EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: 4102450/2017

Held in Dundee on 19, 26, 27 and 28 August, 20 September, 11 October, and 28 and 29 November 2019

Employment Judge M Sutherland

Louise Kennedy	**Claimant** **Represented by:** **Mr M Briggs,** **Solicitor**
Tayside Health Board	**Respondent** **Represented by:** **Mr R Davies,** **Solicitor**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The judgment of the Tribunal is the Claimant was not unfairly dismissed.

REASONS

Introduction

1. The Claimant presented a complaint of unfair dismissal. The Claimant initially sought re-instatement or re-engagement as a remedy but she subsequently advised that she was seeking compensation only.

2. The Claimant was represented by Mr M Briggs, Solicitor. The Respondent was represented by Mr R Davies, Solicitor.

3. A final hearing was listed on 11 to 14 December 2018. On the first day that hearing was converted to a preliminary hearing and the final hearing was postponed. Parties agreed to produce a chronology of agreed events and a table identifying the findings made in the dismissal letter including whether the Claimant accepts the findings. At that hearing it was agreed that the issues to be determined were:

   a. Did the Respondent have a potentially fair reason for dismiss and if so what was it?

   b. If the reason for dismissal was the conduct of the claimant:

      (i). Did the Respondent have a genuine belief in the alleged conduct of the Claimant?

      (ii). If so, were there reasonable grounds for that belief?

      (iii). If so, did those grounds follow a reasonable investigation?

   c. If the reason for dismissal was the capability of the claimant:

      (i). Did the Respondent hold a reasonable belief as to the Claimant's lack of capability?

      (ii). Did the Respondent provide the Claimant with sufficient notice that her work was not of the required standard?

      (iii). Did the Respondent provide the Claimant with sufficient opportunity to improve?

      (iv). Did the Respondent consider alternative employment?

   d. Was the dismissal unfair on the basis that the Respondent did not follow a fair and reasonable procedure given the length of time which it took for the procedure to take place?

   e. Was the decision to dismiss within the range of reasonable responses?

   f. If the Claimant was unfairly dismissed:

      (i). How much compensation should be awarded?

(ii). Should any compensation be reduced to take account of contributory conduct and/or the application of Polkey?

4. A final hearing was listed on 3, 11 and 12 June 2019 but was postponed.

5. At the final hearing the Respondent led evidence from Justine Craig (Head of Midwifery), Jill Forbes (Clinical Services Manager), Arlene Wood (General Manager), Sheila Tunstall-James (Non-exec Board Member), Julie Greenlees (Clinical Services Manager). The Claimant then gave evidence on her own behalf.

6. The parties lodged an agreed set of documents. Additional documents were lodged during the hearing.

7. The parties made closing submissions.

8. The following initials are used as abbreviations in the findings of fact–

Initials	**Name**	**Title**
AD	Allan Drummond	UNISON
AW	Arlene Wood	General Manager
CM	Carol Miller	HR Business Adviser
CS	Charles Sinclair	Associate Nurse Director
DC	Daniel Courtney	HR Business Lead
FR	Frances Rooney	Director of Pharmacy
HM	Honor MacGregor	Midwifery Team Manager
KF	Kenny Forbes	UNISON
KR	Keith Russel	Associate Nurse Director
JC	Justine Craig	Head of Midwifery
JF	Jill Forbes	Clinical Services Manager

JG	Julie Greenlees	Clinical Services Manager
JW	Jenna Whytock	HR Business Adviser
STJ	Sheila Tunstall-James	Non-exec Board Member
VB	Valerie Beattie	Head of HR Resourcing

Findings in fact

9. The Tribunal makes the following findings in fact:

10. The Claimant was employed by the Respondent as a Band 6 Midwife from 18 August 2011 until 27 March 2017. The role involves antenatal, intra partum, and postpartum care delivered to women and their children before, during and after childbirth.

11. It was a requirement of the role that the Claimant was registered as a midwife with the Nursing and Midwifery Council ("The NMC"). The NMC Code contains the professional standards that registered midwives must uphold. The Claimant had been registered as a midwife with the NMC since November 2008.

12. The Respondent is a large employer with access to significant resources and has a dedicated HR function.

13. Under their Conduct Policy, the Respondent adopted the same process for the disciplinary hearing and appeal hearings. The investigating officer presented their case with the opportunity for the Claimant and/or their representative to ask questions. The Claimant then presented her case with the opportunity for the investigating officer and the panel to ask questions. The same process was adopted for any witnesses called.

14. The Respondent's Employee Conduct Policy provides that: "To ensure impartiality, panel members, including the Chair, must have had no prior involvement in the case"; dismissal with notice is competent for repeated

misconduct or without notice for gross misconduct; the sanction applied should take into account the seriousness of the allegations and any mitigation; and the same process is followed for disciplinary hearings and for appeal hearings.

15. Appendix D of the Conduct Policy states: “Examples of gross misconduct may include: …gross negligence or irresponsibility;…persistent wilful refusal to perform to the required standards of the job role;…unprofessional conduct as defined by reference to generally accepted standards of conduct or ethics within a staff group;…wilful failure to adhere to clinical governance/infection control policies.”

16. The Respondent’s Capability Policy applies where an employee is unable to perform their work to the required standard despite trying to do so. The Respondent’s Conduct Policy applies where an employee is able to perform their work the required standard but chooses not to do so. Where the Capability Policy applies the employee will be offered support and an improvement plan. Dismissal will only be considered where support and improvement has failed to bring their work up to the required standard.

17. In March 2016 the Claimant attended her GP with peri-menopausal symptoms (having had related blood tests in February 2016).

18. On 9 and 10 June 2016 Patient 1 underwent a caesarean section and care was delivered by the Claimant. On 28 August 2016 Patient 1 submitted a letter of complaint in relation to the care given on 9 and 10 June. In that letter Patient 1 complimented a number of staff, made a number of complaints which did not pertain to the Claimant, and made complaints regarding the breastfeeding support provided by the Claimant which she asserted was wrong and regarding the unacceptable and inappropriate attitude of the Claimant. JC asked HM to investigate the complaint regarding the Claimant.

19. On 2 September 2016 the Claimant was advised in writing of Patient 1’s complaint and invited to an investigatory hearing on 16 September 2019 under the Respondent’s Conduct Policy.

20. On 6 to 7 September the Claimant delivered care to Patient 2. On 7 September 2016 a Datix: Adverse Event Report was submitted by Billie Nicholson, Staff Midwife regarding the transfer of out of the labour suite of a woman in preterm labour (Patient 2).

21. On 10 to 11 September the Claimant delivered care to Patient 3. Issues with the care came to light as a result of routine mandated review of a stillbirth.

22. On 16 September 2016 the Claimant attended an investigatory hearing with HM in relation to Allegation 1 ("care delivered to a woman between 9 until 11 June 2016 was below the standard expected by a midwife and a subsequent complaint from the woman and her family").

23. From 17 September 2017 until her dismissal, the Claimant was absent from work on account of stress and anxiety.

24. On 3 October 2016 the Claimant was invited to an investigatory hearing under the Respondent's Conduct Policy in relation to Allegations 2 and 3 (initially referred to as intrapartum and postnatal care delivered on 7 and 8 September 2016 in error and later corrected to such care delivered on 7 and 10 September 2016).

25. On 27 October 2016 HM advised the Claimant of her decision to escalate Allegation 1 to a disciplinary hearing.

26. On 28 October 2016 the Claimant attended an investigatory hearing with HM in relation to Allegation 2 ("Intrapartum and postnatal care delivered on the nightshift of 6 into 7 September 2016 was below the standard of that expected of a midwife") and Allegation 3 ("Intrapartum and postnatal care delivered overnight on 10 into 11 September 2016 was below the standard of that expected of a midwife").

27. On 8 November 2016 JC emailed HM to advise that she had met with Patient 1 and stated, "I have assured her that appropriate actions are being taken."

28. On 15 November 2016 the Claimant attended an investigatory hearing with HM in relation to Allegation 2 ("Intrapartum and postnatal care delivered on the

nightshift of 6 into 7 September 2016 was below the standard of that expected of a midwife") and Allegation 3 ("Intrapartum and postnatal care delivered overnight on 10 into 11 September 2016 was below the standard of that expected of a midwife").

29. The Claimant was very distressed during the investigatory hearings and found it difficult to answer questions. The Claimant and her union rep complained about the tone and language used by HM during the hearing and she later apologised.

30. On 21 November 2016 HM conducted a witness interview with BN, Staff Midwife regarding Patient 2. She was on the ward when Patient 2 was transferred who was particularly distressed and in pain. At the time she asked the Claimant whether she had given her pain relief and she said no but she would get some. BN considered that Patient 2 was in established labour. She recalled it being a reasonably busy night but not too hectic.

31. On 28 November 2016 HM conducted a witness interview with Bernadette McStea, Midwife regarding Patient 2. She was unable to recall much about the relevant shift.

32. On 7 December 2016 HM advised the Claimant that she was escalating Allegations 2 and 3 to a disciplinary hearing (together with Allegation 1).

33. On 14 December 2016 HM conducted a witness interview with Lorna Murphy, Senior Midwifery Team Leader regarding Patient 3. She was unable to recall the relevant shift.

34. On 19 December 2016 HM conducted a witness interview with Justine Anderson, Senior Charge Midwife regarding Patient 3. She recalled a midwife being called to translate for the Claimant's patient. She could not recall being asked to look over the Claimant's notes but if she had she would have been concerned by the small amount of documentation.

35. On 19 December 2016 HM conducted a witness interview with Jane Tracey, Midwife regarding Patient 3. She was unable to recall the relevant shift.

36. On 30 December 2016 HM wrote to the Claimant inviting her to attend a disciplinary hearing in respect of the following allegations: "1. Care delivered to a woman between 9 until 11 June 2016 was below the standard expected by a midwife and a subsequent complaint from the woman and her family. 2. Intrapartum and postnatal care delivered on the night shift of the 6 into 7 September 2016 was below the standard of that expected by a midwife. 3. intrapartum and postnatal care delivered overnight on 10th into 11 September 2016 was below the standard of that expected by a midwife." HM advised the Claimant that Allegations 1, 2 and 3 would be heard together at a disciplinary hearing on 1 February 2017. The Claimant was advised that the hearing was being convened in accordance with the conduct policy and may result in her dismissal. The Claimant was advised of her right to be accompanied. The Claimant was advised that she would be provided with the management case and was entitled to submit a statement of case including documents and calling witnesses.

37. The Claimant was not suspended at any time during the disciplinary process prior to her dismissal.

38. On 20 January 2017 the Claimant was advised that the disciplinary hearing had been postponed until 13 February 2017.

Documentary Evidence Considered by the Respondent

39. In addition to applicable policies and procedures, HM considered the following documentation in relation to the following patients as part of the disciplinary investigation:

- Patient 1: the MEWS (Maternity Early Warning Score) Chart for 9 June 2016 but not 10 June; Labour and Birth documentation (patient notes) for 10 June but not 9 June.
- Patient 2: the MEWS Chart for 6 September 2016; Labour and Birth documentation (patient notes) for 6 and 7 September 2016; the Labour and birth summary; the Prescription Record for 6 and 7 September 2016; the Prescription and Fluid Balance chart for 6 September 2016.

