Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 January – Friday, 10 January 2025

Virtual Hearing

Name of Registrant:	Victoria Christine Reed
NMC PIN:	99H0042E
Part(s) of the register:	Registered Midwife RM: Midwife (26 August 2002)
Relevant Location:	Nottingham
Type of case:	Misconduct
Panel members:	Des McMorrow (Chair, registrant member) Sophie Lauren Kane (Registrant member) Alison Lyon (Lay member)
Legal Assessor:	Lucia Whittle-Martin
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Elizabeth Hartley, Case Presenter
Ms Reed:	Present and represented by Wafa Shah of Counsel
Facts proved by admission:	All charges
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) Between 01 September 2020 to 15 September 2021, you accessed 1,214 clinical records without authority or clinical justification.

2) On or around 15 October 2021, during an investigation into your conduct you made the following representations which were untrue:

    a) That before 11 September 2021, you had not logged on and reviewed patient records from home before and/or that you did not know that you could.

    b) That between 10 and 15 September 2021, you had only accessed patient records on Lawrence Ward.

3) Your conduct set out in charge 2(a) and 2(b) was dishonest, in that you intended to minimise the extent of your access to clinical records.

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

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

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

Ms Hartley supported this application.

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

Having heard that there may be references [PRIVATE], the panel determined to hold the hearing partly in private in order to preserve the confidential nature of those matters. The panel is satisfied that these considerations justify that course, and that this outweighs any prejudice to the general principle of hearings being in public.

Background

You were referred to the NMC on 9 March 2022 by the Director of Midwifery of Nottingham University Hospitals NHS Trust (the Trust). The alleged facts are as follows:

In September 2021, you were working as a Band 6 Midwife at the Trust, on a maternity ward. You had worked at the Trust since September 2002.

An audit into a possible breach of confidentiality by another member of staff noted that your login on the Trust's software Nerve Centre had been used to access the record of a patient who was not in your care. The use of Nerve Centre requires an individual to actively log in, using a personal user ID and password. It does not record all user activity, only activity it considers anomalous to the user's account.

Following the discovery that you had accessed the record of a patient not in your care, the Trust conducted a fact-find to see if your login had otherwise been used to access patient information inappropriately. You were excluded from work while the investigation was conducted.

Initially, the Trust's enquiries related to the period between 11 September 2021 and 14 September 2021. Those initial enquiries demonstrated that one patient's records had been

accessed 11 times. That patient was an adult patient who was not accessing maternity services.

As a result of those findings, a more in-depth investigation was conducted involving an access audit for your login, covering the same period i.e. between 11 September 2021 and 14 September 2021. During a review of that audit, further inappropriate access was identified. In particular, it was highlighted that 87 records were accessed inappropriately. These included Adult Intensive Care patients, adult trauma patients, Neonatal patients and one Coroner referral.

You met with the investigating officer, Ms 1, on 14 October 2021. You accepted that you accessed Nerve Centre repeatedly over the three-day period in question, and that no one else had used your credentials. In the course of the meeting, you claimed that before 11 September 2021, you had not logged on and reviewed patient records from home before and/or that you did not know that you could and that between 10 and 15 September 2021, you had only accessed patient records on the Lawrence Ward.

Following that meeting, Ms 1 requested a further audit of Nerve Centre for a longer period of time. Your user access was reviewed from 1 August 2021 to 31 August 2021 and showed that 252 patient records were accessed inappropriately.

That finding was considered to support a fuller lookback and an audit of your user login from 1 September 2020 and 15 September 2021 demonstrated that 1,214 patient records were accessed inappropriately. This included sporadic inappropriate access from November 2020 to March 2021, then an increase in activity from April 2021, until the pinnacle of activity in September 2021. The records accessed included those of 640 trauma in-patients, 387 adult ICU patients, and 97 neonatal patients.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Shah on your behalf, who informed the panel that you made full admissions to all the charges.

The panel therefore finds all the charges proved in its entirety, by way of your admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Registrant's evidence

You provided a number of positive character references from previous midwife colleagues and your current deputy manager and evidence of further training regarding data protection and data security.

You gave evidence under affirmation. You said that you currently work at a health spa hotel in a completely different capacity to your previous employment as a midwife. You

said that your general role is that of a housekeeper which was greeting guests or maintaining the rooms of a guest area which you had been doing since March 2022.

You said that you started an online data protection course four and a half months after you had finished employment with the Trust. You stated that this was more in-depth training than you had undertaken during your employment as a midwife.

