Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday, 27 August 2024- Thursday, 5 September 2024

Virtual Hearing

Name of Registrant:	Diane Macdonald
NMC PIN:	88E0102S
Part(s) of the register:	Nurses Part of the Register-Sub Part 1 RN1: Adult nurse, level 1 (23 September 1991) Midwives Part of the Register RM: Midwife (30 May 1994)
Relevant Location:	Isle of Lewis
Type of case:	Lack of Competence
Panel members:	Tracy Stephenson (Chair, Lay member) Laura Wallbank (Registrant member) Christine Moody (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Samantha Aguilar
Nursing and Midwifery Council:	Represented by Sean White, Case Presenter
Miss Macdonald:	Not present and not represented at the hearing
No Case to Answer:	Charge 1
Facts proved:	Charges 2.1, 2.2, 2.3, 3, 4, 5.1, 5.2, 5.3, 6, 7, 8, 9, 10, 11.1.1, 11.1.2, 11.1.3, 11.1.4, 11.1.5, 11.2, 11.4, 11.5, 11.6, 12.1, 12.2, 12.3, 12.4, 12.5, 12.6, 12.7, 13.1, 13.2, 13.3, 13.4 and 13.5
Facts not proved:	Charge 11.3

Fitness to practise:	Impaired
Sanction:	**Suspension Order with review (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charges (as amended)

1. On an unknown date in or around 2016 did not have a CTG in place. **[NO CASE TO ANSWER]**

2. On 4 April 2016, you:

   2.1 Cut Patient A's umbilical cord underwater **[FOUND PROVED]**

   2.2 Asked if you could give Patient A opiates in the birthing pool **[FOUND PROVED]**

   2.3 Did not document clearly whether or not Syntometrine had been administered to Patient A **[FOUND PROVED]**

3 On an unknown date in or around 2016, did not use a CTG for monitoring when a Patient was being administered intravenous Syntocinon **[FOUND PROVED]**

4 On an unknown date in 2017, did not identify that a CTG trace was abnormal **[FOUND PROVED]**

5 On one or more occasions in 2017, while on a support improvement plan:

   5.1 Did not accurately record Patient details on blood samples **[FOUND PROVED]**

   5.2 Did not accurately record Patient details in Patient notes **[FOUND PROVED]**

   5.3 Did not record Patient details comprehensibly in Patient notes **[FOUND PROVED]**

6 On 13 July 2017, while on a supported improvement plan, you did not refer Patient C, a high risk patient, to a Consultant prior to sending them home. **[FOUND PROVED]**

7 On 14 July 2017, while on a Supported Improvement Plan, you delivered Baby D without calling for a second Midwife. **[FOUND PROVED]**

8 Your decision not to call a second midwife at charge 7 above was made because you were concerned that Colleague A, the second midwife, would have advised Patient D to come out of the birthing pool against their wishes, when it would have been clinically appropriate to give that advice **[FOUND PROVED]**

9 On an unknown date between 1 April and 31 May18, attempted to look for a Patient's womb level while the Patient was sat up **[FOUND PROVED]**

10 On one or more occasions between 1 April and 31 July 2018 recorded incorrect dates of birth for Patients on a blood transfusion form. **[FOUND PROVED]**

11 On 5 June 2018, while subject to a Capability Process, in relation to Patient B's induction of labour:

11.1 Your completion of medical notes was inadequate and/or inaccurate in that:

11.1.1 Your notes did not make clear whether or not use of opiates had been discussed with Patient B prior to induction **[FOUND PROVED]**

11.1.2 Yours notes did not record observing the signs of transition to second stage labour **[FOUND PROVED]**

11.1.3 There was a large gap in the notes **[FOUND PROVED]**

11.1.4 You made an entry concerning pain relief based on something you overheard rather than a discussion with the relevant doctor **[FOUND PROVED]**

11.1.5 As a result of your action at 11.1.4 above, your entry concerning pain relief did not record a direction from the doctor about Patient B **[FOUND PROVED]**

11.2 Your use of fresh eyes stickers was inadequate for CTG tracing **[FOUND PROVED]**

11.3 You proposed to Colleague C that Patient B be administered opiates when the CTG trace was suboptimal **[FOUND NOT PROVED]**

11.4 Your CTG tracing included a gap of 1 hour and 15 minutes without a fresh eyes review and/or was otherwise poor **[FOUND PROVED]**

11.5 You escalated a syntocinon infusion without recording a clear rationale **[FOUND PROVED]**

11.6 You informed Colleague B that you were confident and competent in applying a foetal scalp electrode, when you had never used or applied one before **[FOUND PROVED]**

12 While on a Supported Practice Placement at Aberdeen Maternity Hospital between 21 October 2019 and 30 October 2019:

12.1 On 21 October 2019, were unsure of what steps to take when a placenta was not delivered immediately after the delivery of a baby **[FOUND PROVED]**

12.2 On 21 October 2019 did not identify and/or escalate to Colleague D a change in a CTG trace **[FOUND PROVED]**

12.3 On 21 October 2019 and 22 October 2019 required prompting to apply Personal Protective Equipment **[FOUND PROVED]**

12.4 On 26 October 2019, when inserting a urinary catheter, did not adequately or at all employ a ‘clean hand, dirty hand’ aseptic technique **[FOUND PROVED]**

12.5 On 22 October 2019 and 29 October 2019, were unable to artificially rupture a membrane **[FOUND PROVED]**

12.6 On 28 October 2019, during an instrumental delivery, were unable to tell a

doctor the strength or duration of a contraction from abdominal palpatations **[FOUND PROVED]**

12.7 On two occasions, when planning Second Stage care, were unable promptly to plan next steps of care without assistance from Colleague D **[FOUND PROVED]**

13 While on a Supported Improvement Plan, did not, between 10 May 2021 and 2 September 2021, complete one or more of the following objectives:

13.1 Documentation **[FOUND PROVED]**
13.2 Appropriate care planning according to Red/Green Pathway **[FOUND PROVED]**
13.3 Assessment of intrapartum care needs **[FOUND PROVED]**
13.4 Decision making **[FOUND PROVED]**
13.5 Management of patient requiring induction of labour **[FOUND PROVED]**

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Macdonald was not in attendance and that the Notice of Hearing letter had been sent to Miss Macdonald's registered address by recorded delivery and by first class post on 24 July 2024.

Mr White, on behalf of the Nursing and Midwifery Council (NMC), submitted that the NMC had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). Mr White informed the panel that there is a receipt of postage and there was a tracking number attached. Unfortunately, when checking this online, there was an issue with the tracking number, so

the NMC had been unable to confirm whether it was signed for or not. However, the receipt at the top of the page confirmed that it was posted on 24 July 2024.

Mr White submitted that the notice of the hearing was posted to Miss Macdonald further to a request that was sent by Miss Macdonald that any additional communications be sent to her by post rather than e-mail. Mr White informed the panel that Miss Macdonald sent an email on 24 August 2024 in which she simply confirms that she will not be attending. Mr White submitted that there is nothing to suggest that Miss Macdonald was otherwise unaware of the hearing or did not receive the notice.

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Macdonald

The panel next considered whether it should proceed in the absence of Miss Macdonald. It had regard to Rule 21 and heard the submissions of Mr White who invited the panel to continue in the absence of Miss Macdonald. He submitted that Miss Macdonald had voluntarily absented herself.

Mr White referred the panel to the email dated 23 August 2024 from Miss Macdonald which stated:

‘Thank hearingyou for the Email, I will not be attending,
[PRIVATE]*, I am unable to concentrate just now,*
I also wish to inform you that I have no bison in my right,, and [PRIVATE]*, I also have* [PRIVATE]*, I have consistently stated I would not be returning to work in NHS OR ANYOBE ELSE.i am waiting to remove myself from the register ASAP,*
Pleased pass on info to relevant people.
I await your reply.’ [sic]

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’*.

The panel decided to proceed in the absence of Miss Macdonald. In reaching this decision, the panel considered the submissions of Mr White, the email from Miss Macdonald dated 23 August 2024, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It considered that:

- No application for an adjournment has been made by Miss Macdonald;
- Miss Macdonald sent the NMC an email on 23 August 2024 stating that she was not attending.
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Eight witnesses are due to attend to give live evidence.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;

- The charges relate to events that occurred from 2016;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Macdonald in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Miss Macdonald from her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Macdonald's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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

At the outset of the hearing, Mr White made a request that this case be held partly in private on the basis that references may be made 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).

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.

Background

Miss Macdonald joined the NMC register on 23 September 1991 as an registered adult nurse. On 30 May 1994, she qualified as a registered midwife. She began working for Western Isles Hospital ("the Hospital") in August 2015 on the maternity ward ("the Ward").

From 2016, concerns began to arise regarding Miss Macdonald's practice and competency as a band 6 midwife.

In April 2016, whilst providing care for Patient A, who was labouring in a birthing pool, the following allegations were made:

- It is alleged that Miss Macdonald cut Patient A's baby's umbilical cord under water, in breach of the Hospital's birthing pool guideline
- Miss Macdonald asked if she could give opiates to Patient A whilst Patient A was in the birthing pool, in breach of the Hospital birthing pool guideline.
- Miss Macdonald allegedly failed to clearly document whether Syntometrine had been administered to Patient A.

An internal investigation began; however, [PRIVATE]. She returned to work in February 2017. On Miss Macdonald's return, she was made subject to the Hospital's Capability Process. Following this, a Supported Improvement Plan ("SIP") was put in place on 6 April 2017. It was agreed that the SIP would be in place for three months.