- Patient 3: the MEWS Chart for 10 September 2016; Labour and Birth documentation (patient notes) for 10 September 2016; the Labour and Birth summary; the Partogram; the Prescription and Fluid Balance chart for 10 September 2016.

40. In January 2017 HM produced her Investigation Report which extended to 26 pages (plus 48 Appendices extending to 422 pages). The Investigation Report relied almost exclusively upon the documentation considered by HM and the Claimant's investigatory hearing. The other witness interviews provided limited information. The Report was by way of narrative that did not make separate explicit statements regarding each alleged act of misconduct. It was written in fairly dense prose and concerned matters of a technical nature.

Findings made by the Respondent

41. The Investigation Report made a number of findings based upon the documents considered by HM and the investigatory hearings held by HM. The Respondent also made findings based upon statements made by the Claimant during the disciplinary hearing.

Regarding Patient 1 on 9 and 10 June

42. The Respondent made the following findings regarding Patient 1's care on 9 and 10 June -

a. Failure to stop the magnesium sulphate infusion

A doctor had twice written in the patient notes that the infusion should stop at 2310. The Claimant did not stop the infusion at 2310 and allowed it to run on until finished. The Claimant asserted that a doctor had told her to allow the infusion to run on until finished but there was no entry in the notes to this effect. In certain circumstances magnesium sulphate may cause respiratory arrest.

b. Writing the MEWS chart in retrospect and not recording the respiratory rate.

MEWS charts are used to assess whether a patient's condition is deteriorating and requires early medical intervention. Their effectiveness depends upon the recording of contemporaneous observations regarding a patient's vital signs (temperature, heart rate, blood pressure, etc). These recordings generate yellow or red scores. A doctor must then be contacted if a patient triggers one red or two yellow scores at any one time. At the disciplinary hearing Claimant admitted having documented the MEWS chart in retrospect. This undermines the effectiveness of the MEWS chart. The respiratory rate is relevant to monitoring the pre-eclampsia and the effect of the infusion. The Claimant did not document the respiratory rate between 20:00 and 23:54. The respiratory rate was also not documented for over an hour prior to the Claimant's shift.

c. Failure to follow the Pre-eclampsia guidelines

The Pre-eclampsia guidelines states that the respiratory rate should be taken every 30 minutes and if it falls below 12 the magnesium sulphate infusion should be stopped. The urine output should be documented. The magnesium sulphate infusion started at 0130 on 10 June 2016. The MEWS chart relied upon by the Respondent was competed on 9 June 2016 (and not 10 June 2016).

d. Making retrospective entries in the notes but not noting this

The NMC Code states that midwives must keep clear and accurate records. The Respondent's Midwifery Record Keeping Guideline expects records to be "timely and completed as close as possible to the event; records should be complete, this includes all charts, early warning systems etc;…they should also state who carried out the care…anyone else assisting with care should be similarly documented…unapproved abbreviations must not be used;…midwives should ensure that where verbal consent is required for procedures this is documented on the record; records should always be written contemporaneously or as soon as possible after the event…the entry should be written as "written in retrospect"". At the disciplinary hearing the Claimant admitted that the MEWS chart was filled in in retrospect but did not state this on the notes.

e. Failure to observe the women from 2000 to 2345

The Claimant (and others) had not completed the MEWS chart with the respiratory rate or the urine output. Record keeping is a description of what happened. If it is not written down the practice is to infer that it didn't happen. The Respondent believed that the Claimant had not observed her respiratory rate or urine output.

f. Failure to escalate red triggers on MEWS chart

On the MEWS chart on four occasions there were red scores of 2 and on six occasions red scores of 1. A doctor must be contacted if a patient triggers a record at any one time. The Respondent understood that there was no midwifery documentation between 2100 and 2250 and that there was no record of escalation. The Claimant asserted at the disciplinary hearing that the team leader had escalated the red triggers.

g. Use of a personal notebook

The Claimant admitted to using a personal notebook but understood others did so too. The notebook did not form part of a patient's official records. There were concerns regarding the safe storage of a personal notebook. Staff sometimes make temporary notes but the information is transferred to the patient's record as soon as possible and the temporary notes are then destroyed.

h. Assertion that SCM LA was assisting

The Claimant stated at the disciplinary hearing the SCM LA was assisting with the expression of breast milk and the Claimant did not physically help the patient. The relevant patient notes were made by the Claimant and stated that she had assisted with hand expressing. The notes made no reference to SCM LA assisting. If an action is not recorded this indicates it did not happen. The Respondent's Midwifery Record Keeping Guideline expects records to state who carried out the care and whether anyone else was assisting with care. The Respondent believed that the either statement was false or the notes were false.

i. Failure to discuss the choice of infant feeding

The issue of expressing breastmilk was initiated by the patient and not the Claimant. The Claimant had been told by colleagues that the patient did not want to breastfeed. The Claimant admitted that she ought to have asked the patient about breastfeeding.

j. No update on breastfeeding since 2012

During the disciplinary investigation the Claimant stated that she had not done a breastfeeding update since 2012. The relevant LearnPro module was up to date and she had a 1-1 with an infant feeding coordinator in May 2016.

k. Failure to reflect on allegations of being rude and abrupt

The NMC Code provides that midwives must "use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice". In her disciplinary interview regarding Patient 1, the Claimant stated that the only change would make about her care was the documentation. In her personal statement to the disciplinary hearing the Claimant stated that "I am absolutely devastated to think that I left a patient feeling this way, although I feel this patient would have complained regardless of how I cared for her, I still feel I have let her down and failed to meet her needs. This is completely out of character for me." The Respondent considered this to be a lack of reflection.

Some limited concerns had been raised informally with the Claimant in 2012 and 2015 (the Claimant was not aware these concerns were on her personnel file).

Regarding Patient 2 on 6 to 7 September

43. The Respondent made the following findings regarding Patient 2's care on 6 to 7 September -

a. Failure to act as an advocate for the woman, inappropriately transferring a high risk woman.

The NMC Code provides that a midwife must "raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace". The baby was preterm and this was a high risk pregnancy. The woman was showing signs of being in labour and the Claimant

thought she might have been. The woman was being moved out of the labour suite on the instructions of a consultant, which may be difficult to challenge. The Claimant did not try to challenge that instruction. An hour later the woman was transferred back to the labour suite and delivered a preterm infant within 30 minutes of the transfer. The Respondent considered the transfer to be inappropriate.

b. Failure to complete a datix

The Claimant did not complete a Datix: Adverse Event Report. The purpose of a datix is to identify adverse events and prevent their recurrence. A Datix was completed by another midwife. The Claimant accepted that she should have taken her concerns further.

c. Failure to documents the fetal heart rate

There was no documentation of the fetal heart rate by the Claimant during the second stage of labour from 00.01 hrs until the birth of the baby at 00.28 hrs. This was a high risk labour. The fetal heart rate should be recorded after every contraction or every 5 minutes. The heart rate is monitored to identifying problems.

d. Discrepancies between the patient notes and the MEWS chart

The patient's blood pressure is noted as 120/74 at 2040 in the patient notes and as 126/68 at 2045 in the MEWS chart.

e. Failure to monitor the fetal heart rate and obtain cord PH samples

PH cord samples were not taken by the Claimant. The samples are used to test for blood gases which are indicative of the baby's condition. The CTG was not used and the Claimant could not recall how the heart rate was monitored. Heart rate monitoring was not documented. The Respondent did not believe that the heart rate monitoring had occurred.

f. Wrongly documented the administration of the third stage drug

The Claimant recorded on the patient notes that the patient had been prescribed "syntometrine 5iu". The Claimant advised that she always recorded it this way. 1ml of syntometrine contains 500 micrograms ergometrine maleate and 5IU oxytocin. The Claimant ought to have noted "syntometrine 1 ml" (or oxytocin 5iu).

g. Failure to act on the observed blood loss of the woman

The patient records note that there was a blood loss of 570 ml. When blood loss exceeds 500ml this is considered a postpartum haemorrhage and a midwife should undertake maternal observations including blood pressure, pulse and fundal palpation. The Claimant admitted not undertaking any observations.

h. Confusion in third stage of active management and maternal effort

The patient notes record that an oxytocic was administered but that the placenta and membrane were delivered by maternal effort rather than by active management involving controlled cord traction to reduce the risk of haemorrhage and retained placenta. The Respondent was concerned that the Claimant did not understand the difference between active management and maternal effort which is a matter of basic midwifery.

i. Failure to consider delayed cord clamping

The baby was premature. There was no record of delayed cord clamping having been undertaken or considered by the Claimant. Delayed cord clamping increases blood flow to the baby and should be considered for premature babies.

j. Failure to document consent to intimate examination

The Respondent's Midwifery Record Keeping Guideline states: "midwives should ensure that where verbal consent is required for procedures this is documented on the record". The Claimant undertook an examination of the patient's perineum. There was no record of consent having been obtained. The Claimant considered that there was implied consent.

k. Failure to record findings regarding perineal examination or advice regarding perineal care

The Respondent's Midwifery Record Keeping Guideline states: "all records must include the following: clear evidence of care required, assessment, care planning, interventions and evaluation of care and patient/ client response". The records do not note the Claimant's findings regarding perineal examination or her advice regarding perineal care.

l. Failure to document perineal trauma accurately regarding Patient 4

The Claimant documented that patient 4 sustained a second degree tear. There was no muscle involvement and this ought to be document as a first degree tear.

