Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 09 September 2024 – Wednesday, 18 September 2024

Virtual Hearing

Name of Registrant:	Nadine Wilson
NMC PIN:	97Y0127O
Part(s) of the register:	Midwives Part of the Register: RM: Midwife (19 March 2001) Nurses Part of the Register Sub Part 1: RN1: Adult nurse, level 1 (14 August 1997)
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Sarah Lowe (Chair, Lay member) Sophie Kane (Registrant member) Isobel Leaviss (Lay member)
Legal Assessor:	Lizzy Acker
Hearings Coordinator:	Jack Dickens
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Ms Wilson:	Present and represented by Dr Abbey Akinoshun, ERRAS Legal Services
Facts proved:	First set of charges (2019): Charges 1, 2, 3, 5 Second set of charges (2023): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14(a), 14(b), 15 ,16
Facts not proved:	First set of charges (2019): Charge 4 Second set of charges (2023): Charge 14(c)

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

Details of charge

First set of charges (2019)

That you a registered nurse and/or registered midwife:

1) On 5 March 2019 in relation to the preparation of an intra venous (I/V) Syntocinon, infusion for Patient A:
   a) Failed to read the prescription chart;
   b) Failed to prepare 10 international unts (iu) per 500 ml of sodium chloride;
   c) Prepared 40 iu per 500 ml of sodium chloride;
   d) Prepared a label with 40 iu per 500 ml of sodium chloride.

2) On 5 March 2019 in relation to Patient A failed to demonstrate knowledge of the correct dosage of Syntocinon to be administered to a patient who was in labour.

3) On 5 March 2019 in relation to Patient A failed to carry out the required:
   a) Observations every hour;
   b) Blood sugar/glucose tests;
   c) Vital signs;
   d) Amniotic fluid checks;
   e) Foetal Heart monitoring.

4) In the alternative to charge 3, on 5 March 2019 in relation to Patient A failed to record:
   a) Observations every hour;
   b) Blood sugar/glucose tests;
   c) Vital signs;
   d) Amniotic fluid checks;
   e) Foetal Heart monitoring.

5) Having been subject to undertakings as varied on 13 October 2022 failed to complete the undertakings within 6 months

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

Second set of charges (2023)

That you, a registered nurse and/or registered midwife, between 18 December 2022 and 19 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in the following:

1) On or around 19 December 2022, in relation to patient 2:
   a) Administered intravenous medication.

   b) In relation to charge 1(a) was acting outside her level of competency.

2) On 3 January 2023 failed to escalate Patient 3's condition, namely that they were hypothermic.

3) On 9 January 2023 in relation to Patient 4:

   a) Failed to support the patient's perineum effectively;
   b) Failed to ensure the CTG was correctly; recording during the third stage of labour;
   c) Did not recognise the correct order of the labour procedure, namely:
      i. The administration of Syntocinon:
      ii. Delivery of the placenta;
      iii. Suturing.

4) On 18 January 2023 in relation to Patient 5:

a) Did not make a record in a timely manner; namely within 30 minutes;
b) Did not recognise a Post-Partum Haemorrhage (“PPH”).

5) On 19 January 2023, in relation to Patient 6:
   a) The management and administration of medication, namely:
      i. Oramorph;
      ii. Syntocinon.
   b) Incorrect labelling of a blood sample;
   c) Delayed Patient 6 receiving an epidural.

6) On 25 January 2023 in relation to Patient X:
   a) In regard to the timings of listening to the foetal heart rate in the first stage of labour, namely every 15 minutes;
   b) In regard to Cardiotocography (CTG) physiology.

7) On 3 February 2023 in relation to patient 7:
   a) Administered intravenous antibiotics on the incorrect occasion;
   b) Did not make a proper record in regard to the administration of the intravenous antibiotics.

8) On 4 February 2023 in relation to patient 8:
   a) Did not provide the correct information during labour, namely the direction in which to push;
   b) In regard to the battery on the Cardiotocography equipment:
      i. Allowed the battery to cease to function;
      ii. Failed to have a backup battery.
   c) Did not stimulate Patient 8’s baby without prompting;
   d) Did not provide third stage labour medication without prompting.

9) On 5 February 2023 in relation to an unknown patient:
   a) Did not complete records in a timely manner;

b) Failed to stimulate the baby of the patient.

10) On 10 February 2023 in relation to an unknown patient required prompting to:
    a) Check the patient's blood pressure;
    b) Escalate the patient's condition;
    c) Administer fluids.

