Neutral Citation Number: [2011] EWHC 927 (Admin)

Case No: CO/6183/2010

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**
**ADMINISTRATIVE COURT**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/04/2011

**Before** :

**THE HONOURABLE MRS JUSTICE COX DBE**

- - - - - - - - - - - - - - - - - - - - -

**Between :**

| | |
|---|---|
| **COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE** | **Appellant** |
| **- and -** | |
| **(1) NURSING AND MIDWIFERY COUNCIL**<br>**(2) PAULA GRANT** | **Respondents** |

- - - - - - - - - - - - - - - - - - - - -

(Transcript of the Handed Down Judgment of
WordWave International Limited
A Merrill Communications Company
190 Fleet Street, London EC4A 2AG
Tel No: 020 7404 1400, Fax No: 020 7831 8838
Official Shorthand Writers to the Court)

- - - - - - - - - - - - - - - - - - - - -

**Robert Jay QC** (instructed by **Baker and McKenzie LLP**) for the **Appellant**
**Melanie McDonald** (instructed by **The Nursing and Midwifery Council**) for the **First Respondent**
**Ijeoma Omambala and Nadia Motraghi (**instructed by **Thompsons, Solicitors)** for the **Second Respondent**

Hearing dates: 11 February 2011

- - - - - - - - - - - - - - - - - - - - -

Judgment
As Approved by the Court

**Mrs Justice Cox :**

1. Pursuant to the provisions of Section 29(4)(b) of the NHS Reform and Health Professions Act 2002, the Appellant, the Council for Healthcare Regulatory Excellence (CHRE), has referred to this Court the decision of a Conduct and Competence Committee (the Committee) of the Nursing and Midwifery Council (NMC), dated 21 April 2010. The Committee's decision was that the Respondent Paula Grant, a registered nurse and midwife, was guilty of misconduct, but that her fitness to practise was not thereby impaired.

2. The CHRE considers that the Committee's decision as to fitness to practise was unduly lenient in this case and therefore appeals against it to this Court. The NMC adopts and supports the CHRE's appeal. Ms Grant (the Registrant) contends that the Committee's decision as to her fitness to practise was a decision which was reasonably open to them, as the specialist disciplinary tribunal considering all the evidence, and is therefore a decision with which this Court should not interfere.

**The Relevant Background**

3. The Registrant became a registered nurse in 1983 and a registered midwife in 1986. She had worked for what is now the Basildon and Thurrock NHS Foundation Trust since 1986 and she became a Sister in 2002.

4. During 2006 and 2007 she was employed at the Basildon University Hospital in Essex as a Midwifery Sister and Audit Lead Midwife.

5. Three separate complaints about her conduct were made to the NMC, by a former Patient, Patient B (on 12 September 2007); by a junior midwife and colleague, Dolly Hewett (on 2 October 2007); and by the NHS Trust then employing her (on 23 November 2007). A full investigation was carried out and it was decided that the allegations required a hearing.

6. The matter was therefore referred to the Committee in November 2007 at which time the NMC, having regard to the seriousness of the charges and to the need for the protection of the public, suspended the Registrant from practice by Interim Order.

7. The fact-finding hearing, in respect of the five charges laid against the Registrant, took place before the Committee between 6 and 10 July 2009. The hearing was then adjourned for final submissions to 1 December 2009 and the Committee gave their decision on 2 December.

8. The charges related to events which extended over a total period of some 20 months. The Registrant put the NMC to proof in relation to all the charges, save for the allegations made in Charge 4(e) and (f), as explained below.

**The Charges**

9. Charge 1 was as follows:

> "While employed as Audit Lead Midwife at the Basildon University Hospital, Essex you:

1. On or around March 5th 2006 failed to provide appropriate assistance and/or support to a junior colleague in that you:

   (a) failed to perform a vaginal examination of Patient A when requested to do so by a midwife still on preceptorship and who was unsure of the baby's presentation.

   (b) Refused a second request by the said junior midwife to perform a vaginal examination on Patient A."

10. In summary it was alleged that, on the relevant date, the Registrant had been asked on two separate occasions by Dolly Hewett, then a junior midwife on preceptorship, to carry out a vaginal examination (VE) on Patient A. Ms Hewett had noted, and been concerned by decelerations on the CTG and she sought assistance from the Registrant, being uncertain as to the correct interpretation of her own VE of this patient. The Registrant attended Patient A, but did not carry out any VE at that point. She subsequently attended on Patient A again, at Ms Hewett's request, and on this occasion she noted the presence of grade 3 meconium liquor. She did not then carry out a VE, but summoned a doctor, who conducted his own examination. The baby was found to be in breech position and an emergency caesarean section was carried out.

11. The Registrant's case in defence was that Ms Hewett had asked her only once to perform a VE. As she approached Patient A she noticed the meconium liquor, which led to her decision to seek obstetric assistance rather than conduct a VE herself.

12. Ms Hewett's nursing notes recorded that at 15:50, at a time when there was no record of any meconium staining, she had asked the Registrant to assess Patient A. The first reference to meconium staining in the notes was at 16:12 and Ms Hewett's evidence was that she had asked the Registrant to assess the patient a second time, shortly before 16:30 by which time, on the Registrant's evidence, the presence of grade 3 meconium was a contra-indication to a VE. The Registrant's case was that Ms Hewett's evidence and the record she had made at the time were wrong.

13. The Committee found Charge 1(a) proved, giving the following reasons:

> "It accepts Midwife Dolly Hewett's evidence that she did request the registrant to assess patient A as she had not understood her findings following a vaginal examination on Patient A. She had conducted that examination because the CTG reading was giving her some concerns and indeed Patient A was wanting to push. The registrant explained that she refused a request to carry out a vaginal examination on Patient A because there was grade 3 meconium liquor, something which warranted a doctor being summoned. The panel does not accept her evidence that that was the case at the time. In fact she only referred to one request from Midwife Hewett to carry out a vaginal examination. The panel find that the request to which she was referring was in fact Midwife Hewett's second request. … Moreover she did not write up

any notes. She therefore advances no explanation for her failure to carry out the examination. The panel do not consider that there was any justification for the registrant failing to perform a vaginal examination on Patient A when it was first requested by Midwife Hewett. The latter was unsure of the presentation. She turned to the senior midwife on duty. Patient A wanted to push. If there was any justification for not assisting her, it behoved the registrant to write it up. In fact she did not. The panel therefore find that there was an obligation on the registrant to carry out a vaginal examination which she failed to discharge. By reason of these matters the panel find that the registrant failed to provide appropriate assistance and/or support to a junior midwife. "

14. Charge 1(b) was found not proved. Although the Committee accepted that the Registrant had refused Ms Hewett's second request, they found on the evidence that the presence of grade 3 meconium meant that the failure to carry out a VE and the decision to summon obstetric help at that stage was justified.

15. Charge 2 was as follows:

> "2. Between March 2006 and February 2007 you subjected a junior colleague to bullying and/or harassment in that you:
>
> (a) On numerous occasions in an unpleasant and/or intimidating manner questioned the junior midwife about the fact that she had reported the matters set out at 1 above, to her preceptorship leader.
>
> (b) On or around October 20th 2006 locked the said junior midwife in a room and questioned her about the statement she had made regarding the incident set out at 1 above, in a threatening and/or aggressive manner."