Regarding Patient 3 on 10 to 11 September 2016

44. The Respondent made the following findings regarding Patient 3's care on 10 and 11 September -

a. Failure to obtain a translator

The patient did not speak English. The Respondent's Translation and Interpretation Policy provides that patients who do not speak English should have access to an interpreter and it is not appropriate to use a friend. A translator was not sought and initially the patient's friend translated and then a midwife. The patient's friend was not there for the entire period and left before 2230. The patient had had a stillborn baby. The Respondent considered that a translator should have been sought when the friend left.

b. Falsification of case records

The Claimant made an entry in the patient records at 0115 that "maternal observations all within normal limits. Happy to discharge home - phone number of ward given - knows to contact us if any concerns Advised [friend] if she beings to have any flashbacks herself then to contact her GP". During the disciplinary interview Claimant advised that the patient had left without her knowledge and she had discussed her postnatal care with the community midwife. The friend who was translating had left about 2230. The Respondent believed that the Claimant had not discharged the patient at 0115 and the entry in the patient notes was false. The Respondent believed that the Claimant had not given her important follow up information and support.

c. Failure to follow or document correct process for active management of third stage

There is a higher risk of postpartum haemorrhage with a stillbirth. This risk is managed by active management of the third stage by giving an oxytocic drug immediately after the baby is born. The baby was delivered by the Claimant at 2015 and the oxytocic was administered by the Claimant at 2055. There was a delay in

administration of the oxytocic. Following administration of oxytocin the placenta and membranes ought to have been removed manually by the midwife. The Claimant recorded in the patient notes that the placenta and membranes were removed manually ('active management') by the doctor at 2140. The doctor records that they were removed maternal effort and minimal traction.

d. Failure to follow the management of retained placenta guidelines

A placenta is considered retained if there is a 30-minute delay in delivery of the placenta with active management, or 60 minutes with physiological management. Following administration of oxytocin the third stage was being actively managed. Oxytocin was administered at 2055. The placenta was not delivered by 2125 and accordingly the Retained Placenta Protocol would apply. The Protocol required monitoring of blood pressure and pulse every 15 minutes, blood loss charted accurately and a fluid balance chart completed by monitoring urine output. The Claimant did not record this monitoring.

e. Wrongly documented the administration of the third stage drug

The Claimant recorded on the patient notes that the patient had been prescribed "syntometrine 5iu". The Claimant advised that she always recorded it this way. 1ml of syntometrine contains 500 micrograms ergometrine maleate and 5IU oxytocin. The Claimant ought to have noted "syntometrine 1 ml" (or oxytocin 5iu).

f. Statement that 6 years since dealt with a stillborn was false

During her disciplinary interview the Claimant had advised that it had been six years since she had dealt with a stillborn baby. The delivery of a stillborn is very rare. At the disciplinary hearing the Claimant stated that she may have confused the patient another woman who had suffered pregnancy loss on the previous shift. The Respondent inferred that the first statement was false.

g. Failure to carry out any post-natal observations

The baby was delivered at 2015 and no post-natal observations were recorded until 2200. The Respondent concluded that no post-natal observations were undertaken by the Claimant in the period between birth and 2200. Observations ought to have been undertaken every 15 minutes following administration of the oxytocic at 2055.

h. Failure to complete the Labour Summary

Midwives complete a Labour and Birth Summary for patients. The Labour and Birth Summary was not fully completed by the Claimant. No time entry was made for the end of the third stage and no entry was made for the total duration of labour. No entries were made regarding maternal observations. There is a reference to the MEWS chart which contains only one entry at 2200 after the placenta was delivered at 2140. At the disciplinary hearing the Claimant advised that she may have been confused with another woman who had been in the Tulip room (for pregnancy loss) on the previous shift.

45. The investigation report concluded by making a general statement that the Claimant had not provided the fundamentals of safe intrapartum and postnatal care to these three Patients.

The Claimant's Statement of Case

46. The Claimant was provided with a copy of the Investigation Report shortly before the disciplinary hearing. The Claimant did not have sufficient time to read, digest and prepare following receipt of that report in advance of the disciplinary hearing. The Claimant felt unable to respond to the allegations themselves. The Claimant prepared a statement of case for the disciplinary hearing which focused on mitigation and not exculpation. It referred to the deaths of a close relative and a friend in the previous year and her mental health having suffered as a consequence; she advised she was also diagnosed with early menopause and suffered memory loss, depression and anxiety; "I have been a midwife for almost 9 years and have never had any concerns about my practice or my behaviour"; she was sorry if she had let down her patients and her high standards. The statement did not seek to make specific denials regarding each of the allegations. The statement was accompanied by references from doctors and midwives she had worked alongside which commended her high standard of work.

Disciplinary Hearing

47. On 13 February 2017 the Claimant attended a disciplinary hearing. The disciplinary panel comprised JF (Clinical Services Manager) (Chair), JC (Head

of Midwifery) and JW (HR). JF is a registered general nurse. She ceased working for the Respondent in April 2018. The panel were dependent upon JC's knowledge of midwifery. The panel had previously read the Investigation Report. The Claimant was represented by her union rep KF. Her union rep raised concerns with JC being on the panel given her prior involvement. The panel did not accept his concerns. No witnesses were called. HM presented the management report and was asked questions by KF. The Claimant's presented her response and was asked questions by HM. The hearing was adjourned for around two hours. During that adjournment the panel had over 25 separate allegations to consider. During that adjournment they summarised the allegations. Although there is a chair the decision is taken as a panel and their decision was unanimous. The hearing reconvened and the panel advised the Claimant that they were upholding the three allegations. Reasons were read out at the hearing.

Regarding Patient 1 on 9 and 10 June

48. The following reasons were read out at the hearing regarding Patient 1 on 9 and 10 June -

    a. "you did not stop the magnesium sulphate infusion at the time required"
    b. "the MEWS chart was written in retrospect and did not contain any recordings of the women's respiratory rate".
    c. "you failed to follow the Pre-eclampsia guidelines"
    d. "there was no entry in the notes from anybody else, in particular SCM LA" [that she was assisting]
    e. "you made retrospective entries in the notes for recordings from 2000 until 2345 but you did not evidence that you had done this in retrospect"
    f. "you failed to observe the women throughout this period" [from 2000 to 2345]
    g. "you failed to utilise the MEWS chart with the red triggers" [by not escalating them]

h. “your record in the notes reads as if you delivered care to the woman regarding breastfeeding when [you stated] it was the HCA [Health Care Assistant] who did it…this brings into question your integrity”
i. “You advised that you had no update on breastfeeding since …2012 however you had completed a LearnPro module and had a 1-1 with [an infant feeding coordinator]”
j. “The woman felt you had been rude and abrupt and there was no evidence that you had used this to reflect”

49. Separately the panel referred to her use of a personal notebook to document patient care and raised concerns regarding whether it was kept securely and how the notes were translated into patient notes.

50. The reasons given orally at the hearing did not refer to her alleged failure to discuss the choice of infant feeding with the woman which subsequently formed part of the reasons given in the letter of dismissal.

Regarding Patient 2 on 6 to 7 September 2016

51. The following reasons were read out at the hearing regarding Patient 2 on “10 September 2016” (That date was stated in error and the Respondent ought to have referred to 6 to 7 September 2016)-

a. “you failed to act as an advocate for the woman” by advising that she was probably in labour
b. “you did not complete a datix about this matter” being an inappropriate transfer
c. “there is no documentation of the fetal heart rate during the second stage of labour”
d. “there are inaccuracies between the recording of the woman’ blood pressure between the [patient] notes and the MEWS chart”
e. “you failed to ensure that the relevant tests that aid in the assessment of the baby were undertaken”
f. “you wrongly documented the third stage drug that was administered”

g. “you failed to observe the blood loss of the woman and took no action around this”
h. “you failed to document …whether consent was obtained from the women for an examination”
i. “You provided inaccurate documentation regarding perineal trauma”

52. The reasons given orally at the hearing did not refer to the following reasons which were subsequently referred to in the letter of dismissal: administration of an oxytocic (active management) but delivery the placenta and membranes by maternal effort; failure to consider delayed cord clamping despite the baby being preterm at 31 weeks; failure to document that she had discussed her findings or advice for perineal care; and failure to document perineal trauma accurately regarding Patient 4.

Regarding Patient 3 on 10 to 11 September 2016

53. The following reasons were read out at the hearing regarding Patient 3 on “7 September 2016” (That date was stated in error and ought to have referred to 10 to 11 September 2016)-

a. “you failed to follow the Translation and Interpretation Policy” by not contacting a translator
b. “You falsified the records on two occasions” [regarding] “the woman’s discharge” [and] “removal of the placenta”
c. “you failed to follow the retained placenta guidelines”
d. “you incorrectly recorded the administration of the drugs administer during the third stage of labour”
e. “you advised that it had been 6 years since you had dealt with a stillborn however you had” dealt with pregnancy loss in the previous shift
f. “you failed to carry out any post-natal observations”
g. “you failed to complete the Labour Summary within the notes”

54. The reasons given orally at the disciplinary hearing did not refer to the following which subsequently formed part of reasons given in the letter of dismissal: her

alleged failure to follow correct process for active management of third stage despite stillbirth being increased risk of postpartum haemorrhage.

55. At the disciplinary hearing the panel also stated that –

- they did not believe that issues with her health had affected her conduct.
- her alleged failure to raise concerns regarding her health was in breach of the NMC Code.
- she had tried to mislead them by advising that there had been no previous concerns regarding her practice, when they had been advised that concerns of a similar nature had been raised previously.
- She had shown a complete lack of insight
- The character references did not include any from the Midwifery team leaders
- she knew what she was doing, understood what she was required to do, and chose to act in this way and accordingly the failures fell under the Conduct rather than the Capability Policy
- they had considered other alternatives to dismissal
- the case amounted to misconduct and the Claimant was dismissed with pay in lieu of notice.

Letter of Dismissal

56. On 15 February 2017 a letter of dismissal was issued to the Claimant. She was dismissed with payment in lieu of notice on 27 March 2017. The Claimant was asked to return property belong to the Respondent but was not specifically asked to return the Notebook.

Regarding Patient 1 on 9 and 10 June

57. The letter of dismissal stated:

a. “you did not stop the magnesium sulphate infusion at the time required by written medical instruction. The documentation by Dr S clearly states ‘discontinue MgSOG @ 2310 in two places in the entry at 2120hrs when you were caring for this lady…At the investigatory meeting on the 16

September 2016 you have said ‘Doctor said it could just run until finished’. There is no evidence that this was the case”

b. “you clearly stated that the MEWS (Maternity Early Warning Score) chart was filled in retrospect using value from the machine;…it was not documented that this was written in retrospect and did not record the women’s respiratory rate”.

c. “you failed to follow the eclampsia/pre-eclampsia guidelines which state that the respiratory rate should be undertaken every 30 minutes…there is no respiration rate documented from 2000hrs until 2354hrs …In addition you did not document urine output per the guidelines”

d. “You stated [at the disciplinary hearing] that SCM LA had been helping you and was looking after the lady, but there was no entry in the notes …The records are in your handwriting and at the investigatory hearing held on 16 September 2016 you have not raise that SCA LA was assisting. This brings into question your integrity”

e. “you made retrospective entries in the notes for recordings from 2000 until 2345hrs but did not document that you had done this in retrospect[t] or when”

f. “you failed to observe the women throughout this period” from 2000 to 2354hrs

g. “you failed to utilise the MEWS chart with the red triggers. In that you failed to escalate two ‘red trigger’ scores on four occasions and one ‘red trigger’ score on 6 occasions”

h. “You used a personal notebook to document patient care which is not kept securely…You did not transcribe information from the notebook to clinical notes”

i. “you record in the notes reads that you personally delivered care to the woman regarding expressing breast milk when it was in fact the HCA (Health Care Assistant) who delivered the care”

j. “You failed discuss the choice of infant feeding with the woman”

k. “You advised that you had no update on breastfeeding since…2012 however you had completed the LearnPro module and you had a 1-1 with JD, infant feeding coordinator”

l. “The woman felt you had been rude and abrupt and there was no evidence that you had used this feedback to reflect”