11) On 11 February 2023 in relation to Patient 9:
    a) Did not escalate Patient 9's condition to:
        i. A midwife in charge
        ii. An anaesthetist
    b) Provided incorrect information to:
        i. Colleague Y regarding Patient 9's heart rate;
        ii. To Patient 9, namely the reasons for the administration of Terbutaline.

12) On 12 February 2023 in relation to Patient 10 in labour:
    a) Delayed the care of Patient 10;
    b) Did not or did not adequately, communicate with Patient 9 during delivery of Patient 10's baby;
    c) Delayed the stimulating and/or covering of Patient 10's baby.

13) On or around 13 February 2023 failed to store a placenta correctly.

14) On 16 February 2023 in relation to Patient 11, failed to:
    a) Recognise low sodium levels;
    b) Carry out one or more tests/checks on sodium levels;
    c) In the alternative to (b) above failed to record one or more tests/checks on sodium levels;
    d) Escalate Patient 11's condition regarding sodium levels to:
        i. A senior colleague;
        ii. A doctor.

15) On 17 February 2023 in relation to Patient 11, failed to:
    a) Recognise or take appropriate action when Patient 11 suffered a post-partum haemorrhage;
    b) Record Patient's 11 blood loss in a timely manner.
    c) To keep proper and/or accurate records.

16) Did not effectively communicate with colleagues during handovers on:

    a) 9 January 2023
    b) 18 January 2023
    c) 19 January 2023
    d) 25 January 2023
    e) 4 February 2023
    f) 11 February 2023
    g) 12 February 2023

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

Day 1 and Day 3

The panel were informed at the outset of the hearing on Monday, 9 September 2024, that Dr Akinoshun, your representative, was not available to attend the hearing on Monday 09 September 2024 or Wednesday 11 September 2024.

Ms Stevenson, on behalf of the Nursing and Midwifery Council ('NMC') did not oppose either of the adjournments.

The panel therefore adjourned the hearing until Tuesday, 10 September 2024 in order to ensure you were represented.

The panel also adjourned the hearing on Wednesday, 11 September 2024 and recommenced on Thursday 12 September 2024.

Decision and reasons to waive notice of the hearing

At the outset of the hearing the panel noted that the notice of hearing was defective in that it did not outline both sets of charges nor did it contain the correct sanction bid. The panel invited submissions from both parties.

Ms Stevenson submitted that there would be no prejudice caused to you if the hearing were to proceed.

Ms Stevenson outlined that the notice of hearing stated the dates, time and venue of the hearing. She stated that, although the notice of hearing only referred to one set of charges, you and your representative still had notice of both sets of charges as these were sent in the Case Management Forms.

Ms Stevenson told the panel that, although the sanction bid in the notice of hearing was incorrect, the revised sanction bid had been communicated to you and your representative ahead of this hearing. Your representative confirmed that the first communication of the revised sanction bid was on 7 August 2024.

Dr Akinoshun, on your behalf, submitted there was no objection to the hearing continuing.

The panel confirmed with you that you understood the impact of waiving the notice of hearing.

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

The panel was of the view that no unfairness would be caused in proceeding with the hearing.

In reaching its decision, the panel noted that the notice of hearing was defective in that it did not outline both sets of charges and that it stated the incorrect sanction bid. However, the panel was satisfied that no unfairness would be caused as your representative had confirmed that you were aware of both sets of charges and the revised sanction bid. The panel was satisfied that Ms Stevenson affirmed the completed Case Management Forms, one for each set of charges, were signed and returned by you to the NMC.

The panel determined to continue with the hearing.

Decision and reasons on application to amend the charges

The stem of the charges

The panel heard an application made by Ms Stevenson, on behalf of the NMC, to amend the wording of the stem of the charges, to read as follows:

'That you a registered nurse **and/or a registered midwife'**

And

'That you, a registered nurse **and/or a registered midwife**'

Ms Stevenson submitted that this amendment would ensure that your correct registration appears in the charge.

Dr Akinoshun submitted that there was no objection to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of Nursing and Midwifery Council (Fitness to Practise) Rules 2004, ('the Rules').

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was of the view that it was appropriate to allow the proposed amendment as it would correctly reflect your registration. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed.

Charge 5, of the first set of charges (2019)

The panel heard an application made by Ms Stevenson, on behalf of the NMC, to amend the wording of Charge 5, of the first set of charges (2019), to read as follows:

> '5) Having been subject to undertakings as varied on 13 October **2022** failed to complete the undertakings within 6 months'

Ms Stevenson submitted that this amendment ensures the correct period of time regarding the incident is reflected in the charge. She further submitted that such an amendment would not be unfair.

