Nursing & Midwifery Council

Conduct and Competence Committee

Substantive Hearing – Appeal Case (Impairment and Sanction)

12– 14 November 2013

Nursing and Midwifery Council, 20 Old Bailey, London, EC4M 7LN

Name of Registrant Nurse:	Julia Ann Duthie
NMC PIN:	75U2113E
Part(s) of the register:	Registered Nurse – Sub-part Adult – 4 December 1978 Registered Midwife – 15 February 1980 Specialist Community Public Health Nurse 3 January 1989
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Alexander Coleman (Chair - Lay member) Ruben Livingstone (Lay member) Evette Roberts (Registrant member)
Legal Assessor:	Peter Jennings
Panel Secretary:	Azra Karup
Representation	
Nursing and Midwifery Council:	Represented by Rachel Ellis, on behalf of the Nursing and Midwifery Council
Ms Duthie:	Present and represented by Barbara Hewson
Fitness to practise:	Not impaired
Sanction:	N/A
Interim Order:	N/A

Charges:

That you, a Registered Midwife, whilst engaged by Mrs A to provide care to her during the antenatal period and labour period of her pregnancy, failed to provide an appropriate standard of care to her and her baby, Baby B, in that you

4) Failed to informs 2, the supervising midwife, on August 28th and/or September 2nd that Ms A was reluctant to have a vaginal examination as recommended in the Supervisory Plan of Support (the support plan") that Ms 2 had prepared

7) On or around 24 August 2007, failed to convey the estimated foetal weight of 4.66kg, to:

   a) the second Midwife who was due to assist you, Ms 4;
   b) the supervising midwife, Ms 2.

8) On 2nd and/or 3rd September 2007, failed to inform the Ambulance Service that Mrs A was in labour and may need transfer to hospital.

9) Your actions as set out in Charge 8 were contrary to the support plan prepared by Ms 2.

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

Determination on Misconduct and Impairment:

Ms Duthie,
At your appeal against the decision of the panel which heard your case in 2011, the High Court quashed the previous panel's findings of fact in relation to charges 1 and 6 but upheld the findings that charges 4, 7, 8 and 9 were proved. The court has remitted your case to the Conduct and Competence Committee under Article 38 of the Nursing and Midwifery Order 2001 for reconsideration of impairment and sanction. The function of this panel on the remission is to consider the issues of impairment and, if necessary, sanction.

The panel has considered, on the basis of the matters found proved, whether your fitness to practise is currently impaired by reason of your misconduct. The NMC defines fitness to practise as a registrant's suitability to remain on the register without restriction.

In reaching its decision on impairment, the panel has considered all the evidence that has been placed before it, including the relevant parts of the transcript of the previous decision, the judgment of Mr Justice Irwin and the Order of the High Court sealed on 05 November 2012. The panel also took into account the oral evidence of Mr 1, an emeritus professor of midwifery practice and a Supervisor of Midwives, and the submissions made by Ms Ellis, on behalf of the NMC, and by Ms Hewson, on your behalf.

The panel heard and accepted the advice of the legal assessor. He advised that with regard to the conduct set out in the charges the panel should first consider whether or not the facts proved amount to misconduct and whether that misconduct is serious. If the panel does find misconduct has been established, it should then consider whether or not, having regard to all of the information available to the panel, your fitness to practise is currently impaired by reason of your misconduct.

The panel was referred to the 2004 edition of the "NMC Code of professional conduct: standards for conduct, performance and ethics" (the Code) as well as the cases of *Roylance v General Medical Council (No 2)* [2000] 1 A.C. 311, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). The panel took into account the guidance provided by Dame Janet Smith in the Fifth Shipman Report which was endorsed in *CHRE v NMC and Grant.*

The panel exercised its own judgment in determining whether the facts found proved amount to misconduct; and if so, whether your fitness to practise is currently impaired. In its approach to the question of impairment the panel has kept in mind the need to protect the public, to maintain public confidence in the nursing and midwifery professions, and to uphold proper standards of conduct and performance.

Submissions

Ms Ellis submitted that the matters as set out in the charges are of such a nature that they clearly amount to serious misconduct. She submitted that you have breached the preamble of the 2004 edition of the NMC Code, as well as a number of specific paragraphs of the Code.

In relation to impairment, Ms Ellis submitted that through your actions and omissions as set out in the charges found proved, you failed to demonstrate the standards of knowledge and skills required of a registered midwife. She reminded the panel of the principle set out in *Grant* that the more serious the misconduct, the more difficult it is to justify a finding of no impairment. She submitted that a patient was put at unwarranted risk of harm. As the lead midwife, it was your duty to identify the risk factors present and communicate this information to your colleagues so that appropriate preparation measures could be planned. Ms Ellis also submitted that your actions and omissions were not isolated in nature and have brought the profession into disrepute and breached fundamental tenets of the profession.