Regarding Patient 2 on 7 September 16

58. The letter of dismissal stated regarding Patient 2 on “10 September 2016” (that date was stated in error and ought to have referred to 7 September 2016):

a. “you failed to act as an advocate for the woman. …You did not advocate for the woman by discussing and sharing your assessment that this woman was probably in preterm labour with Dr G or SCM E, instead you inappropriately transferred a high risk woman, on their instruction to the antenatal ward placing her, her baby and your colleagues at risk”.
b. “you did not complete a datix about this matter”
c. “there is no documentation at all of the fetal heart rate, method of fetal heart rate monitoring or interpretation of maternal and /or fetal wellbeing during the late first stage and the second stage of labour when you resumed care at 00.01 hrs until the birth of the baby at 00.28 hrs…You said it must be on the partogram however a copy of the partogram was shown to you and it was blank”
d. “there are inaccuracies between the recording of the woman’ blood pressure between the notes and the MEWS chart”
e. “you failed to ensure that the relevant tests that aid in the assessment of the baby were undertaken”
f. “you wrongly documented the administration of the third stage drug that was administered”
g. “you failed to act on the observed the [sic] blood loss of the woman and undertook no maternal observation, you did not palpate the fundus at 0130hrd when the blood loss had increased and the loss exceeded 500mls”
h. “you administered an oxytocic (active management) but delivered the placenta and membranes by maternal effort (physiological), you did not consider delayed cord clamping or document why this did not occur, despite the fact that the baby was preterm at 31 weeks gestation”

i. “you failed to document whether consent was obtained from the women regarding examination of her vagina, labia and rectum to assess if there had been trauma”
j. “You failed to document that you had discussed your findings and/or advice for perineal care with the woman”
k. “You did not document regarding perineal trauma accurately” [this was in respect of Patient 4]

Regarding Patient 3 on 10 September 2016

59. The letter of dismissal stated regarding Patient 3 on “7 September 2016” (which ought to have referred to 10 September 2016):

a. “you failed to follow the Translation and Interpretation Policy. The panel were concerned that you felt that this was acceptable as another midwife had not contacted a translator either”
b. “You falsified the case record on two occasions”
c. “the information you documented around the removal of the placenta by the doctor was also incorrect. You failed to follow the correct process and guideline for active management of third stage or document why this did not occur, despite knowing that stillbirth is an increased risk for post partum haemorrhage”
d. “You did not follow the management of retained placenta guidelines”
e. “you incorrectly recorded the administration of the drugs administered during the third stage of labour”
f. “you advised that it had been 6 years since you had dealt with a stillborn baby however you had been working in the Tulip Room on your previous shift caring for a woman with pregnancy loss”
g. “you failed to carry out any post-natal observations”
h. “you failed to complete the Labour Summary within the notes”
i. “You failed to ensure that a woman who did not speak English, whose friend had left some time prior to discharge and who had a stillborn baby, had access to an interpreter to ensure that she could discuss her discharge, follow up and ongoing care and supportive services available”

60. The letter of dismissal also stated: -

- "The situation regarding your health had only come to light within your statement of case that your presented at the hearing today, there is no evidence that you previously raised these concerns." The panel regarded her failure to raise concerns regarding her health as a breach of the NMC Code.
- "Throughout this process you had not expressed that you did not know what you were doing. The panel felt you fully understood and you choose to act in the way that you had therefore this was conduct and not capability"
- "It was not one aspect of your practice that was causing concern it was your overall practice as a Midwife that was causing concern and alarm. You failed to bring evidence to the hearing that demonstrated good practice." The panel considered that in some instances she had failed to provide basic midwifery care. The panel were concerned that the failures were wide ranging and pertained to a many elements of her practice as a midwife.
- "You claimed that what happened had been out of character however the panel heard today that concerns of a similar nature have been raised with you previously since 2012. The panel also felt you had tried to mislead them by advising that that had been no previous concerns regarding your practice. This called into question your honesty and integrity."
- "The panel acknowledged the character reference that you had submitted but noted that there were not any from any of the Midwifery Team Leaders or anyone you worked with on a day to day basis". The panel did not seek other character references from Midwifery Team Leaders or otherwise.

NMC Conditions and Suspension

61. On 17 February 2017 the Respondent referred the Claimant to the NMC in respect of allegations 1, 2 and 3. Following a hearing on 15 March 2017 the RMC determined that an interim conditions order was necessary for the protection of the public namely that the Claimant must not be the lead/named midwife and that she must work at all times under the direct observation of a

registered midwife. The order was reviewed and varied on 12 June 2017. The order was reviewed again on 4 January 2018 and an interim suspension order was issued.

Stage 1 Appeal

62. On 23 February 2017 the Claimant submitted her appeal. The grounds of her appeal were that the sanction was too severe in the circumstances.

63. On 19 April 2017 the Claimant was invited to a Stage 1 Appeal Hearing. She was advised details of the appeal panel and of her right to submit a statement of case together with supporting documentation and of her right to be accompanied to the hearing and to call witnesses.

64. In her statement of appeal the Claimant submitted a complaint regarding HM, investigation officer, namely that she was patronising, condescending and derogatory and had prejudged the allegations.

Claimant's response to findings regarding Patient 1

65. In her statement of appeal the Claimant responded to some but not all of the Respondent's findings regarding Patient 1. In summary she stated that: Patient 1 had a propensity to complain; early on the Claimant had notice the patient's blood pressure was rising and had contacted the medical team; despite medication the patient's blood pressure did not improve, the medical team were called again and the infusion commenced; the Claimant had been told by previous midwives that the patient wished to formula feed; and she assisted her with hand expressing.

Claimant's response to findings regarding Patient 2

66. In her statement of appeal the Claimant responded to some but not all of the Respondent's findings regarding Patient 2. In summary she stated that: she had four patients that night, each overlapping the next; the doctor wanted the patient admitted to the ward; she was transferred back again and delivered quite quickly; her trolley was taken out of the room by a colleague to do cord

gasses and check the placenta; the doctor had remained in the room throughout every stage of the patient's care; once the patient was in the shower she completed as much of her notes as possible and then went for a break; on return her notes had been taken by 'paeds' which is common practice, she did a set of observations and checked her blood loss.

Claimant's response to findings regarding Patient 3

67. In her statement of appeal the Claimant responded to some but not all of the Respondent's findings regarding Patient 3. In summary she stated that: the midwife in the clinic had determined that her baby had died and delivery was arranged; an interpreter not previously been in attendance; the couple did not speak any English and their friend was translating; the baby was delivered by another midwife; the Claimant was upset at the delivery and had to excuse herself; she was left to care for the couple 20 minutes after the delivery; the mother and father of the stillborn were sobbing and screaming and she did not feel it appropriate to commence any observations; the placenta had not delivered and the doctor removed the placenta; after removal the doctor discussed post-natal care through the friend; she was then pulled from her room to provide break relief; after some time she returned to the room to complete the documentation and perform other tasks; shortly after the post-mortem discussion the friend left and the couple left shortly afterwards; the Claimant was given another patient to care for whilst trying to complete the documentation; and she asked midwifery team leaders to check the her documentation.

68. In summary the Claimant also made general statements in her statement of case that: she has worked in all aspects of maternity services and in the busiest hospitals; she has never had to attend disciplinary hearings or received sanctions or warnings; there are no formal or regular teams meetings and there is no formal support apart from colleagues; on the nights of Allegations 1, 2 and 3 they were working below the minimum number of staff. The Claimant also re-submitted the same references from colleagues commending her high standard of work together with an additional reference.

GP Letter

69. The Claimant submitted a GP letter with her statement of appeal which stated that she has been suffering from peri-menopausal symptoms. She was seen in March 2016 with menopausal symptoms, no prescription was issued but the Claimant described significant flushing and weight gain. The Claimant also submitted advice and guidance on working with the menopause from the Royal College of Midwives and from trade unions.

Stage 1 Appeal Hearing

70. On 11 May 2017 the Stage 1 appeal was heard by JG (Clinical Services Manager) (Chair), CS (Associate Nurse Director) and CM (HR). JC and HM were called as witnesses by the Respondent. The Claimant was accompanied by her union rep AD. The Claimant did not call any witnesses.

71. JF presented the management case to the appeal panel. She advised that a disciplinary transfer to another healthcare role had been considered but this required adherence to a similar code which the Claimant had failed to follow. HM advised the panel that she had correlated the number of staff on duty during the patient activity and that she was content there was adequate staff. HM advised the panel that there was support available to midwives through the Senior Charge Midwife, the Wellbeing Centre and the Chaplain. JC advised the panel that the Claimant had never raised an issue with her health before, that she had joined the nursing bank and was therefore taking on extra shifts, and under the NMC Code she must raise issues with her health. She advised the disciplinary panel had considered and discounted a programme of support and improvement because it would require to expand across the whole of her practice, she had previously been given support and there were issues with her integrity and honesty.

72. The Claimant presented her response to the appeal panel. She was not aware that she was having problems with her health and the effect this was having on her. She read out her statement of appeal. She accepted that she acted in breach of the Code by not raising her health concerns but she didn't realise the

symptoms were impacting upon her. The service was short staffed and she felt a duty of responsibility to her colleagues to do extra shifts through the bank.

73. On 23 May 2017 JG wrote to the Claimant advising her that her Stage 1 appeal was not upheld and "The Disciplinary Panel felt that there was sufficient evidence to prove that you had failed to deliver care that would be expect by a midwife in respect of all 3 allegations". The disciplinary appeal panel understood that: "You accepted the Disciplinary Panel's determined of the facts and accept the above allegations happened. Your appeal was on the basis that the panel had not taken into consideration the mitigating factors related to your health which you feel impacted upon your decision making and the actions that you took" and further "the sanction was too severe in relation to the allegations that had been made against you". The mitigatory factors were understood to be as follows: her health; the positive references; the absence of prior formal warnings; inadequate support; and insufficient staff on duty. The appeal panel advised that they had taken into consideration the mitigatory facts but upheld the decision to dismiss because of a wilful failure to adhere to rules and procedures; unprofessional conduct; and falsification, inconsistencies and gaps in patient documentation. The Claimant was advised of a further right of appeal.

Stage 2 Appeal

74. On 8 June 2017 the Claimant submitted her second appeal. The grounds of her appeal were that the sanction imposed was not reasonable and that the panel had not taken into consideration the mitigating factors related to her health.

75. On 1 August 2017 the Claimant was invited to a Stage 2 Appeal Hearing. She was advised details of the appeal panel and of her right to submit a statement of case together with supporting documentation and of her right to be accompanied to the hearing and to call witnesses.

