's baby for approximately 5-10 seconds.

Patient I was adamant that this incident occurred and gave a demonstration of how you shook the baby in her oral evidence. Patient I stated that *'she absolutely did this'*

The panel was satisfied that it finds no reason to discredit what Patient I has said.

g) Without consent, squeezed Patient I's nipples.

h) Whilst/after squeezing Patient I's nipples, used words to the effect *'See you've got no milk, that's why he is crying, you need to give him formula.*'

In Witness I's witness statement she states:

> *'The Midwife did not say anything to me before doing this and I did not consent to her touching me, I felt violated by this act. It was basically an assault; I felt violated and very unsafe. I think I was in my gown at the time with my breast out having been trying to breastfeed but I cannot remember for sure'.*

In the internal Investigation meeting you said that '*I don't do hands on care...If I did hands on it would be done with verbal consent and written in the notes'*. When challenged in live evidence, you said that you do not recollect this incident and would never do this without getting consent first.

The panel determined that there was sufficient evidence in significant detail in Patient I's witness statement, complaint letter dated 13 May 2021 and also in her oral evidence. The panel determined that her evidence was consistent throughout.

The panel determined that there was nothing to question the veracity of Patient I's statement. The panel finds that Patient I to be a credible and reliable witness.

The panel finds this charge proved in its entirety.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

The panel heard evidence from you under oath.

Mr Joshi invited the panel to take the view that the charges found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (The Code) in making its decision. Mr Joshi identified the following specific sections which he submitted were breached by your actions: 1.1, 1.2, 1.4, 2.1, 2.6, 7, 8, 14,1, 20.1, 20.2, 20.3 and 20.5.

Mr Joshi referred the panel to NMC guidance FTP-2a on Misconduct. He submitted that the regulatory concerns include your failure to treat people with dignity, respect, kindness and compassion, lack of communication with patients and colleagues, as well as failing to provide an adequate standard of care to patients in your care. He submitted that your conduct of poor practice indicates a dangerous attitude to the safety of people receiving care to be particularly serious.

Mr Joshi referred the panel to NMC guidance FTP-3 'How we determine seriousness'. He submitted that the charges found proved are serious in nature and was not an isolated incident. He submitted that your behaviour went on for over a year involving a number of patients who were at their most vulnerable and alone, during the Covid-19 pandemic. He referred the panel to the contemporaneous text messages from Patient E to her husband describing how she was being treated by you and how bad she felt.

Mr Joshi submitted that your actions may be considered to be attitudinal in nature and therefore the concerns may be more difficult to put right. He submitted that patients receiving care were put at risk of harm and virtually all of the patients involved are still traumatised by their experiences of how they were treated by you.

Mr Joshi submitted that your actions above are sufficiently serious to amount to misconduct.

Ms Adeyemi invited the panel to find that some of the charges found proved do not amount to misconduct. She referred the panel to the legal principles found in the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311.

Ms Adeyemi submitted that the following charges found proved do not amount to misconduct: 1d, 3d, 3f and 6c. She further submitted the Code 20.2 as referred to by Mr Joshi is not relevant as your honesty and integrity are not engaged in these matters.

In relation to charge 1d Ms Adeyemi submitted that the words used are a recognised turn of phrase used to comfort someone, telling them not to cry or be upset. She submitted that it was not accompanied with more, such as '*why are you being loud',*

'you're causing a disturbance' or *'what's your problem?'* She submitted that, had that been the case, it could be open to say that this is serious misconduct but as it stands it is not an unreasonable thing to say.

In relation to charge 3, Ms Adeyemi submitted that what this amounted to was a conversation where it was being asserted that, notwithstanding the fact that the sheets were stained, they had been cleaned. She submitted that such a conversation does not amount to serious misconduct. She further submitted that in relation to charges 3d and 3f she invited the panel to consider the context that it was said to the patient and that a valid explanation was given to the patient why the procedure could not take place. She submitted that the NMC have not put forward any evidence to show that this was a medically incorrect stance.

In relation to charge 6c, Ms Adeyemi submitted that it is important to understand what the workload might have been and that it be considered in the context of a busy shift during the Covid-19 pandemic in relation to not providing medication immediately.