16. Ms Hewett had reported her concerns about the incident involving Patient A to her preceptorship leader, Sister Ponting, and as a result an internal investigation was carried out. It was alleged that between March 2006 and February 2007 the Registrant had repeatedly questioned Ms Hewett about what she had reported and why, to the extent that Ms Hewett had felt threatened and intimidated by what she regarded as aggressive and bullying behaviour by the Registrant. In October 2006 she alleged that the Registrant had told her to accompany her to a small room, where she had then locked the door, barring her exit and had subjected her to further aggressive questioning about the statement she had made. Such was the effect of all this behaviour upon Ms Hewett that she had eventually asked for the internal investigation to be stopped.

17. The Registrant's case in defence was one of denial. As is clear from the transcript she maintained her position, under sustained cross-examination, that none of these incidents had happened and that any discussions she had with Ms Hewett about the incident involving Patient A had been entirely amicable.

18. The Committee did not believe her, finding Charge 2 proved in its entirety and stating:

> "The Panel find the facts of Charge 2 as particularised in Charge 2 (a) proved. … the panel prefer the evidence of Midwife Hewett concerning this issue rather than that of the registrant. The panel regarded Midwife Hewett as credible about the manner in which the registrant spoke to her. Indeed Midwife Hewett explained that in consequence of this, she changed her shift, she talked to a close friend. And eventually she asked Lynn Cook, the Head of Midwifery and Gynaecology, to abandon the investigation. Those matters are consistent with Midwife Hewett feeling that she was being bullied. It finds that subjectively and objectively the registrant was questioning her in an unpleasant and intimidating manner.
>
> Likewise the panel find the facts of Charge 2 as particularised in Charge 2 (b) proved. The panel prefer the evidence of Midwife Hewett about this. It finds that the registrant did lock her in a room and questioned her about a statement which she claimed to have seen in respect of the incident the subject of Charge 1. It accepts Midwife Hewett's evidence that her manner was threatening and aggressive both subjectively and objectively.
>
> In the light of these findings the panel finds that, between March 2006 and February 2007, the registrant subjected a junior colleague to bullying and harassment."

19. Charge 3 contained the following allegations:

> "3. On or around February 1st 2007, you failed to provide appropriate care to Patient B who had been admitted for the delivery of her baby who had died in utero, in that you:
>
> (a) Spoke to Patient B in a rude and/or insensitive manner.
>
> (b) Asked patient B why she wanted to see a priest.
>
> (c) Failed to explain to patient B that she would be unable to use the SANDS room for the delivery.
>
> (d) Told Patient B and her partner that the birth of a dead baby was as traumatic for the midwife as it was for the parents.
>
> (e) Failed to reassure Patient B properly or at all about the circumstances under which the delivery would take place."

20. Very sadly, Patient B's baby had died in utero at 20 weeks gestation and she was admitted to hospital on 1 February 2007 for delivery to be induced. To begin with she was situated in a delivery room where she could hear other women in labour and newborn babies crying, which she found extremely distressing. After some delay the

Registrant attended. Patient B complained that she had spoken roughly to her and did not properly explain the circumstances in which her delivery would take place. She felt unable to ask her any questions because of her cold and insensitive manner towards her. She had previously been told that she would be able to deliver her baby in a special room away from the general labour ward, but when she asked the Registrant whether she would be moving to another room she was rebuked for making the request. The Registrant did not explain to Patient B that the reason that she could not deliver in the Still Birth and Neonatal Death Charity (SANDS) room was because that room was occupied by another bereaved couple at the time.

21. Patient B then asked the Registrant if she could see a priest, but her response was to ask why she wanted this. When asked by Patient B and her fiancé whether she understood how traumatic this was for them the Registrant had shouted aggressively, whilst banging her hands together at each word, "Look, it is just as hard on the midwife doing the delivery as it is on the parents." This had caused Patient B shock and distress at such an aggressive and uncaring attitude. It had made her afraid to ask the Registrant for help or advice and had significantly increased her unhappiness at what was, in any event, a very sad time.

22. The Registrant denied all the allegations of rudeness and insensitivity and denied that she had questioned Patient B's request to see a priest. She also denied that she had ever said words to the effect that the death of a baby in such circumstances was as traumatic for the midwife as it was for the parents. The only concession she made during cross-examination was that she regretted not spending more time with Patient B, and accepted that she could have used more appropriate language and explained why she could not use the SANDS room.

23. The Committee found Charge 3 proved in its entirety, regarding Patient B as a "completely credible witness" and stating:

> "The registrant herself made some concessions in respect of this charge. She conceded that the ward was busy and that she could have used more appropriate language. She regretted not spending more time with her. She admits that she did not explain to patient B that she would not be able to use the SANDS room for delivery. But in the view of the panel these admissions, and the apologies which she says attended them, did not address the matters identified in the charge. Patient B explained in graphic terms how her experience on the ward would be ingrained in her memory. By contrast some 4 months after the incident the registrant contended that she had no independent recollection of Patient B's labour. That position persisted even when she had sight of the notes. In consequence it was not possible for the internal investigation to come to a conclusion. Nevertheless the registrant gave evidence about this incident before the panel. With that background, the panel found Patient B's evidence much more credible than that of the registrant.
>
> …

By reason of the matters set out in Charge 3 (a) to (e), the panel find that the registrant failed to provide appropriate care to Patient B whose baby had died in utero."

24. Charge 4 made the following allegations:

> "4. On February 11th 2007 you failed properly to supervise and/or record the birth and death of a baby of 20 weeks gestation in that you:
>
> (a) Instructed the junior midwife allocated to the case, to record the delivery as a Termination of Pregnancy, notwithstanding the fact that the mother, Patient C, had gone into spontaneous labour.
>
> (b) Failed to ascertain whether the baby was born alive.
>
> (c) Failed to heed the observation both of the said junior midwife and Patient C and her partner, that the baby had been born alive.
>
> (d) Failed to provide appropriate support to the junior midwife who had not dealt with a similar situation before.
>
> (e) Altered the funeral form to show that the baby's time of death was the same as the time of birth.
>
> (f) Removed the entry from the Live Births register and entered it instead on the Non-Viable Register."

25. On 11 February Ms Hewett was attending Patient C, who gave birth to a baby of 20 weeks gestation. Syntocinon had been administered to augment labour because Patient C was suffering from an infection and suspected chorioamniotisis. After the baby was delivered the Registrant instructed Ms Hewett to record the delivery on the Perinatal Loss Check List as a termination of pregnancy.

26. Further, when the baby was delivered Ms Hewett had indicated quietly to the Registrant that the baby had moved its arms and legs, but the Registrant told her to put the baby into a kidney dish. The Registrant left the room approximately 5 minutes after delivery and did not check the baby's heart and respiration rates, despite the observations of Ms Hewett, Patient C and her partner to the effect that the baby was moving. Ms Hewett had stayed with Patient C for 29 minutes after delivery. During that time she noticed that the baby was moving and, whilst Patient C and her partner were holding the baby, they too observed movement and nasal flaring. Once the placenta had been delivered Ms Hewett left the room, returning a few minutes later, at which time she said she saw that the baby was no longer moving. Ms Hewett therefore recorded the time of birth as 18:36 and the time of death as 19:15. However, the Registrant subsequently changed the time of death on the funeral form to 18:36. She also removed the entry from the Live Births register and entered the details re this baby on the Non-Viable register.

27. The Registrant's case in relation to Charge 4, paragraphs (a) to (d) was that, for the period of 5 to 10 minutes for which she stated that she was present in the room, she had not witnessed any signs of life in this baby. This was also her explanation for altering the funeral form and entering the birth on the Non-Viable register (charges (e) and (f)), which she admitted. She denied telling Ms Hewett to place the baby in a kidney dish. During cross-examination, whilst denying that Ms Hewett had pointed out to her that the baby's arms and legs were moving, she also said, somewhat inconsistently, that she had told her that this was just a reflex action. In her evidence she also referred to this having just been a reaction, by the baby, to being expelled rapidly from the uterus.