76. On 4 October 2017 the Claimant was advised that the Stage 2 appeal hearing had been postponed.

77. On 14 November 2017 the Claimant intimated to the panel statements of personal reflection.

78. On 28 November 2017 the Stage 2 appeal was heard by AW (General Manager) (Chair), KR (Associate Nurse Director) and DC (HR). The appeal started about 9.45 am and concluded about 5:30pm. JC and HM and JG were called as witnesses by the Respondent. The Claimant was accompanied by her union rep AD. Her previous rep KF was called as a witness by the Claimant. JF presented the management case. The Claimant presented her response. In summary the Claimant stated that the references from colleagues were unfairly discounted; they did not consider the effect that receiving Allegation 1 had on her conduct in relation to Allegations 2 and 3; the investigation was not thorough and utilised closed questions; references were made to the 2012 processes; she accepted that in relation to Patient 1 her behaviour was not good enough; she wished she had challenged the findings of the Disciplinary Hearing; that the NMC have not considered suspension to be necessary and instead she is to be supervised; she accepted that it was reasonable to question her integrity; the span of her incompetence should have been supported by an improvement plan.

79. JC explained that she supported dismissal because the Claimant didn't follow guidelines, documentation and basic procedures, she didn't show integrity or reflection, she didn't follow medical orders which were clearly documented, she wasn't able to describe care in the third stage of labour, overall she was not delivering safe and effective care, the issues related to the stillbirth were inexcusable, in the case of the pre-term the foetal heart rate was not monitored, she did not advocate for the patient and she did not assess perennial trauma.

80. On request the Claimant handed the personal notebook to the panel.

81. On 12 December 2017 AW (Chair) wrote to the Claimant advising that her Stage 2 appeal was not upheld. The appeal outcome letter noted that the grounds of her appeal were that the sanction imposed was not reasonable and that the stage 1 panel had not taken into consider the mitigating factors related to her health. It noted however that during the hearing the claimant also raised

a number of other issues with some of the findings in fact, the investigation and the impartiality of JC at the disciplinary hearing. It noted that: at the Stage 1 Appeal the Claimant had accepted the facts of management case; the issue of JC's involvement had previously been considered, the allegations were wider than those raise by the patient and JC was well placed to advise the disciplinary panel regarding the professional expectations of a midwife; the reference to the incidents in 2012 and 2015 were relied upon by the Stage 2 panel in response to her assertion that there had not been previous concerns raised; her misleading statement that the NMC had found she had no case to answer; her personal reflection did not include personal responsibility or professional insight; no mention was made of memory loss until the Stage 1 hearing; during the Stage 2 hearing it became apparent that the Claimant had the notebook which contained patient identifiable information and was not stored appropriately; the Stage 1 panel was right to classify this as repeated misconduct but the Stage 2 panel considered this should be classified as gross misconduct being persistent wilful refuse to perform to the required standards, unprofessional conduct and breach of confidentiality. The Claimant was advised of her final right of appeal.

Final Stage Appeal

82. On 18 December 2017 the Claimant submitted her final appeal. The grounds of her appeal were that: the disciplinary investigation and subsequent disciplinary and appeal hearings had failed to follow the conduct policy; the sanction imposed was disproportionate to the alleged misconduct; and there had been reliance upon factually incorrect statements and personal supposition during the investigation and hearings.

83. On 13 February 2018 the Claimant was invited to a Final Stage Appeal Hearing. She was advised details of the appeal panel and of her right to submit a statement of case together with supporting documentation and of her right to be accompanied to the hearing and to call witnesses.

84. In January 2018 the Claimant received the full set of notes in respect of all of the allegations from the NMC. On 26 February 2018 the Claimant advised

having now seen the full patient records she was only now able to reflect fully on the allegations against her. She asked for the full patient records for the relevant dates to be made available to the appeal hearing but this was not actioned. The Claimant did not include any of these records with her statement of case.

Claimant's response to findings regarding Patient 1

85. In her statement of appeal the Claimant responded to some but not all of the Respondent's findings regarding Patient 1. In summary she stated that: she did not have experience with magnesium sulphate infusion, the Respondent's policy states that a patient should have the infusion for at least 24 hour, the infusion is delivered via a time pump, when she went to stop the pump she was confronted by an angry patient, she did not consider it appropriate to start disconnecting the pump, and instead endeavoured to calm them and address their concerns which resulted in a 45 minute delay; her statement that the MEWS chart was filled in retrospect was given under extreme duress; although her respiration rates were not documented she had monitored patient breathing and she had documented her urine output; she had assisted the patient with her hand expressing breastmilk and she had not falsified the notes.

Claimant's response to findings regarding Patient 2

86. In her statement of appeal the Claimant responded to some but not all of the Respondent's findings regarding Patient 2. In summary she stated that: the patient was concerned she was in labour and observations were taken and she was having mild contractions, on review by medical staff her cervix was closed and she was not in established labour and should be transferred to the ante-natal ward for observations; the Claimant was not in attendance when she was transferred back to the labour ward and remained in the observation area for 25 minutes; CTG monitoring was undertaken in the delivery room; syntometrine was given by the assisting midwife and the placenta was delivered using controlled cord traction; the trolley was taken away by the MTL to check the placenta and take cord gases; she checked patient blood loss; the

consultant and a number of midwives were present throughout; when she returned from a break she found that her notes had gone; the MEWS chart clearly shows observations and the two documented by her are both correct; the labour notes record that Patient 3's perineum was intact (this allegation pertained to Patient 4).

Claimant's response to findings regarding Patient 3

87. In her statement of appeal the Claimant responded to the Respondent's findings regarding Patient 3. In summary she stated that: the ward was short staffed; she had not looked after anyone having a still born at term before; the senior midwife advised that the patient and her partner had little understanding of English but at 1245 hours they agreed they wished their friend to translate – she would have failed in her duty had she gone against the families wishes and arranged an external translator; the still born was delivered at 2015 hrs and the parents were very upset; the claimant was also very upset and asked to be excused – the senior midwife was in charge and she ought to have administered the syntometrine; the claimant was upset when she returned and took over care; at 2055 she noticed the syntometrine had not been given and she administered it; there were no obvious signs of placental separation and she began using controlled cord traction but felt some shearing and escalated her concerns; at 2130 hrs the consult delivered the placenta at her request including manual removal of membranes; the blood loss was minimal and the perineum intact; her pulse was within normal limits; her blood pressure had been within normal limits and she did not feel it necessary to take it until 2200 hours; she was called away to attend to other women with healthy babies; the midwife in charge approved recourse to a consultant who spoke Bulgarian rather than contact translation services; the consultant obtained their consent to the post mortem; the claimant had to perform clinical duties on the still born including taking tissues samples which was highly distressing; she prepared and gave the parents the memory box; she was called away to other duties and on her return she completed a set of observations and gave her contact numbers and postnatal advice; she discussed postnatal analgesia; their friend stated she had to leave and at that point she made sure the couple had all they

needed because they were wanting to leave; she was called away again and on her return the couple had left the room.

Management Statement of Appeal

88. The management statement of appeal was prepared by JF as Chair of the Disciplinary Hearing. In summary she stated that: the findings of the investigation were significantly below the standards expected of a midwife; the care provide to Patient 2 risked them not having a well baby; she had failed to follow guidance regarding Infant Feeding, Retained Placenta, Pre-eclampsia, Fetal Heart Monitoring, Record Keeping and Translation Policy; the issues with the Claimant's health had only been raised at the disciplinary hearing and she did consider that there was a link to the defects in her practice; the Claimant did not express that she didn't know what she was doing and they believed that she fully understood and chose to act that way and therefore this was an issue of conduct and not capability; the NMC had placed a conditions order which covered the majority of her role for reasons which closely reflected the disciplinary issues; the Claimant lacked professional insight having advised she would change only the documentation; in her grounds of appeal the Claimant accepted the Disciplinary panel's determination of the facts and the allegations; the Claimant was inconsistent about whether she had a notebook which contained patient identifiable information.

Final Stage Appeal Hearing

89. On 14 March 2018 the Stage 1 appeal was heard by STJ (Chair), FR (Director of Pharmacy) and VB (HR). The panel had previously read the Investigation report and referred to its appendices together with the notes and outcome from the Disciplinary Hearing and the prior Appeal Hearings. The Chair had previously overturned decisions on appeal. The Claimant was accompanied by her union rep AD. The Claimant did not call any witnesses.

90. JF presented the management case to the appeal panel. HM was called as a witness by JF during the hearing. HM stated that the Claimant did have access to the patient records during the disciplinary investigation. The Claimant

presented her statement to the appeal panel which was in summary: there was no case to answer regarding the issue in 2012; menopausal symptoms had impacted upon her ability to perform her duties but she had not been aware of the symptoms; she had also suffered a family bereavement during this time; that Patient 1 had not expressed concerns at the time about the care she had received; there were five other midwives in the room with Patient 2 along with the consultant supporting her; re Patient 3, she had never looked after a woman at full term with a still born child; the previous shift she had cared for a patient who had terminated at 16 weeks; she had reflected everyday regarding these three patients; the issues with Patients 2 and 3 arose in the same week she was invited to an investigation meeting regarding Patient 1 and this affected her; the positive character references should not have been discounted; having seen the documentation she was now denying all of the allegations. The Final Stage Appeal was not restricted to a review of the earlier appeal processes but entailed a reconsideration of the allegations. (In the Claimant's opinion "every stage felt like a re-hearing of the disciplinary hearing").

91. On 26 March 2018 STJ (Chair) wrote to the Claimant advising that her Final Stage Appeal was not upheld. The reasons given by the panel for the decision in summary were that: a thorough investigation was undertaken; the disciplinary panel and the stages 1 and 2 appeal panels, had sufficient evidence to reach the decision to dismiss; there was evidence that she failed to adhere to the NMC Code; her personal reflection lacked professional insight and evidence of learning regarding the practice failings; the panels had considered her health but did not consider it was a mitigating factor and it was not reasonable to link the symptoms described by her GP to her practice failings; she had not returned the notebook despite the request to return all property (because she considered it her property) which called into question her integrity; the Claimant had advised the panel that she had recently validated her NMC and signed up to courses but when questioned she admitted that she was subject of an interim suspension order since January 2018 which called into question her integrity. The Claimant was advised that she had no further right of appeal.

NMC Fitness to Practice Hearing

92. On various dates in 2019 the Claimant attended an NMC Fitness to Practice Hearing. The NMC charges related to the same patients and the same period of care that had been the subject of the internal disciplinary investigation (namely Patient 1 between 9 and 11 June 2016; Patient 2 on 6 and 7 September 2016; Patient 3 on 10 and 11 September 2016; and Patient 4 on 7 September). In addition the Claimant was charged with providing midwifery services in breach of her interim conditions order. The NMC charges were not identical to the internal disciplinary allegations but overlapped significantly. The NMC panel found 57 of the charges to be proven and 4 not proven. (14 of the 57 charges were found to be proved by admission.) The NMC panel concluded that her fitness to practice was impaired because she had breached numerous provisions of the NMC Code, there was a risk of significant harm, she had acted dishonestly, and she had brought the midwifery profession into disrepute. In September 2019 the panel determined that the Claimant should be struck off the NMC Register. The Claimant is currently appealing that decision. The Claimant's registration was suspended for 18 months pending the outcome of that appeal.

Financial losses

93. The Claimant's gross weekly wage at the date of termination was £714.70 and her net weekly wage was £570. She was entitled to an employer's pension contribution of 9.5%. The Claimant was 49 years old at the termination date.