[PRIVATE]. You said that you were supporting patients and colleagues throughout this period. [PRIVATE]. You said that you did 12 hour shifts twice a week and that you helped out doing extra shifts on the ward and the induction suite. You said that these shifts were mainly on the ward or the induction suite as they were always full. Staffing levels were at a minimum and there was very little support. You said that you were predominantly in charge of supporting colleague midwives and junior colleagues, as well as looking after yourself and the patients.

[PRIVATE]. [PRIVATE]. You said that these shifts consisted of doing four hourly checks, making sure that patient care was safe, that observations were done on time and paperwork was completed. [PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE]. This then progressed to other areas of the hospital and the wider Trust. You said that you did not actively source out any patient records in particular and nor did you know individuals concerned. You said that no information was shared or retained. You recognise that you had no authority or clinical justification to have done this.

[PRIVATE].

You said that patients have a right to trust midwives and healthcare professionals as this is their private confidential information. You said that they have a right to respect and dignity and that they did not deserve to have their trust broken. You said that you felt like you let your colleagues down and that you have put them in a more difficult situation due to your actions.

You said that it is part of your code to always be honest and open. You said that if you are dishonest, it would have a detrimental effect on patient's care and the wider public interest. You said that you recognise the seriousness of your mistakes through reflection and remediation and that you have learnt from this. [PRIVATE].

Submissions on misconduct

In coming to its decision, the panel had regard 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 Hartley invited the panel to take the view that the facts found proved amount to misconduct. She encouraged the panel to have regard to The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision. Ms Hartley referred the panel to parts of the Code, specifically 1.2, 1.5, 5.1, 5.2, 20, 20.1, 20.2, 20.3 and 23, which she submitted had been breached.

Ms Hartley submitted that 1214 individual patient records were accessed and in addition to this, you had acted dishonestly in the course of the investigation. She submitted that your actions involve a serious departure from the standard set out in the Code. Ms Hartley submitted that you have abused the professional position of trust within the profession.

Ms Shah submitted that you have admitted to the alleged misconduct in this case. She submitted that you have been engaging with the NMC proceedings.

Submissions on impairment

Ms Hartley 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).

Ms Hartley submitted that both grounds of impairment are imperative in this case. She submitted that direct harm to patients was caused by a breach of their rights as patient information was not kept private and confidential. In doing so, you failed to protect the dignity and privacy of those patients. She submitted that there was a further risk of harm to patients in that, due to the breach in trust and confidentiality, patients may be unwilling to access health services in the future.

Ms Hartley submitted that the risk of harm increased as you were using a mobile device at home. She submitted that this added a further potential risk of associated breaches of confidentiality and privacy as the records were not accessed in a work environment.

Ms Hartley submitted that a finding of impairment is also required to protect the wider public interest. She submitted that the breaches took place over a long period of time and demonstrate a continuous and repeated disregard for fundamental tenets of the profession.

Ms Hartley submitted that there has been acceptance of you undertaking data protection and data security training between September 2020 and 2021, which would have taken place on at least four different occasions.

Ms Hartley submitted there is a deep-seated attitudinal concern. She submitted that the dishonesty in this case relates to a failure to provide a consistent and meaningful explanation for your misconduct.

[PRIVATE].

Ms Shah submitted that the NMC have not identified a purpose for you accessing the patient records. She submitted that there was no specific reason for you doing this. [PRIVATE].

Ms Shah submitted that you have deeply reflected on your actions and that you have been apologetic. She submitted that you clearly understand the consequences of your actions and accept that you have betrayed the trust of the patients. Ms Shah submitted that you recognise the gravity of your actions and that there is no likelihood of repetition of this conduct.

Ms Shah submitted that you have been honest with the panel today and that you have acknowledged your dishonesty.

The panel 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 *PSA for Health and Social Care v GMC and Uppal* [2015] EWHC 1304.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.5 respect and uphold people's human rights

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to

act as a witness in any hearing that forms part of an investigation, even after you have left the register.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined, in light of its findings above, that your actions, taken together, were serious in that they put patients at risk of harm, were repetitious over a period of a year, and were compounded by your dishonesty. Your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

You accept that you had been scrolling through patient records for over a year and that this resulted in 1214 patient records being accessed. This was a clear breach of confidentiality, and the panel concluded that it put patients at risk of harm in that there was a risk that the patients affected would not be confident in sharing relevant medical information with health services in the future, leading to potential difficulties with their treatment plans.

The panel took account of the fact that prior to your misconduct that you had an unblemished career of some 18 years. The panel also took into account your remorse and apology for your conduct. The panel noted that you have provided a reflective piece [PRIVATE] and how your behaviour impacted patients and colleagues.