On 7 July 2017, during a discussion about Miss Macdonald's progress, it was agreed that her SIP would be extended for another month to give her a further opportunity to improve and complete the SIP.

On 13 July 2017, further concerns were raised. It was alleged that Miss Macdonald did not refer Patient C (who was a high-risk patient) to a consultant prior to sending her home.

On 14 July 2017, it is alleged that Miss Macdonald delivered Patient D's baby without calling for a second midwife, which was the Hospital policy. It was alleged that Miss Macdonald said she did not call a second midwife because she was worried that the second midwife would try and get Patient D out of the birthing pool, which is not what Patient D wanted.

On 24 July 2017, Miss Macdonald progressed to formal stage 1 of the Capability Process. Following delays as a result of multiple factors, a letter was sent to Miss Macdonald on 1 February 2018 explaining why she was progressed to formal stage 1 of the Capability Process.

On 18 April 2018, a meeting took place to discuss outstanding issues in Miss Macdonald's SIP. The outcome of the meeting was that she would be placed on a revised action plan. This also included that Miss Macdonald must be mentored by midwife mentors on the Ward.

On 5 June 2018, the following alleged concerns were raised in respect of Miss Macdonald's care of Patient B, whose labour was being induced:

- Miss Macdonald's record keeping: for example, missing information in clinical notes, some blank columns being left uncompleted, a miscommunication regarding opiates and Syntocinon use.
- The use of *'Fresh Eyes'* stickers were not adequate for CTG tracing being carried out throughout the labour episode, and the tracing was of poor quality for a lengthy period of time;
- 1 hour and 15 minutes without a *'fresh eyes'* review was too long, particularly for an unsatisfactory tracing;
- Miss Macdonald informed her supervising midwife that she was competent and confident in applying a Fetal Scalp Electrode ("FSE"), but later allegedly said that she has never used or applied a FSE before.

On 7 May 2021, the Hospital decided that Miss Macdonald would progress to formal stage 2 of the Capability Process. As part of this, she was placed on a SIP, commencing on 10 May 2021, which included the following seven objectives:

1. documentation
2. appropriate care planning according to the Red/Green pathway
3. assessment of intrapartum care needs
4. decision making
5. management of patient requiring induction of labour
6. self-awareness of own health issues and signs of deterioration
7. to fully complete the Ward Induction document.

Miss Macdonald worked alongside mentors who completed supervision notes at the end of each shift. Various concerns arose across the shifts which was noted by each mentor in the supervision notes.

By week 14 of being on the SIP, Miss Macdonald had only allegedly met two of her seven objectives. The two objectives met were objective 6 (self-awareness of own health issues and signs of deterioration), and objective 7 (to fully complete the Ward Induction document).

On 2 September 2021, a final stage 2 meeting took place, and it was decided that Miss Macdonald was to progress to formal stage 3 of the Capability Process.

No Case to Answer in respect of Charge 1

At the close of the NMC's case, Mr White submitted that Charge 1 was a duplication of Charge 3. As such, he invited the panel to disregard this charge on the basis that there was an error in the drafting of Charge 1. In these circumstances, he submitted that this charge should not be allowed to remain before the panel.

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

The panel agreed that Charge 1 was a duplication of Charge 3. It therefore found that there is no case to answer in Charge 1 and it will place weight on the relevant evidence in respect of Charge 3 once it begins its consideration on the facts.

Typographical error in Charge 11.1.1

Mr White referred the panel to Charge 11.1.1 and submitted that there was a minor typographical error in the wording of the charge:

> '11.1.1 Your notes did note make clear whether or note use of opiates had been discussed with Patient B prior to induction'

Mr White submitted that Charge 11.1.1 should state:

> '11.1.1 Your notes did **not** make clear whether or **not** use of opiates had been discussed with Patient B prior to induction'

Mr White invited the panel to consider what the charge ought to read and the relevant evidence before it.

The panel accepted that there had been minor typographical errors in the wording of Charge 11.1.1 and therefore allowed the amendment to correct this.

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 White.

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

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

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

- Witness 1/Colleague B: Head of Midwifery and Miss Macdonald's line manager.
- Witness 2: Midwifery Team Leader and Miss Macdonald's supervisor in late April 2018 for three months and between May 2021 and September 2021.
- Witness 3/Colleague C: Integrated Midwife, Lead for Badgernet and Miss Macdonald's Clinical Supervisor in 2018 and between May 2021 and 31 August 2021.
- Witness 4: Head of Clinical Governance and Professional Practice, supervisor of midwifery and asked to undertake a fact-finding chronology into Ms Macdonald's practice.
- Witness 5/Colleague A: Colleague and Miss Macdonald's mentor in 2016, 2017 and 2018.
- Witness 6/Colleague D: Midwife and Miss Macdonald's former supervisor at the labour ward

	at Aberdeen Hospital between 21 October 2019 and 30 October 2019.
• Witness 7:	Colleague on the labour ward, Project Lead for Badgernet and supervisor between 12 May 2021 and 31 July 2021.
• Witness 8:	Child and Family Health Manager and Head of Midwifery for NHS Shetland at the time of the alleged events and Investigator into Miss Macdonald's practice in 2018.

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

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

Charge 2

2. On 4 April 2016, you:
   2.1 Cut Patient A's umbilical cord underwater
   2.2 Asked if you could give Patient A opiates in the birthing pool
   2.3 Did not document clearly whether or not Syntometrine had been administered to Patient A

Charge 2 is found proved in its entirety.

The panel first considered the evidence in respect of Charge 2.1. The panel took account of Miss Macdonald's contemporaneous note of the incident in the patient records on 4 April 2016:

> *'16:46 Progressed with next contraction to waterbirth (SVD) of live boy. Cord x1 tight around neck unable to slip over head* […] *Clamped + cut prior to delivery of body'*

The panel noted in Witness 4's investigation that she had been asked to provide a fact-finding chronology dated 13 May 2016 – 6 June 2016 of the birthing pool incident which included:

> *'Ms Macdonald clamped and cut the umbilical cord underwater prior to delivery.'*

This was further supported by the entry within the chronology Witness 4 exhibited which was dated 13 May 2016 – 6 June 2016:

> *'4/4/16-1646* […] *Midwife* [Diane Macdonald] *conducting delivery felt for nuchal cord and clamped and cut underwater prior to delivery.*
>
> *Assisting midwife was concerned by this action and called* [Witness 1/Colleague B]
>
> *Evidence Source: Notes*
> *Verbal Account from* [Witness 1/Colleague B]
>
> *Supervisor of Midwives Commentary: Concerned RE practice of feeling for and cutting nuchal cord under water.*
> *This is strongly advised against in both local guidelines and in literature as can stimulate inspiration by neonate.'*

The panel also had regard to the birthing pool guidelines in place at the relevant time which stated in bold letters, *'Under no circumstances should the nuchal cord be clamped and cut under water'*. The panel heard from Witness 1/Colleague B that Miss Macdonald would have had access to the birthing pool guideline as part of her induction at the Hospital. She also stated during her oral evidence that Miss Macdonald had joined the Trust with a significant amount of *'labour ward and pool experience*'.

Witness 1/Colleague B explained in her witness statement:

> *'*[…] *Once the umbilical cord is clamped and cut, the oxygen supply to the baby is cut off.* […] *There is a risk of clamping the umbilical cord whilst a baby is under water. If the baby's head is out, the baby may take a breath under water and inhale water'*

Witness 1/Colleague B explained in her oral evidence that when the incident was discussed with Miss Macdonald, she responded that *"babies could survive underwater for 30 minutes"*. When informed that the umbilical cord had already been cut, so the baby would not have survived underwater for 30 minutes, Witness 1/Colleague B further stated:

> *"I was alarmed by what she said* […] *we had done a lot of teaching and a lot of discussions with staff in respect of using the pool. This was somebody who had highlighted to me that she had many years of experience of pool births in her previous employment and it concerned me greatly"*

The panel found that there was sufficient evidence before it to find Charge 2.1 PROVED.

The panel next considered the evidence in respect of Charge 2.2. The panel had regard to the birthing pool guideline which stated:

> *'Opiates should not be administered when using the pool.*

Opiates may affect the dive reflex of the fetus at delivery/ disrupt the physiology of normal labour.'

The panel noted in Witness 4's statement that she had been asked to provide a fact-finding chronology of the birthing pool incident which included:

'Ms Macdonald considered giving a small dose of opiates to a patient in the birthing pool.'

In Witness 4's fact-finding chronology dated 13 May 2016 – 6 June 2016, it stated:

'4/416-15:40- Woman now in pool and midwife [Diane Macdonald] *considering giving a small dose of opiate* […] *Discussed use of opiate with* [Witness 1/Colleague B] *and advised against as contraindicated in pool.*
[…]
Pool guidelines indicate opioids contraindicated in pool or in the preceding 4 hours prior to entering pool.
Entries in notes not signed.'

The panel noted that Witness 5/Colleague A was clear in her evidence that Miss Macdonald had asked Witness 5/Colleague A whether she could give opiates to Patient A.