Ms Adeyemi submitted that your actions do not amount to behaviour falling far short of what is expected of a registered midwife and is also not deplorable.

Ms Adeyemi invited the panel to find that your actions above do not amount to serious misconduct.

Submissions on impairment

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

Mr Joshi addressed the panel on the issue of impairment and reminded the panel 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. He submitted that your actions have the potential to damage public confidence in the profession.

Mr Joshi referred the panel to NMC guidance DMA-1 on impairment. He submitted that managing the risk of harm is something that the panel will have to consider in this particular case as it involves deliberately causing harm to people receiving care and the neglect of vulnerable adults.

In relation to insight and strengthening your practice, Mr Joshi questioned whether you have taken accountability and / or responsibility for your behaviour. He submitted that in spite of everything, you cannot remember or identify what took place, therefore you cannot possibly demonstrate what it is that you are going to be dealing with.

Mr Joshi submitted that considering the number of the charges found proved and the period of time during which the incidents took place and the fact that those patients are still traumatised, were the panel to reach a decision of no impairment, it will need to explain why such a finding is in the public interest.

Ms Adeyemi submitted that when the panel considers all the information available, it can confidently find your approach, attitude and interactions with patients are reflective of a high standard that you would expect of a midwife and that there is no risk of repetition of the conduct outlined in the charges. In addition, she submitted that the public interest would not be served with a finding of impairment being made.

Ms Adeyemi submitted that you have worked extensively in the area of remediation and strengthening your practice. She submitted that you have undertaken a variety of courses that are directly applicable to the regulatory concerns raised. She submitted that following the periods of concern you have demonstrated an understanding and commitment to the core areas of concern, for example: duty of care, compassionate care, communication in labour, human rights and maternity care.

Ms Adeyemi referred to the email from Person 2 dated 21 May 2024, which states:

'I have witnessed her interaction with women and pregnant people and again she has developed and maintained good clear communication with the women and pregnant people she cares for. I have witnessed this in her daily interactions within the clinical area.'

Ms Adeyemi referred the panel to your Action Plan Table which indicates that the four objectives set by Person 2 were all satisfied. She also referred the panel to the positive character references from patients and colleagues attesting to you being '*very kindly*', '*very helpful'* and '...*deals respectfully and kindly with the women and takes her responsibilities seriously.'*

Ms Adeyemi submitted that you are not currently impaired and there is no risk of repetition due to the fact that you have been working consistently for the last few years with no issues. She submitted that the core of the role that you are currently doing involves communication and using your core midwifery skills. She submitted that you have been doing the same type of work since 2020/2021.

Ms Adeyemi submitted that the panel can be assured that you can work without restriction and there is no public interest concern engaged that would require that a finding of current impairment be made.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments which included the case of *Sawati v General Medical Council* [2022] EWHC 283 (Admin) and *Roylance v General Medical Council.*

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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.'*

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

The panel found that your actions did fall significantly short of the standards expected of a registered midwife, and that your actions amounted to breaches of the Code, specifically the following:

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

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must

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

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

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

4 Act in the best interests of people at all times

To achieve this, you must:

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

7 Communicate clearly

8 Work co-operatively

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel carefully considered all of the oral and documentary evidence before it, in relation to each of each of the charges found proved.

Charge 1: Patient H

The panel was of the view that you spoke to Patient H in an aggressive tone whilst requesting a blood sample and failed to provide an adequate standard of care to her after having a caesarean section and was vulnerable. The panel determined that your conduct was of a poor practice which indicates a dangerous attitude to the safety of people receiving care. Accordingly, the panel concluded that your behaviour on the maternity ward toward Patient H amounted to serious misconduct.

Charge 2: Patient E

The panel was of the view that your conduct was attitudinal in nature. Your tone was not only aggressive but you also spoke in a patronising manner about the reasons why Patient E's baby might have been crying. The panel determined that your failures of not receiving consent before taking Patient E's baby into the corridor and not providing medication in a timely manner amounted to serious misconduct.

Charge 3: Patient G

The panel was of the view that you spoke to Patient G in an abrupt manner, failed to offer her food, water or pain relief and not responding to her call buzzer in a timely manner, amounted to serious misconduct.

