Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 27 August 2024 - Friday, 30 August 2024
Monday, 2 September 2024 – Wednesday, 4 September 2024

Virtual Hearing

Name of Registrant:	Harriette Lango Seiwoh
NMC PIN	18F0175E
Part(s) of the register:	RNA: Registered Nurse – Adult (20 May 2019) RHV: Registered Specialist Comm Public Health Nurse – HV (9 November 2020)
Relevant Location:	Bexley
Type of case:	Misconduct
Panel members:	Catherine Devonport (Chair, registrant member) Lisa Holcroft (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Yewande Oluwalana
Nursing and Midwifery Council:	Represented by Louise Jardine, Case Presenter
Miss Seiwoh:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 2c, 3 (Schedule 1 (a), (b), (c), (e), 4 and 5
Facts not proved:	Charge 3(Schedule 1 (d), (f) and (g))
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**

Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

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

Ms Jardine, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Miss Seiwoh 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 Seiwoh

The panel next considered whether it should proceed in the absence of Miss Seiwoh. It had regard to Rule 21 and heard the submissions of Ms Jardine who invited the panel to continue in the absence of Miss Seiwoh. She submitted that Miss Seiwoh had voluntarily absented herself.

Ms Jardine submitted that there had been no engagement at all by Miss Seiwoh with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. She

said the only engagement was in the form of an email dated 7 June 2022. Ms Jardine further stated that there is public interest in the expeditious disposal of this case, and she invited the panel to proceed in Miss Seiwoh's absence.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Seiwoh. In reaching this decision, the panel has considered the submissions of Ms Jardine and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Seiwoh;
- Miss Seiwoh has not engaged with the NMC save for one email in June 2022 and has not responded to any of the letters sent to her about this hearing;
- Miss Seiwoh has not provided the NMC with details of how she may be contacted other than her registered email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence, others are due to attend and not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- 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.

The panel acknowledges that there is some disadvantage to Miss Seiwoh in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. Miss Seiwoh 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 Seiwoh's decision 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 Seiwoh. The panel will draw no adverse inference from Miss Seiwoh's absence in its findings of fact.

Details of charges (as amended)

That you being a registered health visitor,

1. On the 10 August 2021,
   (a) failed to complete a new birth visit for Patient A's baby. **(FOUND PROVED)**
   (b) recorded a weight of 3.2 kg in Patient A's baby's notes when in fact no such weighing had taken place. **(FOUND PROVED)**
   (c) in the event that Patient A was not present at her address on the 10 August 2021, failed to arrange an alternative date for a new birth visit or refer the case back to a coordinator for reallocation; **(FOUND PROVED)**

2. On the 13th September 2021,

(a) Completed only 10 minutes of a mandatory 1-hour new birth assessment for Patient I’s baby **(FOUND PROVED)**

(b) failed to weigh Patient I’s baby, a requirement imposed by virtue of it being tongue tied. **(FOUND PROVED)**

(c) Failed to discuss with Patient I safe sleeping positions and/or cot death prevention (SIDS). **(FOUND PROVED)**

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor’s notes within 48 to 72 hours.

4. On the 9 April 2021, in conducting a removal into case load visit for Patient B and her children, failed in your assessment to take into account Patient B’s medical records and/or a Maternity Safeguarding Notification dated 11 September 2020. **(FOUND PROVED)**

5. Placed Patient B on a normal universal caseload instead of a universal plus caseload **(FOUND PROVED)**

And in the light of the above misconduct, your fitness to practise is impaired.

Schedule 1

(a) In conducting a new birth visit for Patient C on the 4 August 2021, completed the notes on the 15 August 2021. **(FOUND PROVED)**

(b) In conducting a new birth visit for Patient D on the 4 August 2021, completed the notes on the 15 August 2021. **(FOUND PROVED)**

(c) In conducting a new birth visit for Patient E on the 5 August 2021, completed the notes on the 11 August or 15 August 2021. **(FOUND PROVED)**

(d) In purporting to conduct a new birth visit for Patient A on the 10 August 2021, completed the notes on the 14 August 2021 and then amended them on the 26 August 2021. **(FOUND NOT PROVED)**

(e) In conducting a new birth visit for Patient F on the 20 August 2021, completed the notes on the 1 September 2021. **(FOUND PROVED)**

(f) In conducting an antenatal visit for Patient G on the 20 August 2021, completed the notes on the 23 August 2021 and amended them on the 1 September 2021. **(FOUND NOT PROVED)**

(g) In conducting a new birth visit for Patient H on the 30 September 2021, completed the notes on the 1 October 2021 and amended them on the 4 October 2021. **(FOUND NOT PROVED)**

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Jardine under Rule 31 to allow the hearsay evidence of Patient A which is contained in exhibit MB/06 of Witness 2 into evidence and also hearsay evidence from Patient I which is contained in exhibit DB/18 of Witness 1 into evidence. Patient A and Patient I were not present at this hearing and were not considered to be needed to give evidence in this case as the NMC would be relying on other evidence. It is submitted that the evidence is highly relevant which the panel accepted.

Ms Jardine referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and what it should consider when deciding on whether to allow hearsay evidence. She highlighted the test that panel needed to consider:

> *(1) whether the statements were the sole or decisive evidence in support of the relevant allegations,*

(2) the nature and extent of the challenge to the contents of the statements,
(3) whether there was any suggestion that the witnesses had reasons to fabricate their allegations,
(4) the seriousness of the charge, taking into account the impact which adverse findings might have on [Miss Seiwoh's] *career,*
(5) whether there was a good reason for the non-attendance of the witnesses,
(6) whether the Respondent had taken reasonable steps to secure their attendance, and
(7) the fact that [Miss Seiwoh] *did not have prior notice that the witness statements were to be read.*

Ms Jardine submitted that Patient A's evidence is relevant to charge 1 subsections (a) and (b). She said this evidence is an email from Patient A which is a contemporaneous note of a complaint Patient A had made to Witness 2. Witness 2 will be in attendance at this hearing and can speak to the email being received at that time. Ms Jardine submitted there is no indication why Patient A would fabricate her account. Ms Jardine stated that Miss Seiwoh had made partial admissions in her email to the NMC dated 7 June 2022 and the complaint is also consistent with gaps in Patient A's child's medical records found at exhibit MB/08. Ms Jardine said that in Witness 2's witness statement she stated that Patient A confirmed they did not want anything further to do with the internal investigation and the NMC did not take steps to engage Patient A in these proceedings.