Witness 5/Colleague A stated in her statement to the NMC signed 9 October 2022:

'On 4 April 2016, Ms Macdonald asked if she could give diamorphine, a type of opiate, to a patient who was in the birthing pool. […] *I told Ms Macdonald that administering to a woman in a birthing pool was against birthing pool guidelines.* […] *I told Ms Macdonald that I was not happy about her question. I wanted to run what Ms Macdonald had asked past* [Witness 1]'

Witness 5/Colleague A told the panel in her oral evidence that she was not happy about Miss Macdonald's question because it was inappropriate for Miss Macdonald to ask this. Witness 5/Colleague A stated that from her recollection, midwives were given a two-hour training solely on birthing pools.

The event was further supported by Witness 1/Colleague B's evidence. In her statement dated 16 September 2022 to the NMC, she stated:

> *'Ms Macdonald's rationale for why she asked if she could give opiates to Patient A whilst she was in the birthing pool* […] *She stated that she was used to giving opiates in a birthing pool at her previous workplace* […] *She said it is common practice to give multiple does. I found this incredible as no guidance I am aware of advocates for this.'*

Witness 1/Colleague B told the panel during her oral evidence:

> *"I found this an alarming practice that they were giving multiple doses of opiates because we know of the sedative effects, and having somebody in the pool, this for me creates a huge risk for this woman. Should she, for any reason, be left unattended whilst in the birthing pool, there are huge risks associated with that."*

The panel concluded that Charge 2.2 is found PROVED.

The panel considered the evidence for Charge 2.3. The panel had sight of Miss Macdonald's notes within the patient records on 4 April 2016:

> '[…] *Patient A happy to remain in pool meantime.*
> *1702 Third stage is slow, by 1702 no signs of placenta.. 1 ml syntometrine given* […]'

The panel also had regard to the birthing pool guidance:

> *'7.3 Active Management of the Third Stage out of Water*
>
> *Women can opt for active management at any time, but this must take place out of the water'*

Witness 1/Colleague B stated in her statement to the NMC dated 16 September 2022:

> '[…] *An issue with Ms Mcdonald's documentation, in terms of whether Syntometrine had been administered to Patient A (the record was unclear on the medication administration).*
>
> […]
>
> *Ms Macdonald's notes made it difficult to work out whether or not Syntometrine had actually been administered to Patient A. Due to the way that Ms Macdonald had completed her documentation, it concerned me that she had given Syntometrine to Patient A whilst she was in the pool. This worried me because Syntometrine should not be administered to a patient whilst they are in the pool, as there is a risk of water embolism.* […]
>
> *The entry that Ms Macdonald made did not make it clear as to whether she had helped Patient A out of the birthing pool before administering Syntometrine.* […] *Following my investigation into this, it turned out that Ms Macdonald had not administered Syntometrine to Patient A whilst she was in the pool, and instead had helped her to come out of the pool first'*

The panel also had regard to the fact-finding chronology by Witness 4 dated 13 May 2016-6 June 2016 and stated the following in respect of the incident:

‘Not evident in notes that woman had left the pool when Syntometrine was administered. However, midwife confirmed verbally that it was administered after leaving the pool – poor record keeping.’

In respect of the above evidence, the panel found Charge 2.3 PROVED.

Charge 3

3. On an unknown date in or around 2016, did not use a CTG for monitoring when a Patient was being administered intravenous Syntocinon

Charge 3 is found proved.

The panel had regard to NHS Western Isles Induction of Labour Guidelines in place at that time which set out the procedure:

’Indication:
Syntocinon may be used for induction of labour and for augmentation of labour where there is ineffective uterine activity or after pre-labour spontaneous rupture of membranes.
[…]
Procedures
[…]
30 minute CTG prior to Syntocinon (if no CTG as yet in labour) and then continuous monitoring
[…]*’*

The panel also took into account Witness 7’s statement to the NMC dated 11 October 2022, in which she was a direct witness to the incident:

'[…] *It was around 2016, I was taking over from Ms MacDonald* […] *The patient was being administered intravenous Syntocinon.* […] *If a patient is being administered intravenous syntocinon, they must be monitored using a Cardiotocography ("CTG") machine. This is because the intervention of Syntocinon can cause fetal distress* […] *The CTG machine monitors the baby's heart rate to check if it is coping.* […] *However Ms Macdonald did not have a CTG machine running for that patient. The concern is without that CTG machine tracing, Ms Macdonald wouldn't know if the baby is in distress and would not know to intervene or escalate the situation.*

[…]

Knowledge of giving IV Syntocinon and having a CTG machine in situ at the same time is fundamental to midwife training and care of a patient having augmented labour. […] *No harm came to the patient or baby because I put the CTG machine on the patient when I took over care and I reviewed the CTG tracing* […] *I am not aware of follow up because I left it with my manager* [Witness 1/Colleague B], *to deal with and I had no further involvement'*

The panel found Witness 7's evidence to be reliable and consistent in her NMC witness statement and her oral evidence. As such, the panel found Charge 3 PROVED.

Charge 4

4. On an unknown date in 2017, did not identify that a CTG trace was abnormal

Charge 4 is found proved.

The panel took into account Witness 3/Colleague C's statement to the NMC dated 6 October 2022:

> *'Ms Macdonald verbally told me what she could see on the tracing and this was that the tracing was normal. However, when I reviewed the tracing of the CTG, I considered it abnormal.* […] *I remember I could see reduced variability* […] *it is normal for the fetus to have accelerations and decelerations in heart rate, but it is a concern if these do not return quickly to baseline variability.*
>
> […] *As a band 6 midwife, she should be competent in this skill. She would have had it as part of her general midwife training. It is mandatory training requirement to complete CTG training program annually. I don't know if Ms Macdonald was up to date with her mandatory training.*
>
> […]
> *If Ms Macdonald is not interpreting a CTG tracing correctly, there is a serious risk that she could miss an important indicator that the baby is in distress. It is fundamental that a midwife can recognise signs of fetal distress, such as the baby is not coping with labour. An intervention maybe required if this is the case.'*

The panel noted that the above evidence is supported by Witness 5/Colleague A's evidence. She told the panel in her oral evidence that she had concerns about Miss Macdonald's competency, particularly as mandatory training was given annually and therefore Miss Macdonald should have been able to interpret the CTG tracing particularly with her level of experience. The panel found Witness 5/Colleague A to be reliable and professional. She was consistent in her witness statement and oral evidence in conveying her concerns about Miss Macdonald's competency. Accordingly, the panel found Charge 4 PROVED.

Charge 5

5. On one or more occasions in 2017, while on a support improvement plan:
   5.1 Did not accurately record Patient details on blood samples
   5.2 Did not accurately record Patient details in Patient notes
   5.3 Did not record Patient details comprehensibly in Patient notes

Charge 5 is found proved.

The panel took into account Witness 5/Colleague A's witness statement dated 9 October 2022:

> '*A meeting took place on 28 June 2017* […] *During this meeting, I informed* [Witness 1/Colleague B] *of issues with Ms Macdonald's attention to detail, particularly regarding blood samples and forms. I recall there being a number of occasions where incorrect or wrong information was recorded on blood samples, such as a surname spelt wrong or a wrong address recorded. This was an issue that did not occur every day, but it was frequent.*
>
> […] *I also recall mentioning an instance where Ms Macdonald made a note about in the diary about a particular patient but, when it came to the day of the patient's appointment on the Ward, the details had not been recorded properly. Staff members could not comprehend the details recorded about the patient. I cannot recall any further details about this, but I recall that whenever Ms Macdonald put patients into the diary, there were frequent errors.*[…]'

The panel also considered the accounts of the various witnesses who have attended the hearing. It understood that there was a general theme which supported the account that Miss Macdonald's midwifery practice in relation to her documentation fell short of what was required. Accordingly, the panel found Charge 5 PROVED.

Charge 6

6. On 13 July 2017, while on a supported improvement plan, you did not refer Patient C, a high risk patient, to a Consultant prior to sending them home.

Charge 6 is found proved.

The panel had regard to Witness 1/Colleague B's statement to the NMC dated 16 September 2020:

> *'A Supported Improvement Plan ("SIP") was put in place for Ms Macdonald which was discussed with her on 6 April 2017.* […] *Both Ms Macdonald and I signed the SIP on this date. It was agreed that the SIP would be in place for three months.*
> […]
> *The SIP was produced after* [Witness 4] *had said what her findings were* […]*'*

Witness 1/Colleague B also exhibited a copy of the SIP which was dated and signed by Witness 1/Colleague B and Miss Macdonald on 6 April 2017.

Witness 5/Colleague A provided a contemporaneous record of the incident dated 14 July 2017, in which she stated:

> *'Following handover midwife* [Witness 3/Colleague C], *approached me and asked to speak to me in private. She informed me that she had concerns about a CTG performed on the evening of Thursday 13/7/17, and that she didn't feel she could sign the buddy review sticker.*
> *Diane had seen a woman who presented at 40+2 with a history of reduced fetal movement,* […]

The woman was allowed home with the advice to return if labour established.
[Witness 3/Colleague C] *stated that she was worried and thought that the CTG required to be repeated. I spoke to* [Dr 1]*, the CTG did not concern me, however she had risk factors of previous C/S, reduced fetal movement and postdates.*
[Dr 1] *wished her to come to ward for CTG and management plan.*
Diane had not discussed management with on call consultant on Thursday 13/7 having seen the woman.'