Ms Ellis conceded that you are currently practising safely and that there is no risk of repetition or harm to patients. However, she reminded the panel of its duty to uphold public confidence in the profession. She stressed that a finding of impairment is necessary on the grounds of public interest in order to mark the seriousness of your misconduct. She referred the panel to the case of *Nicholas-Pillai v General Medical Council [2009] EWHC 1048 (Admin)* which established that the panel is entitled to take into account a practitioner's attitude towards the events that gave rise to the facts found proved. In that case Dr Pillai's dishonest conduct was compounded by the fact that he had given inconsistent and unreliable evidence at the hearing. Ms Ellis invited the panel to consider that your reflective statement goes behind the findings of fact in relation to Charge 4. Further, the seriousness of this case is compounded by the fact that your evidence was rejected by the previous panel.

For these reasons, Ms Ellis submitted that your current fitness to practise is impaired.

Ms Hewson, on your behalf, submitted that your fitness to practise is not currently impaired. She reminded the panel that the facts found proved do not allege responsibility for the stillbirth. Ms Hewson submitted that the charges relate to your failings of communication which you accept. She submitted that the failure to inform your colleagues of the estimated fetal weight of 4.66 kg was not a deliberate omission but should be seen in the context of a complex situation. She drew the panel's attention to the unusual features of this case as referred to by Mr Justice Irwin in the High Court. These include the client's strong wish for a particular mode of delivery and her particular history.

In addressing the panel on the issue of remediation, Ms Hewson referred the panel to the evidence of Mr 1 who commended your communication skills and submitted that your conduct

has been remedied. She also referred the panel to your reflective statement which in her submission indicated that you have profoundly reflected on your conduct and acknowledged that it fell short of what was expected. She submitted that the public would be impressed by the detail and level of your reflection and insight.

Ms Hewson drew the panel's attention to the elements of this case which distinguish it from the case of *Grant* including the fact that this was a one-off episode of failings over a short period. Further, she submitted that there are no deep seated attitudinal problems and that you are a sensitive and caring practitioner.

Ms Hewson submitted that all professionals can at times fall short of the expected standards and that a finding of impairment is inconsistent with the public interest. Ms Hewson also submitted that the facts found proved do not amount to misconduct.

For these reasons, Ms Hewson submitted that your fitness to practise is not currently impaired.

Misconduct

When deciding whether the facts found proved amount to misconduct the panel looked at each charge separately and also cumulatively.

The panel bore in mind the words of Lord Clyde in the case of *Roylance* cited above which established that:

> *"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required by a practitioner in the particular circumstances..."*

The panel had regard to the 2004 Code.

The panel considered that you have breached the principles in the preamble to the 2004 Code which states:

> 1.2 *As a registered nurse, midwife or specialist community public health nurse, you must:*

- *protect and support the health of individual patients and clients*
- *act in such a way that justifies the trust and confidence the public have in you*
- *uphold and enhance the good reputation of the professions.*

1.3 You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.

1.4 You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.

It also found that your behaviour represented a departure from following provisions of the Code:

4.1 The team includes the patient or client, the patient's or client's family, informal carers and health and social care professionals in the National Health Service, independent and voluntary sectors.

4.3 You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients.

4.5 When working as a member of a team, you remain accountable for your professional conduct, any care you provide and any omission on your part.

The Code makes clear that failure to comply with the Code may bring a registrant's fitness to practise into question. The panel kept in mind that not every breach of the code or shortfall in standards will be sufficiently serious that it can properly be described as misconduct.

In all the circumstances, the panel found that your conduct found proved with regard to charge 7 amounted to misconduct and that that misconduct was serious. While the omissions found proved under charges 4, 8 and 9 were inappropriate and should not have occurred, the panel considered that they were not sufficiently serious to warrant a finding of misconduct.

Charge 4

The previous panel found that you failed to inform Ms 2, the supervising midwife, that Mrs A, the mother, was reluctant to have a vaginal examination as recommended in the support plan which Ms 2 had prepared.

Mrs A's case was for a number of reasons one involving higher than usual risks, but she had engaged you as an independent midwife because she wanted a home birth rather than a hospital birth. Your named supervisory midwife was Ms 3, at the RDE Hospital, but for this case you were supervised by Ms 2 at the Torbay Hospital. After she had spoken to you, Ms 2 prepared the support plan. You told the panel in your reflective statement that the support plan was prepared without first discussing its contents with you. The plan provided for regular vaginal examinations.