In respect of Patient I, Ms Jardine submitted that the evidence relates to a Datix exhibited in DB/18. Ms Jardine submitted that it is fair to admit this into evidence as it is reliable, and a contemporaneous note given shortly after the incident. It evidenced a complaint raised about Miss Seiwoh during a routine appointment.

Ms Jardine submitted there is no other direct evidence which is supportive of Patient I's account, however there is no reason to believe that Patient I would fabricate her account. Ms Jardine submitted that the evidence sought to be admitted is similar to instances of

concern as outlined by witnesses who will be in attendance at this hearing. All evidence was sent to Miss Seiwoh and she has not communicated any objection to it.

In all the circumstances, Ms Jardine submitted that it is fair to admit the evidence of Patient A and Patient I.

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

The panel considered the application in regard to Patient A's complaint exhibited at MB/06 and Patient I's account exhibited in DB/18 serious consideration and found them to be relevant to charges 1 and 2. The panel then went onto consider the fairness in admitting this evidence.

The panel noted that exhibit MB/06 was exhibited as evidence by Witness 2, who is a Registered Nurse and Registered Health Visitor, and [PRIVATE] handled the complaint of Patient A. Witness 2 will be in attendance at this hearing and has the opportunity to be questioned by the panel. It further noted that MB/06 was not the sole or decisive evidence on which the NMC wishes to rely upon.

In respect of Patient I's account exhibited at DB/18, the panel noted that there is no other direct evidence that supports Patient I's account. However, the panel was of the view that this complaint was taken seriously enough for a Datix to be produced and was completed by a person acting in their professional capacity. The Datix was referenced as part of the internal investigation into the concerns regarding Miss Seiwoh.

The panel determined that exhibit MB/06 goes to the heart of charge 1. It noted the seriousness of the charge and the impact this may have on Miss Seiwoh's career. It considered that there was no reason why Patient A would fabricate her account and this evidence can be tested by questioning Witness 2 and by examining other supporting evidence. In respect of charge 2, this is also a serious charge and relates to Patient I, the

panel was of the view that there is no reason for this information to be fabricated and it was recorded contemporaneously.

The panel considered that as Miss Seiwoh had been provided with a copy of the witness statements of Witness 1 and Witness 2, the exhibits bundle including exhibits MB/06 and DB/18. As the panel had already determined that Miss Seiwoh had chosen voluntarily to absent herself from these proceedings, it acknowledged that she would not be in a position to cross-examine Witness 1 and Witness 2. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that any unfairness to Miss Seiwoh could be mitigated by the panel asking questions of Witness 1 and Witness 2 who can speak to exhibits MB/06 and DB/18.

In these circumstances, the panel was satisfied that it would be fair and relevant to admit into evidence the hearsay evidence of Patient A's complaint exhibited as MB/06 and Patient I's Datix exhibited at DB/18, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

On 11 May 2022, the NMC received a referral from Bromley Healthcare (Trust) raising concerns about Miss Seiwoh, a Band 6 Health Visitor. The following incidents were included in the referral: On 9 April 2021, during a removal into caseload visit, Miss Seiwoh failed to review Patient B's medical records and therefore failed to notice and record Patient B's significant history [PRIVATE].

On 4 August 2021, Miss Seiwoh completed two new birth visits for Patient C and Patient D but did not document these until 15 August 2021. On 5 August 2021, Miss Seiwoh completed a new birth visit for Patient E but this was not documented until 11 August 2021.

On 10 August 2021, Miss Seiwoh was scheduled to make a new birth visit to Patient A. This visit was confirmed and written up by her on 14 August 2021 and amended on 26 August 2021. On 17 September 2021, Patient A received a 6-8 week contact by telephone from the health visiting service and informed them that she had not received a new birth visit from Miss Seiwoh on 10 August 2021. Patient A sent a further email on 8 October 2021 with regard to this matter.

On 13 October 2021, Miss Seiwoh's manager, made a visit to Patient A's home and found no evidence of a new birth visit being recorded in the baby's PHCR-red book. Miss Seiwoh had recorded the baby's weight as 3.2kgs when she had not seen the infant. The medical records for the baby also showed a discharge summary from the hospital [PRIVATE], however, Miss Seiwoh's records do not show any evidence that she was aware of this.

On 20 August 2021, Miss Seiwoh completed a new birth visit to Patient F which was not documented until 12 days later on 1 September 2021.

On 20 August 2021, Miss Seiwoh completed an antenatal visit to Patient G which was not documented until three days later on 23 August 202.

On 11 October 2021, during a 6-8 week visit, Patient I explained that during her new birth visit by Miss Seiwoh on 13 September 2021, Miss Seiwoh had only been in her house for 10 minutes and had not weighed her baby which had a tongue tie so required weighing.

Regulatory concerns included poor patient care, poor record keeping, and failure in care planning and risk assessing.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Jardine. It also took into account Miss Seiwoh's email to the NMC dated 7 June 2022.

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

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: Family Nurse Partnership Supervisor at the Trust, internal investigator of various incidents of Miss Seiwoh's conduct at the time.

- Witness 2: Registered Nurse and Registered Health Visitor.

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 and also Miss Seiwoh's email to the NMC dated 7 June 2022.

The panel considered Ms Jardine's submission in respect of charge 3 and a possible amendment, it had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) and the powers in which the panel can amend a charge.

Following careful consideration, the panel decided to amend charge 3 in order to provide more clarity to the charge and what it was being asked by the NMC to find proved.

The original charge reads as follows:

3. On various dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

The amendment being made by the panel is as follows:

3. On ~~various~~ **some or all of the** dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Seiwoh and no injustice would be caused by the amendment being made.

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

Charge 1a

'That you being a registered health visitor,

1. On the 10 August 2021,

(a) failed to complete a new birth visit for Patient A's baby.'

This charge is found proved.

In reaching its decision, the panel took into account oral evidence from Witness 1 and Witness 2. It also considered the following documentation: Patient A's complaint email dated 8 October 2021, Patient A's medical record, a copy of Patient A's baby's red book, Miss Seiwoh's appointment diary, Miss Seiwoh's job description, the Standard Operating Procedure for Bexley 0 to 19 Service (SOP), meeting minutes between Miss Seiwoh and Witness 1 dated 28 October 2021, Investigation report by Witness 1 dated 28 February 2022, and Miss Seiwoh's email to the NMC dated 7 June 2022.