The above contemporaneous record by Witness 5/Colleague A was further supported by her oral evidence and her statement to the NMC dated 9 October 2022, she stated:

'*On 14 July 2017,* [Witness 3/Colleague C], *Midwife, approached me to inform me that she had been asked by Ms Macdonald to review a cardiotocograph ("CTG") recording of a fetal heart rate after the CTG had been completed on 13 July 2017 for* [Patient C]. *Patient C had already been sent home. This is wrong because if the second midwife reviewing the CTG had any concerns that needed to be acted upon, it is no use if the patient has already been sent home.*

The issue here was also that Patient C was high risk. Patient C was high risk because she was a previous caesarean section patient, there was reduced fetal movement, and some uterine activity. […] *When I look at the CTG, the CTG tracing itself did not concern me. However, the fact that Patient C was high risk and had not been referred to the consultant by Ms Macdonald concerned me. Given that Patient C was high risk, there needed to be the involvement of a consultant.'*

In light of the above evidence, the panel found Charge 6 PROVED.

Charge 7

7. On 14 July 2017, while on a Supported Improvement Plan, you delivered Baby D without calling for a second Midwife.

Charge 7 is found proved.

In considering Charge 7, the panel had regard to Witness 1/Colleague B's statement to the NMC dated 16 September 2020:

> *'A Supported Improvement Plan ("SIP") was put in place for Ms Macdonald which was discussed with her on 6 April 2017.* […] *Both Ms Macdonald and I signed the SIP on this date. It was agreed that the SIP would be in place for three months.*
> […]
> *The SIP was produced after* [Witness 4] *had said what her findings were* […]*'*

Witness 1/Colleague B also exhibited a copy of the SIP which was dated and signed by Witness 1/Colleague B and Miss Macdonald on 6 April 2017.

The panel also took into account the contemporaneous handwritten notes from Witness 5/Colleague A dated 14 July 2017:

> *'Diane was allocated to look after a lady who was being induced* [Patient D].
> *At 3-4cms dilation, she became distressed was taken to pool room, mid morning. I called Student Midwife in, after clarifying womans consent.*
> *When I knocked at door of delivery room on arrival of student, Diane informed me that woman had delivered.*
> *I entered room and mum was in pool holding baby, and I could see that placenta was also delivered in pool.*
> *All appeared well.*
> […]

When Diane returned to office and was completing delivery documentation, I said to her, "You didn't press call bell for delivery" and she replied that I would have wanted the woman to come out of the pool and that the woman didn't wish to come out. […]'

Witness 5/Colleague A told the panel in her oral evidence:

"Yes, I was very surprised. At the same time, I'm running a ward with lots of other things going on, so I expect the midwife in the labour ward to cooperate fully with me as the coordinator, which she didn't. I think it's the fact that she even had the audacity to tell me that she didn't call me because I would have asked the woman to come out of the pool. I think that it's very unprofessional. And she's forgetting that this woman, above all else, needs to deliver safely. It's not about really what the midwife felt about the type of delivery she should have.

If she had delivered very quickly in the pool and Diane had never said that to me, that would have been a completely different scenario. I would have accepted that as the woman delivered quickly, there is nothing you can do about that, but it's the fact that she decided to tell me that she didn't call me because I would have asked the woman to come out- it's very unprofessional and quite bizarre to say that to a midwife colleague."

The panel noted that the birthing pool guidelines stated:

'If the woman goes on to birth in the pool, two staff members should be present i.e. 2 midwives, for health and safety of mother and baby'

Witness 1/Colleague B stated in her oral evidence:

"We've usually got two midwives working per shift. […] The first is there for delivery, the second midwife is there for the baby".

The panel found that Witness 5/Colleague A's evidence was reliable, given that she made contemporaneous notes when the incident occurred. This was further supported by Witness 1/Colleague B's evidence. As such, it found Charge 7 PROVED.

Charge 8

8. Your decision not to call a second midwife at charge 7 above was made because you were concerned that Colleague A, the second midwife, would have advised Patient D to come out of the birthing pool against their wishes, when it would have been clinically appropriate to give that advice

Charge 8 is found proved.

The panel had regard to the evidence as noted in Charge 7. It determined that in light of the above evidence, the panel found Charge 8 PROVED.

Charge 9

9. On an unknown date between 1 April and 31 May18, attempted to look for a Patient's womb level while the Patient was sat up

Charge 9 is found proved.

The panel took into account Witness 2's statement to the NMC dated 27 September 2022:

'My concern with witnessing Ms Macdonald looking for a patient's womb level whilst the patient was sat up was that it highlighted Ms Macdonald's

lack of insight and lack of understanding of a post-natal examination. It is a vital aspect of a post-natal examination as it allows for the level of uterine involution to be assessed. This is important because sub-involution can be a strong indicator of an infection or other complication. This assessment is carried out with the patient in the supine position to allow for palpatation to identify the level of involution. As a rule of thumb, you would anticipate a uterus to involute one finger-breadth daily, although in breast feeding mothers this can be more rapid.

In this particular instance, there was no chance that the assessment carried out by Ms Macdonald would be remotely accurate, as the patient was sitting up. It would be difficult to palpate the uterine fundal level due to her being in that position. It was wholly unacceptable practice for Ms Macdonald to try and carry out the assessment in this way'

The panel took the view that the above statement was supported by Witness 2's oral evidence. She stated:

"[…] *these are procedural things that you are taught at a very junior level in midwifery* […] *They're always conducted in a supine position* […] *I couldn't believe what I was seeing.* […] *bearing in mind this is a band 6 experienced midwife who frequently told us she had lots of experience* […] *at no time would you ever conduct an examination with a patient sitting up."*

The panel found Witness 2's evidence reliable and professional. She was a team leader at the time of the charge alleged, providing supervision and training to Miss Macdonald. The panel therefore placed weight on her account and found Charge 9 PROVED.

Charge 10

10. On one or more occasions between 1 April and 31 July 2018 recorded incorrect dates of birth for Patients on a blood transfusion form.

Charge 10 is found proved.

The panel took into account the reflection form dated 18 May 2018, signed by Miss Macdonald and Witness 2. In the summary of points discussed, it highlighted *'Forms and attention to detail'* as a concern.

The panel also had regard to Witness 2's statement to the NMC dated 27 September 2022:

> *'On the Registrant's reflective account for the shift of 18 May 2018, it mentions that she was unaware of issues raised by me. These issues were the completion of forms and her attention to detail. On the Ward, we have to complete information on blood transfusion bottles which have to be handwritten. When writing on the labels, you cannot be distracted and you have to focus. When looking at the corresponding forms, I saw incorrect dates of birth ("DOBs") which concerned me as forms, and checking details should be ingrained in a band 6 midwife. I gave Ms Macdonald plenty of time to complete the forms and labels. I asked her to go and complete the forms and put them into folders so I could check them. Often when I would go to check them. Nothing would have been prepared. Ms Macdonald always had an excuse for why it had not been done, such as not being told, but it was also things that she should not need to be told to do.'*

The panel found Charge 10 PROVED.

Charge 11

11. On 5 June 2018, while subject to a Capability Process, in relation to Patient B's induction of labour:
    - 11.1 your completion of medical notes was inadequate and/or inaccurate in that:
        - 11.1.1 Your notes did not make clear whether or not use of opiates had been discussed with Patient B prior to induction
        - 11.1.2 Yours notes did not record observing the signs of transition to second stage labour
        - 11.1.3 There was a large gap in the notes
        - 11.1.4 You made an entry concerning pain relief based on something you overheard rather than a discussion with the relevant doctor
        - 11.1.5 As a result of your action at 11.1.4 above, your entry concerning pain relief did not record a direction from the doctor about Patient B
    - 11.2 Your use of fresh eyes stickers was inadequate for CTG tracing
    - 11.3 You proposed to Colleague C that Patient B be administered opiates when the CTG trace was suboptimal
    - 11.4 Your CTG tracing included a gap of 1 hour and 15 minutes without a fresh eyes review and/or was otherwise poor
    - 11.5 You escalated a syntocinon infusion without recording a clear rationale
    - 11.6 You informed Colleague B that you were confident and competent in applying a foetal scalp electrode, when you had never used or applied one before

Charge 11.1.1, 11.1.2, 11.1.3, 11.1.4, 11.1.5, 11.2, 11.4, 11.5, 11.6 is found proved.

Charge 11.3 is not proved.

The panel considered Charge 11.1.1. It noted Witness 1/Colleague B's statement to the NMC which confirmed that Miss Macdonald was subject to a Capability Process on 5 June 2018.

The panel had regard to the minutes of the Capability Meeting on 2 October 2018.

> *'DMD said that Patient* [B]*'s main issue was the use of diamorphine, as she had expressed to DMD that she was not to be given diamorphine under any circumstances, 'even if she begged for it'.*
>
> [Witness 8] *pointed out that this had not been documented, and was not evident from the notes.* [Witness 8] *asked DMD what her understanding of the consultant's reason for doing the induction was. DMD replied that she thought the consultant was concerned that she was under the Growth Assessment Protocol for her BMI, and she was concerned that the CTG was altered and in her opinion it would be safer for her to deliver'*

The panel found that this was supported by Witness 8's statement to the NMC dated 17 October 2022:

> *'My findings were that due to poor documentation by Ms Macdonald, it is difficult to establish if the patient had discussed with Ms Macdonald the use of opiates before her induction. The documentation did show the patient was becoming more distressed during her labour and therefore would have required either opiates or more support to cope with the increasing pain'.*

The panel therefore found 11.1.1 PROVED.