28. The Committee found the entirety of the disputed facts proved in relation to Charge 4, preferring the evidence of Ms Hewett wherever it was inconsistent with the Registrant's account, and finding that the Registrant had only observed this baby for some 5 minutes, stating:

> "It may be that the registrant anticipated that the baby would not be born alive, but it was not good enough to assume that the baby would be born dead. She did not check for heart rate or respiratory rate, although she asserted that there [were] no such rates. There was no explanation for the movement other than that the baby was born alive. The registrant's explanation for movement after birth, namely that it was a consequence of the baby being expelled quickly, could not have endured for as long as 40 minutes, or even for the duration of the period when she was present. In consequence she failed to ascertain whether the baby was born alive."

29. In finding Charge 4(d) proved, the Committee stated:

> "Midwife Hewett was a junior member of staff. The registrant acknowledges that she was asked to provide Midwife Hewett with support. Yet she left her to cope with a situation where the baby was moving but certain to die shortly thereafter. She instructed her to complete the Perinatal Loss Check List inaccurately. She changed the date on the funeral form. Lynn Cook asserted that she had not provided adequate support. The panel accept that."

30. Charge 5 alleged that:

> "5. Between June 2007 and November 2007 you failed to comply with the academic requirements of the period of supervised practice you were required to undertake."

31. This arose because, following the events which were the subject of Charge 4, the Trust required the Registrant to undertake a period of supervised practice, comprising both clinical and academic elements, between June and November 2007. The Registrant passed the clinical element of the supervised practice, but issues had arisen regarding her timely completion of three pieces of academic work. It was alleged that, despite extensions of time, she did not submit the completed academic work within the deadline and as a result did not complete her period of supervised practice.

32. The Registrant denied this Charge and, on the evidence, the Committee found that they were left in some doubt as to what the Registrant's obligation actually was and where fault lay for the fact that the academic work submitted did not reach the academic supervisor. This Charge was therefore found not to have been proved.

**Misconduct and Impairment of Fitness to Practise**

33. At the conclusion of the fact-finding decision the hearing was adjourned part heard, yet again, to 19 April 2010. On that date the Committee turned to consider whether, in light of their findings of fact, the Registrant's fitness to practise was as at that date impaired by reason of misconduct.

34. At this hearing the Registrant gave further evidence to the Committee. In her evidence in chief she referred to the period of her supervised practice and also to a number of courses that she had attended. It appears that these courses had started in June 2009.

35. At one point, in answer to questions from her counsel Ms Motraghi, she responded as follows:

> MS MOTRAGHI "....So taking those matters that we have gone through, your supervised practice, the academic and practical parts, and the fact you have been on the counselling course and other courses that you have attended, if you are given the opportunity to return to practice, how do you feel you would act differently and do you feel you would meet the standards of a safe practitioner?
>
> A. I would meet the standards of a safe practitioner because I have had time to reflect and I have reflected and I have taken steps to improve upon my practice. I mean I am ashamed and very sorry for what took place.....
>
> A. .....I have worked very hard and I have reflected. I have gained insight. (Registrant distressed). The safety of midwifery has always been paramount to me.
>
> Q. I am sorry, I did not hear that.
> A. The safety of midwifery has always been paramount in my mind. I have never been an unsafe practitioner.
>
> Q. MS MOTRAGHI: How do you feel you would be able to better relate to patients and members of their families and your other colleagues?
> A. I will better relate because, as I say, the communication and counselling course has helped and I will apply that to my practice.
>
> Q. And how did supervised practice in itself assist you?
> A. Supervised practice made me reflect because that is the whole idea of supervised practice; you reflect on your actions, and I did. I was not given the opportunity to prove what I learnt in supervised practice because I was suspended from practice on 9 November so I was not

given the opportunity. I was looking forward to being given that, but, saying that, you know, I did not work and I am taking the initiative to do the counselling course to enhance the whole communication issue."

36. The Registrant was closely cross-examined by counsel for the NMC, Ms Baljit, who sought to test her assertion that she had truly reflected on her conduct, had gained insight and had been effectively rehabilitated. On several occasions it was suggested to the Registrant that her reflection was in fact limited to an acceptance of the Committee's findings of fact, as to which she had little choice, and that she had no genuine insight into her conduct, or remorse for what she had done.

37. I have read the transcripts of the evidence in their entirety, but the following passages, during the Registrant's cross-examination, are in my view of particular significance in this case.

"[Re Charge 1]
Q. Were you acting in good faith, Ms Grant, when you failed to comply with a request of a junior midwife?
A. I would not say that I failed to comply with a request. As I said, the situation at the time – this was 2007 – and at the time I did not perform the VE, and I apologise for that. I have reflected on this and it is something I would not do again. There is nothing else, you know, I could have done --- Sorry, on reflection now I should have done the vaginal examination and I am sorry. At the time the situation that was going on with everything else I didn't perform the VE and I hold my hand up to that and I was wrong."

…

"Q. You accept that with regard to charge 1(a) and with regard to charge 2 that before the NMC you disputed these allegations. Is that right?
A. Well, I wrote statements about it, yes.

Q. You disputed the allegations, the subject matter of charge 1(a) and charge 2, you didn't accept them when you came before the Conduct and Competence Committee of the Nursing and Midwifery Council; do you accept that?
A. Well, I gave evidence to the situation at the time, yes, but, you know, I have been proven and I just want to accept what has been said and what has been proven. I will accept that. That is the case and I can only move forward.

Q. Do you accept that your reflection is based upon the facts having been found proved?
A. My reflection is based on myself, the whole me, just to relook at myself completely. This is my reflection. On everything else that I have done in the past."

…

"[Re Charge 3]
Q. … you said that you were in a hurry and you were in a rush at the time.
A. Well, I had other patients.

Q. How does that justify speaking to a patient in a rude and insensitive manner?
A. At the time I did not feel that I was rude but I accept that is the decision that I was rude and I will apologise and I will not be rude to patients that I look after in this sort of situation. I did not on that day set out to be rude to Patient B. It was not my intention to go into Patient B and to be rude. I was perceived to be rude and I accept that I am sorry the way Patient B felt and the upset it caused her. And I apologise and I will endeavour not be rude again.

Q. You said that you accept it now. Do you accept that your conduct was in the way described by charge 3 because the Panel found charge 3 proved?
A. I accept that the standard that was expected of me was not right, it was not high. I had failings on the day and I accept that and want to improve. I want to improve it.

Q. And the reason why you accept that is because it was found proved? (After a short pause) You can agree or disagree, Ms Grant.
A. Well, I will agree."

…

"[Re Charge 4]
Q. You did not act upon the concerns of the junior midwife when she said that the baby was moving. That's correct, is it not?
A. Yes, I agree with that, yes.

Q. You assumed that the baby would be born dead, didn't you?
A. (After a short pause) I acted on what I saw at the time.

Q. Having observed what you say you observed and being told thereafter that the baby had moved, because you had assumed that the baby would be born dead, you disregarded that information, didn't you?
A. Again I acted on what I saw at the time."

…

"Q. And again your reflections are based upon the fact that the Panel found charge 4 proved?
A. Well, I would say my reflection is on everything, on my entire midwifery practice. All these things are included but I reassessed, I re-evaluated, I re-looked and saw how what I did, you know, why I did it.

Because this is all done in my reflection when I did my communication and record keeping and I went over the whole thing and, you know, I looked at it all, and it was wrong and, you know, I have moved on. I have, you know. I have done quite a lot of things that will prevent this from happening again."