Dr Akinoshun submitted that there was no objection to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was of the view that it was appropriate to allow the proposed amendment as it would correctly particularise the charge to include the year in which the allegations occurred. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed.

Charge 13, of the second set of charges (2023)

The panel sought to amend Charge 13 of the second set of charges (2023) to read as follows:

'13) On **or around** 13 February 2023 failed to store a placenta correctly.'

The panel invited submissions from both parties.

Ms Stevenson submitted that there was no objection, on the part of the NMC, to this proposed amendment.

Dr Akinoshun submitted that there was no objection to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel noted that there was a discrepancy between the dates with some documents referring to the incident occurring on 12 February 2023 and others stating 13 February 2023; therefore, the panel was of the view that it was appropriate to allow the proposed amendment as it would allow for greater certainty of the date of the alleged incident. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed.

<u>Charge 10, of the second set of charges (2023)</u>
The panel sought to amend Charge 10 of the second set of charges (2023) to read as follows:

'10) On 10 February **2023** in relation to'

The panel invited submissions from both parties.

Ms Stevenson submitted that there was no objection and that the NMC would support the application.

Dr Akinoshun submitted that there was no objection to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was of the view that it was appropriate to allow the proposed amendment as it would correctly particularise the charge to include the year in which the allegations occurred. The panel also considered that this amendment would provide clarity. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed.

Decision and reasons on further documentation

Documentation relating to Charge 5 of the first set of charges (2019)
The panel having heard the admissions noted that there was no evidence in the NMC's evidence bundle to Charge 5 of the first set of charges (2019), but that this was admitted by you. It sought this evidence from the NMC. Before doing so, the panel had regard to Rule 31 of the Rules and heard representations from Ms Stevenson and Dr Akinoshun.

Both Ms Stevenson and Dr Akinoshun agreed to the admission of evidence to Charge 5. Both parties and the legal assessor saw the documentation before it went before the panel. Neither party objected to this evidence going before the panel.

Nevertheless, the panel had regard to the test of whether this information was relevant and fair. It considered that it was relevant as it was the basis of Charge 5 and that it was fair in the circumstances of an admitted charge to ensure that there was evidence to clarify and thereby limit the facts admitted by you.

Documentation relating to impairment.

On the papers before the panel and during the course of submissions made by Dr Akinoshun, reference was frequently made to a wealth of documents submitted by you to the NMC. It was unclear when, and to whom, these documents were sent to, and the panel did not seek to explore whether the documents were before the NMC prior to the hearing. The panels concern was to ensure that everything you believed to be relevant to your case was before it. The panel therefore asked Ms Stevenson and Dr Akinoshun to review their records.

Dr Akinoshun provided a number of documents, three of which were not before the panel. Ms Stevenson found further documents that were not before the panel or submitted by Dr Akinoshun.

The panel invited submissions from both parties.

Both parties were in agreement that these documents should be before you. Having seen the documents in advance, neither the legal assessor nor the parties objected to these documents going before the panel.

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

The panel considered these documents to be relevant as they went to your efforts to remediate your admitted impairment and your developing training and insight. It would only be fair that these matters were before the panel as these were documents you had submitted to the NMC. If these were sent to other departments of the NMC but intended them to be before the panel that should not prejudice you.

Background

On 20 March 2019, the NMC received a referral from the Labour Ward manager at Hillingdon Hospitals NHS Foundation Trust ('Hillingdon Hospital'). At this time, you were working at Hillingdon Hospital as a Band 6 registered midwife.

As part of your induction, you were required to complete a cardiotocograph ('CTG') study day. The CTG study day had a requirement of completing and passing a test. It is alleged that you failed this test three times. On 21 January 2019, following further training and support, it is alleged that you passed the test.

It is alleged that there was further mandatory training that you failed to complete in a timely manner despite being given the time to undertake it.

On the 5 March 2019, it is alleged that whilst caring for Patient A you prepared four times the specified amount of Syntocinon for this patient. This mistake is said have been noticed when a colleague completed the second check of the dose dispensed by you.

It is further alleged that whilst caring for Patient A you failed to correctly monitor their blood sugars, conduct observations every hour, check their vital signs, conduct amniotic fluid checks, and failed to carry out foetal heart monitoring.