The panel next considered Charge 11.1.2. It had regard to Witness 8's statement to the NMC dated 17 October 2022:

'I could not find evidence that Ms Macdonald noted the signs of transition to second stage labour. Documentation of this is expected and Ms Macdonald would know this from training and experience. However, I did not find evidence that Ms Macdonald withheld opiates because she contacted the consultant and asked [Witness 3/Colleague C], *a senior midwife to review.'*

The panel accepted that if Patient B's labour had progressed quickly that there may have not been time to detail this in Patient B's notes. However, it took the view that there should have been some form of a record even if it was written retrospectively, to record the signs of transition to the second of stage of labour. Given that there is no evidence of any form of notes in Patient B's records contemporaneously or retrospectively, the panel found Charge 11.1.2 PROVED.

In considering the evidence for 11.1.3, the panel had sight of Miss Macdonald's notes. It noted a retrospective entry dated 21 June 2018:

'Prior to [Dr 1] *attaching FSE I performed VE to apply FSE.*
Cx mid position, soft, stretch 4cms to dilated, can stretch to 6cms. Spines well applied-DOA position no moulding FSE not applied as wishing [Dr 1] *to perform procedure.'*

The panel noted that context was provided by Witness 1/Colleague B in her statement to the NMC dated 16 September 2022:

'At page 4 of Patient B's notes […] *, an entry has been completed in retrospect. When I reviewed Patient B's notes* […] *I saw a huge gap in this area of the notes. When I asked Ms Macdonald about this, she said she left it blank for* [Dr 1] *, Consultant, to write in there. I said, no, that there is no reason for it to be blank as, even if a consultant does not write in the notes, the midwife can complete the entry. This entry was not added until 21 June 2018*

[…]

Leaving gaps on a patient's notes is not up to the standards of the NMC because no one has documented what has happened. If there has to be an investigation into the case and a patient's notes need reviewing for a serious adverse event, there would be questions as to why there is nothing documented. I would expect a band 6 midwife to competently complete documentation correctly.'

The panel found that in light of the above evidence that there was a large gap in Miss Macdonald's notes. This was practice not expected from a band 6 midwife. It therefore found Charge 11.1.3 PROVED.

The panel considered the evidence for 11.1.4. Miss Macdonald wrote in Patient B's notes:

'Written in retrospect I heard [Dr 1] *stating until CTG improves to hold back further pain relief. Discussion held with manager re delivery management. I hope this review will help bring forward to* [Patient B] *peace of mind'*

Witness 1/Colleague B said in her statement to the NMC dated 16 September 2022:

'As a midwife, Ms Macdonald should have had a discussion with [Dr 1] *and double checked what was said in respect of opiates. Ms Macdonald should have documented what was said rather than going by what she overheard and making the entry in retrospect. What Ms Macdonald states to have overheard was also not heard by any other staff on shift'.*

The panel noted that based on the contemporaneous notes made by Miss Macdonald in which she admitted having added an entry concerning pain relief based on what she allegedly overheard, the panel found Charge 11.1.4 PROVED.

The panel next considered the evidence for 11.1.5. In particular, Witness 1/Colleague B's note of her conversation with Dr 1 dated 6 July 2018:

> *'Consultant does not recall saying not to give opiates to this patient.'*

This was further supported by Witness 1/Colleague B's statement to the NMC dated 16 September 2022:

> *'I also spoke with* [Dr 1] *on 6 July 2018 and she stated she did not recall saying not to give opiates to Patient B.'*

The panel therefore found Charge 11.1.5 PROVED.

The panel next considered Charge 11.2. The panel had sight of the CTG tracing, and it appears that from the entries in the patient records that Miss Macdonald was responsible for Patient B's care from 15:30 and the panel noted that in the Capability Meeting on 2 October 2018 that she was *'not involved in* [Patient B]*'s care that much until 3:30pm'*. The first CTG assessment was carried out at 17:30 and signed by Witness 3/Colleague C. There was no other evidence of any other Fresh Eyes Sticker or formal assessment carried out by anyone else.

The panel heard from Witness 1/Colleague B in detail during her oral evidence about the Fresh Eyes policy, which was contained in the Cardiotocography Guideline:

> *'CTGs should be formally assessed every hour and Fresh Eyes Buddy Review stickers to be used and placed in notes.'*

At the Capability Meeting on 2 October 2018, Miss Macdonald was interviewed regarding the Fresh Eye stickers:

‘[Witness 8] *asked DMD why there were no ‘Fresh Eyes’ looking at Patient* [B]*’s CTG considering the fact that the reason for her induction was a poor CTG reading. DMD replied that Patient* [B] *was distressed about being induced when she did not want to be induced. DMD said that the consultant was in a couple of times, and she could not a reason.*

[Witness 8] *asked DMD what she would say about the situation prior to the ‘Fresh Eyes’. DMD replied that there was reduced variability and no movements had been picked up. DMD said that there were accelerations initially and then a long period of 20 minutes of reduced variability with no accelerations and decelerations, and they did not summon the midwife because she came in. DMD said that she did update the midwife as to what was going on.‘*

The panel concluded that Miss Macdonald had taken over the care of Patient B at around 15:30, and there was no evidence to suggest that a systematic review of the CTG and Fresh Eye stickers were used as part of the care delivered to Patient B until 17:30. The panel concluded that Miss Macdonald’s use of the Fresh Eye Sticker was inadequate, and the panel therefore found Charge 11.2 PROVED.

The panel next considered Charge 11.3. The panel had regard to Witness 3/Colleague C’s statement to the NMC dated 6 October 2022:

‘Ms Macdonald wanted to give the patient opiates because the patient was reporting to Ms Macdonald that she was in pain and the patient was requesting pain relief. Ms Macdonald asked if it was okay to give an opiate for pain relief. She asked me because I was coordinating the shift and this role includes supporting the other midwives on shift.

I suggested we needed a sufficient CTG tracing and to wait for the CTG to look normal before administering opiates due to the CTG being suspicious and due to reduced variability.'

The panel then considered the minutes of the Capability Meeting with Witness 3/Colleague C dated 3 October 2018:

'[Witness 3/Colleague C] *then stated that the student had approached her about giving Patient A diamorphine.* [Witness 3/Colleague C] *said that, because the CTG reading had been suboptimal prior to that with reduced variability and no accelerations, she had told the student to wait for ten minutes and look at the CTG to see if it improved, and maybe they could think about diamorphine at that point.'*

The panel found that there was inconsistency in the documentary evidence in respect of who proposed that Patient B be administered opiates as in Charge 11.3. As such, it decided that it had insufficient evidence before it to find this charge proved. Therefore, the panel found Charge 11.3 NOT PROVED.

In considering Charge 11.4, it noted the following evidence. In Witness 1/Colleague B's statement to the NMC dated 16 September 2022, she stated, *'1 hour and 15 minutes without fresh eyes review was too long, particularly for this unsatisfactory tracing'.*

In Witness 3/Colleague C's statement she stated:

'the tracing was suboptimal which means that there are concerns about the CTG tracing and it does not meet the normal criteria […] *This could be because of loss of contact with the patient's skin'*

The panel found that after 15:55 and before 17:10, that the CTG was of a poor quality. There were at least three times which showed a note *'loss of contact'* on the CTG. Witness 1/Colleague B stated in her statement:

> *'I would expect Ms Macdonald to know how to deal with poor quality tracing* […]. *There was a loss of contact with the fetal heart rate* […] *I would expect Ms Macdonald to act much earlier than 1 hour and 15 minutes whilst waiting for fresh eyes.'*

The panel next had regard to the minutes of the Capability Meeting dated 2 October 2018:

> *'*[Witness 8] *told DMD that she did not have a problem with the CTG reading or with syntocinon being administered, but she wanted to ask her if she was happy with the syntocinon being administered.* [Witness 8] *said that there was lots of deceleration, and the documentation was not clear enough for her to follow what was happening.* [Witness 8] *added that there was a significant loss of contact from what seemed to be 4pm, and syntocinon continued to be escalated during that period.* [Witness 8] *asked DMD to talk her through the thought processes she was having at this point. DMD replied that they could hear the FH louder than the monitor was picking it up, and she was looking to see if there was any difference in the CTG that had been taken before that. DND said it takes half an hour for the syntocinon to work, and at this stage she* […] *were trying their hardest to get into a normal place to hear the FH.'*

The panel found that Miss Macdonald's CTG tracing showed a long period of poor quality CTG recording and a gap of 1 hour and 15 minutes without a fresh eyes review. As such, it found Charge 11.4 PROVED.

In considering Charge 11.5, the panel had regard to Witness 5/Colleague A's statement to the NMC dated 17 October 2022:

'It was also difficult to understand Ms Macdonald's rationale for escalating the infusion without a clear reactive CTG. This is because she had not documented her rational for escalating the IV Syntocinon when there was not a normal tracing from the CTG machine. This may have been the right thing to do in the situation, but she had not documented her reasoning.'

The panel found that Miss Macdonald escalated a Syntocinon infusion without recording a clear rationale. It therefore found Charge 11.5 PROVED.

The panel considered the evidence for Charge 11.6. Witness 1/Colleague B was a direct witness to this incident:

'Ms Macdonald informed me that she was competent and confident in applying a Fetal Scalp Electrode ("FSE"), but at a later date told me that she had never used or applied one before.

[…]

During Ms Macdonald's interview before she joined the Hospital, she explained that she had had a lot of labour ward experience. I asked Ms Macdonald if she was confident and competent to fit a FSE during my conversation with her on 21 June 2018. Ms Macdonald responded by saying she was, but she just could not fit it on this occasion.