The panel recognised that where a failure is alleged the NMC must establish a corresponding duty exists. Miss Seiwoh had a duty to attend the visit to Patient A as this was allocated to her in her health visitor diary, and her duties were outlined in her job description and referenced in the SOP.

The panel noted the Trust received a complaint from Patient A regarding Miss Seiwoh's non-attendance for a new birth visit. This was investigated further by Witness 2 who spoke with Patient A directly and also examined the baby's red book, during a home visit to follow the complaint up, which showed no entry of the baby's weight had been made for 10 August 2021. Further, it noted that Patient A's red book had an error regarding the first entry recorded by the midwife on the first visit. The panel determined the remaining entries in the red book written by other professionals were accurate and correlated with subsequent visits. Therefore, there was no reason to doubt the reliability of the red book as a source of evidence.

The panel noted that the entry on Patient A's EMIS records indicated an entry made by Miss Seiwoh on 26 August 2021 recording information of a purported visit to Patient A on 10 August 2021. It also noted that Miss Seiwoh, in her email to the NMC on 7 June 2022 stated;

> *'Going back on my work, the period of august* [PRIVATE]*, I failed to communicate with my team that I had tried to complete a visit and mum was not at home, as-well as writing up another families notes on the supposed visit.'*

The panel determined that this was a partial admission which indicates that the visit had not taken place as scheduled.

The panel determined that Miss Seiwoh had failed to complete a new birth visit of Patient A's baby and therefore this charge is found proved.

Charge 1b)

That you being a registered health visitor,

1. On the 10 August 2021,

(b) recorded a weight of 3.2 kg in Patient A's baby's notes when in fact no such weighing had taken place.

This charge is found proved.

In reaching this decision, the panel took into account the same information as stated in Charge 1a above.

The panel had sight of Patient A's EMIS records where the weight of 3.2kgs was recorded by Miss Seiwoh. Witness 2 told the panel that a template is populated on EMIS which would need to be completed with information by the health visitor. She said that a health visitor should only record the weight of the baby if they had carried out the visit and weighed the baby.

Patient A's baby's redbook did not have an entry on the 10 August 2021 with the corresponding weight of 3.2kg. As established in charge 1a Miss Seiwoh did not attend the home.

The panel also considered Miss Seiwoh's partial admissions in her email to the NMC on 7 June 2022, where she stated, *'I had tried to complete a visit and mum was not at home'.*

The panel determined that Miss Seiwoh did not attend Patient A's home on 10 August 2021 and therefore could not have weighed Patient A's baby as she recorded on EMIS that she had. The panel finds this charge proved.

Charge 1c)

That you being a registered health visitor,

1. On the 10 August 2021,

(c) in the event that Patient A was not present at her address on the 10 August 2021, failed to arrange an alternative date for a new birth visit or refer the case back to a coordinator for reallocation.

This charge is found proved.

In reaching its decision, the panel took into account the evidence of Witness 1 and Witness 2, the Standard Operating Procedure for Bexley 0 to 19 Service (SOP), meeting minutes between Miss Seiwoh and Witness 1 dated 28 October 2021 and Miss Seiwoh's email to the NMC dated 7 June 2022.

Under the requirements of the SOP Miss Seiwoh had a duty, that if she was unable to establish contact with a client, she was to communicate this to her line manager, and the coordination centre for rescheduling.

The panel noted the oral evidence of Witness 1 and Witness 2 who both stated that it is known practice to reschedule a home visit if contact is not made.

The panel had sight of the SOP in particular 15.7.1.

> *'15.7.1 Unable to Establish Contact with Family in the Area*
>
> *…*
>
> *The* [Specialist Community Public Health Nursing] *SCPHN must document all actions taken in the EMIS records for the child and family members advising that they have been unable to establish contact with family, recording the episode as a 'significant event'.*

The panel also had regard to the meeting minutes between Miss Seiwoh and Witness 1 on 28 October 2021,

'[Witness 1] said what would happen if [Miss Seiwoh] went to a visit and there was no one there.

[Miss Seiwoh] said she would email duty, the CCC and if the mum did make contact she would do this on the day and if she didn't she would copy and send the details so they can re-schedule the visit.'

The panel was of the view that Miss Seiwoh was aware of the procedure that she had to follow in the event that no contact was made. It also accepted in Miss Seiwoh's email to the NMC dated 7 June 2022, she admitted,

'*I failed to communicate with my team that I had tried to complete a visit and mum was not at home'.*

Taking everything into consideration, the panel determined that Miss Seiwoh had failed to arrange an alternative date for a new birth visit or refer the case back to a coordinator for reallocation. This charge is found proved.

Charge 2a

That you being a registered health visitor,

2. On the 13th September 2021,
   (a) Completed only 10 minutes of a mandatory 1-hour new birth assessment for Patient I's baby

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Datix (Bromley Healthcare Incident Reviewing Form) dated 11 October 2021, meeting minutes between Miss Seiwoh and Witness 1 dated 25 November 2021 and Miss Seiwoh's email to the NMC dated 7 June 2022.

The panel is aware that the only information in relation to Patient I was contained within the Datix form which it had admitted into evidence as hearsay evidence. The panel noted that it did not have the Datix for the incident but the incident reviewing form and it did not have Patient I's medical records.

The panel noted that the complaint was raised by another health visitor who was completing the 6-8 week visit with Patient I. In the description box of the incident reviewing form, it stated the following,

> *'During my 6-8 week contact with this client, mother raised concerns as to why the health promotion advise that was given at the 6-8 week contact was not discussed at NBV* [New Birth Visit]. *Mother reported that that* [sic] *the health visitor who saw her at the NBV only spend* [sic] *around 10 minutes in her home and did not discuss health promotion advise such as SIDs.'*

Although the panel did not hear evidence from the author of the original Datix, the panel did hear from Witness 2 who was the author of the Bromley Healthcare Incident Reviewing Form. The panel had no reason to believe that the information was fabricated as it was completed by a person acting in their professional capacity. It also had Witness 2 who was named as the lead investigator of the complaint giving evidence at this hearing. In Witness 2's evidence she confirmed that the information contained in the description box of the incident reviewing form came from the Datix. The panel had information that the Trust were unable to contact Patient I to investigate the complaint further or to further verify with the patient the allegations.