Charge 4: Patient J

The panel was of the view that your behaviour was attitudinal in nature and you displayed poor practice by not ensuring that Patient J's bed linen was changed and by shouting at her, whilst vulnerable, when she required assistance from you after giving birth. The panel determined that your actions amounted to serious misconduct.

Charge 5: Patient A

The panel was of the view that your tone was aggressive and alarming to Patient A and this displayed a bad attitude towards patients in your care. You failed to provide Patient A with assistance at her most vulnerable and despite this you did not send a colleague back to check on her which was poor practice. The panel therefore determined that your behaviour amounted to serious misconduct.

Charge 6: Patient F

The panel was of the view that to roll your eyes and ignore Patient F when she asked you about the blood in her baby's nappy was poor practice. The panel also determined that to not provide pain relief to Patient F in a timely manner and responding to her request aggressively was very concerning. The panel therefore determined that your behaviour amount to serious misconduct.

Charge 7: Patient I

The panel was of the view that shouting at Patient I, not providing assistance and removing her baby without her consent to shake the baby, fell short of the standards expected of you as a registered midwife. The panel was also concerned that squeezing Patient I's nipples without showing any empathy, amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

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

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

d) *...'*

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of your misconduct. Your misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the midwifery profession would be undermined if its regulator did not find your misconduct to be serious.

The panel considered your registrants response bundle, which included a character references from a former colleagues and colleagues from the Hospital, as well as the training certificates you provided.

The panel was of the view that the misconduct identified in this case is capable of being addressed. However, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account relevant training you have undertaken. The panel believes that you succeeded in completing your action plan which was done under restrictions and monitored by your manager. The panel acknowledges the current reference from your manager that signed off your action plan. The panel determined that your insight is not sufficiently developed, in particular you are not able to show insight into why you behaved in the way you did, where you went wrong and the impact of your behaviour on the patients concerned. Nor were you able to demonstrate how you would behave differently if working in the circumstances in which your misconduct occurred. For these reasons, the panel determined that your insight is not sufficiently developed.

The panel is of the view that there is a risk of repetition based the attitudinal nature of the regulatory concerns identified, which occurred on seven different occasions with women who were about to give birth or had already given birth. The panel determined that, notwithstanding the fact that you have spent two years without being subject to conditions of practice, there remains a risk of harm in relation to your failure to

communicate with patients in your care. In relation to you working Bank shifts on the Ward, the panel further determined that you were not able to provide a satisfactory example of providing safe and adequate care in an empathetic manner in the circumstances which gave rise to your misconduct. 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 determined that a fully informed member of the public would be appalled that you acted in the manner you did and would not expect that behaviour from a midwife. The panel was of the view that these incidents occurred during the Covid-19 pandemic, and one incident over the Christmas period when the patients had no one with them. The panel therefore determined that a finding of impairment on public interest grounds is required.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have 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 Badruddin informed the panel that in the Case Management Form (CMF) sent to you, the NMC had advised that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Badruddin submitted that a striking off order was still the appropriate sanction to protect the public and in the wider public interest.

Mr Badruddin emphasised that the panel must consider proportionality and the NMC's overarching objective of public protection. The least restrictive sanction should be considered that protects the public and meets the public interest. He submitted that your misconduct caused physical and emotional harm to multiple patients in your care, by deliberately neglecting the provision of care with verbal and physical abuse of patients, including shaking a baby. He submitted that you ignored or were dismissive of patient needs and shouted at patients and treated them with disrespect.

Mr Badruddin highlighted several aggravating factors, including: the violation of respect and dignity of vulnerable patients; abuse of a position of trust; placing those patients at a significant risk of harm; you demonstrated a pattern of misconduct, repeated failures to prioritise patient safety that stemmed from underlying attitudinal issues; and a failure to demonstrate any meaningful level of remediation remorse and insight. He submitted the key factor with your failure to demonstrate sufficient insight, remediation or remorse is that it leads to a risk of repetition, which in this case is high.

Mr Badruddin also stated that the panel may consider mitigating factors, such as your engagement with the NMC and having demonstrated safe practice by having a previous interim order revoked. However, he submitted that these did not mitigate the seriousness of the case.