Ms Macdonald later told me that she had never applied a FSE before. When Ms Macdonald was asked about this during the meeting on 27 August 2018, she stated that she had planned for the FSE but asked the consultant to do it. However, [another midwife] *confirmed to me on 3 August 2018 that Ms Macdonald had attempted to apply the FSE. Having spoken with the*

consultant, it is apparent that when they came in to apply the FSE that the FSE had been used/attempted to be used'

During the course of Witness 8's investigation, she stated in her statement to the NMC dated 17 October 2022:

'[…] *I found clear evidence that Ms Macdonald had unsuccessfully attempted to apply FSE. This was despite Ms Macdonald initially denying she attempted application of FSE.'*

The panel noted that during the minutes of the Capability Meeting on 2 October 2018:

'[Witness 8] *asked DMD whether she had ever used a fetal scalp electrode before. DMD replied that she had not.* [Witness 8] *asked DMD whether she had felt competent in the use of a fetal scalp electrode. DMD replied that she would have been if there was someone to supervise her after having explained the procedure.* [Witness 8] *asked DMD to confirm that she had not been trained to do the procedure, and did not feel competent enough to do it. DMD replied that she had been trained, but had never practiced as junior doctors always done it.*

[Witness 8] *said that notes said that the fetal scalp electrode had not been applied, and then it said 'fetal scalp electrode attached and working,' which did not make sense. DMD said that* […] *came into the room and the fetal scalp electrode was different to the one she was used to.'*

In light of the available evidence before the panel, it found Charge 11.6 PROVED.

Charge 12

12 While on a Supported Practice Placement at Aberdeen Maternity Hospital

between 21 October 2019 and 30 October 2019:

12.1 On 21 October 2019, were unsure of what steps to take when a placenta was not delivered immediately after the delivery of a baby

12.2 On 21 October 2019 did not identify and/or escalate to Colleague D a change in a CTG trace

12.3 On 21 October 2019 and 22 October 2019 required prompting to apply Personal Protective Equipment

12.4 On 26 October 2019, when inserting a urinary catheter, did not adequately or at all employ a 'clean hand, dirty hand' aseptic technique

12.5 On ~~26~~ **22** October 2019 and 29 October 2019, were unable to artificially rupture a membrane

12.6 On 28 October 2019, during an instrumental delivery, were unable to tell a doctor the strength or duration of a contraction from abdominal palpatations

12.7 On two occasions, when planning Second Stage care, were unable promptly to plan next steps of care without assistance from Colleague D

Charge 12 is found proved in its entirety.

The panel noted that Witness 4 had been asked to organise a period of supported practice. This was supported by her statement to the NMC dated 10 October 2022:

> *'In 2019, I was asked to organise somewhere for Ms Macdonald to go for a period of supported practice. I was asked to do this because it fell within the remit of my clinical governance role. I looked for a suitable maternity unit for Ms Macdonald to get experience, which ended up being Aberdeen Maternity Hospital ("Aberdeen").*
>
> […]

I attended a meeting on 2 December 2019 where the completed period of supervision at Aberdeen was discussed with Ms Macdonald.

From my recollection, during this meeting, Ms Macdonald explained that she felt really invigorated and that it 'lit her fire again' to practice clinically. Throughout the meeting, Ms Macdonald appeared positive. However, Ms Macdonald felt it was quite unfair to be assessed somewhere strange and unfamiliar but as far as I am aware, Ms Macdonald was not formally assessed at Aberdeen.'

The panel noted that Witness 6/Colleague D was appointed as Miss Macdonald's supervisor at Aberdeen. As such, she provided written and oral evidence during the period of her supervision and her concerns regarding Miss Macdonald's midwifery practice.

In considering Charge 12.1, Witness 6/Colleague D discussed an incident that occurred on 21 October 2019 regarding a patient who had not yet delivered the placenta shortly after the birth of their baby:

'An example was the delivery of the placenta on 21 October 2019, Sometimes, a woman does not deliver the placenta immediately following the delivery of the baby. The placenta must be delivered in a timely manner or there is a risk to the mother of major bleeding or infection. Therefore, there are steps to take to ensure the placenta is delivered within 60 minutes of the baby's delivery or the situation needs to be escalated to a doctor. This is basic midwife training and knowledge I would expect from a band 6 midwife. It is part of a midwife's role in assisting a woman to give birth safely.'

This evidence was supported by the supervision notes completed on 21 October 2019:

'What could have gone better

Could demonstrate when level of care changes in relation to CTG monitoring & retained Placenta'

The panel noted that on this same shift, an incident with CTG occurred which is contained in Charge 12.2. Witness 6/Colleague D stated in her statement to the NMC dated 27 September 2022:

'[…] *We were caring for a patient on a Cardiotocography monitor ("CTG")* […] *I reviewed the CTG tracing and noticed a change in the tracing that Ms Macdonald had not verbalised to me. I asked her questions about the tracing and she was very hesitant with her answers. My concern was that Ms Macdonald did not have the insight to pick up on changes and communicate them. I would expect a band 6 to be able to pick up on any changes because this is basic midwife knowledge.'*

This was supported by Witness 6/Colleague D's supervision notes completed on 21 October 2019:

'What could have gone better: Could demonstrate level of care changes in relation to CTG monitoring'

On the same shift, Witness 6/Colleague D gave evidence that Miss Macdonald had to be prompted to apply Personal Protective Equipment ("PPE") as noted in Charge 12.3. Witness 7's supervision notes dated 21 October 2019 detailed:

'What could have gone better:

Should wear appropriate PPE.

[…]

Encouragement to wear Appropriate PPE when handling body fluids. Also when carrying out procedures such as ARM, delivery, baby care. Especially as patient had Hep C.'

The panel found Witness 6/Colleague D to be a reliable and professional witness. She was able to provide the panel with contemporaneous notes from her supervision of Miss Macdonald on 21 October 2019. She was consistent in her oral evidence and was able to recall the incident on the 21 October 2019. The panel therefore found Charges 12.1, 12.2 and 12.3 PROVED.

The panel also noted that on a shift on 26 October 2019, Witness 6/Colleague D attested that Miss Macdonald did not adequately or at all employ a 'clean hand, dirty hand' aseptic technique. Witness 6/Colleague D wrote in the supervision record:

'Catheterisation technique demonstrated no insight to the principals of aseptic technique.'

Witness 6/Colleague D provided further context in her statement to the NMC dated 27 September 2022:

'Ms Macdonald was given the necessary equipment but, when performing the task, she appeared to have no insight into having a clean hand and dirty hand. She was touching sterile equipment with her dirty hand. […] *I would have expected Ms Macdonald to have learnt the correct technique.* […] *Ms Macdonald's agreed she needed to refresh her aseptic technique during feedback on this.'*

In light of the evidence from Witness 6/Colleague D, the panel found Charge 12.4 PROVED.

The panel considered Charge 12.5. It had regard to Witness 6/Colleague D's statement to the NMC dated 27 September 2022:

> *'Another example was that Ms Macdonald was unable to artificially rupture membranes ("ARM") on two occasions being on 22 October 2019 and 29 October 2019* […] *I performed the task instead.* […] *I would expect a band 6 midwife to completely carry out this task although occasionally it can be difficult depending on the stage of labour that the woman is in. it is a skill taught in general midwifery training.'*

The panel noted that this was supported by Witness 6/Colleague D's supervision notes dated 22 October 2019 which stated, *'unable to perform ARM'* and those dated 29 October 2019 stated, '*unsuccessful ARM'.*

The panel noted that during the course of their deliberation that there was an error in the dates of the charge in respect of the 26 October 2019, and following legal advice and of its own volition changed it to 22 October 2019. On this basis, the panel found Charge 12.5 PROVED.

Witness 6/Colleague D further stated that on 28 October 2019, she witnessed a doctor asking Ms Macdonald about a patient's contractions (Charge 12.6). She stated in her statement to the NMC dated 27 September 2022:

> '[…] *Ms Macdonald was not able to tell the doctor what strength or the duration of the contraction was from her abdominal palpitations. Again, I only witnessed this once so it is difficult to assess if Ms Macdonald was competent in assessing uterine contractions. However, this is fundamental knowledge for the role of a midwife. It would be learnt in basic midwifery training. Ms Macdonald's response during feedback for the shift was that it was difficult to be in a different environment'.*

This was supported by Witness 6/Colleague D's supervision notes dated 28 October 2019 which stated:

> *'Feedback from Medical Staff:-*
>
> *Appeared unsure when timing contractions.'*

The panel therefore found that there was sufficient evidence to find Charge 12.6 PROVED.

The panel noted that there was a consistent theme in which Miss Macdonald was uncertain about her next steps. Witness 6/Colleague D described two further incidents in which Miss Macdonald was unable to promptly plan the next steps of care without assistance from Colleague D (Charge 12.7). In Witness 6/Colleague D's statement to the NMC dated 27 September 2022:

> *'I witnessed the hesitancy on two occasions during second stage management.* […] *I would expect a band 6 midwife to know what observations to carry out and how regularly, but I felt I needed to prompt Ms Macdonald with this because she was not forthcoming with the next steps. No harm came because I was always supervising and intervening when necessary.'*

The panel had regard to Witness 6/Colleague D's supervision notes dated 29 October 2019 which supported the evidence, *'Requires prompting for next step'* and '*Diane remains hesitant at times'.* In Witness 6/Colleague D's supervision notes dated 30 October 2019, *'more awareness of second stage management, requires gentle prompting* […]' and *'still requires support in intrapartum care'.* The panel therefore found Charge 12.7 PROVED.