In the internal meeting minutes between Miss Seiwoh and Witness 1 dated 25 November 2021, Miss Seiwoh acknowledged her car had broken down that day. Miss Seiwoh also stated in the meeting that the appointment for the home visit was added to her diary late. The panel inferred from these facts that Miss Seiwoh was likely distracted and pressed for time on that day.

The panel bore in mind the advice it had received from the legal assessor and interpreted the meaning of 'only 10 minutes' to be an indication of insufficient time to complete all of the activities required of a health visitor at a new birth visit.

Taking everything into consideration, the panel determined that on the balance of probabilities Miss Seiwoh completed only 10 minutes of a mandatory 1-hour new birth assessment for Patient I's baby. This charge is found proved.

Charge 2b

> That you being a registered health visitor,
> 2. On the 13th September 2021,
> (b) failed to weigh Patient I's baby, a requirement imposed by virtue of it being tongue tied.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Datix (Bromley Healthcare Incident Reviewing Form) dated 11 October 2021, meeting minutes between Miss Seiwoh and Witness 1 dated 25 November 2021.

The panel recognised that according to the SOP, Miss Seiwoh had a duty to weigh Patient I's baby.

The panel noted in Witness 1's witness statement she stated;

> *'It is not essential to weigh the baby at a new birth visit unless the baby had a low birth weight under 2.5kgs or if there were feeding difficulties. In this case, Patient I's baby was tongue tied so it would have been required for Miss Seiwoh to weigh the baby. Miss Seiwoh would have known this because it is a fundamental of basic health visiting.*'

The panel considered that Miss Seiwoh was very clear that she had not recorded the weight, the panel found this to be a contemporaneous admission. The panel noted that Miss Seiwoh in the meeting minutes with Witness 1 on 25 November 2021 stated the following,

> '[Miss Seiwoh] *said that the baby had been weighed by midwife and mum was ok with that.* [Miss Seiwoh] *had recorded the weight as the one done by the midwife.'*

The panel concluded that on the balance of probabilities Miss Seiwoh failed to weigh Patient I's baby, a requirement imposed by virtue of it being tongue tied. This charge is found proved.

Charge 2c

> That you being a registered health visitor,
> 2. On the 13th September 2021,
> (c) Failed to discuss with Patient I safe sleeping positions and/or cot death prevention (SIDS).

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Datix (Bromley Healthcare Incident Reviewing Form) dated 11 October 2021 and the meeting minutes between Miss Seiwoh and Witness 1 dated 25 November 2021.

The panel had established from the Bromley Healthcare SOP and Witness 2's oral evidence that Miss Seiwoh had a duty to discuss safe sleeping positions and/or cot death prevention (SIDS).

In the Bromley Healthcare Incident Reviewing Form dated 11 October 2021 which mentioned,

> *'Mother reported that that* [sic] *the health visitor who saw her at the NBV* [New Birth Visit] *only spend* [sic] *around 10 minutes in her home and did not discuss health promotion advise such as SIDs.'*

Witness 2 in her oral evidence stated if a health visitor did nothing else, they would at least be expected to have discussed safe sleeping arrangements on a new birth visit.

The panel determined that on the balance of probabilities it is more likely than not that Miss Seiwoh failed to discuss with Patient I safe sleeping positions and/or cot death prevention (SIDS). This charge is found proved.

Charge 3 (Schedule 1 (a))

> That you being a registered health visitor,
>
> 3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.
>
> <u>Schedule 1</u>
> (a) In conducting a new birth visit for Patient C on the 4 August 2021, completed the notes on the 15 August 2021.

The panel acknowledged that there was a duty of care to record patient notes as soon as possible after a home visit and no later than 72 hours. This was confirmed in the Policy and by Witness 1 and Witness 2 in their oral evidence. This duty applies to all charges in Schedule 1 (a) – (g).

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient C's EMIS records dated 4 August 2021, Patient C's medical record dated 15 August 2021, and Bromley Management of Health Records Policy (Policy).

The panel had regard to the Policy under paragraph 6.1 'Creation Completion and Maintenance of Health Records and Reports' stated,

> *'Entries are made at the time of the patient's/client's visit/attendance or as soon as possible after and before the relevant staff member goes off duty.'*

Witness 1 in her witness statement stated;

> *'Miss Seiwoh should have been writing up records of her health visits up to 72 hours after the visit was conducted.'*

She confirmed this in her oral evidence. The panel found Witness 1 to be consistent and credible in her evidence.

The panel had sight of Patient C's EMIS records and medical records which indicate that Miss Seiwoh completed a face to face consultation on 4 August 2021 with Patient C. In the medical records Miss Seiwoh recorded this consultation on *'15-Aug-2021 and time 20:28:09'.*

This information supports the charge that Miss Seiwoh wrote her notes 11 days after her visit to Patient C which is more than 72 hours. The panel determined that Miss Seiwoh failed to record her health visitor's notes within 48 to 72 hours. This charge is found proved.

Charge 3 (Schedule 1 (b))

That you being a registered health visitor,

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1

(b) In conducting a new birth visit for Patient D on the 4 August 2021, completed the notes on the 15 August 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient D's EMIS records dated 15 August 2021, Patient D's medical record dated 15 August 2021, and Bromley Management of Health Records Policy (Policy).

The panel looked at exhibit DB/08 which was titled 'Patient E's medical record', but this is in fact a clerical error which was acknowledged by Ms Jardine who said Exhibit DB/08 is Patient D's medical records. The panel were content with this explanation. The panel does not find it significant in the determination of the charge.

On this basis the panel considered the evidence before it and noted that a visit was completed on the 4 August 2021, and amendments were made to the records on EMIS on 15 August 2021, this was supported by the information contained in the medical records which had the exact same date and time.

This information supports the charge that Miss Seiwoh wrote her notes 11 days after her visit to Patient D which is more than 72 hours. The panel determined that Miss Seiwoh failed to record her health visitor's notes within 48 to 72 hours. This charge is found proved.