It is alleged that following this the Labour Ward manager met with you and they allegedly noted a lack of insight and understanding of the seriousness of the situation. It is alleged that the Labour Ward Manager then completed an investigation report in relation to these concerns.

It is said that on the 19 March 2019 you were due to have a probationary review meeting, in which the outcome was to be that you had failed probation and you were to be dismissed. Yet before this meeting, on 16 March 2019, it is said that you resigned from Hillingdon Hospital.

On 18 August 2020, the NMC's Case Examiners proposed Undertakings. These Undertakings were agreed and accepted by you.

The Undertakings were varied on three occasions:

- 5 August 2020 due to you finding employment as a nurse.
- 14 July 2021 to relate only to your midwifery practice.
- 13 October 2022 to enable you to find employment as a midwife.

On 29 September 2022, you received an unconditional offer from Kingston Hospital NHS Foundation Trust ('Kingston Hospital') for a post as a Midwife. You commenced employment at Kingston Hospital on 31 October 2022. Kingston Hospital were aware of the Undertakings which included working under the supervision of a senior midwife, to have fortnightly meetings with your line manager, and to declare your Undertakings to the midwife in charge on each shift.

In January 2023 further concerns relating to your midwifery practice were raised. It is alleged that seven incidents and eight near misses were reported and this is said to demonstrate that you were unsafe to work as a Midwife. The alleged concerns are as particularised in the second set of charges, 1 to 16, above.

On 15 March 2023, your employment at Kingston Hospital was terminated. It is alleged that you failed your probationary period in light of the concerns that were raised.

Following this, the Case Examiner's considered that the undertakings had been breached as you were unable to complete it within the specified six months.

These cases were then referred to the Fitness to Practice Committee for adjudication.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Dr Akinoshun, who informed the panel that you made full admissions to all the charges.

The panel therefore finds all of the charges proved in their entirety by way of your admissions, save for Charge 4 of the first set of charges and Charge 14(c) of the second set of charges.

Charge 4 of the first set of charges is worded in the alternative to Charge 3. Therefore Charge 4 falls away due to Charge 3 being found proved.

Charge 14(c) of the second set of charges is worded in the alternative to Charge 14(b). Therefore Charge 14(c) falls away due to Charge 14(b) being found proved.

Fitness to practise

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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, your 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.'*

Ms Stevenson referred the panel to the following case law:

- *Sadler v General Medical Council* [2003] UKPC 59
- *Krippendorf v General Medical Counsel* [2001] 1 WLR 1054
- *Holton v GMC* [2006] EWHC 2960 (Admin)
- *Calhaem v GMC* [2007] EWHC 2006 (Admin)

Ms Stevenson also referred the panel to the NMC's guidance on lack of competence for the purposes of fitness to practise proceedings ('FTP-2b').

Ms Stevenson invited the panel to take the view that the facts found proved amount to a lack of competence. Ms Stevenson identified the following sections of The Code: Professional standards of practice and behaviour for nurses and nurses and midwives 2015 ('the Code') in making its decision.

> ***Prioritise people***
>
> *4 Act in the best interests of people at all times*
>
> ***Practise effectively***
>
> *8 Work cooperatively*
>
> *To achieve this, you must:*

8.5 work with colleagues to preserve the safety of those receiving care

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

To achieve this, you must:

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

10.4 attribute any entries you make in any paper or electronic records to yourself…

18 ***Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

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

Ms Stevenson submitted that the facts found proved amount to a lack of competence. Ms Stevenson submitted that this was a fair sample of work. She submitted that the actions that give rise to a lack of competence are wide-ranging and relate to fundamental aspects of practice.

Ms Stevenson submitted your actions fell significantly short of what is expected of a registered midwife. Ms Stevenson submitted that you have not been able to meet the requirements, nor have you met the standard of your professional work that is reasonably to be expected of you.

Ms Stevenson submitted that the lack of competence in this case is serious. She said it covered two separate employers over a total of five months, with some concerns occurring whilst you were subject to Undertakings. Ms Stevenson submitted that during this period you practised in an unsafe manner in the care you provided to multiple patients.

Ms Stevenson submitted that there is a clear concern with your clinical practice.

Ms Stevenson submitted that, despite your efforts and willingness, there remains lack of competence.

Dr Akinoshun submitted that you accept a lack of competence in your practice.

Submissions on impairment

Ms Stevenson 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) NMC (2) Grant* [2011] EWHC 927 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Stevenson submitted that a finding of impairment would protect the public.