94. Since May 2016 the Claimant had been looking to leave her employment with the Respondent. She had been in contact with the UK Birth Centre now called Private Midwives who were looking to expand into Scotland.

95. The Claimant made various applications for work following her dismissal both in health and in retail. Whilst she had some interviews she was not offered any work because she is overqualified. She undertook some work for the private midwifery practice. She has earned £2,535 since her dismissal.

96. The Claimant has not been in receipt of state benefits. The Claimant is not currently working.

Observations on the evidence

97. The witnesses gave their evidence in a measured and consistent manner and there was no reasonable basis upon which to doubt the credibility and reliability of their testimony. They answered the questions in full, without material hesitation and in a manner consistent with the other evidence.

98. The standard of proof is on balance of probabilities, which means that if the tribunal considers that, on the evidence, the occurrence of an event was more likely than not, then the tribunal is satisfied that the event did occur.

99. Patient 2's blood pressure is noted as 120/74 at 2040 in the patient notes and as 126/68 at 2045 in the MEWS chart. The precise blood pressure is not apparent to a lay person from the MEWS chart which appears to indicate a blood pressure of between 120-130/60-70. However the Respondent's interpretation was not challenged by the Claimant and it is therefore accepted that there was a discrepancy.

100. The Claimant stated in evidence that the disciplinary hearing was adjourned for 20 minutes. The Claimant stated in her personal reflection on 14 November 2011 that the adjournment had been 2 hours. JF stated that the disciplinary hearing was adjourned for 3 hours but accepted under cross it could have been 2 hours. The disciplinary hearing lasted 1 day starting at 10am, with about an hour for lunch and concluding around 5 pm. The duration of the adjournment was not noted on the minutes of the disciplinary hearing. The notes of the disciplinary hearing extend to 12 pages with the adjournment being noted towards the end of the 9th page. The Claimant did not suggest during the appeals process or in her claim that the adjournment had been 20 minutes. The issue of the duration of the adjournment was not put to JC. Having regard to all of the evidence it is considered likely that the duration of the adjournment was around 2 hours.

Relevant Law

101. Section 94 of Employment Rights Act 1996 ('ERA 1996') provides the Claimant with the right not be unfairly dismissed by the Respondent.

102. It is for the Respondent to prove the reason for her dismissal and that the reason is a potentially fair reason in terms of Section 98 ERA 1996. At this first stage of enquiry the Respondent does not have to prove that the reason did justify the dismissal merely that it was capable of doing so.

103. If the reason for her dismissal is potentially fair, the tribunal must determine in accordance with equity and the substantial merits of the case whether the dismissal is fair or unfair under Section 98(4) ERA 1996. This depends whether in the circumstances (including the size and administrative resources of the Respondent's undertaking) the Respondent acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the Claimant. At this second stage of enquiry the onus of proof is neutral.

104. If the reason for the Claimant's dismissal relates to her conduct, the tribunal must determine that at the time of dismissal the Respondent had a genuine belief in the misconduct and that the belief was based upon reasonable grounds having carried out a reasonable investigation in the circumstances (*British Home Stores Ltd v Burchell [1978] IRLR 379, [1980] ICR 303*).

105. In determining whether the Respondent acted reasonably or unreasonably the tribunal must not substitute its own view as to what it would have done in the circumstances. Instead the tribunal must determine the range of reasonable responses open to an employer acting reasonably in those circumstances and determine whether the Respondent's response fell within that range. The Respondent's response can only be considered unreasonable if the decision to dismiss fell out with that range. The range of reasonable responses test applies both to the procedure adopted by the Respondent and the fairness of their decision to dismiss *(Iceland Frozen Foods Ltd v Jones [1983] ICR 17 (EAT)).*

106. In determining whether the Respondent adopted a reasonable procedure the tribunal should consider whether there was any unreasonable failure to comply with their own disciplinary procedure and the ACAS Code of Practice on Disciplinary and Grievance Procedures. The tribunal then should consider whether any procedural irregularities identified affected the overall fairness of the whole process in the circumstances having regard to the reason for dismissal.

107. Any provision of a relevant ACAS Code of Practice which appears to the tribunal may be relevant to any question arising in the proceedings shall be taken into account in determining that question (Section 207, Trade Union and Labour Relations (Consolidation) Act 1992). The ACAS Code of Practice on Disciplinary and Grievance Procedures provides in summary that –

    a. Employers and employees should raise and deal with issues promptly and should not unreasonably delay meetings, decisions or confirmation of those decisions.

    b. Employers and employees should act consistently

    c. Employers should carry out any necessary investigations, to establish the facts of the case.

    d. Employers should inform employees of the basis of the problem and give them an opportunity to put their case in response before any decisions are made.

    e. Employers should allow employees to be accompanied at any formal disciplinary or grievance meeting.

    f. Employers should allow an employee to appeal against any formal decision made

108. Compensation is made up of a basic award and a compensatory award. A basic award, based on age, length of service and gross weekly wage, can be reduced in certain circumstances.

109. Section 123 (1) of ERA provides that the compensatory award is such amount as the Tribunal considers just and equitable having regard to the loss sustained

by the Claimant in consequence of dismissal in so far as that loss is attributable to action taken by the employer.

110. Where, in terms of Section 123(6) of ERA, the Tribunal finds that the dismissal was to any extent caused or contributed to by any action of the Claimant, then the Tribunal shall reduce the amount of the compensatory award by such proportion as it considers just and equitable having regard to that finding.

111. An employer may be found to have acted unreasonably under Section 98(4) of ERA on account of an unfair procedure alone. If the dismissal is found to be unfair on procedural grounds, any award of compensation may be reduced by an appropriate percentage if the Tribunal considers there was a chance that had a fair procedure been followed that a fair dismissal would still have occurred (Polkey v AE Dayton Services Ltd [1987] IRLR 503 (HL)). In this event, the Tribunal requires to assess the percentage chance or risk of the Claimant being dismissed in any event, and this approach can involve the Tribunal in a degree of speculation.

112. Section 207A of the Trade Union and Labour Relations (Consolidation) Act 1992 ("TULRCA") provides that if, in the case of proceedings to which the section applies, it appears to the Tribunal that the claim concerns a matter to which a relevant Code of Practice applies, and the employer or the employee has unreasonably failed to comply with the Code in relation to that matter, then the Tribunal may, if it considers it just and equitable in all the circumstances, increase or decrease the compensatory award it makes to the employee by no more than 25%. The ACAS Code of Practice on Disciplinary & Grievance Procedures is a relevant Code of Practice.

Respondent's submissions

113. The Respondent's submissions in summary were as follows-

- An employer must consider but not necessarily extensively investigate each line of defence (*Shrestha v Genesis Housing Association Ltd* [2015] EWCA Civ 94)

- For a procedural defect to affect fairness it must deny the Claimant the opportunity to show that the reason for dismissal was insufficient (*Westminster City Council v Caba 1996 ICR 960*) Procedural issues do not sit "in a vacuum" and should be considered together with the reason for the dismissal (Sharkey v Lloyds Bank plc [20015] UKEAT/0005/15)
- Where there is a defect in the disciplinary hearing but the employee has appealed the issue is whether the disciplinary process as a whole amounted to a fair hearing, rather than whether the appeal is a complete re-hearing rather than merely a review (*Taylor v OCS Group [2006] IRLR 613*)
- Only faults which have an impact on the decision to dismiss are likely to affect reasonableness of the procedure (*City and County of Swansea v Gayle UKEAT/0501/12*)
- It is irrelevant whether or not the Tribunal would have dismissed the employee – the Tribunal must not substitute its view (*Foley v Post Office; Midland Bank plc v Madden [2000] IRLR 82)*. This applies to the decision to dismiss and the investigation which let to that decision (*Sainsbury's Supermarkets Ltd v Hitt [2003] IRLR 23*).
- Accurate and comprehensive record keeping is central to the role of the midwife.
- The Claimant's failures included: failing to stop administration of a drug at time prescribed; failing to escalate red trigger scores; failing to monitor the vital signs of a patient; failing to advocate for an at-risk mother in early labour; failing to assess and document foetal heart rate during the birth of a premature baby; failing to keep accurate and contemporaneous records; failing to act on post partum haemorrhaging of a mother; fraudulently creating patient records relating to the discharge of a patient.
- The findings of dishonesty were made by those in the room at the time and shouldn't be second guessed
- The Claimant's persistent failure to follow prescribed procedures put vulnerable mothers and babies at risk
- The Claimant admitted the allegations during the disciplinary process and any later disputes about allegations were minor. The Claimant's

Statements of Case for the appeal stages did not attempt to address the findings until the final appeal stage.

- Following due consideration, the Respondent did not believe the Claimant's explanations and justifications. The Claimant had taken on extra shifts on the nurse bank at times when she said stress was affecting her ability to work properly. Furthermore continuing to work when your standard of care is being affected by your health is a breach of the NMC Code. The GP evidence in relation to menopause did not support the assertion that this affected her work performance.
- The Claimant knew how to perform the duties of her role but was doings to negligently.
- The findings met the definition of misconduct even if some of the findings could have been treated as capability
- There was a reasonable basis for the Respondent's belief that had committed the acts of misconduct following a reasonable investigation
- JC's role was restricted to considering whether there was a prima facie case in relation to Patient 1 that required investigating. JC did not sit on the appeal panels.
- The Claimant was offered access to all of the patient notes but did not take up that offer
- The Claimant had fair notice of precise allegations at the appeal hearings where she could challenge those findings or present further evidence
- The Claimant complained that the appeal panels were going over and over the events of the care of the patients and said "it was as if I was going through the disciplinary hearing again".
- The Claimant stated that she could not tell her team leaders about her menopausal symptoms because she was not aware of them but had been to her GP about them in March 2016
- The Stage 1 Appeal panel understood that she was challenging the sanction and not the findings of misconduct
- The Claimant did not raise delay as a problem at the Appeal stages and there was no assertion or evidence of prejudice

- At the Final Stage Appeal hearing the Claimant gave new evidence about the findings and asserted that she now disputed all of the allegations. The Final Stage Chair noted the inconsistency between her earlier admission and her later denial.
- The Claimant admitted some of the findings at the NMC hearing. It is just and equitable to reduce the basic award by 100% due to the conduct of the Claimant
- The compensatory award should be reduced by 100% for contributory conduct

Claimant's Submissions

114. The Claimant's written submissions were in summary as follows: -

- in the first stage the burden of proof is on the Respondent to show the reason for dismissal. In the second stage the burden is neutral as to whether the Respondent acted reasonably in all the circumstances.
- if the reason relates to conduct, the Respondent must have an honest belief as to the Claimant's guilt by showing it had reasonable grounds sustained by having carried out as much investigation as was reasonable in the circumstances. The investigator had tunnel vision and did not consider the wider context.
- the decision to dismiss must be one a reasonable employer could have taken
- the decision to dismiss the claimant was predetermined – the disciplinary hearing panel had a closed mind. JC who sat on the disciplinary panel, when sanctioning the investigation remarked to HM investigation officer that she had "assured [Patient 1] that appropriate actions [were] being taken." Within 8 days of the invite to the disciplinary investigation regarding Patient 1, the Respondent had identified incidents on 7 September regarding Patient 2 and on 10 September regarding Patient 3 which warranted investigation. They were not from complaints about the Claimant's practice or concerns raised by colleagues. The disciplinary panel only spent 20 minutes deliberating. NMC hearing took 20 days. The employment tribunal hearing took 8 days. There was insufficient time in

the adjournment for the disciplinary hearing to consider, debate and determine the allegations and then write the fairly detailed conclusion that was then presented to the Claimant.