Mr Badruddin submitted that taking no action or issuing a caution would be wholly inappropriate due to the seriousness of the misconduct. He submitted that your misconduct has not been fully remediated and the insufficient insight into your failings presents an ongoing risk to patients. He submitted that a caution order is only attracted to misconduct on the lower end of the spectrum and is not applicable in this case. He submitted that these sanctions would not protect the public or address the public interest in this case.

Mr Badruddin also submitted that a conditions of practice order would not be appropriate or proportionate when considering the regulatory concerns and aggravating factors in this case. He submitted that this is not a case primarily about clinical practice. He submitted that there are no conditions of practice capable of preventing a midwife from deliberately refusing pain medication, shouting at mothers on the postnatal ward and squeezing a patient's nipples without consent.

Mr Badruddin submitted that a suspension order would be insufficient to protect patient safety, the risk to patients and public confidence. He submitted that there is clear evidence of attitudinal problems. He submitted that were you permitted to return to practise unrestricted, there is a very high risk that the misconduct may occur again, therefore, temporary removal is not suitable.

Ms Badruddin invited the panel to impose a striking-off order. He submitted that the public protection and public interest components that have been raised in this decision will remain unaddressed unless you are removed from the register today. He submitted that this was the only sanction that would fully protect the public, maintain professional standards, and uphold trust and confidence in the nursing profession and its regulator.

Ms Adeyemi, in her submissions on your behalf, emphasised that the purpose of a sanction is not punitive but to protect the public and uphold the public interest, while also considering your rights and livelihood. She highlighted the principle of proportionality, stressing the need to balance public protection with your ability to continue practising in your chosen profession which you have committed to for many years.

Ms Adeyemi acknowledged that the panel have found that you are currently impaired. Ms Adeyemi invited the panel to take a holistic approach, taking into account all the evidence before it including the updated reference from your employer and your remediation. Ms Adeyemi submitted that the purpose of a sanction is to protect the public and also to bring a registrant back to safe practice.

Ms Adeyemi submitted that you have worked unrestricted for a significant period of time. She submitted that the panel should consider sanctions from the least restrictive to the most severe. Ms Adeyemi submitted that imposing a caution order or conditions of practice order were appropriate sanctions.

Ms Adeyemi commented on what has been said to be a pattern of misconduct. She submitted that this behaviour took place over a ten-month period which, although not an insignificant period of time, asked that it is viewed in the context of your career now.

Ms Adeyemi submitted in mitigation that the panel has acknowledged some insight from you and there is evidence in the form of references and comments from senior colleagues attesting that you are following good practise and that you have apologised.

Ms Adeyemi submitted that the only purpose that permanent removal or even temporary removal from the register would serve in the current context would be to punish you. She submitted that the seriousness of your behaviour has been adequately reflected in the disciplinary and robust regulatory process that has taken place over the last few years.

Ms Adeyemi submitted that a striking off order would be wholly disproportionate and serve no effective purpose. She submitted that the factors for its imposition are not indicated in the guidance other than to be punitive. She submitted that to strike off an individual who has demonstrated a willingness to try, engage, do everything that has been asked of her to do, it would not be appropriate to then conclude that striking off is the only measure to protect the public and uphold confidence in the profession.

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Ms Adeyemi submitted that you are continuing to practise without any further incidents and you are supported by positive references from your current employer. She submitted that there is no evidence that you have provided that should cause the panel concern that members of the public would be put at risk, if you were permitted to practise without restrictions.

Ms Adeyemi concluded by inviting the panel to impose a conditions of practice order, submitting that this sanction would protect the public and allow you to return to safe practice under supervision and further remediate your practice.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG and the NMC's guidance on 'How we determine seriousness' (FTP-3) and 'Considering sanctions for serious cases (SAN-2). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel accepted the advice of the legal assessor which included reference to the case of *Bolton v The Law Society* [1993] EWCA Civ 32. The panel reminded itself that the reputation of the profession is more important than the fortunes of any individual member.