However, you remain unclear as to why this misconduct occurred, and what you gained from it, if anything, and without this understanding the panel concluded that your insight is limited.

The panel also took into account that the conduct could not be sufficiently addressed at this stage as you have not been practicing as a registered midwife. The panel concluded that the misconduct in charge 1 is difficult to remediate due to its repetition over a significant period of time, and the misconduct in charges 2 and 3 are difficult to remediate due to its nature.

In those circumstances, the panel concluded that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel considered with care Ms Shah's submission that the regulatory process, together with a finding of misconduct, is sufficient to mark the seriousness of your behaviour, and that a finding of impairment of fitness to practise is not required in the circumstances. However, the panel disagreed with that view in light of the seriousness of the misconduct and the future risk of harm that you would pose to members of the public if permitted to practice unrestricted.

The panel bore in mind 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 decided that your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that

confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel determined that a well-informed member of the public, who was aware of the extent of your insight and remediation, would still be extremely concerned if no finding of impairment was made, in light of the seriousness of your misconduct. The panel concluded that public confidence in the profession, and the NMC as its regulator, would be undermined if a finding of impairment were not made in this case. Accordingly, the panel was satisfied that your fitness to practise is impaired on the ground of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your 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 Hartley submitted that a striking off order was the appropriate sanction in the circumstances.

Ms Hartley submitted that there were five aggravating factors in this case.

Firstly, that you had been trusted to access the patient records and had breached that trust by accessing them without authority or clinical justification.

Secondly, that you had accessed 1214 clinical records without authority or clinical justification over a period of more than one year, which amounted to a pattern of behaviour, and brought with it a high risk of repetition.

Thirdly, that this behaviour had created both harm and a risk of harm to patients, in that confidentiality is a basic requirement which allows for the honest and free flow of information, and in that a failure to maintain confidentiality risks patient harm through the potential that patients may choose to avoid sharing information with health professionals in the future.

Fourthly, your dishonesty amounted to a deliberate breach of your professional duty of candour, in that in the course of an investigation meeting, held on 14 October 2021, you sought to cover up the fact that you had accessed earlier clinical records. Ms Hartley submitted that this dishonesty could not be described as spontaneous or opportunistic, and instead was for personal gain, in the sense that you had been aware for a month prior to the investigation meeting that you were to be questioned, and you made the deliberate decision to cover up your past actions during the meeting. She submitted that this was a deliberate and calculated failure in your duty of candour.

Fifthly, your lack of insight in that you have not provided a consistent or meaningful explanation for your actions. Ms Hartley submitted that the evidence of strengthened practice that you have provided is limited in that the courses you have completed do not add to the knowledge you already have had at the time of your misconduct, with the exception of the 2022 data privacy course, but that course was not healthcare related. She submitted that your disregard for the training on confidentiality that you had received prior to your misconduct amounted to an attitudinal concern.

[PRIVATE]. She submitted that the testimonials you had provided were of little weight as they contained no contact details, and it was unclear from their content whether the writer was aware of the misconduct.

Ms Hartley submitted that a lesser sanction than a striking-off order would be insufficient to address the requirements of public protection and the public interest. She submitted that fundamental questions had been raised about your lack of professionalism through your sustained departure from standards, which was followed by a deliberate failing of candour, which in turn was followed by a lack of insight. She submitted that a suspension order would be insufficient due to a serious lack of insight, the evidence of a deep-seated attitudinal concern and the absence of sufficient strengthened practice.

Ms Shah submitted that a suspension was the appropriate and proportionate sanction in the circumstances.

Ms Shah submitted that you had admitted the allegations and had not sought to provide any reason for being dishonest other than to hide your past misconduct. She submitted that the ability to admit your misconduct was the first [PRIVATE] start to the road to insight.

[PRIVATE].

Ms Shah submitted that the fact that you are unable to piece together the reason why you acted in the way you did does not mean that you are unable to develop insight. She submitted that the only appropriate sanction was a suspension order, and this would give you an opportunity to develop further insight and ensure that your practise is restricted to some extent.

Ms Shah submitted that you have taken the difficult step of accepting the charges and you have been fully honest with your reasonings for being dishonest.

Ms Shah submitted that the mitigating feature in this case include your genuine remorse, your admissions to the allegation, the fact that the dishonesty only occurred on one occasion, and lastly the fact that the misconduct took place in the aftermath of Covid, [PRIVATE].

Ms Shah submitted that you acknowledged and bore responsibility for your misconduct and had explained to the panel your appreciation of how it had harmed patients.