Charge 3 (Schedule 1 (c))

That you being a registered health visitor,

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1

(c) In conducting a new birth visit for Patient E on the 5 August 2021, completed the notes on the 11 August or 15 August 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient E's EMIS records dated 15 August 2021, Patient E's baby's EMIS records dated 15 August 2021 and Bromley Management of Health Records Policy (Policy).

The panel noted that there were two sets of EMIS records provided one for Patient E and one for Patient E's baby. It also noted that Witness 1 in her oral evidence acknowledged that she had made an error in her witness statement by writing 11 August 2021, when the EMIS records clearly show 15 August 2021.

This information supports the charge that Miss Seiwoh wrote her notes 10 days after her visit to Patient E which is more than 72 hours. The panel determined that Miss Seiwoh failed to record her health visitor's notes within 48 to 72 hours. This charge is found proved.

Charge 3 (Schedule 1 (d))

That you being a registered health visitor,

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1

(d) In purporting to conduct a new birth visit for Patient A on the 10 August 2021, completed the notes on the 14 August 2021 and then amended them on the 26 August 2021.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient A's EMIS records dated 26 August 2021, Patient A's discharge summary dated 4 August 2021 and Bromley Management of Health Records Policy (Policy).

The panel noted that Witness 1 in her witness statement stated,

'On 10 August 2021, Miss Seiwoh was scheduled to make a new birth visit to Patient A. This visit was confirmed and written up by Miss Seiwoh on 14 August 2021 and amended on 26 August 2021.'

The panel noted in Witness 2's witness statement she stated,

'I also noted how Miss Seiwoh had written that she had completed the new birth visit for Patient A on 10 August 2021. She then completed the record on 14 August 2021 and amended it on 26 August 2021…'

The panel was mindful that apart from the witnesses written evidence there was no documentary evidence to support that Miss Seiwoh had completed the record on 14 August 2021. The evidence before the panel in regard to Patient A's EMIS records indicates an entry on 26 August 2021 only, there is no other evidence to support whether the original record was made on 14 August 2021 or before or after that date.

The panel determined that the NMC had not discharged its burden of proof. It therefore finds this charge not proved.

Charge 3 (Schedule 1 (e))

That you being a registered health visitor,

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1

(e) In conducting a new birth visit for Patient F on the 20 August 2021, completed the notes on the 1 September 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient F's EMIS records dated 1 September 2021, Patient F's medical records dated 1 September 2021 and Bromley Management of Health Records Policy (Policy).

The panel was provided with a screenshot of Patient F's EMIS records which clearly showed that a face to face consultation happened on 20 August 2021, but the records are dated 1 September 2021. This information was supported by Patient F's medical records which included the same date and time of the edit.

This information supports the charge that Miss Seiwoh wrote her notes 12 days after her visit to Patient F which is more than 72 hours. The panel determined that Miss Seiwoh failed to record her health visitor's notes within 48 to 72 hours. This charge is found proved.

Charge 3 (Schedule 1 (f))

That you being a registered health visitor,

3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1

(f) In conducting an antenatal visit for Patient G on the 20 August 2021, completed the notes on the 23 August 2021 and amended them on the 1 September 2021.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient G's EMIS records which included two dates 23 August 2021 and 1 September 2021, Patient G's medical records dated 1 September 2021 and Bromley Management of Health Records Policy (Policy).

The panel noted that Miss Seiwoh conducted her health visit with Patient G on 20 August 2021 at 12:00. The first entry on Patient G's EMIS records was on 23 August 2021 at 00:04:08. This was subsequently followed by an amendment on 1 September 2021 at 22:30:03. This information was further corroborated in Witness 1's witness statement where she stated,

> *'On 20 August 2021, Miss Seiwoh completed an antenatal visit for Patient G which was not documented until 3 days later, on 23 August 2021.*
>
> *…*
>
> *I produce Patient G's EMIS records at Exhibit DB/15. I produce Patient G's medical record at Exhibit DB/16. This displays that Miss Seiwoh conducted a new birth visit*

for Patient G on 20 August 2021 but didn't write up a record of this until 23 August 2021. This was amended further on 1 September 2021'.

The panel concluded that from the information before it, Miss Seiwoh had recorded information within 60 hours of her visit which was in the prescribed timeframe of 48 to 72 hours. The panel finds this charge not proved.

Charge 3 (Schedule 1 (g))

That you being a registered health visitor,
3. On some or all of the dates set out in Schedule 1, failed to record your health visitor's notes within 48 to 72 hours.

Schedule 1
(g) In conducting a new birth visit for Patient H on the 30 September 2021, completed the notes on the 1 October 2021 and amended them on the 4 October 2021.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Patient H's medical records dated 4 October 2021 and Bromley Management of Health Records Policy (Policy).

In Witness 1's witness statement she stated,

'On 30 September 2021, Miss Seiwoh had conducted a New Birth Visit for Patient H's new-born which was written up by Miss Seiwoh on 1 October 2021 and amended on 4 October 2021.'

The panel had sight of Patient H's medical records and noted amended records dated 4 October 2021. There was no EMIS records provided to support the charge that Miss

Seiwoh recorded information on 1 October 2021. The evidence before the panel in regard to Patient H's medical records indicated an entry on 4 October 2021. However, there is no other documentary evidence to support Witness 1's claims that a record was made on 1 October 2021 and then subsequently amended.

The panel finds that the NMC have failed to establish the details of the charge as alleged, there being no sufficient evidence to establish on the balance of probabilities that the original record was not completed within the timetable of 48 to 72 hours alleged.

The panel finds this charge not proved.

Charge 4

That you being a registered health visitor,

4. On the 9 April 2021, in conducting a removal into case load visit for Patient B and her children, failed in your assessment to take into account Patient B's medical records and/or a Maternity Safeguarding Notification dated 11 September 2020.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2, Maternity safeguarding notification dated 11 September 2020, Patient B's EMIS records dated 9 April 2021, the Standard Operating Procedure for Bexley 0 to 19 Service (SOP), and the Antenatal booking summary dated 9 September 2020.

The panel has established from the SOP that a health visitor has a duty to review the records. Both witnesses stated that records should be reviewed before a visit or immediately after by a health visitor.

The panel noted that the maternity safeguarding notification dated 11 September 2020, had specified Patient B's [PRIVATE] and highlighted serious issues that needed to be considered by Miss Seiwoh and factored into any assessment she made on her visit and subsequently recorded on Patient B's records.