The panel was impressed by the evidence of Mr 1. Mr 1 said that a Supervisory Plan is not only important but essential when dealing with complex cases. However, he emphasised the need for such a plan to be constructed with the direct involvement of the woman concerned which is at the heart of autonomous, self regulated practice. He explained that a failure to do so makes the supervisory midwife a part of the problem and imposes conditions on the midwife which no supervisor is entitled to make. Further, without the involvement or consent of the woman concerned, the plan introduces a mechanism of coercion. The panel also took into account Mr 1's oral evidence that it is possible to deviate from a care plan and that in certain circumstances it is appropriate for a midwife to use her own judgment.

This panel noted that the previous panel accepted that there is a reasonable body of opinion that the progress of labour can be established by means other than vaginal examinations. That was the evidence of Mr 1 to this hearing, and also of Ms 7, another professor who gave evidence at the 2011 hearing.

The panel has also taken account of the fact that the charge proved was that Mrs A was "reluctant" to have a vaginal examination rather than that she categorically refused to do so. Mrs A's evidence to the 2011 hearing was that she had a preference not to have such examinations.

The evidence as set out in the judgment of Mr Justice Irwin is that Ms 2's evidence was that you had told her that you thought that Mrs A would in the event agree to vaginal examinations. The

evidence of Ms 3, the Supervisory Midwife at the RDE Hospital who spoke to Mrs A herself about this, was that "Ms A has agreed to vaginal examination if labour establishes." The notes you made at the time state: "Vaginal examinations discussed [Mrs A] not sure how she'll feel about this, she may decline but be willing to examine herself & describe her findings to me."

In your reflective statement you stated that you should have set up a meeting with everyone present to try to reach an agreed course of action and that you would do so in future situations where such plans are to be involved. You further acknowledged that it would have been helpful if you had put in writing to Ms 2 where Mrs A currently stood in relation to vaginal examinations. In your past experience, clients who were reluctant to have vaginal examinations eventually agreed when the time came.

The panel noted that the need to carry out vaginal examinations was expressly specified in her care plan. The panel found that given Mrs A's history of complications and the risk factors involved, this was an important aspect of her care and her refusal to undergo a vaginal examination should have been communicated to Ms 2. The panel, however, found it significant that Mrs A had expressed reluctance rather than a total refusal to undergo a vaginal examination.

The panel determined that your omission in relation to charge 4 was a departure from the standards expected of a registered midwife. However, based on the information before it, the panel did not consider this failure to be sufficiently serious to constitute misconduct.

Charge 7

The panel had regard to the findings of the previous panel which held that the estimate of the baby's weight was a relevant and important risk factor and that you should, in order to comply with your duty of care, have conveyed to Ms 4, the second midwife who was assisting you. It stressed that this information would have assisted Ms 4 in ensuring that the necessary equipment was readily available and preparing for any potential need to resuscitate the baby. That panel was satisfied that you personally, as the lead midwife, were under a duty to ensure that your supervisor (Ms 2) was informed of the baby's weight, whether or not anyone else involved in Mrs A's care was under a similar duty.

Mr 1 gave evidence that fetal weight is an important parameter of care in any birth and one to which all midwives should be alert. This is especially so in the presence of a malpresentation such as a breech. He said that it is incumbent on the Supervisor and those involved in care to ask the relevant questions and in not asking those questions they are equally at fault.

In your reflective statement, you stated that after Mrs A had contacted you to inform you of the estimated weight you advised her to speak to Ms 5, an experienced independent midwife who was advising you. Ms 5 reassured Mrs A. You accepted that you should have contacted Ms 2.

Mr Justice Irwin found that the panel was entitled to find that Ms 2 and Ms 4 were not apprised of the weight of the baby. However, in his judgment, he observed that it seems unlikely that the weight of the baby would have made any difference, given the fact that Mr 6, the consultant obstetrician, and Ms 3 knew of it and gave advice based on that fact which was rejected by Mr and Mrs A.

This panel accepted that fetal weight was a significant factor and that all parties involved had a responsibility to enquire about the baby's weight. However, the panel took the view that corporate responsibility did not absolve you of your individual duty to communicate the estimated weight of the baby to Ms 2 and Ms 4.

The panel found that given the high risk involved, it was essential for all health professionals involved in Mrs A's care to collaborate effectively and prepare for any potential complications that may arise especially during labour and birth. Further, this duty was heightened by the fact that you were an independent midwife and should have been aware of the importance of collaborating with your colleagues. The panel found that as the main midwife of a high risk client with a complex history, you should have been more cautious in collaborating fully with colleagues to manage the risks and ensure the safest possible outcome.