38. Cross-examined a little later on about the account the Registrant had written in November 2007, about Charge 4 and the movement of the baby after delivery, which she had described in her evidence in chief as a "reflective account", Ms Baljit put to her the following:

> "Q. You stated: 'However, some involuntary movements, perhaps due to the spinal reflex, were interpreted by the midwife and parents as indicating a live birth.' That was your assessment after ten months of reflection. Is that correct?
> A. I mean, this is the description of the incident, so I'm writing about the incident. Reflection covers a whole thing. The reflection is really going to go ahead from the evaluation, the analysis – it's the whole – I was describing the incident here.
>
> Q. We will go on to that in due course. The question I am asking is simply your opinion at that paragraph: 'However, some involuntary movements, perhaps due to the spinal reflex, were interpreted by the midwife and the parents as indicating a live birth.' Is that your opinion ten months after the incident?
> A. That's written down here, so I would just have to accept yes. It is in 2007, yes.
>
> Q. Based upon your reflection, subsequent to that, at the hearing in July of last year, that was also your opinion of the incident. Was it not?
> A. I'm sorry, can you say that again?
>
> Q. When you gave evidence in July of last year, your evidence to the Panel, when you denied the charge, was that there was not any movement and that any movement was due to the rate of expulsion of the baby. Do you recall that?
> A. Yes, I do recall that – I recall saying that, yes.
>
> Q. You accept today that the Panel found that that could not have been the case.
> A. Yes."

39. The Registrant was also cross-examined about some further concerns that had been expressed about her by others, during the period of her supervised practice, which were documented and marked as "exhibit 8".

40. These were, firstly, a complaint from a patient on the labour ward, on 16 August 2007, about the Registrant being "very abrupt" with her. The Registrant agreed that

this incident had occurred after concerns about her manner with patients had been brought to her attention and some two months into her period of supervised practice. In response she referred to having "written a statement" about it and added:

> "...but in looking at this, this was in August and my communication and recording carried on in September and October and was improved."

41. Secondly, the Registrant was referred to an email sent by Dr Ghoorun, staff training and development manager, following his visit to Basildon Maternity Unit on 16 August 2007, in which he said:

> "Paula Grant I found to be rude with an air of arrogance. Two incidents of note were Paula speaking to another member of staff when her manner was very abrupt and a rude comment overheard 'Well, you'll just have to wait there'. Further to that when I enquired about seeing a patient a member of staff was going to take me to see her when Paula interrupted sharply saying patient was not ready and would have to wait outside. It left me feeling quite belittled. I was surprised at Paula's attitude knowing she has attended in-house workshops within the Education Centre, on two occasions she has been a participant on the communications course, one of these sessions being a one-to-one session."

42. Once again, when questioned about this, the Registrant referred to having written a statement about it. The Chairperson of the Committee asked her "Was that a statement accepting that behaviour?" The Registrant replied:

> "A. No, it was not, it was not accepting the behaviour. I can't exactly --- I responded to what was written on here and I can't remember the exact words that I wrote. I think I wrote what was happening at the time. I do not have this statement here."

43. The third incident, on 24 August 2007, involved a patient refusing to return to the labour ward from the X-ray department because "she would rather go home than be looked after by 'that' midwife again" (a reference to the Registrant). Once again the Registrant's response, when questioned about it, was merely to refer to having written a statement about it.

44. The final matter concerned an email from Patient D's mother-in-law, complaining about the Registrant's "unprofessional" behaviour on 15 August 2007, when she made a personal and rude comment about the names chosen for her daughter-in-law's twins and said that they would be bullied at school as a result.

45. The Registrant's response, when questioned about this, was that she was not the midwife allocated to Patient D, that there had just been general conversation in which "everyone joined in", and that she had written a statement about it.

46. When she was re-examined the Registrant pointed out that no disciplinary action was taken against her in respect of any of these incidents. The NMC applied for permission to adduce evidence to explain why that was, but the Committee refused that application. The matter was therefore left there.

47. Towards the end of her cross-examination the Registrant was questioned as follows:

> "Q. You were asked a question by your counsel. Ms Motraghi asked you: 'How confident are you regarding interacting with patients and colleagues?' Your response (and this is just from my note) was that you worked hard and reflected and gained insight into the – and the safety of midwives has always been paramount. 'I've never been an unsafe practitioner.' Do you recall saying that?
> A. Until this incident I've never had my practice, you know, to say 'You're unsafe', because if you are unsafe you would be coming up to the NMC; you are not safe to practise. This is the first time that this has come to light and has got to this stage.
>
> Q. Do you accept that during these incidents you were an unsafe practitioner?
> A. (After a short pause) I would have to disagree with I was unsafe. (After a short pause) And the reason that I would disagree is because I called the doctor when the doctor was needed, because there was a high risk lady who became high risk with meconium stains, so as a safe practitioner that is what is expected, that it was the norm, undeviated, and if you're safe you will just carry on, you won't involve the doctor, and with the funeral form I did went to a doctor. I did seek advice of a medical doctor and I did seek advice from a senior colleague. So that's not unsafe …"

48. The various courses undertaken by the Registrant had started only in June 2009, shortly before the fact-finding hearing was due to begin. Curiously, she was not asked any questions, either in chief or in cross-examination, about what had happened between the end of her period of supervised practice in November 2007 and the first course she had taken in June 2009. A member of the Committee then asked her about this, as follows:

> "Q. Can you tell us what you did between October 2007 and June 2009?
> A. I was gravely ill.
>
> Q. THE CHAIRMAN: You were what? I did not hear.
> A. I was gravely ill. I had bilateral pulmonary embolism with deep vein thrombosis.
>
> Q. Thank you very much. I did not hear you.
> A. I nearly died."

49. For reasons which are unclear no-one asked the Registrant any further questions about this evidence as to her illness, and I am told that there was no medical evidence relating to this before the Committee.

50. The Registrant called evidence in support from two senior colleagues, Sylvia Williams and Ladoze Dowuona, who both described the Registrant as a dedicated and competent midwife, for whom there were no problems whatsoever with her clinical practice. They both declared themselves satisfied with the progress she had made during the period of her supervised practice.

51. Following submissions from both counsel the Committee's decision was as follows:

> "**Reasons for the finding of impairment:**
> The panel finds that the matters proved against the registrant amount to misconduct.
> In respect of Charge 1, by failing to perform a vaginal examination on patient A when requested to do so by a midwife on preceptorship, the registrant failed to co-operate with another health care professional and failed to facilitate her to develop her competence.
>
> In respect of Charge 2, the registrant subjected a junior colleague to bullying and harassment on 4 occasions over a significant period of time. Thereby she did not treat her fairly. She did not treat her respectfully and with consideration. By her intimidating behaviour she did not uphold the reputation of the profession.
>
> In respect of Charge 3 the registrant failed to treat Patient B with sufficient respect. Patient B had been admitted for the delivery of her baby who had died in utero. Yet the registrant spoke to her insensitively and treated her arrogantly. She did not fully consider Patient B's distress or act in a manner consistent with a professional midwife. Thereby she did not uphold the reputation of the profession of midwifery, nor did she justify the trust and confidence the public had a right to have in her.
>
> In respect of Charge 4, the registrant overrode a junior midwife by not accepting her observation that Patient C's baby was showing signs of life, notwithstanding that she, the registrant, did not stay with patient C, nor did she examine the baby. She assumed that the baby was born dead. The registrant changed the records inappropriately and in a way which might have meant that Patient C and her partner were no longer able to have the funeral which they had chosen. In fact the baby had died after birth following spontaneous labour. The registrant should not have altered the funeral form to show the baby's time of death as the same as the time of birth. She removed the entry from the live birth register to the non-viable register. Further she failed to provide sufficient support for the junior midwife. By acting as she did, she failed to discharge her duty of care to Patient C. She failed to respect the skill, expertise and contribution of the junior midwife, who was in fact right in respect of her assessment. She made entries in the heath

care record which were inaccurate. She failed to justify the trust and confidence the public had a right to have in her.