Witness 1 in her oral evidence said that Patient B's information was readily available on the electronic system and easily accessible. It is the health visitor's role to read the records of the client they are planning to visit beforehand and address any concerns with the client. Witness 1 in her witness statement said that Miss Seiwoh had not checked the records of Patient B. Miss Seiwoh acknowledged that she had not checked Patient B's medical records or the maternity safeguarding notification document.

Both Witness 1 and Witness 2 in oral evidence said that training in respect of record-keeping was standard for health visitors.

The SOP at paragraph 5.16 stated,

> *'5.16 Requesting Records for External Removal Ins*
>
> *Any previous records should be requested by the SCPHN HV via the CCC.*
>
> *On receipt of the records the SCPHN HV should review the record.'*

Therefore, there was a duty on Miss Seiwoh to review the records of Patient B when she received them, this would have included the maternity safeguarding notification dated 11 September 2020 and the antenatal booking summary dated 9 September 2020 which catalogued Patient B's [PRIVATE], which Miss Seiwoh did not review prior to the visit.

The panel had sight of Patient B's EMIS records and noted Miss Seiwoh following her assessment of Patient B did not mention any of Patient B's [PRIVATE].

The panel determined on the balance of probabilities that on the 9 April 2021, in conducting a removal into case load visit for Patient B and her children, Miss Seiwoh failed in her assessment to take into account Patient B's medical records and/or a Maternity Safeguarding Notification dated 11 September 2020. This charge is found proved.

Charge 5

That you being a registered health visitor,

5. Placed Patient B on a normal universal caseload instead of a universal plus caseload.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 2 and Patient B's EMIS records dated 9 April 2021.

The panel noted that Patient B's EMIS records dated 9 April 2021 showed *'Accepted onto caseload Universal Service'.* Further it considered Witness 1's witness statement, in which she stated,

> *'My concerns with Miss Seiwoh's conduct is that there was no evidence that Miss Seiwoh's assessment highlighted* [PRIVATE] *Patient B's records when completing her assessment. Miss Seiwoh then failed to identify that the family may have required additional support. This could have been provided by placing Patient B on a universal plus case load in which additional contacts to the client are made.'*

The panel acknowledged from the information before it, meeting minutes between Miss Seiwoh and Witness 1 dated 26 January 2022 that Miss Seiwoh had reported that the maternity cause for concern had not been flagged to her. However, the panel has already

seen sufficient evidence to establish that it was Miss Seiwoh's duty to review Patient B's medical records before she made any visits and subsequent assessments.

The panel noted that if Patient B was placed on a universal plus caseload, this may have affected the levels of support Patient B may have been offered. There was no evidence on Patient B's EMIS records that Miss Seiwoh had taken into account Patient B's medical records and the maternity safeguarding notification dated 11 September 2020.

The panel finds this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Jardine invited the panel to take the view that the facts found proved amount to misconduct and 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.

Ms Jardine identified the specific, relevant standards where Miss Seiwoh's actions amounted to misconduct. She referred the panel to the following Codes: 3, 10, 10.1, 10.3, 17, 17.1, 19, 19.1 and 20. She submitted that Miss Seiwoh's actions fell short of the requirements of the code.

Ms Jardine submitted that the breaches identified from the charges found proved, are a serious departure from the Code that had the potential to harm patients. This amounted to serious misconduct. The breaches of the code occurred on more than one occasion over the course of several months. The patients in question were vulnerable, as they were newborn babies and new mothers. Further it was submitted that the concerns regarding Miss Seiwoh's conduct are serious which could result in harm if not put right.

Submissions on impairment

Ms Jardine moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v GMC* [2007] EWHC 581 (Admin). Ms Jardine also

referred the panel to the fundamental principles of the NMC at Article 3 (4) and 3 (4A) of the 2001 Order.

Ms Jardine submitted that Miss Seiwoh's conduct fell below the standards of a registered nurse and that she is currently impaired.

Ms Jardine submitted that the overarching objectives of this panel are:

- to protect, promote and maintain the health, safety and wellbeing of the public;
- to promote and maintain public confidence in the professions regulated under this Order; and
- to promote and maintain proper professional standards and conduct for members of those professions.

Ms Jardine submitted that limbs a, b and c in *Grant* were engaged. She submitted that Miss Seiwoh has (a) 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. She submitted that the charges found proved relate directly to patient care. Miss Seiwoh had put vulnerable patients at risk of harm. She referred to Patient B's case, Miss Seiwoh failed to write Patient B's records up expeditiously. She said that Witness 1 in evidence mentioned that if someone had looked at the records, they would not be aware that a visit had taken place. There was also a risk that the records were inaccurate as proved to be the case with Patient A. Ms Jardine submitted that by Miss Seiwoh not keeping accurate records, she risked another medical professional not having the full medical records of a vulnerable patient in their care. Ms Jardine submitted that looking to the future, Miss Seiwoh save for the email received in June 2022, where she had referenced mistakes on her part and a need for further learning, there has been no evidence of any steps taken to improve her practise. It was submitted that, until Miss Seiwoh engages with the regulatory process and evidence of insight and learning is shown, there is a risk of future harm to patients.

Further, Ms Jardine submitted that Miss Seiwoh has (b) in the past brought the nursing profession into disrepute. She submitted that in the past, Miss Seiwoh's actions resulted in

two complaints from patients to the Trust she worked for. Both Patient A and Patient I were aggrieved at the level and the quality of care they were offered by Miss Seiwoh. In respect of Patient B, according to Witness 1 there was a missed opportunity to provide further support. Ms Jardine submitted that Miss Seiwoh had failed to adhere to the Code and in doing so had brought the profession into disrepute. As previously mentioned, Miss Seiwoh has shown little engagement with the NMC process, and no evidence has been provided of her learning from her mistakes or taking steps to improve her practise. Accordingly, there remains a risk of the misconduct bringing the nursing profession into disrepute in the future.

Ms Jardine submitted that Miss Seiwoh, has (c) in the past breached and/or is liable in the future to breach one of the fundamental tenets of the nursing profession. Ms Jardine submitted that the fundamental tenets as set out in the Code, prioritise people, practise effectively, preserve safety, and to promote professionalism and trust have been breached by Miss Seiwoh.