The panel took into account the following aggravating features which it considered apply in this case:

- Your misconduct was over a prolonged period of time (ten months)
- You caused physical and emotional abuse to patient, including shaking of a patients baby
- You deliberately neglected to provide fundamental midwifery care
- You violated the dignity and respect of patients
- You acted without empathy or compassion

- You repeated the type of misconduct, refusing pain relief, ignoring patients, treating patients with disrespect
- Your misconduct and lack of empathy stemmed from underlying attitudinal issues
- Your insufficient insight into the regulatory concerns

The panel also took into account the following mitigating features, which it considered apply in this case:

- Successful completion of an action plan resulting in the revocation of an interim order

The panel referred to its earlier decisions regarding the seriousness of the facts found proved which led to its finding on current impairment. It was satisfied that your serious misconduct amounted to wide-ranging and serious failings over a prolonged period of time. It determined that your behaviour, which involved a deliberate breaches of the Code, your aggressive behaviour towards patients, and failings in patient safety, all indicated a dangerous attitude to the safety of vulnerable people receiving care, whilst under your direct care.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, and it would not protect the public. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It 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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your 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 order on your registration would be an appropriate and proportionate response. After careful consideration, the panel concluded that although it may be possible to draft conditions that would protect the public in the short term, there are no practical or workable conditions that could be formulated to address the attitudinal concerns identified. Nor would conditions of practice adequately address the wider public interest, given the seriousness of the concerns and your insufficient insight into your failings. Therefore, the panel determined that a conditions of practice order would not adequately protect the public and would not be sufficient to address the public interest.

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

The panel acknowledged that there was no evidence of repetition of your behaviour since the incidents, however it was satisfied that:

- Your misconduct was not an isolated incident but involved seven patients over a significant period of time.
- The majority of the charges found proved stemmed from harmful attitudinal issues posing a risk of repetition
- Your lack of sufficient insight into your failings

Your misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel determined that your failings amounted to a serious breach of the fundamental tenets of the profession and are fundamentally incompatible with you remaining on the register.

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

The panel went on to consider a striking-off order and took account 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?*

The panel found that the regulatory concerns raise fundamental questions about your professionalism, in particular the attitudinal concerns arising from your repeated serious misconduct. The panel concluded that your actions, in failing to treat vulnerable patients safely, professionally and with kindness were significant departures from the standards expected of a registered midwife and are fundamentally incompatible with remaining on the register.

The panel determined that your actions were so serious that to allow you to remain on the register would undermine the public's trust and confidence in the nursing

profession, in the NMC as a regulatory body and in the standards expected of registered midwives.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is a striking-off order.

The panel understands that this order will have an adverse effect on you but considers that it is necessary for the protection of the public, to maintain public trust and confidence in the profession and to send to the public and the profession a clear message about the standards of behaviour required of a registered midwife.

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 your 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 Badruddin. He referred the panel to the guidance on interim orders, namely INT-2 and INT-3. He submitted that the regulatory concerns in this case are serious as already identified by the panel in their written determination. He submitted that the imposition of an interim order is to cover any appeal period if so pursued by you or Ms Adeyemi. He submitted that the application is being made on both grounds of public protection and public interest.

Mr Badruddin invited the panel to consider an interim suspension order for 18 months.,

The panel also took into account the submissions of Ms Adeyemi, who opposed the application for an interim suspension. She reminded the panel that an interim order can only be imposed on the basis of necessity. She submitted that you are entitled to an appeal period and it is not a matter of course that an interim order should be imposed in circumstances where you have an individual who has been working without any issue.

Ms Adeyemi submitted that there was no risk to members of the public if you were permitted to continue to work, and make arrangements to wind things down prior to the strike off coming into effect.

She submitted that you have not acted in a way during the course of these proceedings or during the course of your referral to the NMC that should give rise to doubt about her integrity or ability to abide by anything that has been put in place. She submitted that there is no new risk during the period before the substantive order takes effect.

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 risks to patients and the public identified by the panel in its earlier decision and reasons for imposing the substantive order.

This panel has identified a risk and that it would be inconsistent with its findings not to impose an interim order.

The panel determined that an interim suspension order was necessary to protect the public and uphold public confidence in the nursing profession and to do otherwise

would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

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

This will be confirmed to you in writing.

That concludes this determination.