Therefore the panel has considered whether by reason of the misconduct, the registrant's fitness to practise is impaired. The panel has addressed this question on the basis of Mr Justice Silber's 3 fold test referred to in the case of Cohen, namely:

Is the conduct of the registrant remediable; Has it been remedied; Is it highly unlikely to reoccur.

When considering this, the panel has taken into account the following matters:

1. by October 2007 the clinical facilitators (Supervisors of Midwives) who had been appointed by the Trust to consider the registrant's clinical practice in respect of a range of matters, in particular communication and record keeping, were satisfied that she was a competent midwife. This was reflected in the Notes of the Meeting between Joy Kirby, (the LSA Midwifery Officer), Lynne Cooke (Head of Midwifery), Colleen Beg (Deputy Head of Midwifery) and Gillian Ottley (Ward Manager) dated 24th October 2007 which was based on feedback from clinical facilitators, the assessment documentation and women.

2. It was the academic element of the supervised practice which the registrant did not pass. However, that was only because it was alleged that she had not submitted her work in time. In fact the panel found that allegation (which was the gravamen of Charge 5) not proved. As to the quality of her work, the academic supervisor Trudy Stevens, senior lecturer in midwifery, effectively indicated that she was satisfied with this element in an e-mail dated 2nd November 2007.

3. It is right to observe that in August 2007 there were 4 criticisms of the registrant's practice, which formed the subject of Exhibit 8. Those criticisms related to the registrant's manner towards certain patients and a member of staff. It is fair to say that the panel found the material in respect of these criticisms unsatisfactory. Only one of the criticisms was brought to the attention of one of those supervising Sister Grant, and then only because she herself was involved in the matter. No action was taken in respect of these criticisms of the registrant, notwithstanding that the Trust was aware of them. Moreover there is this point. Even if the matters betrayed unsatisfactory practice in August 2007 on the part of the registrant, that was at a time when the registrant was really on the threshold of addressing the shortcomings in her practice. One of her supervisors, from whom the panel heard evidence, acknowledged that the registrant had found it difficult to come to terms with the criticisms which had been made of her at the outset of her period of supervision in June 2007. By October 2007 she said that she

had thoroughly come to terms with her failings and had addressed them. August 2007 may be said to have been at a relatively early stage in the process of the registrant's journey of self awareness.

4. On 24th June 2009 and 14th January 2010 the registrant accessed a Supervisor of Midwives outside her NHS Trust to enable her to keep her practice up to date. The first of these occurred before such time as any evidence had been heard.

5. From June 2009 the registrant has embarked on a range of courses including:

   a. Maternity and gynaecological training on 22nd June 2009;

   b. A 2 day course starting on 30th September 2009 on maternity and newborn care;

   c. A communication skills course on 6th March 2010;

   d. On 20th March 2010 a course called HIV, a Midwife's Dilemma.

6. She joined the Stillbirth and Neo natal Death Charity (SANDS) in December 2009.

7. Significantly the registrant embarked upon a year's Diploma Course with the Counselling and Psychotherapy Central Awarding Body in September 2009. She paid for this course herself. Her practice had been suspended by the NMC in November 2007. Therefore a course on communicating with others within the nursing and midwifery profession was not available to her. The course upon which she did embark includes a significant element in relation to communicating empathic understanding. The registrant explained that this was a most important matter in enabling her to reflect upon her ability to deal with others, i.e. her interpersonal skills. It addressed the very matters which were lacking in her attitude in her practice.

It was urged upon the panel by Miss Baljit that the registrant did not admit the Charges in July 2009 when the case was first listed. That is right, although the panel observe that the registrant did make a number of concessions when giving her evidence on the facts of the case. Miss Baljit's point would be a good one if there was nothing to suggest that the registrant's attitude to these matters in April 2010 has changed since July 2009. The panel accept that it has changed. Indeed the panel discerned something of a profound difference in the registrant's demeanour and manner of giving evidence in April 2010 as opposed to July 2009. It was interesting that one of the witnesses whom she called, Sister Williams, a Band 7 Senior Midwife and Supervisor of

Midwives, indicated that it was the Counselling and Communication Course which has made a significant difference to the registrant's attitude and practice. The panel accept that.

The panel does not underestimate the seriousness of the allegations which it has found proved against the registrant. The misconduct of the registrant revealed her at that time as someone who was behaving arrogantly and impatiently with junior members of staff and patients.

The panel consider that she has addressed this unfortunate poor performance. If it did not, the panel would have had no hesitation in finding the registrant's fitness to practise to be impaired today. It may be observed that the registrant took no steps to address deficiencies in her practice between about November 2007 and about June 2009. In part this is attributable to the Interim Suspension Order imposed in November 2007 which deprived her of much opportunity. It is to her credit that the registrant ultimately sought ways of getting round that. But the main reason for her inactively (*sic*) throughout most of this period was because the registrant was seriously unwell.

The panel is confident in the registrant. It accepts the observations of Sister Williams and Sister Dowuona that the registrant is a competent midwife. The mere fact that the registrant has been out of practice since November 2007 is immaterial. Indeed the registrant has had sufficient hours of practice within the period of the last 3 years to meet the NMC's requirements of a practising midwife as set out in the Post registrant Education and Practice (PREP) handbook. Quite why she behaved in the way she did in the period March 2006 to February 2007, the panel cannot say. But it does accept that the consequences of her behaviour represented a profound wake up call to the registrant. The panel does not find that the registrant's fitness to practise is impaired. The behaviour of the registrant was remediable. It has been remedied. The panel consider that it is most unlikely that the registrant will commit misconduct again."

**The Legal Framework**

**References by the CHRE**

52. The principles which govern this appellate jurisdiction are now well established and there is no dispute about them before me.

53. Section 29 provides, so far as is material, as follows, the reference to "relevant court" being a reference to this Court.

> "(4) If the Council considers that –
>
> (a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both, or

(b) a relevant decision falling within subsection (2) should not have been made,

and that it would be desirable for the protection of members of the public for the Council to take action under this section, the Council may refer the case to the relevant court.

…

"(8) The court may-

(a) dismiss the appeal,

(b) allow the appeal and quash the relevant decision,

(c) substitute for the relevant decision any other decision which could have been made by the committee or other person concerned, or

(d) remit the case to the committee or other person concerned to dispose of the case in accordance with the directions of the court, and make such order as to costs... as it thinks fit."

54. The authorities establish that Section 29(4) is sufficiently broad to include both unduly lenient findings of fact and unduly lenient sanctions; see in particular **Council for the Regulation of Healthcare Professionals v. General Medical Council and Basiouny** [2005] EWHC 68 (Admin). It appears that there is, as yet, no decided case concerning an unduly lenient failure to find impairment of fitness to practise; but all counsel accept, and I agree, that by parity of reasoning Section 29(4) will apply to undue leniency in that respect in addition.

55. Similarly I consider that the test to be applied in determining whether there has been undue leniency in a case such as the present will be that which has been held to apply in those cases concerning undue leniency in relation to factual findings or sanctions.

56. The leading case in this area is now **Council for the Regulation of Healthcare Professionals v. General Medical Council and Ruscillo** [2005] 1 WLR 717, where the Court of Appeal considered in detail the relevant statutory framework and the purpose behind implementation of the NHS Reform and Health Professions Act 2002.