Ms Jardine referred the panel to the case of *Cohen* and the three questions the panel had to consider. She said that the conduct is remediable if Miss Seiwoh were to engage with the NMC process, however given the lack of engagement this suggests that the conduct is attitudinal in nature and therefore more difficult to remediate. She further submitted that Miss Seiwoh has not provided any evidence of steps she has taken to remediate her conduct. Ms Jardine submitted that without the steps being taken to remediate the conduct, there is a risk that it is likely to be repeated.

Ms Jardine submitted that the charges found proved amounted to misconduct as they breached the rules of the Code. The misconduct creates a risk of harm to patients and brings the nursing profession into disrepute and breaches the fundamental tenets of the professions. There has been no evidence presented to the panel that the risks have been mitigated. Therefore, a finding of impairment is necessary for the protection of the public.

Is also necessary to maintain public confidence in the profession and to maintain proper professions standards and conduct.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

> *'**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*
>
> ***3.3** act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*
>
> ***Practise Effectively***
>
> ***8.2** maintain effective communication with colleagues*
>
> ***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> ***10.1** complete all 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 all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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*

Promote professionalism and trust
You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code... This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined when looking at the charges found proved, both individually and combined, Miss Seiwoh's actions fell below the standards expected of a registered health visitor.

Regarding Charges 1a, 1b and 1c, Miss Seiwoh exposed the patient to risk of harm, she did not attend a visit to Patient A and her baby when she had a duty to conduct a new birth visit. Any issues would not have been identified as the visit did not take place. Furthermore, she created an inaccurate record, including the baby's weight. The panel finds Miss Seiwoh's actions amounted to serious misconduct.

In respect of Charge 2, Miss Seiwoh took 10 minutes to conduct a new birth visit, left the mother without the necessary information and advice on a range of health promotion and prevention issues, and failed to weigh the baby who had a tongue-tie and whose weight was a concern due to compromised feeding. The Bromley Healthcare Policy states clearly that babies with tongue-tie should be weighed. There was a failure to discuss sleeping positions and/or Cot death (SIDS), which had the potential to result in harm to the patients. The panel finds Miss Seiwoh's actions amounted to serious misconduct.

Regarding Charge 3, the panel determined that the sub charges found proved under Schedule 1 cumulatively amounted to serious misconduct as they demonstrated a pattern of behaviour. If it was just an isolated incident the panel may have taken a different view.

In respect of Charge 4, Miss Seiwoh may have exposed Patient B to an unnecessary risk. Patient B was a removal in and as such Miss Seiwoh had a duty to read Patient B's medical notes before visiting. Miss Seiwoh failed to do this and therefore did not have a full picture of Patient B's [PRIVATE] when carrying out the assessment. The panel finds Miss Seiwoh's actions amounted to serious misconduct.

Regarding Charge 5, because of Miss Seiwoh's actions at charge 4, Patient B was not given an opportunity for greater access to support and care which may have been offered through additional contact from health professionals. This occurred because Patient B was placed on a Universal caseload, when she should have been placed on a Universal plus caseload. The panel finds Miss Seiwoh's actions amounted to serious misconduct.

The panel is of the view that this was a registered nurse and health visitor who should have known what her duties and responsibilities were as a health professional. The panel finds that Miss Seiwoh's actions were a serious departure from the NMC's rules. It noted that the breaches occurred over a period of several months and determined that her practise could potentially put patients at risk of harm, if not put right.

The panel found that Miss Seiwoh's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, on Impairment (Reference: DMA-1, last updated 27 February 2024), 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.'*

The panel also took account of the context in which things had happened in this case:

- Personal factors relating to the professional
- Professionals working environment and culture
- Learning, insight and steps taken by the professional to strengthen their practise.

Nurses 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 nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

d) ...'

The panel finds limbs (a), (b) and (c) of the *Grant* test engaged. It determined that patients were put at risk and may have been caused harm as a result of Miss Seiwoh's misconduct. The breaches were wide-ranging and involved multiple patients. Miss Seiwoh's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case may be capable of being remedied. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Seiwoh has taken steps to remedy and strengthen her practice. The panel took into account an email from Miss Seiwoh to the NMC dated 7 June 2022. The email provided as explanation as to Miss Seiwoh's practise at the time and her circumstances. Miss Seiwoh stated,

> *'I believe despite my mistakes I am capable of doing my job as a nurse and if given the opportunity will learn from my mistakes and deliver safe patients cantered* [sic] *care.*
>
> *I have learnt so much whilst working as a nurse and only hope to continue my learning. Being a nurse requires ongoing training and I have reflected on my mistakes to ensure this doesn't happen again. These are the early stages of my career and there will always be room for improvement and development.'*

However, the panel, had no further information as to what actions, if any, Miss Seiwoh had taken. No further information has been received from Miss Seiwoh in relation to her current employment status or ways in which she may have strengthened her practice.

Regarding insight, the panel considered that Miss Seiwoh in her email dated 7 June 2022 made early acknowledgements of some of her mistakes, but the panel found this to be limited in scope and focused on giving a partial explanation of the circumstances. The email did not contain a reflection on what Miss Seiwoh would have done differently if she faced a similar situation and there was no reflection on the impact her actions may have had on her patients, colleagues and the nursing profession.

The panel also noted that Miss Seiwoh had stated *'I have reflected on my mistakes to ensure this doesn't happen again'.* However, there was no evidence of an action plan from Miss Seiwoh or what steps she has taken to ensure the mistakes do not happen again.

The panel determined that save for email dated 7 June 2022 from Miss Seiwoh, there is no evidence that Miss Seiwoh has remediated the misconduct. There is no evidence before the panel that Miss Seiwoh has addressed the concerns. The panel is also of the view that there is no evidence before it of remorse from Miss Seiwoh.

Therefore, the panel determined that the risk of repetition is high and decided that a finding of impairment is necessary on the ground of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because any fully informed member of the public or the profession who knew of the circumstances of this case would be concerned if Miss Seiwoh were allowed to practise unrestricted as a registered health visitor given the charges found proved.

Having found serious misconduct across a wide ranging set of charges, the panel determined that not to make a finding of impairment would significantly undermine the public's trust and confidence in the nursing profession. It is also necessary to mark the seriousness of the misconduct and to uphold proper standards and conduct for members of the nursing profession.