- the disciplinary hearing started at 10 am and concluded at 5pm with an hour for lunch. If the disciplinary panel spent 3 hours deliberating this would only have given them 3 hours to hear both sides before the adjournment which is not credible or likely given the number and complexity of the allegations
- the generalised allegations regarding “care delivered” on specified dates in the disciplinary hearing invite letter, is not aided by the investigation report which is obtuse and written in dense prose. This approach the stands in contracts to the particularised allegations in the disciplinary letter. The generalised allegations were far too vague to allow the Claimant to properly prepare a defence.
- As a consequence the Claimant had no alternative but to present a plea in mitigation rather than an outright denial. Only at the Final Stage appeal did the Claimant first feel able to dispute the allegations as fact. The Claimant couldn’t deny the allegations if she didn’t know what they were. The Respondent shouldn’t infer guilt from the absence of a denial – there is no onus on the Claimant to respond to the allegations.
- no express reference is made to dishonesty or integrity in the generalised allegations in the disciplinary hearing invite letter and the Claimant was not able to properly defend herself. These dishonesty allegations ought to have been particularised in the form in which they appeared in the letter of dismissal.
- there are two parts to a lie: saying something which is not true; and knowing that it was untrue (or being reckless as to its probity). Both parts require an analysis by the decision maker – Was the statement by the Claimant false? Did the Claimant know it was false? There is no evidence that the Respondent properly applied its mind to both questions during the disciplinary process. The Respondent failed to establish an intent to deceive. Whilst some of the practice allegations are of a serious nature, the Respondents approach was coloured by its findings that the Claimant

had lied. If the dishonesty allegations fall away then the allegations are all practice issues.

- there are no specific criticism of the appeal panels per se beyond the fact that none carried out a review of the case in sufficient detail to cure the defects of the disciplinary panel. The appeal panel should have either remitted the matter to another disciplinary hearing or re-opened the investigation. The appeal hearings were simply a review of the process, they did not consider the evidence or make any findings, and accordingly were insufficient to remedy earlier defects. New allegations were introduced during the appeal process.
- the decision to dismiss was out with the band of reasonable responses – the Claimant was being held up to a gold standard. The practice issues do not amount to gross negligence because the Respondent failed to identify the serious risk.
- the NMC finding is fruit from the poisoned tree because the matter was referred by JC, Head of Midwifery and she gave evidence at the NMC hearing

Decision

115. The Claimant was dismissed by the Respondent for misconduct on the ground that the care she had provided to Patients1, 2 and 3 was below the standard expected of a midwife. There was no evidence that the disciplinary panel had another unrelated reason in mind when they made the decision to dismiss. The tribunal therefore concludes that the reason for dismissal was the stated ground. This reason related her conduct which is a potentially fair reason within the meaning of Section 98(1) of the ERA 1996.

116. The letter of dismissal narrated specific reasons for the general finding of a failure to provide adequate care to Patient 1 on 9 and 10 June, in summary –

a. Failing to stop the magnesium sulphate infusion at the time instructed
b. Completing the MEWS (Maternity Early Warning Score) chart in retrospect
c. Failing to document the respiratory rate or urine output during the magnesium sulphate infusion

d. Making a false statement as to who assisted with hand expressing
e. Failing to observe the women from 2000 to 2354hrs
f. Failing to escalate red trigger scores on the MEWS chart
g. Using a personal notebook to document patient care
h. Failing to discuss the choice of infant feeding
i. Advising that she had no update on breastfeeding since 2012
j. Not reflecting on patient feedback

117. The letter of dismissal narrated specific reasons for the general finding of failure to provide adequate care to Patient 2 on 6 to 7 September, in summary –

a. Failing to act as an advocate for a woman in preterm labour and instead transferring her to the antenatal ward
b. Not completing a Datix about the transfer
c. Failing to document the fetal heart rate during the late first and second stage of labour
d. Inaccurately recording the woman's blood pressure
e. Failing to undertake the relevant tests that aid in the assessment of the baby
f. Wrongly documenting the administration of the third stage drug
g. Failing to act on the observed blood loss of the woman
h. Administering an oxytocic (active management) but delivering the placenta and membranes by maternal effort (physiological management)
i. Failing to consider delayed cord clamping
j. Failing to document whether consent was obtained for intimate examination
k. Failing document findings and/or advice for perineal trauma and care
l. Failing to document perineal trauma accurately regarding Patient 4

118. The letter of dismissal narrated specific reasons for the general finding of failure to provide adequate care to Patient 3 on 10 to 11 September, in summary –

a. Failing to ensure that a woman did not speak English and who had a stillborn baby had access to an interpreter

b. Falsifying the case record
c. Failing to actively manage and document the third stage of labour
d. Failing to carry out any post-natal observations per retained placenta guidelines
e. Incorrectly recording third stage of labour drug
f. Advising that it had been 6 years since she had dealt with a stillborn baby when she had cared for a woman with pregnancy loss the previous shift
g. Failing to complete the Labour Summary within the notes

119. The letter of dismissal also narrated other concerns regarding her failure to raise her health concerns previously and that she had tried to mislead by advising that there had been no previous concerns regarding her practice.

120. The factual basis for the specific reasons in respect of Patient 1 on 9 and 10 June was as follows -

a. The patient notes showed that the Claimant had failed to stop the magnesium sulphate infusion at the time instructed. During the investigatory hearing the Claimant asserted that another doctor had said it could run on until finished but this was not captured in the patient notes. During the Final Stage Appeal the Claimant noted that according to the Respondent's policy a patient should have the infusion for at least 24 hours.
b. At the disciplinary hearing Claimant admitted having documented the MEWS chart in retrospect but failed to note these were completed in retrospect. At the final stage Appeal the Claimant said that admission had been made under duress.
c. The magnesium sulphate infusion commenced at 1:30 on 10 June 2016. The patient notes showed that the Claimant had not documented the respiratory rate or the urine output from 2000hrs until 2354hrs. However the patient notes relied upon pertained to 9 June 2016 and not 10 June 2016. This error was not noticed by either the Respondent or the Claimant during the disciplinary process.

d. At the disciplinary hearing the Claimant stated that SCM LA was assisting with the expression of breastmilk. The relevant patient notes stated that she had assisted and made no reference to SCM LA assisting.
e. The patient notes showed that the that there were red triggers on the MEWS chart between 21:00 and 23:10 but the notes don't show any escalation during that period. The Claimant asserted at the disciplinary hearing that the team leader had escalated the red triggers.
f. The Claimant admitted to using a personal notebook to document patient care. The Claimant had retained the notebook as a personal possession but returned this at the Stage 2 appeal hearing.
g. The Claimant advised at the investigatory hearing that she had been told by colleagues that the patient did not want to breastfeed and it was the patient who initiated the discussion regarding breastfeeding.
h. The Claimant stated that she had not done a breastfeeding update since 2012. The relevant LearnPro module was up to date and she had a 1-1 with an infant feeding coordinator in May 2016.
i. In her disciplinary interview, the Claimant stated that the only change would make about her care was the documentation. The Claimant did not undertake written reflection on the Allegations until called to the disciplinary hearing.

121. The factual basis for the specific reasons in respect of Patient 2 on 6 to 7 September, was as follows –

a. The patient's cervix was closed and the consultant instructed her transfer to the ward. However the patient was showing other signs of being in pre-term labour (she was having contractions and was distressed and in pain). The Claimant did not try to challenge that instruction and transferred a high risk patient.
b. The Claimant did not complete a Datix about the transfer which was done by a colleague.
c. There was no documentation of the fetal heart rate from 00.01 hrs until the birth of the baby at 00.28 hrs. This was a high risk labour and the fetal heart rate should be recorded after every contraction or every 5 minutes.

d. The patient's blood pressure is noted as 120/74 at 2040 in the patient notes and as 126/68 at 2045 in the MEWS chart.
e. PH cord samples were not taken by the Claimant. The baby's heart rate was not documented.
f. The Claimant recorded "syntometrine 5iu" and not "syntometrine 1 ml". The Claimant advised that she always recorded this way.
g. The patient records note that there was a blood loss of 570 ml. The Claimant admitted not undertaking any observations including blood pressure, pulse and fundal palpation.
h. The patient notes record that an oxytocic was administered but that the placenta and membrane were delivered by maternal effort rather than by active management.
i. There was no record of delayed cord clamping having been undertaken or considered by the Claimant.
j. There was no record of consent for intimate examination having been obtained. The Claimant considered that there was implied consent.
k. The records do not note the Claimant's findings regarding perineal examination or her advice regarding perineal care.
l. The Claimant documented that Patient 4 sustained a second degree tear. There was no muscle involvement and this ought to be document as a first degree tear.

122. The factual basis for the specific reasons in respect of Patient 3 on 10 to 11 September was as follows –

a. The patient had a stillborn baby and did not speak English. Initially the patient's friend translated but she left. The Claimant did not arrange access to an interpreter.
b. The Claimant made an entry in the patient records at 0115 that she had properly discharged the patient. During the disciplinary interview Claimant advised that the patient had left without her knowledge and she had discussed her postnatal care with the community midwife. The friend who was translating had left about 2230. The Respondent believed that the

Claimant had not discharged the patient at 0115 who had left earlier and the entry in the patient notes was therefore false.

c. The records note that an oxytocic was administered by the Claimant at 2055. The Claimant recorded in the patient notes that the placenta and membranes were removed manually ('active management') by the doctor at 2140. The doctor records that they were removed maternal effort and minimal traction. At the final stage appeal the Claimant raised that the doctor had manually removed membranes.

d. According to the patient notes the baby was delivered at 2015, Oxytocin was administered at 2055 and the placenta was not delivered by 2125 but no post-natal observations were recorded until 2200. Blood pressure and pulse ought to have been monitored every 15 minutes.

e. The Claimant recorded "syntometrine 5iu" and not "syntometrine 1 ml".

f. During her disciplinary interview the Claimant had advised that it had been six years since she had dealt with a stillborn baby. At the disciplinary hearing the Claimant advised she may have confused her with another woman who had suffered pregnancy loss on the previous shift. During the final stage appeal hearing the Claimant explained that it had not been in respect of a still born to term but rather a voluntary termination at 16 weeks.

g. The Labour and Birth Summary was not fully completed by the Claimant and a number of entries were missing. At the disciplinary hearing the Claimant advised that she may have been confused with another woman who had been in the Tulip room (for pregnancy loss) on the previous shift.