57. Lord Phillips MR, giving the judgment of the Court, stated as follows at paragraphs 73 and 77:

"**73** What are the criteria to be applied by the court when deciding whether a relevant decision was 'wrong'? The task of the disciplinary tribunal is to consider whether the relevant facts demonstrate that the practitioner has been guilty of the defined professional misconduct that gives rise to the right or duty to impose a penalty and, where they do, to impose the penalty that is appropriate, having regard to the safety of the public and the reputation of the profession. The role of the court when a case is referred is to consider whether the disciplinary tribunal has properly performed that task so as to reach a correct decision as to the imposition of a penalty. Is that any different from

> the role of the council in considering whether a relevant decision has been 'unduly lenient'? We do not consider that it is. The test of undue leniency in this context must we think, involve considering whether, having regard to the material facts, the decision reached has due regard for the safety of the public and the reputation of the profession.
>
> …
>
> **77** … In any particular case under section 29 the issue is likely to be whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and-the interests of the public."

58. In **Basiouny** Richards J used the phrase "manifestly wrong", but in my view this is essentially the same test.

59. The appeal before this Court therefore involves a review of the merits of the decision. In this case, the question is whether the Committee arrived at a decision as to impairment of the Registrant's fitness to practise which was manifestly inappropriate, having regard to her proven misconduct and the interests of the public. Both Mr Jay QC, on behalf of the CHRE, and Ms McDonald, appearing for the NMC, rightly emphasise the importance of the interests of the public in this analysis. I agree that it has particular significance when considering regulatory decisions concerning medical or nursing practitioners, which will inevitably engage issues of real public interest.

60. In answering that question it is important to acknowledge the expertise of the decision-making body below, and to recognise that the judgment being exercised by this Court is "distinctly and firmly a secondary judgment" (per Laws LJ in **Raschid and Fatnani v. General Medical Council** [2007] 1WLR 1460).

61. At paragraph 78 in **Ruscillo** Lord Phillips said this:

> "**78** The question was raised in argument as to the extent to which the council and the court should defer to the expertise of the disciplinary tribunal. That expertise is one of the most cogent arguments for self-regulation. At the same time, Part 2 of the Act has been introduced because of concern as to the reliability of self-regulation. Where all material evidence has been placed before the disciplinary tribunal and it has given due consideration to the relevant factors, the council and the court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. "

62. Courts considering challenges to decisions of this kind will therefore acknowledge the deference due to the specialist tribunal seized with the task of determining the nature or gravity of the misconduct, and the extent to which it is likely to undermine public confidence in the profession.

63. Cases in this jurisdiction are, however, particularly fact-sensitive. The degree of deference is likely to be higher where issues of technical competence or clinical practice arise, in assessing how best the needs of the public and of the profession should be protected. It is likely to be lower, where the case concerns behavioural issues such as dishonesty or sexual misconduct; see for example the observations to this effect in **The Council for the Regulation of Health Care Professionals v General Dental Council and Fleischmann** [2005] EWHC 87 (Admin).

**The Statutory Scheme for Misconduct by Nurses and Midwives**

64. This Scheme is set out in the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 [2004 SI No. 1761] and in particular Rule 24, which provides for staged hearings addressing the factual findings, impairment of fitness to practise and finally, as appropriate, sanctions.

65. The term "impairment of fitness to practise" has not been defined in these rules, and this is also the position in relation to those schemes which apply to other, medical practitioners. Thus, as Dame Janet Smith pointed out in her Fifth Report from **The Shipman Enquiry** (9 December 2004), the concept has the advantage of flexibility, being capable of embracing a multiplicity of problems, but also the disadvantages that flow from a lack of clarity and definition. Further, recognising impaired fitness to practise inevitably involves making a value judgment (see paragraphs 25.42 et seq).

66. Judicial guidance as to how the issue of impairment of fitness to practise should be approached now appears in a number of authorities. The Committee in this case were referred to the decision of Silber J in **R (on the Application of Cohen) v. General Medical Council** [2008] EWHC 581 (Admin), and that of Mitting J, more recently, in **Nicholas-Pillai v. General Medical Council** [2009] EWHC 1048 (Admin).

67. In **Cohen** Silber J was concerned with serious professional failings by a consultant anaesthetist, on an isolated occasion, in relation to a patient undergoing major surgery. There was little dispute as to the facts, most of which appear to have been admitted.

68. Against that background the judge said as follows, in relation to impairment of fitness to practise:

> "**[62]** Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the'(*sic*). In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed: s 35D of the Act.

> **[63]** I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired.
>
> **[64]** There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet (sic) exercise whether the practitioner's fitness to practise has been impaired. Indeed s 35D(3) of the Act states that where the Panel finds that the practitioner's fitness to practise is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance'.
>
> **[65]** Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the Appellant were '*easily remediable*'. I concluded that they did not consider it relevant at [that] stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so."

69. It is clear, notwithstanding the references in those passages to whether fitness to practise "has been" impaired, that the question is always whether it is impaired as at the date of the hearing, looking forward in the manner indicated by Silber J in his judgment. The question for this Committee as at 21 April 2010 was therefore "is this Registrant's current fitness to practise impaired?"

70. An assessment of current fitness to practise will nevertheless involve consideration of past misconduct and of any steps taken subsequently by the practitioner to remedy it. Silber J recognised this when referring, at paragraph 65, to the necessity to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

71. However it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

72. This need to have regard to the wider public interest in determining questions of impairment of fitness to practise was also referred to by Goldring J in **R (on the Application of Harry) v. General Medical Council** [2006] EWHC 3050 (Admin) and by Mitting J in **Nicholas-Pillai**, where he held that the Panel were entitled to take

into account the fact that the practitioner had contested critical allegations of dishonest note-keeping, observing that:

> "[19] In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him."

73. Sales J also referred to the importance of the wider public interest in assessing fitness to practise in **Yeong v. GMC** [2009] EWHC 1923 (Admin), a case involving a doctor's sexual relationship with a patient. Pointing out that **Cohen** was concerned with misconduct by a doctor in the form of clinical errors and incompetence, where the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently impaired, Sales J considered that the facts of **Yeong** merited a different approach. He upheld the submission of counsel for the GMC that:

> "… Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence."

74. I agree with that analysis and would add this. 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.

75. I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment.

76. I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from **Shipman**, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> "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."

The value of this test, in my view, is threefold: it identifies the various types of activity which will arise for consideration in any case where fitness to practise is in issue; it requires an examination of both the past and the future; and it distils and reflects, for ease of application, the principles of interpretation which appear in the authorities. It is, as it seems to me, entirely consistent with the judicial guidance to which I have already referred, but is concisely expressed in a way which is readily accessible and readily applicable by all panels called upon to determine this question.

**The Appeal**

77. On behalf of the CHRE Mr Jay advances two main grounds of appeal. The first ground is that the Committee erred in misinterpreting the decision in **Cohen** as advocating a "legal test" for determining impairment of fitness to practise, rather than identifying relevant factors to be taken into account, as appropriate, on the particular facts of each case; and that they erred in failing to direct themselves to the need to have regard to public interest considerations when deciding that issue. He further submits that it is clear from their reasons that they did not in fact have regard to those wider considerations in arriving at their conclusion.

78. Adopting this submission on behalf of the NMC Ms McDonald submits that, on the particular facts of this case, the Committee's failure to have regard to the nature of the Registrant's misconduct and how it might impact on wider public interest considerations was a fundamental error. The misconduct found in this case was both serious and prolonged; and the Committee fell into error in approaching it on the basis of a narrow three-stage "test", without reference to those wider considerations.