Ms Stevenson submitted that your actions as found proved put patients at unwarranted risk of harm and caused actual harm to one patient (Charge 15 of the second set of

charges (2023)). Ms Stevenson submitted that the is a real risk of repetition if you were to be able to practise unrestricted.

Due to the wide-ranging concerns, Ms Stevenson submitted that it is difficult to identify the *'gap and training'* to address the concerns but that *'it may be possible to address them'*.

Ms Stevenson submitted that there is evidence of insight and remediation and evidence of steps you have taken to strengthen your practice, such as training courses.

Notwithstanding this, Ms Stevenson submitted that there is limited evidence to show that you are not at risk of repeating the actions, should you be allowed to practise.

Ms Stevenson submitted that your actions bring the profession into disrepute.

Ms Stevenson submitted that you have plainly breached the fundamental tenets of the profession.

Ms Stevenson submitted that there were no contextual factors that contributed to the failings.

In light of the concerns and that you have not been able to meet the required standard that are reasonably expected of you as a registered midwife, Ms Stevenson submitted that it is in the public interest to find that you are impaired.

Dr Akinoshun confirmed that there were no contextual or personal factors at the time of the failings.

Dr Akinoshun submitted that you accept you are impaired. Nevertheless, he implored the panel to make its own independent judgement on impairment.

Dr Akinoshun submitted that you have displayed insight into the failings. He said that this is evidenced in the reflective statements before the panel. He submitted that the insight demonstrates the lessons learned in order to avoid a risk of repetition.

Dr Akinoshun submitted that you have made tremendous efforts to remedy the failings by attending and completing training courses, of which there are certificates before the panel Dr Akinoshun submitted that weight should be attached to this.

The panel asked questions of clarification to Dr Akinoshun, who took instructions from you.

The panel invited you to give evidence in relation to impairment and your insight. It invited the legal assessor to advise you on the differences between submissions and evidence. The panel clarified that you understood the differences and the impact of giving evidence and choosing not to give evidence.

The panel had questions for you particularly around the application and understanding of the learning you had undertaken and around your current insight. The panel had concerns arising from your lack of insight at the time and it was not satisfied by your written reflections which it considered to be convoluted and lacking in clarity. The panel was of the view that it would have been assisted in its assessment of your current impairment by an opportunity to explore your current understanding and insight further.

You confirmed that you had understood but nevertheless, you decided you did not wish to give evidence to the panel.

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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*

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

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

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*

7 Communicate clearly
To achieve this, you must:

7.4 *check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*

8 Work cooperatively
To achieve this, you must:

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

8.2 *maintain effective communication with colleagues*

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

8.5 *work with colleagues to preserve the safety of those receiving care*

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

10.3 *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*

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*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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*

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures*

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'*

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average Band 6 registered midwife and not by any higher or more demanding standard.

The panel concluded that the charges in this case cover a fair sample of work. It considered that the facts found proved spans five months over two different employers. The panel determined that the work was broadly the same between those employers and covered many aspects of fundamental practice and care, such as intrapartum care of the mother, care of the newborn, CTG, administration of medication, and communication with colleagues. The panel noted that the concerns were raised by multiple colleagues and related to 14 different patients across 15 shifts. It also noted that concerns of your

competence were raised not only verbally by fellow practitioners but also through balanced probationary reviews. The panel considered that there was a systematic and supportive environment in which your performance was assessed.

Having determined that the period of work particularised in the charges was a fair sample, the panel next considered whether the actions fell below the expected standards in the Code, as identified above. The panel considered that your actions did fall below the expected standards of a nurse/midwife with the same number of years practice as you. The panel noted that there was a pattern of concerns which were serious and wide-ranging, relating to basic fundamentals of care. Despite a supportive programme of support, which included a period of work supernumerary, the panel considered that you were still working unsafely and noted that there were a number of near misses reported in relation to the care you provided. For example, there are three charges, in close periods of time, which all relate to a failure to stimulate the baby at the time of birth. The panel noted that there could have been serious consequences and harm caused by your actions. Further, the panel considered that your actions were sufficiently serious to the extent where patients felt unsatisfied with the care being provided. Therefore, the panel determined that your actions were serious deviations from the Code and the standards expected of a fully qualified nurse and midwife.

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

In all the circumstances, the panel determined that your 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, your 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.'*

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that your 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 determined that the first three limbs of Grant were engaged.

The panel found that patients were put at risk of serious harm by your lack of competence. The panel also determined that actual physical harm was caused to one patient, particularised in Charge 15, as a result of your lack of competence. Of particular importance for the panel was the level of harm posed to patients by the failures regarding Syntocinon, which could have been fatal to mother and baby.