Having regard to all of the above, the panel is satisfied that Miss Seiwoh's fitness to practise is currently impaired on both public protection and public interest grounds.

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 Seiwoh'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

Ms Jardine informed the panel that in the Notice of Hearing, dated 23 July 2024, the NMC had advised Miss Seiwoh that it would seek the imposition of a suspension order for a period of 12 months if the panel found Miss Seiwoh's fitness to practise currently impaired.

Ms Jardine highlighted to the panel the following aggravating and mitigating features that would justify a restriction on Miss Seiwoh's practice.

In respect of the aggravating features:

- The conduct was repeated over a period of seven months.

- Conduct concerns harm or risk of harm to nine patients. Harm or risk of harm to new mothers and new babies.
- Miss Seiwoh's conduct regarding Patient B was a serious clinical error.
- Miss Seiwoh has shown a lack of insight into why her conduct was harmful, and no evidence of steps taken to remediate the conduct.

Ms Jardine submitted that these aggravating features push the type of sanction towards the serious end of the spectrum.

In respect of mitigating features, Ms Jardine submitted that Miss Seiwoh's mitigation fell under the category of personal mitigation factors such as [PRIVATE] and level of experience.

She highlighted the following:
- [PRIVATE]
- Miss Seiwoh was in the early stages of her career and her training was disrupted by the pandemic.

Ms Jardine submitted that due to these mitigating features the most serious sanction available to the panel, would not be appropriate for the registrant.

Ms Jardine took the panel through the sanctions that were available for the panel to consider. She submitted that taking no further action or a caution order would not be appropriate in this case given the risk of harm identified to patients, this case is not at the lower end of the spectrum. She said if Miss Seiwoh practice were not restricted this would undermine public confidence in the nursing profession.

Ms Jardine then considered a conditions of practice order. She submitted that a conditions of practice order may be appropriate if a registrant demonstrates a willingness to respond positively to retraining. Ms Jardine submitted that there is no evidence that Miss Seiwoh would comply with the conditions of practice order or undertake necessary training as

there has been a lack of engagement with the NMC regulatory process. She said that Miss Seiwoh's lack of engagement raises attitudinal concerns. Further, there are no conditions that could be imposed to protect the public from the risk of harm identified. She therefore submitted that a conditions of practice order would not be appropriate in the circumstances.

Ms Jardine submitted that a suspension order is the most appropriate sanction. She said that Miss Seiwoh's conduct was not fundamentally incompatible with her remaining on the register. She submitted that the public would be protected by the temporary removal of Miss Seiwoh for a period of time. Ms Jardine submitted that the aggravating features identified, especially around the conduct of Patient B was serious and a suspension order would mark this. A suspension order for a period of 12 months will give Miss Seiwoh the opportunity to engage with the regulatory process.

In respect of a striking-off order, Ms Jardine submitted this would be too restrictive in light of the mitigating features identified.

Ms Jardine submitted that in light of the findings on impairment, a suspension order for 12 months is the most appropriate order to protect the public.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Seiwoh'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 misconduct over a period of time. Miss Seiwoh repeated her conduct over a period of seven months.
- Conduct concerning harm or risk of harm to nine patients because of delayed inaccurate recording and a poor risk assessment.
- Serious risk of harm to vulnerable new mothers and new babies
- Miss Seiwoh has shown a lack of insight into why her conduct was harmful and there is no evidence of any remedial steps taken by her.

The panel also took into account the following mitigating features:

- [PRIVATE]
- Miss Seiwoh was a newly qualified health visitor, working within a community setting, within the first year of qualification. She was working during Covid-19 and post Covid-19 timeframe.

The panel noted as part of the context of the incidents, the role of health visitor is an autonomous one. Miss Seiwoh would have been expected to carry out health visits on her own either in a clinic or in the patient's home. The panel also noted that Miss Seiwoh was supported in the workplace as there was evidence of one to one monthly meetings with her line manager and her mentor.

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 Seiwoh'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 Seiwoh's misconduct was not at the lower end of the spectrum as it involved a risk of harm to vulnerable new mothers and new babies, 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 Seiwoh'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:

- *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;*

The panel is of the view that conditions of practice may have been appropriate to protect the public, but Miss Seiwoh would need to show that she is willing to engage in training. However, the panel have no evidence from Miss Seiwoh as to her current circumstances and whether she would be willing to retrain as Miss Seiwoh has not engaged with the regulatory process save for the email dated 7 June 2022. Therefore, the panel determined that there are no practical or workable conditions that could be formulated at this time, given the nature of the charges in this case.

Furthermore, the panel concluded that the placing of conditions on Miss Seiwoh' s registration would not adequately address the seriousness of this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered what the SG stated about suspension orders and when it may be appropriate.

The panel noted that this was not a single instance of misconduct, but a pattern of behaviour over several months. The risk identified raised serious concerns about Miss Seiwoh's practice concerning vulnerable new mothers and new babies. The panel noted there was a lack of insight from Miss Seiwoh as identified in their finding of impairment and no evidence of any remedial steps taken. The panel also considered the mitigating features identified and was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel considered whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Miss Seiwoh's case to impose a striking-off order.

Taking everything into consideration, the panel concluded that a suspension order would be the appropriate and proportionate sanction.

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

The panel considered that this order is necessary for the protection of the public and to mark the importance of maintaining public confidence in the profession. This order also sends a clear message to the public and the profession about the standard of behaviour required of a registered nurse and health visitor.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the charges found proved. This length of the

suspension order would give Miss Seiwoh the opportunity to engage with the regulatory process, if she so wishes, and, to reflect on the charges found proved and take actions to remediate her practice.

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 statement from Miss Seiwoh relating to the charges found proved, steps taken to remediate and to prevent repetition;
- Evidence of any training or professional development undertaken to address the concerns relating to the charges found proved; and
- Testimonials from a line manager or supervisor or mentor that detail your current work practices, whether paid or unpaid.

This will be confirmed to Miss Seiwoh in writing.

Interim order

As the substantive 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 Seiwoh's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Jardine. She submitted that an interim order is necessary to protect the public and meet the wider public interest. She

invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

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

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public and is otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made 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 Seiwoh is sent the decision of this hearing in writing.

That concludes this determination.