79. Ms Omambala for the Registrant submits that these criticisms are misplaced. The Committee were entitled to have regard to the relevant factors identified in **Cohen** and could not fairly be said to have ignored the public interest element. The Committee's decision should not be read in the same way as the judgment of a court. It is clear from the transcript that the need to have regard to the wider public interest was properly placed before them, and this Court can be confident that it was at the forefront of their considerations.

80. The second ground of appeal advanced, and the one upon which Mr Jay primarily focussed his submissions, is that the Committee's decision on fitness to practise was, on all the evidence in this case, clearly wrong. The misconduct in this case was not an isolated lapse of professional standards, immediately recognised and admitted. On the contrary, there were prolonged and serious failings by this Registrant over an extended period of time. Further, the allegations were strongly denied by her at the fact-finding stage, where her evidence was rejected as incredible. As such, her conduct was not easily remediable, and the Committee erred in concluding on the evidence before them that her fitness to practise was not impaired. On analysis, the reasons they gave for that conclusion are unsustainable. The Committee's decision was therefore unduly lenient.

81. Ms McDonald adopts and supports these submissions on behalf of the NMC.

82. Ms Omambala submits that deference is due to this Committee, who clearly observed a "profound change" in the Registrant, over the course of a lengthy hearing with a number of adjournments. They were in the best possible position to assess both that change and her current level of fitness to practise. The evidence before them included evidence from the Registrant herself as to her efforts at rehabilitation, through appropriate courses; and from senior midwives who expressed confidence in her abilities and level of insight. The Committee were entitled to find as they did on the evidence and their conclusion as to the Registrant's fitness to practise should not be disturbed.

**Discussion and Conclusions**

83. Reading the transcript it is correct, first, that at the close of all the evidence and at the very start of her submissions, Ms Baljit for the NMC reminded the Committee of their duty "… to protect the public from harm, to uphold public confidence in the profession and also to uphold public confidence in the regulatory function of the NMC." She then turned to the issue of misconduct, which she addressed in some detail by reference to the facts found proved.

84. Turning to impairment of fitness to practise, she reminded the Committee of the need to look forward, not back, and of the relevance of past conduct in assessing current fitness to practise. Directing the Committee to the "three questions" formulated by Silber J in **Cohen** she addressed each question in turn in some detail, submitting that the Registrant's misconduct demonstrated fundamental flaws in her behaviour, which were difficult to remedy and which the evidence did not show her to have remedied or to be unlikely to repeat. She did not refer again at any point, in her submissions on fitness to practise, to the importance of wider public interest considerations in considering that issue.

85. In her submissions on behalf of the Registrant Ms Motraghi described the "legal test" in **Cohen** as "the appropriate test to be employed". Conceding that if the Registrant had taken no steps and showed no insight or remorse, it would be difficult to conclude that her fitness to practise was not impaired, Ms Motraghi then addressed the facts of the case, in submitting that they should not come to that conclusion. She did not make any further submissions on the law.

86. The Legal Assessor then advised the Committee. When addressing misconduct the Assessor too advised the Committee, correctly, that "Misconduct is conduct falling seriously short of what the public has a right to expect from a registrant nurse or midwife; hence, I say it is based upon your own expertise."

87. However, in advising the Committee on the approach to impairment of fitness to practise, whilst emphasising that the question was whether fitness to practise was impaired "as of today" I note that the Assessor also referred to "the three-fold test" in **Cohen** which was "accepted to be the appropriate test to apply".

88. There was then some additional discussion, during which further reference was made by counsel to the correct approach when "applying the test set out in **Cohen**"; at which point the Legal Assessor then referred once again to the "three-fold test" in that case.

89. Against that background it is perhaps unsurprising that, when considering impairment of fitness to practise, the Committee said that they had addressed this question "on the basis of Mr Justice Silber's 3-fold test referred to in the case of **Cohen**, namely: is the conduct of the registrant remediable; has it been remedied; is it highly unlikely to reoccur."

90. Nowhere in their reasons for this decision do the Committee refer to the importance of wider public interest considerations. Nowhere do they refer to the need for substantial weight to be given to the protection of the public, the maintenance of public confidence in the profession, and the upholding of proper standards of conduct and behaviour.

91. There is therefore considerable force in the submissions of Mr Jay and Ms McDonald that, when considering fitness to practise, the Committee appear to have concentrated exclusively on the three questions posed by Silber J at paragraph 65 of his judgment, which they apparently regard as the "3-fold test" to be applied, and as being determinative of that issue.

92. I make due allowance for the fact that this is not the judgment of a court. However, one looks in vain in the Committee's reasons for any reference to the public interest, or to the need to maintain public confidence in the profession, when they are considering impairment of fitness to practise. This is in stark contrast to their consideration of the issue of misconduct, where they make specific reference to the Registrant's failure to "uphold the reputation of the profession of midwifery", and to her failure to "justify the trust and confidence the public had a right to have in her." The absence of such considerations when addressing fitness to practise is therefore a particularly glaring omission.

93. Nor is there anything in the reasons to suggest they did in fact have regard to those wider considerations, even though no reference is made to them expressly. Ms Omambala drew attention to the Committee's observation that they did not "underestimate the seriousness of the allegations" they had found proved against the Registrant. That, however, is not the same thing as having regard to the wider public interest, and to whether public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances of this case.

94. In misinterpreting the decision in **Cohen** as establishing a three-fold test, rather than identifying relevant factors to be considered, the weight of which would vary from case to case depending on the facts, I agree that the Committee appear to have lost sight of the fundamental, public interest requirements that must be factored in at this stage.

95. No doubt this was due, at least in part, to the way in which the submissions of counsel, and indeed of the Legal Assessor, were formulated before them. However, the result is that the Committee addressed the question of impairment of fitness to practise on an incorrect basis. In this I consider that they were in error.

96. I agree with Ms McDonald that this was a significant error on the facts of this case, given the serious and persistent nature of the Registrant's misconduct. I agree that this was not a case, as in **Cohen,** where there was an isolated lapse in clinical standards and little factual dispute as to what had happened. Nor was there any real concern as to this Registrant's clinical competence. Whilst the various incidents which formed the subject of the charges obviously took place within a clinical setting, I consider that the misconduct running throughout the various heads of charge raised serious, attitudinal or behavioural issues rather than issues of clinical competence.

97. The Registrant's conduct, on two separate occasions, towards patients who, for different reasons, were obviously and understandably distraught displayed, in my view, a disturbing lack of awareness and sensitivity.

98. Her conduct towards a junior colleague, who was still undergoing her training, was found to amount to bullying and harassment over a period of almost 12 months, and to have involved threatening and aggressive behaviour.

99. Further, save in the limited ways I have set out, the Registrant maintained a vigorous denial of the allegations throughout the fact-finding hearing, disputing the facts and therefore requiring the evidence, including the evidence of the patients themselves, to be called and challenged. There was in this case no room for mistake or misunderstanding as to what had occurred.

100. The acts of misconduct found proved were therefore serious violations of the standards of conduct to be expected of a midwife; and they extended over a prolonged period. In my judgment they were more analogous to misconduct of the type found in **Yeong,** rather than that identified in **Cohen**. Thus, whilst I agree that the three factors identified in the latter case were relevant factors to be considered, the wider issues of public interest and public confidence in the profession were of fundamental importance in assessing impairment of this Registrant's fitness to practise. This was especially so where a finding that her fitness to practise was not impaired would amount, as Ms McDonald pointed out, to a complete acquittal in the face of serious and persistent misconduct.