The panel determined that your lack of competence brings the professions into disrepute. It considered that if a member of the public were to learn of the concerns the profession would be brought into disrepute. The panel noted that at least two patients rejected care and colleagues expressed concern in working alongside you as they deemed it unsafe.

Given the above, the panel concluded that your lack of competence had breached the fundamental tenets of the nursing and midwifery professions. As outlined above, it considered your lack of competence to relate to fundamental skills of the professions which are expected of even newly qualified nurses and midwives.

The panel next considered the context in which these concerns occurred. It noted that there were structured inductions at both hospitals. The panel took into account that there was structured support and training in place, including probationary reviews and proactive feedback. The panel had no evidence of external factors, lack of resources, or excessive workloads, being contributing factors to the failures as found proved.

The panel considered whether the failings can be addressed. It noted that the concerns are wide ranging, multifaceted and relate to your practice and clinical competency. Nevertheless, it was of the view that, although there are many significant aspects to be addressed, these concerns are theoretically capable of being remedied.

However, the panel was not satisfied that these concerns have been addressed as yet.

The panel had before it numerous certificates of attendance at training courses (predominately completed online and unassessed) and reflections. The panel was not satisfied that you have demonstrated a sufficient understanding of how you would apply the learning into your practice in the future. The panel was of the view that there was insufficient evidence of how you would address the multifaceted issues that have been identified. The panel was concerned that the courses and training you have completed were not practical and/or assessed. The panel further noted that some of the competence issues with your nursing and midwifery practice are in areas and skills that cross over with work as a Health Care Assistant, such as communication, record keeping, and escalating concerns. It was of the view that your reflections could have incorporated this practical application of improvement. The panel also noted that most of the training that you have evidenced is mandatory training which you would have been required to complete

annually throughout your career as a registered nurse and midwife, including before the concerns in these cases occurred.

The panel next considered that your insight into your lack of competence. It had sight of multiple reflections which you had completed and the chronology of these reflections. Having started with very limited insight which minimised the concerns and deflected the issues in your practice, the panel could see that you are starting to develop a greater understanding of the issues. The panel remained concerned that your insight is not sufficiently developed in that your understanding of the concerns and what you would do differently has not been sufficiently demonstrated to the panel, for example although it was noted that you had reflected on the concerns regarding medication administration, it was of concern to the panel that you were reflecting on it being a positive experience as no drug error was made in Charge 1. However, this was viewed by the panel as "missing the point", due to the fact you should not have administered any IV's as of yet as you were not signed off as competent to do so in your new role. The panel considered that the fact that you did not make an error on this occasion could be viewed as a near miss and not a good experience as you referred to in your reflection. The panel also had concerns regarding the insight demonstrated in relation to Charge 3 which stated *'when next I am administering medication, I can have a brief discussion with my colleague to ensure that we are following the correct procedure to reduce the risk of medication errors.'* However, the panel was of the view that there was a lack of situational awareness and this placed an onus on the second checker. The panel was satisfied that in this context the error was not the amount of drug prepared, rather that it was the inappropriate stage of labour to prepare and administer the drug, namely Syntocinon. It considered that there was a lack of acknowledgement as to the catastrophic impact this could have had on the mother and her unborn baby if the midwife who was checking it had not been so situationally aware and had an oversight of this patients care as the midwife in charge.

The panel determined that although these concerns are capable of being remediated, insufficient evidence was before the panel to satisfy it that you demonstrate a level of insight or that you have sufficiently strengthened your practice to lower the risk of

repetition. Therefore, the panel was of the view that a finding of impairment was necessary for the protection of the public.

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 and 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 impairment on public interest grounds was required due to the serious nature of the facts found proved and the failings and lack of competence that was far below the standards expected of a registered nurse and midwife. The panel was of the view that a member of the public would be concerned if they were to learn a nurse/midwife with such findings of lack of competence as these was not found to have their fitness to practice be impaired. Furthermore, it determined that confidence in the profession, and the NMC as their regulator, would be diminished and standards of nursing and midwifery undermined, if a finding of impairment were not found.

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

Sanction

The panel has considered this case very carefully and has decided to impose a suspension order for a period of 12 months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Ms Stevenson submitted that a nine-month suspension order with a review is the appropriate and proportionate sanction. Ms Stevenson submitted that it must be with a review as you should be monitored to see if you make progress.