Charge 13

13 While on a Supported Improvement Plan, did not, between 10 May 2021 and 2 September 2021, complete one or more of the following objectives:

13.1 Documentation

13.2 Appropriate care planning according to Red/Green Pathway

13.3 Assessment of intrapartum care needs

13.4 Decision making

13.5 Management of patient requiring induction of labour

Charge 13 is found proved in its entirety.

In reaching this decision, the panel took into account the documentary and oral evidence provided by the witnesses, which identified a number of areas where Miss Macdonald had failed to achieve her objectives.

The panel found that despite measures in place to assist Miss Macdonald in fulfilling her role as a band 6 midwife, there were evidence of recurrent clinical practice concerns. The panel had sight of the letter dated 8 September 2021 of the outcome from the Stage 2 Final Review Meeting which stated that Miss Macdonald had failed to complete the objectives as highlighted in Charges 13.1-13.5:

'Unfortunately, satisfactory improvement has not been achieved in the following areas:

- *Documentation;*
- *Appropriate care planning according to red/green pathway;*
- *Assessment of intrapartum care needs;*
- *Decision making;*
- *Management of patient requiring induction of labour;'*

The panel also had sight of the Supported Improvement Plan dated 10 May 2021 which detailed the specific areas and whether Miss Macdonald had achieved her objectives.

In light of the documentary evidence before the panel, it found Charge 13 proved in its entirety.

Fitness to practice

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

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

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

Mr White invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

Mr White identified the specific, relevant standards where Miss Macdonald's actions amounted to a lack of competence. This included sections 10, 13, 15, 18, 19, 20 and 20.1.

Mr White submitted that lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Miss Macdonald was made aware of the issues around their competence?
- Is there evidence that they were given the opportunity to improve?
- Is there evidence of further assessment?

Mr White submitted that the facts found proved show that Miss Macdonald's competence at the time was below the standard expected of a band 6 registered midwife. Mr White referred the panel to the relevant case law which included *R (Calheam) v General Medical Council* [2007] EWHC 2606 (Admin) and *Yeong v the General Medical Council* [2009] EWHC 1923 (Admin) and the relevant NMC Guidance.

Mr White submitted that the panel found all of the charges proved (except for 11.3), and this demonstrates an unacceptably low standard of professional performance from Miss Macdonald. The charges against Miss Macdonald span over a period of five years, and there are 13 separate charges. He submitted that a number of these charges refer to multiple incidents, over a prolonged period of time in which Miss Macdonald made significant errors.

Mr White submitted that there are numerous examples of incidents in which Miss Macdonald's practice had the potential to increase the risk of harm to patient safety. If it were not for the actions of Miss Macdonald's colleagues, Mr White submitted that these incidents could have resulted in serious repercussions. He provided the panel with an incident involving Witness 3/Colleague C which relates to Charge 13 and submitted that those circumstances amounted to a close call whereby Witness 3/Colleague C had to intervene to prevent the patient from suffering harm.

In considering the lack of knowledge, skill or judgment, which demonstrates an incapability of safe and effective practice, Mr White submitted that the panel has had sight of sufficient evidence in relation to each of those competencies. For example, with regard to lack of knowledge, Charge 2.2 relates to Miss Macdonald's failure to know that a patient must not be provided opiates while in the birthing pool. For lack of skill, an example of this can be found at Charge 12.5 which relates to Miss Macdonald's failure to artificially rupture a membrane on two occasions. Mr White submitted that Charges 7 and 8 demonstrate Miss Macdonald's lack of judgment in failing to call for a second midwife for the delivery of the baby because she was concerned that the second midwife may ask the patient to come out of the birthing pool.

Mr White submitted that the charges found proved are not a single clinical incident, or the odd mistake or error of judgment. They demonstrate a catalogue of errors over a sustained period of time with very little evidence of improvement in Miss Macdonald's practice during that time despite the support provided by the Hospital. As such, he invited the panel to conclude that Miss Macdonald has demonstrated a lack of competence.

Submissions on impairment

Mr White moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need

to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr White submitted that whilst no serious harm has occurred, there are various examples of patients and babies being placed at unwarranted risk of harm. The number and nature of the reported incidents, and the period of time over which the clinical errors occurred, posed a real risk of harm to patients. These taken together with Miss Macdonald's defensive attitude to the concerns regarding her practice gives rise to concerns of a significant and continuing risk of repeated errors.

Mr White asked the question of whether previous harm or previous risk of harm has been appropriately addressed. Mr White submitted that there is evidence of reflection from Miss Macdonald in the various reflective account forms during the period of the SIP. However, he reminded the panel that a number of the witnesses spoke about Miss Macdonald being defensive in response to serious concerns which had been raised about her practice. For example, Witness 8 described Miss Macdonald as having been aggressive and defensive at the interview when discussing the circumstances around Charge 11. He submitted that in all circumstances, the risk of harm to patients and their unborn babies remains significant and may not be described as remote.

Mr White addressed Miss Macdonald's references to being treated unfairly and bullying. Mr White submitted that these allegations were neither substantiated or supported by the documentation or the witness oral evidence that the panel heard during the course of this hearing. Witness 1/Colleague B sought input from Occupational Health on a number of occasions, but they consistently confirmed that Miss Macdonald's health had no impact on her ability to perform her role. He submitted that neither of those contextual factors identified have particular relevance in this case.

As far as the learning, insight and steps Miss Macdonald has taken to strengthen her practice, Mr White submitted that Miss Macdonald has not engaged in these proceedings. There is no evidence to suggest that she has attempted to improve her practice. There are

various local reflective accounts from Miss Macdonald as mentioned earlier, and Miss Macdonald has from time to time acknowledged the need for improvement. However, it is apparent in many of these reflective pieces that she has not adequately acted upon those reflective pieces in order to improve her practice as consistent errors continued over a prolonged period of time.

Mr White submitted that there is a public interest in a finding of impairment. There is a public expectation that in circumstances where such a sheer number of clinical errors have been made over a prolonged period of time resulting in increased risks to patients and unborn babies, appropriate action must be taken. He submitted that confidence in the profession and the NMC as regulator would be undermined in the eyes of a fully informed member of the public should no finding of the impairment be made.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Calhaem v GMC*, and *Cohen v GMC* [2008] EWHC 581 (Admin).

Decision and reasons on lack of competence

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

'1 ***Treat people as individuals and uphold their dignity***
To achieve this, you must:

1.2 Make sure you deliver the fundamentals of care effectively.

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

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

To achieve this, you must:

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

6 ***Always practise in line with the best available evidence***

To achieve this, you must:

6.2 *Maintain the knowledge and skills you need for safe and effective practice.*

8 ***Work co-operatively***

To achieve this, you must:

8.1 *Respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate.*

10 ***Keep clear and accurate records relevant to your practice***

To achieve this, you must:

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

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

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

13 ***Recognise and work within the limits of your competence***

To achieve this, you must, as appropriate:

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

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

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

19 ***Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

To achieve this, you must:

19.1 Take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.

19.3 Keep to and promote recommended practice in relation to controlling and preventing infection.

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.

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

20.8 Act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to. '

The panel bore in mind, when reaching its decision, that the issue of competence or lack of it is to be assessed against the standard reasonably to be expected of a midwife of Miss Macdonald's qualifications and experience. It had regard to the relevant NMC Guidance.

The panel had found proved multiple charges which provided examples of incidents that demonstrated Miss Macdonald's lack of knowledge, skill and judgment on wide-ranging areas of concern. The panel heard from multiple witnesses that there was a prolonged period of concerns which related to the fundamental basics of being a midwife. Miss Macdonald had up to 20 years of midwifery experience, and despite rigorous support, supervision and at time, her acknowledgement of the issues before her, Miss Macdonald's practice did not significantly improve or reach the standards expected from a midwife.

The panel took the view that Charge 2 in its entirety was particularly concerning. Miss Macdonald clamped and cut the umbilical cord which posed a significant risk of harm to the baby. When asked about the incident, Miss Macdonald stated, *'babies could survive under water for 30 minutes',* which Witness 1/Colleague B told the panel was highly incorrect. Witness 1/Colleague B further stated in her oral evidence:

> *"I was alarmed by what she said* […] *we had done a lot of teaching and a lot of discussions with staff in respect of using the pool. This was somebody who had highlighted to me that she had many years of experience of pool births in her previous employment and it concerned me greatly"*

Witness 1/Colleague B provided evidence that she would expect a competent band 6 midwife to know a baby's umbilical cord cannot be clamped and cut underwater.

The panel also determined that Charge 3 demonstrated a serious lack of competence from Miss Macdonald. Miss Macdonald did not use CTG whilst giving IV Syntocinon. Witness 7 attested in her statement to the NMC dated 11 October 2022:

'Knowledge of giving IV Syntocinon and having a CTG machine in situ at the same time is fundamental to midwife training and care of a patient having an augmented labour'

The panel noted that the witnesses were consistent in their evidence in identifying that written guidelines were available for Miss Macdonald. However, Miss Macdonald's midwifery experience alone should have prompted Miss Macdonald to ensure that a CTG was in place. Subsequently, in Charge 11.4, Miss Macdonald's inability to identify her lack of competence in CTG continued. She failed to recognise that the CTG was a poor quality and included loss of contact for a period of one hour and 15 minutes for which Miss Macdonald failed to act on this.