Ms Shah submitted that whilst you had not yet shown full insight, you have demonstrated developing insight and, in those circumstances, it would be inappropriate to impose a striking-off order.

Ms Shah submitted that you were of previous good character and had admitted your dishonesty at the outset of the hearing.

Ms Shah submitted that it had not been your intention to withhold the contact details for your referees, but that you are no longer in contact with them. She submitted that the references should be given weight in the sense that they provide a snapshot of the type of midwife that you are.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Lack of insight into the reasons for your misconduct
- Conduct where patients were at risk of harm
- Lack of sufficient remediation to date
- The nature of the dishonesty, which was premediated in that you knew you had a duty of candour and yet went into the meeting of 14 October 2021, which took place a month after the telephone call with Ms 2, with the intention of covering up earlier incidents when you had accessed numerous clinical records without authority.

The panel also took into account the following mitigating features:

- You have shown remorse and have been apologetic for your actions and their impact
- [PRIVATE]
- Positive testimonials from former midwifery colleagues and your current manager attesting to your general competence and clinical practice
- Unblemished career of 18 years
- No known personal gain from the conduct

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 misconduct was 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:

- *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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining as at the time of the conduct you had completed the mandatory training to know that this pattern of action was a breach of data confidentiality. The panel also considered that this would not address the dishonesty found proved in this case and that there were concerns remaining regarding your ability to be open and honest.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered the dishonesty elements in this case. The panel noted that the nature of the dishonesty was premediated in that you knowingly gave a false account of having accessed patient records when this was explored with you at the investigation interview on 14 October 2021. You had been alerted to this allegation in the telephone call of 15 September 2021 with Ms 2, so you were aware that the matters were under investigation and had a period to consider your response. You knew you had a duty of candour to admit to your actions. Instead, you intentionally sought to cover up the incidents when you knew you had accessed numerous other clinical records without authority or clinical justification prior to 11 September 2021.

The panel considered that these actions created a risk of harm to patients in that concerns about breaches in confidentiality may lead to the withholding of relevant clinical information which could compromise treatment plans and outcomes.

The panel accepted, however, that there was no evidence of any personal gain resulting from your actions and there appeared to be no rationale for you accessing those records. In all regards the panel considered that the behaviour was without any intended purpose. You apologised and accepted the impact of your behaviour on patients and colleagues and on the wider public confidence. [PRIVATE]. The panel also took into account your unblemished career as a midwife and evidence that there had been no other concerns about your practice and your conduct in the past.

Considering all of these factors, the panel concluded that imposing a suspension order would mark the seriousness of your misconduct whilst allowing you the opportunity to develop your insight and provide evidence to reassure a future panel that there is no risk of repetition of this behaviour. The panel considered that a period of suspension would be sufficient to protect patients, maintain public confidence for midwives and uphold professional standards and public confidence in the regulator.

The panel was satisfied that in this case, your misconduct, whilst serious, was not fundamentally incompatible with remaining on the register. Whilst the panel considered that your attitude at the time of misconduct in accessing records was unacceptable, the dishonesty was limited to one issue culminating in the meeting on 14 October 2021 and the panel concluded that there was no deep-seated attitudinal problem in relation to your misconduct as a whole as there was no personal gain or intended purpose identified. The panel balanced the public interest of marking the seriousness of the misconduct with a striking-off order with the effect of denying the public the services of an otherwise competent and experienced midwife.

It did consider a striking-off order but, taking account of all the information before it, including the mitigation provided, the panel concluded that it would be disproportionate. The panel had concluded that there was no personal gain for you as a result of your misconduct, other than concealing your past behaviour. A well-informed member of the public would consider the public confidence in the profession is maintained as a

suspension from the register is a significant and proportionate sanction. A striking-off order is not the only sanction available to the panel.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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:

- Evidence of support systems in place and coping strategies of how you would act in the future [PRIVATE]
- Any further reflection
- Evidence of strengthened practice by working in a healthcare profession in a non-registrant role
- Up to date evidence of your knowledge and application of duty of candour
- Any additional relevant training sessions
- Up to date personal and professional testimonials

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.

Submissions on interim order

The panel took account of the submissions made by Ms Hartley. She submitted that an interim suspension order is necessary for a period of 28 days on the grounds of public protection and in the wider public interest. She submitted that the interim order is necessary to cover any potential period of appeal.

Ms Shah submitted that this is a matter for the panel.

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 to cover any potential period of appeal.

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

This will be confirmed to you in writing.

That concludes this determination.