Ms Stevenson submitted that a conditions of practice order would not reflect the seriousness of the charges or provide sufficient protection to the public. She reminded the panel that undertakings were in place for almost three years and were not completed.

Dr Akinoshun submitted that you have demonstrated a level of insight and reflected on the charges. He said that you have taken continuous steps over the last five years to remediate gaps in your practice by reflecting, developing insight and undertaking some relevant training. Dr Akinoshun invited the panel to take all these into consideration when deliberating on appropriate sanction.

Dr Akinoshun submitted that the panel should consider proportionality and invited that the sanction imposed must be no more than necessary to satisfy the public interest, which includes the protection of the public. He submitted that the sanction that the panel imposed must strike a fair balance between the rights of the nurse/midwife and the public interest.

Dr Akinoshun submitted that, in light of the efforts made by you in strengthening your practice and developing insight and that you have been on an interim suspension order for 18 months, a sanction of five months suspension without review would be appropriate and proportionate.

Decision and reasons on sanction

Before the panel made its decision regarding sanction, it heard and accepted the advice of the legal assessor.

The panel next considered 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:

- There is a broad range of concerns regarding your practice.
- The concerns relate to fundamental and basic nursing and midwifery skills which are expected of even newly qualified nurses and midwives.
- A pattern of repetition of the issues despite intensive and structured support, supervision, and feedback.
- The risk of harm to patients in all charges that was presented by your lack of competence.
- Actual harm caused to at least one patient.
- Insufficient insight and awareness into the failings and the severity of the issues.
- The impact your actions had on colleagues.

The panel also took into account the following mitigating features:

- Full admissions to the facts.
- A willingness to undertake courses to strengthen your practice.
- Personal mitigation of financial hardship.

The panel bore in mind the submissions made by Dr Akinoshun regarding personal mitigation and a lack of support from Kingston Hospital. However, the panel did not have any evidence before it that corroborated these submissions. Instead, the panel had substantial evidence of the intensive and extensive support that you had been given at Kingston Hospital from a range of colleagues in the form of direct supervision, structured

feedback forms, meetings, mentoring and retraining. The panel acknowledged that working in a hospital maternity unit was likely to be pressured but could see no evidence that you were under undue pressure. Therefore, the panel could not find these to be mitigating features.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your 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 your 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 was determined that conditions of practice would not be the appropriate and proportionate sanction and would not adequately address the seriousness of this case and would not protect the public.

Although areas of practice in which failings occurred have been identified, the panel was of the view that conditions would not be workable. It noted that the concerns in your case are wide ranging, covering fundamental and core nursing and midwifery skills. The panel considered that this amounted to general incompetence in your practice. It considered that if conditions were to be imposed, the requirement of supervision to mitigate the risk to patients at this time given your current insight, would be so onerous that it would be tantamount to suspension and unworkable.

The panel noted that there were issues with you acting outside of your competence. For example, the Charge 1 of the first set of charges (2019), was that you administered medicine when this was outside of your competency and should not have done so without supervision. These actions put patients at risk of harm and had an impact upon your colleagues.

Furthermore, the panel was mindful that you were unable to comply with Undertakings in relation to the first of charges (2019) due to the termination of your employment during the probationary period because of the failings in your practice. It noted that there were issues of a disregard of direct instruction, responding to feedback, and retraining, which did not result in improvements in your practice. Examples include charges 8(c), 9, and 12 of the second set of charges (2023), which all concerned the stimulation of a newborn baby and which occurred within a short period of time of each other, approximately eight days. The panel considered this to be a simple and fundamental midwifery skill which is central to the role of midwife, which a failure to complete could result in significant harm to the newborn baby. A further example is in relation to charges 2, 10, 11, and 14 of the second set of charges (2023), all concerned a failure to escalate risks, and occurred over a short period

of time, approximately seven days. An example of not following direct instruction was outlined in the witness statement from the Band 7 Midwife and Delivery Suite Co-ordinator at Kingston Hospital:

> *'*[you were] *not listening to their advice in regards to management of syntocinon. Ms Wilson had asked* a colleague *about turning the syntocinon off in response to changes in fetal heart rate pattern which* a colleague *did not feel was necessary just yet, however Ms Wilson did not follow the recommendation of the senior midwife they were paired to work with and learn from, and stopped the syntocinon regardless.'*