123. The factual basis for general comments made at the end of the letter of dismissal were that: the Claimant had not raised her health concerns previously; and the Claimant had stated that there had been no previous concerns regarding her practice when previous issues had been raised.

124. Having regard to the above there was a reasonable basis for the disciplinary panel's belief in respect of each of the specific reasons regarding Patients 1, 2 and 3 with the following possible exceptions –

a. There was no reasonable basis for the disciplinary panel's belief that the Claimant had not documented the respiratory rate or the urine output

during the magnesium sulphate infusion for Patient 1 because the disciplinary panel had reached their conclusion in reliance upon the wrong patient notes.

b. The basis for the disciplinary panel's belief that the Claimant had incorrectly documented the third stage of Patient 3's labour as active management was not wholly clear because the patient notes also refer to cord traction and manual removal of membranes.
c. There was no reasonable basis for their belief that the Claimant had falsely stated in respect of Patient 3 that it had been six years since she had dealt with a stillborn baby. The Tulip room provides care for pregnancy loss following termination and following stillbirth. Stillbirths are very rate. It was more likely that she was referring to a termination than a stillbirth.

125. The Respondent's findings were largely based upon the patient notes and the Claimant's testimony. Patient notes are intended as an accurate record of what has occurred. The investigating officer did not include patient 1's notes for 10 June 2016 which were materially relevant to the alleged failure to observe during the magnesium sulphate infusion and ought to have been included and considered. The Claimant had access to all of the patient notes and by the Final Stage Hearing had copies of the patient notes. The Claimant was invited to lodge additional documents but did not lodge any of the additional patient notes. The investigating officer interviewed witnesses in respect of Patient 2 and 3 but not in respect of Patient 1. The Claimant was invited to but did not call any witnesses. The basis for the disciplinary panel's belief in respect of each of the general allegations regarding Patients 1, 2, and 3 arose following a reasonable investigation with the exception of failure to observe during the magnesium sulphate infusion.

126. The members of the Dismissing Panel who gave evidence appeared entirely genuine and sincere in their belief that the standard of care that the Claimant had provided to Patients 1, 2 and 3 was below the standard expected of a midwife. There was no evidence either that they had any other unrelated reason in mind or that their belief was not genuine. There was a reasonable basis for their belief based upon a reasonable investigation. The tribunal

therefore concludes that the Dismissing Panel held a genuine belief in the Claimant's misconduct at the time of her dismissal.

127. The Respondent did not comply with all of the material requirements of their own disciplinary procedure or the ACAS Code of Practice on Disciplinary and Grievance Procedures. Prior to the disciplinary hearing the Respondent did not adequately specify in what way the care given by the Claimant had fallen below the required standard of care in respect of each patient. The Respondent did not therefore properly inform the Claimant of the specific allegations and give her an opportunity to put her case in response before any decisions were made. The specific allegations were properly specified in the letter of dismissal, but this was after the decision to dismiss had been taken.

128. On occasions during the disciplinary process the Respondent referred to the wrong dates in respect of the general allegations regarding Patients 2 and 3 but this was clarified in the Investigation Report and the invite to the disciplinary hearing and there was no evidence or assertion that the Claimant was confused by this.

129. The allegation regarding Patient 4's perineal trauma was not separately specified and caused understandable confusion to the Claimant who at times thought it was a reference to Patient 3 whose perineum was intact. This confusion was not considered or remedied on appeal but the Claimant was dismissed because the standard of care she provided to Patients 1, 2 and 3 (and the Respondent relied upon multiple findings in reaching their general conclusion).

130. JC (Head of Midwifery) had had prior involvement in Patient 1's complaint which then triggered the disciplinary investigation by HM. However, her prior involvement was minor and did not of itself undermine her ability to sit on the disciplinary panel.

131. Whilst appeal process lasted over 1 year there was no evidence regarding the reason for the delay, whether the delay was unreasonable in the circumstances or the effect of the delay.

132. The disciplinary panel adjourned for 2 hours to consider the allegations. Whilst there was sufficient time during the adjournment for the disciplinary panel to prepare the detailed findings that were presented to the Claimant there was not sufficient time during the adjournment for the disciplinary panel to also interrogate the factual basis for the specific allegations given their number and complexity and the disciplinary panel were reliant upon the absence of specific denials by the Claimant.

133. The decision to dismiss was not predetermined. The reassurance given to Patient 1 that appropriate action was being taken was entirely consistent with a disciplinary investigation having commenced (rather than dismissal having been determined), the concerns regarding Patients 2 and 3 had been prompted by a Datix and routine stillborn review, and the disciplinary hearing adjournment was short because there were no specific denials to consider.

134. The Disciplinary Panel reasonably believed that certain statements made by the Claimant were deliberately false or misleading: that the HCA had assisted Patient 1 with hand expressing; that it had been six years since she had dealt with a stillborn; that she had properly discharged patient 3; and that there were no prior concerns regarding her practice. The first statement was made in response to a concern regarding the assistance given with expressing milk. The documents did not support the assertion that HCA LA had been assisting. The Respondent reasonably believed the statement was deliberately false on reasonable grounds. The second and third statements were made in response to concerns regarding her care of a stillbirth. There was no reasonable basis for the belief that the second statement was false (it was likely that the Claimant had cared for a termination on the previous shift and not a stillborn). The third statement was a detailed entry in the patient notes regarding her proper discharge of Patient 3 at 0115 when the patient had already left sometime before without her knowledge. The Respondent reasonably believed that the statement was deliberately false on reasonable grounds. The fourth statement was made in response to concerns regarding her practice. The Claimant was aware that some previous concerns had been raised regarding her practice

(although she had had no formal warnings) and the Respondent reasonably believed that the statement was misleading on reasonable grounds.

135. There were three Stages to the appeal process adopted. The appeal process entailed a detailed reconsideration of the allegations. (According to the Claimant “every stage felt like a re-hearing of the disciplinary hearing”). The Claimant was invited to call witnesses and lodge documents. The Claimant had access to the patient records during the disciplinary process and had a complete copy of patient notes by the time of the Final Stage Hearing. The Claimant had adequate opportunity to put her case in response to the specific allegations. The appeal panels had adequate time to properly interrogate the factual basis for the specific allegations.

136. The chairs of the Appeal panels gave evidence and appeared entirely genuine and sincere in their belief that the standard of care that the Claimant had provided to these patients was below the standard expected of a midwife. There was no evidence that they had any other unrelated reason in mind and that their belief was not genuine.

137. The procedural irregularities did not affect the overall fairness of the process. Considering the disciplinary process as a whole, and having regard to the reason for dismissal, the procedure adopted fell within the range of reasonable responses open to an employer acting reasonably in the circumstances.

138. The Claimant had failed to follow instructions regarding medication; failed to operate a MEWS early warning chart properly; made deliberately false assertions; failed to properly observe patients and their babies; failed to properly manage the third stage of labour; failed to secure translation for a still birth at term; and failed to properly document the care provided. The Respondent reasonably believed that the Claimant had failed to provide basic midwifery care to three patients on separate occasions. The Claimant was not being held to a gold standard of care.

139. The Claimant had asserted in mitigation that she was suffering from stress and the effects of the menopause at the relevant time. The Claimant had not raised any issues with her health until the disciplinary process, she had taken on extra

shifts on the nurse bank, and the medical evidence did not refer to symptoms affecting her work. Accordingly, the Respondent believed on reasonable grounds that her health was not affecting her work. The Claimant asserted in mitigation that there had been no previous concerns regarding her practice when some previous issues had been raised, although there were no formal warnings.

140. The Clamant had 5½ years' service with the Respondent. The Claimant asserted in mitigation that she had been a midwife for almost 9 years, that her general midwifery care was up to standard and lodged character references to this effect. These references did not pertain directly to the allegations and were not from any of the Midwifery Team Leaders. Although the Respondent did not seek references from the Midwifery Team Leaders any such references would not have pertained directly to the allegations. Accordingly, the Respondent was reasonably entitled to merely acknowledge those references.

141. The Claimant asserted in mitigation that there were insufficient staff on duty. HM had correlated the number of staff on duty and was content there was adequate staff. Accordingly, the Respondent believed on reasonable grounds that this was not adequate mitigation.

142. The Claimant asserted in the disciplinary process that the allegations ought to have been consider a matter of capability requiring support and an improvement plan rather than dismissal. The Claimant had almost 9 years' experience as a midwife. The Respondent reasonably believed that the Claimant knew how to properly operate a MEWS early warning chart and understood her obligation to do so, understood her responsibility not to make false assertions, knew how to properly observe patients and their babies and understood her obligation to do so, understood that someone who did not speak English would require an interpreter, and understood her obligations to properly document the care she provided. Whilst there were a few allegations which in isolation could reasonably to have been considered matters of capability rather than conduct (e.g. she did not know how to properly record the third stage drug), it was not unreasonable for the Respondent to consider

that the failings considered as a whole amounted to an issue of conduct rather than capability.

143. In the reasonable belief of the Respondents: the Claimant had failed on a number of occasions to provide basic midwifery care to three separate patients despite knowing how to provide it; the Claimant had not provided adequate explanation or mitigation for her conduct; and her conduct had risked the health of the patients and their babies. The Respondent reasonably believed that the Claimant did not intend to cause or risk harm but that she was reckless as to the potentially serious consequences of her actions. The Respondent also reasonably believed that the Claimant had been dishonest (having made deliberately false statements).

144. The Respondent reasonably believed that her conduct met the definition of gross misconduct in their policy which includes: gross negligence or irresponsibility; persistent wilful refusal to perform to the required standards of the job role; unprofessional conduct; and wilful failure to adhere to clinical governance/infection control policies.

145. The Respondent's beliefs regarding the failure to observe during Patient 1 during her magnesium sulphate infusion and the statement regarding her experience of pregnancy loss in respect of Patient 3 were not held to be on reasonable grounds. However the Respondent relied upon multiple other findings in reaching their general conclusion that the Clamant had not provided the requisite standard of care in respect of Patient 1 and also in respect of Patient 3. The issues with these two findings did not affect the overall fairness of the decision to dismiss on the stated grounds.

146. Another employer of similar size and administrative resources, acting reasonably in the circumstances, might well have taken the decision to dismiss a midwife of 5 ½ years' service (without prior conduct or other warnings), who failed to provide basic midwifery care to three patients on separate occasions despite having almost 9 years' experience and knowing how to provide that care, who had not provided adequate explanation or mitigation for her conduct,

whose conduct risked the health of patients and their babies, and who had been dishonest (having made deliberately false statements).

147. The tribunal therefore determined in accordance with equity and the substantial merits of the case that the Respondent acted within the band of reasonable responses (including the procedure adopted) in treating the reason given as a sufficient reason for dismissing the Claimant in the circumstances.

148. The Claimant was not therefore unfairly dismissed.

Employment Judge: **Michele Sutherland**
Date of Judgment: **20 December 2019**
Date sent to parties: **20 December 2019**