The panel determined that Miss Macdonald's practice did not improve and whilst on a Supported Practice Placement at Aberdeen, the same clinical practice concerns occurred (Charge 12). This included Miss Macdonald's lack of knowledge in that she appeared unsure of what to do when the placenta was not delivered within 30 minutes, she was unable to properly plan the next steps in the second stage of labour without prompt or assistance and she was unable to palpate contractions during an instrumental delivery. The panel took the view that these are fundamental skills required for basic midwifery practice.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Miss Macdonald's practice was below the standard that one would expect of the average registered midwife acting in Miss Macdonald's role.

In all the circumstances, the panel determined that Miss Macdonald's performance demonstrated a lack of competence.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

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

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

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

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

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

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

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

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

d) […]*’*

The panel found that the first three limbs are engaged. Whilst no patients were harmed as a result of Miss Macdonald’s lack of competence, the panel noted that this was only due to the level of supervision that she was subject to, her supervisors’ guidance and intervention which ensured that no harm came to Miss Macdonald’s patients. The panel took the view that patients were placed at unwarranted risk of harm due to her practice. Miss Macdonald’s lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel noted that Miss Macdonald has not provided any reflective pieces for this hearing to demonstrate her insight into the wide-ranging areas of clinical concerns relating to her practice. She has provided limited engagement with the NMC, with the most recent contact being on 23 August 2024 in which she stated that she was not returning to work for the NHS and is waiting to remove herself from the NMC register.

The panel carefully considered Miss Macdonald's assertion that she felt she was treated unfairly and bullied. It had sight of the letters she provided during the period of her employment at the Hospital and in her response during the Capability Meetings. The panel has heard from all eight witnesses that they empathised with the pressure that Miss Macdonald must have felt whilst subject to the Capability Process. They described in detail during their oral evidence about how they wanted to support her, despite the pressures that they were also under in managing the ward. The panel found no support for the suggestion made by Miss Macdonald that she was treated unfairly and bullied.

The panel determined whether there were any indications of attitudinal issues. It had regard to Witness 5/Colleague A's evidence in which she stated that Miss Macdonald admitted that she had not called her for the delivery of Patient D's baby because Witness 5/Colleague A may have told Patient D to come out of the birthing pool. Witness 5/Colleague A stated in her oral evidence:

> *"Yes, I was very surprised. At the same time, I'm running a ward with lots of other things going on, so I expect the midwife in the labour ward to cooperate fully with me as the coordinator, which she didn't. I think it's the fact that she even had the audacity to tell me that she didn't call me because I would have asked the woman to come out of the pool. I think that it's very unprofessional. And she's forgetting that this woman, above all else, needs to deliver safely. It's not about really what the midwife felt about the type of delivery she should have."*

The panel also bore in mind Witness 7's statement to the NMC dated 11 October 2022:

> '[…] *Ms Macdonald said she has a thing about doctors. I do not know what she meant by this comment and we did not discuss what she meant. It is a daily requirement of midwives to communicate with doctors. It was her responsibility because she had assessed the patient and therefore should*

have communicated with the Doctor. I would not expect to hear this from a midwife who needs to work with Doctors regularly.

[…]

[…] *She slammed the forms down in front of me on the table and walked out after the shift to go home*. *There are no notes for this shift because she refused to write anything'*

The panel were mindful that the Capability Process may have been overwhelming for a midwife who had been practising for almost 20 years, given that these charges date as far back to 2016. However, the panel took a view that patient safety is paramount, and Miss Macdonald's defensiveness towards colleagues' feedback that was designed to improve her clinical practice may indicate attitudinal issues. As such, Miss Macdonald's defensive attitude to the concerns regarding her practice poses a significant and continuing risk of repeated errors.

The panel noted that there had been no evidence of Miss Macdonald taking steps to strengthen her practice. However, the panel took the view that whilst the charges found proved are capable of remediation had there been consistent engagement from Miss Macdonald, there had been none. In light of the lack of engagement, willingness to improve and evidence of strengthening of practice, the panel took the view that there is a risk of repetition. 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that, in this case, a finding of current impairment on public interest grounds was required. A well-informed member of the public would be gravely concerned if no finding of impairment was made despite the repeated pattern of midwifery practice falling below the standards expected of a registered midwife.

Having regard to all of the above, the panel was satisfied that Miss Macdonald's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Miss Macdonald's registration has been suspended.

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

Submissions on sanction

Mr White informed the panel that in the Notice of Hearing, dated 24 July 2024, the NMC had advised Miss Macdonald that it would seek the imposition of a 12-month suspension order with review if it found Miss Macdonald's fitness to practise currently impaired.

Mr White referred the panel to the relevant NMC Guidance.

In addressing the aggravating features, Mr White highlighted the following relevant factors:

- A pattern of conduct relevant to the present charges.
- Incidents which placed patients at risk of suffering harm.
- Lack of insight into failings.

Mr White addressed the mitigating factors:

- Miss Macdonald has demonstrated some limited insight which can be seen from the reflective accounts she prepared during the course of her supported placements and recognising that there are certain aspects of her work which required improvement.

Mr White submitted that the panel must consider the least restrictive sanction first. He then talked the panel through the different sanctions available to it. He submitted that no further action is not relevant. Miss Macdonald has continued to present a continuing risk to patients and has been responsible for failings which undermine the public's trust in midwives. She has breached at least one of the fundamental tenets of the profession. As such, Mr White submitted that this is not a case where taking no action would be appropriate.

In addressing a caution order, Mr White submitted that the panel has made a finding that there is an ongoing risk to patient safety, and on that basis, a caution order is not appropriate.

In addressing the conditions of practice order, Mr White referred the panel to the relevant section of the guidance and the factors to consider. He submitted that a conditions of practice order is not relevant given that the panel has made a finding that Miss Macdonald’s defensiveness may indicate attitudinal issues. He made references to Miss Macdonald’s lack of engagement or any indication that she would respond positively to retraining. He further submitted that any conditions imposed would require a significant amount of direct supervision to protect the patients and the panel has heard evidence that Miss Macdonald has not responded well to direct supervision in the past. He submitted that such an order would not be sufficient to achieve public protection and to maintain public confidence.

Mr White invited the panel to impose a suspension order and highlighted the relevant factors in the NMC guidance to support this. He submitted that the circumstances of the

present case brought a number of serious concerns, particularly due to the nature and number of incidents in the prolonged period of time when those incidents occurred. He submitted that a 12-month suspension order would allow sufficient time for Miss Macdonald to reflect and seek to demonstrate that she is ready to return to practice.

Mr White submitted that the last sanction for the panel to consider is a striking off order. However, the NMC guidance states that this cannot be used for lack of competence cases until the registrants have been on either a suspension order or a conditions of practice order for a continuous period of two years.

In all those circumstances, Mr White submitted that a suspension order of 12-months is the most appropriate.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of errors and omissions over an extended period of time.
- Errors and omissions which put patients at risk of suffering harm.
- Attitudinal issues in receiving feedback within the Capability Process.
- Lack of insight into failings.

The panel found no mitigating features, although it noted that Miss Macdonald had almost 20 years of an unblemished career.

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

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 Miss Macdonald's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Macdonald's actions were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

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

The panel is therefore of the view that there are no practical or workable conditions that could be formulated, given that Miss Macdonald is not willing to engage with the regulatory process and there is evidence of a general lack of competence.

Furthermore, the panel concluded that the placing of conditions on Miss Macdonald's registration would not adequately address the seriousness of this case and would not protect the public. Miss Macdonald has provided a limited engagement into these proceedings, and as such, there remains a significant risk of harm to the public which cannot be addressed by the conditions. It also noted that her midwifery practice was made subject to restrictions at a local level whilst she was employed at the Hospital as part of the Capability Process. However, even then, there were still significant amounts of clinical errors and omissions and she demonstrated minimal improvement from her practice.

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:

- *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 lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

Given that the first three of the factors above are not apparent in this case, the panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and the NMC guidance, the panel concluded that a striking off order is not available to them at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the most appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Miss Macdonald. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was the most appropriate in this case.

The panel took into account Miss Macdonald's email dated 23 August 2024 in which she has asked to be removed from the register:

> *'I have consistently stated I would not be returning to work in NHS OR ANYOBE ELSE.i am waiting to remove myself from the register ASAP,*
>
> *Pleased pass on info to relevant people.'*[sic]

The panel is aware that under the NMC Guidance CMT-5, voluntary removal from the register is an option available to Miss Macdonald should she wish to make an application:

> *'If a nurse, midwife or nursing associate is subject to fitness to practise proceedings, they can apply to be removed from the register. Removal while there are ongoing fitness to practise proceedings is only allowed if the Assistant Registrar agrees. We call this the agreed removal process. An agreed removal will conclude the proceedings without consideration by the Fitness to Practise Committee. Agreed removal can support our aim to 'reach the outcome that best protects the public at the earliest opportunity'.*

The panel is not aware of any application made by Miss Macdonald at this stage to be removed from the register.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece from Miss Macdonald addressing the charges found proved.
- Evidence of professional development, including documentary evidence of training.

This will be confirmed to Miss Macdonald in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr White. He invited the panel to impose an interim suspension order for 18 months. He submitted that having found that a suspension order is the most appropriate sanction in this case, he submitted that an

interim suspension order would be appropriate to reflect that for the same reasons. Mr White submitted that the length of 18 months is appropriate to cover the appeal period.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.