The panel noted that there were serious concerns raised about your communication skills including the seven instances that have been particularised at Charge 16 of the second of charges (2023). The supervising midwives were concerned about inappropriate timing and disjointed communication which made it difficult for colleagues to understand, inadequate identification of risks, and failure to hand over key information. In the witness statement of the Lead for Practice and Development for Maternity at Kingston Hospital, they stated :

> *'Ms Wilson's failure to communicate with their colleagues is very serious, because if a member of staff cannot understand what Ms Wilson needs from them / is relaying to them, they cannot make emergency clinical decisions and provide the patient with safe and effective care. The risks of Ms Wilson's lack of clear communication is that patients may deteriorate, receive repetition of care/treatment and may not receive the risk care/treatment.*
>
> *Ms Wilson's failure to communicate clearly with patients is very serious as their lack of communication meant that the patients did not trust them with their care, did not feel supported by Ms Wilson, and were not able to have a say in their own treatment and care.'*

The panel was of the view that these communication failures remain serious, as there was no evidence before it to suggest a strengthen of practice, for the reasons given in the 'Decision and Reasons on Impairment'.

Given the above the panel was of the view that conditions would not be appropriate proportionate, or workable, at this time. It considered that if you were to return to practice with conditions that this would not adequately protect the public or meet the public interest in this case.

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.*

The panel was of the view that the concerns in your case are significantly serious and have a detrimental impact on the safety of patients and colleagues. The panel noted the NMC's guidance titled *'How we determine seriousness'* (FTP-3) last updated on 27 February 2024. It considered that your actions, conduct, and poor practice indicated a dangerous attitude to the safety of people receiving care, for example by failing to sufficiently acknowledge the seriousness of the concerns and the impact of your actions on the patient. The panel was not suggesting that your actions were in any way deliberate. But due to your incompetence, you put multiple patients at unwarranted risk of harm and the panel was not satisfied that your reflections and training since (predominantly

unassessed online courses) were sufficient to enable a return to safe practice, even with conditions. The panel was also of the view that all the charges demonstrate a lack of understanding and awareness of the fundamental skills required of even newly qualified nurses.

As noted above under 'Decisions and Reasons for Impairment', the panel found that there is a risk of repetition and as such, such you be allowed to practice without restriction there is a risk to patient safety if they were allowed to continue to practise even with conditions.

The panel noted that it was bound by Article 29(6) of the Nursing and Midwifery Order 2001, which states:

> *'A striking-off order may not be made in respect of an allegation of the kind mentioned in article 22(1)(a) [(ii* lack of competence*), (iv) or (iva)] unless the person concerned has been continuously suspended, or subject to a conditions of practice order, for a period of no less than two years immediately preceding the date of the decision of the Committee to make such an order.'*

Therefore, the maximum sanction this panel could impose was one of suspension. Had striking off been available, the panel may have considered this to be an appropriate sanction given the seriousness and wide-ranging nature of the concerns.

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to protect the public and mark the seriousness of the failings. It further

considered that 12 months was necessary to give you sufficient time to evidence sustained and consistent improvement in your practice.

The panel take this opportunity to urge you to actively apply your training and learning in to practice through your current employment and to further develop insight and understanding into the concerns.

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

Any future panel reviewing this case would be assisted by:

- Evidence of sustained and consistent application of what you learnt through courses in your practice. Courses and strengthening of your practice should focus on core and fundamental nursing and midwifery skills, such as intrapartum care of the mother, care of the newborn, CTG, administration of medication, and communication with colleagues. This could be evidenced through:
    - Certificates from courses, focussing on courses that are assessed.
    - Testimonials from colleagues.
    - Testimonials from a mentor, who should be another registered nurse or midwife.
    - Reviews by a line manager or mentor of your performance in your current role, in respect of the core skills which can be practised.
- Further reflections, demonstrating a development of insight and full understanding into the concerns.
- Attendance and engagement with the NMC and a further panel.

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 your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Ms Stevenson submitted that an interim suspension order for 18 months is necessary in order to protect the public and is otherwise in the public interest. She submitted 18 months would cover the 28 days in which you may file an appeal and that it would also cover the potential period of an appeal, should you appeal.

Dr Akinoshun submitted that you are indifferent to the application.

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 therefore imposed an interim suspension order for a period of 18 months.

The panel was of the view that, for the same reasons as identified above, an interim suspension order would be necessary to protect the public from the ongoing risk. It also determined that an interim suspension order would be otherwise in the public interest.

The panel was of the view that 18 months would be proportionate in order to cover the time in which you can file an appeal and to cover any potential appeal period arising from that application.

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

That concludes this determination.