The panel concluded that your failure was serious and amounted to misconduct.

Charges 8 and 9

The previous panel stressed that the supervisory plan required you to advise the Ambulance Service of the potential need for a transfer to Hospital. Your explanation was that you attempted to advise them of this but encountered difficulties and that other events then supervened. Whilst

the previous panel accepted that the provisions of the supervisory plan were not mandatory, in that you would not have been precluded from departing from it in the proper exercise of your clinical judgment, it found that you had a duty to ensure that the precaution was put in place in good time before the birth.

In Mr Justice Irwin's judgment he observed that it would have made no difference to the outcome if you had in fact informed the Ambulance Service.

In his evidence Mr 1 stated that he had serious doubts about whether this was an appropriate element in the support plan. He said that it is more appropriate to call an ambulance if and when necessary. An ambulance would not be put on extended standby just in case and calling an ambulance prior to an emergency is not only unusual but unreasonable.

The panel had regard to your reflective statement that you had attempted to ascertain the number for the ambulance service. You said that you contacted Ms 2 on three occasions as well as the RDE switchboard. You said that you will make sure in future that you have the direct contact line for each area's ambulance service as part of your booking procedure.

The panel found that by failing to inform the Ambulance Service as stipulated by the care plan you fell short of what was expected in the circumstances. The panel did not, however, find that this omission was sufficiently serious to constitute misconduct. This panel accepted that you made attempts to comply with the support plan. It determined that informing the Ambulance Service was an unusual course of action, even for a high risk birth.

Accordingly, the panel found that your omissions in relation to charges 8 and 9 did not constitute misconduct on your part.

Impairment:

The panel therefore considered whether your fitness to practise is currently impaired by reason of the matters set out in charge 7 which it has found to be misconduct.

In her ruling in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*, Mrs Justice Cox cited with approval the factors identified by Dame Janet Smith in her Fifth Shipman report. In the light of those factors the

panel considered whether its findings of misconduct show that your fitness to practise is impaired in the sense that you:

> *a. have in the past acted and/or are liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. have in the past brought and/or are liable in the future to bring the profession into disrepute; and/or*
>
> *c. have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the profession.*

The panel did not find that your misconduct has brought the profession into disrepute, nor could it be satisfied that you had breached one of the fundamental tenets of the profession. The panel did, however, consider that you had put a mother at unwarranted risk of harm.

In determining whether your fitness to practise is currently impaired the panel considered whether your misconduct is remediable, whether it has been remedied and whether it is likely to be repeated.

In considering whether your misconduct was likely to recur, the panel had regard to your level of insight. The panel was satisfied that you have reflected profoundly upon your past behaviour and have insight into your failings. The panel found that you have learned from your mistakes, and that if faced with a similar situation in the future, you are unlikely to repeat those mistakes.

The panel considered that your deficiencies are remediable and that they have been remedied. The panel is satisfied, on the basis of all the evidence, that this was a one-off episode and there is no risk of repetition. The panel has had regard, in that respect, to Mr 1's evidence and the supportive references you have provided. The panel was impressed by the evidence of Mr 1 who is a midwife of 33 years' experience. Mr 1 is a Supervisor of Midwives, who had and has an overriding statutory duty to protect the public. Mr 1 has undertaken your supervision since December 2009 and has kept extensive records of your practice, your professional behaviour, and development. He was *"impressed by your motivation, commitment and support of women in your care"* and has no doubt about your competencies and ability to practise safely.

The panel also had regard to your long career in midwifery, and the fact that this was an isolated episode of misconduct. It further considered that you have been practising midwifery under a conditions of practice order for four years since and that there have been no issues with your practice as evidenced by Mr 1. You have taken appropriate remedial action with the support of Mr 1 so as to ensure that your errors will not be repeated. The panel considered that you are not liable in the future to act so as to put patients at unwarranted risk of harm and is satisfied that on the present evidence you are currently safe to practise without restriction. In reaching that conclusion, the panel bore in mind that Ms Ellis, on behalf of the NMC, concedes that you do not present a risk to patients.

The panel next had regard to the question of whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment of fitness to practise were not made. This is a matter concerning a single episode of misconduct in the context of a complex and unusual case. It is the only incident of misconduct in your career; you have practised without incident for four years since then; and the very experienced midwife and supervisor who has supervised you during that period is impressed by your standards and has no doubt regarding your competence and your ability to practise safely. In these circumstances the panel does not consider that public confidence in the profession would be undermined, nor the upholding of standards compromised, by the finding that your fitness to practise is not impaired today.

For these reasons the panel concludes that your fitness to practise is not impaired by reason of your misconduct.