101. The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case. In my judgment, in failing to have regard to these issues and to ask themselves the right questions, the Committee were in error.

102. Further, having read all the transcripts in this case with care, and notwithstanding Ms Omambala's skilful submissions on behalf of the Registrant, I also conclude that the Committee's decision as to impairment of fitness to practise in this case was manifestly inappropriate, having regard to the Registrant's misconduct and the interests of the public; and that it was unduly lenient under section 29. I therefore uphold the second ground of appeal advanced by the CHRE; and I do so for the following reasons.

103. As Mr Jay rightly points out, the more serious the misconduct found the more difficult it should be, in general, to justify a finding that fitness to practise is not impaired. For the reasons I have already given, and as the Committee themselves recognised, this case involved serious and persistent misconduct.

104. The facts in this case were almost entirely in dispute. Save in respect of the falsification of public records (charges 4(e) and (f)), itself a matter of serious misconduct, all the allegations were vigorously repudiated by the Registrant at the fact-finding hearing, where her evidence was rejected as unsupportable or not credible. Whilst it is always possible to conclude that a witness found to be wholly incredible at the fact-finding stage has then given credible and reliable evidence at the subsequent fitness to practise stage, there is a need for caution and for careful scrutiny of the evidence in such circumstances. That is particularly the case where, as here, the patterns of behaviour and attitudes being exhibited by the Registrant were not capable of being easily remedied.

105. In this case, however, that necessary scrutiny and caution appears to be lacking. In marked contrast to the Committee's observations and findings at the fact-finding

hearing, they appear at this stage uncritically to accept the Registrant's assertions as to her insight and rehabilitation, and to accept her evidence as entirely credible. On analysis no proper basis for their doing so appears from their reasons.

106. It is correct, as Ms Omambala emphasises, that those senior midwives who supervised the Registrant's period of clinical practice, before her suspension in November 2007, had formed a positive view of her abilities and competence as a midwife. This however was some 21 months before she gave evidence to the Committee in July 2009, strongly denying the allegations made against her. Whatever benefit that period of supervised practice had brought, it had not therefore impacted on the evidence that the Registrant gave to the Committee, a fact that I consider is highly relevant to a determination as to her level of insight and change of attitude.

107. In any event this period of supervised practice, whilst including 'communication' and 'record keeping' issues, seems to me to have related far more to the Registrant's clinical competence, which was not the concern underlying the allegations of misconduct levelled against her.

108. That supervision had also ended in 2007. Until she was asked a question by a member of the Committee, it is a curious fact that the Registrant had given no evidence at all herself as to what she had been doing between her suspension in November 2007 and June 2009, when she had undertaken some courses. It is therefore surprising, and in my view unsatisfactory, that in view of their previous findings as to her lack of credibility, the Committee appear so readily to have accepted her assertion, unsupported by any medical evidence and not followed up in any further questioning by her counsel, that she had been "seriously unwell" throughout that entire period, and therefore unable to take any steps to address any deficiencies in her practice or behaviour.

109. Further, this uncritical acceptance of the Registrant's evidence is in marked contrast to the Committee's approach to the evidence concerning the further criticisms made of her in August 2007 (exhibit 8), which they describe as "unsatisfactory".

110. As the extracts from the transcript show, the Registrant was repeatedly asked whether or not these incidents had occurred in the various ways described. Whilst, in response, she referred to statements she had written about them, at no stage did she clearly deny that they had occurred or offer any alternative account. Indeed, she appeared implicitly to be accepting the facts put to her. This was evidence which was clearly relevant to the Registrant's level of insight. It tended to show that, even whilst she was still working and under supervision, significant, behavioural issues still needed to be addressed. Given the position she subsequently adopted at the fact-finding hearing, the Committee's apparent acceptance of the suggestion that, by October 2007, she had "thoroughly come to terms with her failings and had addressed them"; and that in August 2007 she could be said "to have been at a relatively early stage in the process of [her] journey of self awareness" is in my view unsustainable.

111. Further the Committee appear to have factored into their decision making, in relation to these incidents, the absence of any disciplinary action taken by the Trust in respect of them. The NMC had sought, but were refused permission to adduce evidence explaining why it was that no action had been taken. In excluding that evidence the Committee had deprived themselves of the opportunity to obtain all the information

which was relevant to that issue. In the circumstances they should not have attached any weight to the absence of disciplinary action as a basis for dismissing what were otherwise significant incidents involving the Registrant in August 2007.

112. Of the "range of courses" identified at paragraph 5 of the reasons as having been undertaken by the Registrant, only that at paragraph c, a one-day course on communication skills on 6 March 2010, appears relevant to the misconduct which was found proved. Further, the diploma course with the Counselling and Psychotherapy Central Awarding Body, referred to at paragraph 7 of the reasons, was a course which the Registrant was only part way through at the time that the Committee were considering fitness to practise. In accepting, uncritically, her assertion that this course had "enabled her to reflect upon her ability to deal with others"; I consider that they placed more weight upon this course than it could properly bear. In any event, having examined the material relating to it, this course appears to me to relate more to counselling and psychotherapy skills in a formal setting, than to bullying and harassing behaviour or attitudinal problems of the sort which ran throughout the heads of charge.

113. The Committee's statement in the final paragraph of their reasons, "Quite why she behaved in the way she did in the period March 2006 to February 2007, the panel cannot say" is entirely unsatisfactory. This was surely the question which they were required to answer if they were to conclude, as they did, that the Registrant's conduct was both remediable and had been remedied. Their following statement, that "the behaviour of the registrant was remediable" is in fact the only point in their reasons at which this point is addressed. That statement and the conclusion immediately following it, that it has been remedied, appear without any analysis of the underlying issues.

114. A great deal of emphasis appears to have been placed by the Committee on the "profound difference" in attitude said to have been discerned from the Registrant's demeanour and manner of giving evidence in April 2010, as opposed to July 2009. Ms Omambala relies heavily on that observation, and that of course is something that this Court is not in a position to gainsay.

115. However, caution is always required before reliance can be placed on demeanour as a sure indicator of truth or reliability. It is, rather, the whole picture on analysis of all the evidence to which the Committee should have had regard in determining impairment of fitness to practise. Reading the transcripts in this case and examining the answers the Registrant gave to the questions being asked of her, it is difficult to see how, viewing the picture as a whole, a profound change can be demonstrated evidentially.

116. When considering whether fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue. In this case there was no recognition or admission of wrongdoing by the Registrant, who maintained a robust defence to the charges. Even at the second stage, when misconduct and fitness to practise were in issue, the extracts from the transcript set out above indicate, in my view, that her acceptance of the allegations was based more on the fact that they had been found proved against her, than on her own recognition as to the unacceptability of what she had done. In circumstances where the Committee had no evidence before them of the Registrant's recent performance in a

clinical setting, her failure clearly and unambiguously to acknowledge her failings was a matter of serious concern.

117. In my judgment, and for these reasons, the Committee's decision that her fitness to practise was not impaired was manifestly inappropriate in this case, having regard to the nature of her misconduct and the wider public interest. The decision was therefore unduly lenient, and this Court should intervene.

118. In these circumstances it is unnecessary for me to go on to deal with the CHRE's third ground of appeal, namely that the Committee's reasons for concluding as they did were inadequate. The appeal is allowed on both the first and second grounds, and I therefore substitute a finding that this Registrant's fitness to practise is impaired. The case will now be remitted to a differently constituted Committee for them to consider the question of sanction. As Ms McDonald points out, it will remain open for a committee dealing with the question of sanction to consider all the facts in determining what action is appropriate in the circumstances of this case.