SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2020] CSIH 40
XA107/19]

Lord Justice Clerk
Lord Brodie
Lord Woolman

OPINION OF THE COURT

delivered by LADY DORRIAN, the LORD JUSTICE CLERK

in the Appeal

by

LK

Appellant

against

A Decision of the Nursing and Midwifery Council

_____

Appellant: Party with PK lay Support
Respondent P Reid; Nursing and Midwifery Council

9 July 2020

Introduction

[1] This a statutory appeal (in terms of section 60 of the Health Act 1999 and articles 29(9) and 38 of The Nursing and Midwifery Order 2001) against a decision of the Fitness to Practice Committee of the Nursing & Midwifery Council ("the committee"), dated 5 September 2019 and communicated to the appellant on 6 September 2019, to issue a striking off order in terms of article 29(5)(a) of the Nursing and Midwifery Order 2001("the

2001 order"). [An interim suspension order is currently in place and remains until the outcome of this appeal.]

[2] The order was issued following consideration of a total of 61 allegations grouped in seven separate sections. The allegations in this case are wide-ranging and relate to fundamental midwifery care including: inaccurate recording of and failure to undertake observations, failures to follow correct procedures and policies, lack of knowledge and falsification of records. Sections 1-4 alleged numerous instances of poor clinical practice and conduct in respect of four patients (A, B, C and D) in 2016 at an NHS hospital, including failure to provide an appropriate standard of midwifery care across a number of areas and practice skills and in particular poor and/or inaccurate record keeping, patient observation, and monitoring. Section 5 alleged that she had allowed her Cardiotocography ("CTG") training to lapse between 2 July 2016 and 11 September 2016. Section 6 asserted that her failures in recording patient notes which were asserted at sections 1.2(g), 1.2(h), 2.1(f) and 3.4 had been dishonest. Section 7 asserted that, pending investigation of the other charges, and whilst employed outwith the NHS, she had provided midwifery services without being under the direct supervision of a registered midwife on one or more occasion(s) between 1 September 2017 and 4 January 2018 (contrary to the terms of an interim sanction order made pending investigation of the other charges).

[3] The committee heard evidence and submissions over of the course of a 16 day hearing which originally commenced on 12 February and concluded, following adjournments, on 5 September 2019. The committee found 58 of the allegations proved on the facts or by the appellant's admission, and of these all but 8 amounted to misconduct. It held that the appellant's actions fell significantly short of the conduct and standards expected of a registered midwife, including multiple breaches of The Code: Professional

Standards of Practice and Behaviour for Nurses and Midwives (2015) ("the Code"); and was satisfied that the appellant's fitness to practice was currently impaired. It concluded that a strike off sanction was appropriate to protect the public and for public safety considerations given the seriousness of the misconduct found, which included findings of dishonesty regarding patient note taking.

[4] In this appeal the appellant challenged the committee's decision on grounds which are specified more fully under the summary of the submissions. Broadly, the grounds were: unreasonable delay in terms of article 6 of the European Convention on Human Rights; application of the wrong standard of proof; inversion of the onus of proof; numerous alleged procedural irregularities; errors as to the admissibility and assessment of evidence; and the imposition of an excessive and disproportionate sanction.

Background

[5] The appellant completed her training and qualified in 2008. She worked in other NHS hospitals before transferring to the hospital in question in 2012. Prior to qualifying she worked in a paramedical capacity for 16 years. As at 2016 the appellant was employed as a part time band 6 midwife at the hospital.

[6] The allegations were brought to the hospital's attention via a number of means, and subsequently investigated by them under their own internal procedures and employee disciplinary policy, resulting in the appellant's ultimate dismissal on 13 February 2017, which was then challenged in various appeals. The allegations were referred to the respondent on 17 February 2017.

[7] In early 2017 the appellant became employed with a supplier of private midwifery services, circumstances pertaining to which led to charge 7.

The regulatory regime

Standards of Practice and Behaviour

[8] In terms of article 3 of the 2001 Order the Nursing and Midwifery Council ("NMC"), is required to set standards of education, training, conduct and performance and to put in place arrangements to ensure that they are met and for the investigation of any alleged findings.

[9] Of particular relevance is "The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives" (2015) which sets out common standards of conduct and behaviour for those on the register. The respondent has also issued Guidance on the Standards of Competency for Registered Midwives (2020), divided into four areas, namely:

- Effective midwifery practice.
- Professional and ethical practice.
- Developing the individual midwife and others.
- Achieving quality care through evaluation and research.

All midwives must demonstrate their knowledge and competence in all these areas to register as a midwife.

The rules

[10] The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the 2004 Rules") sets out the procedure to be followed by the Fitness to Practise Committee when considering any allegation and before making a sanction order under article 29(5), as occurred in the present case.

[11] Rule 24 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 sets out the approach to be taken by a Fitness to Practise Committee at an initial hearing.

Following identification of the registrant, the charges and any objections and admissions the key stages are:

1. Determination of the facts proved or admitted.
2. Assessment of whether the facts found proved amount to misconduct.
3. If so, whether fitness to practise is impaired as a consequence.
4. If so, what, if any, sanction should be imposed.

In terms of Rule 30, where facts relating to an allegation are in dispute the burden of proving such facts rests on the respondent.

[12] Provision about the admission of evidence is contained in Rule 31(1):

> "Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place)."

Guidance

[13] The 2001 Order also provides that the NMC may publish guidance as to matters of practice and as to how the powers conferred by the Order or subsequent rules issued under it are used. An example of such guidance is provided in "*Making decisions on dishonesty charges*" (DMA-6, last updated 12 October 2018). A committee has to decide whether or not the conduct took place, and if so, what was the individual's state of mind at the time. It must consider the background facts or circumstances, and what the nurse or midwife knew or believed about what they were doing. Dishonesty has to be judged applying what it understands the standards of ordinary, decent people to be. It is important to consider whether there was another, innocent explanation for the conduct, pointing away from dishonesty.

[14] Guidance on sanction is available in "*Factors to consider before deciding on sanctions*" (SAN-1, last updated: 31/08/2018), under reference to proportionality, aggravating and mitigating factors and other features which may impact on sanction. Various types of mitigation are addressed.

- Evidence of the individual's insight and understanding of the problem, and their attempts to address it.
- Evidence of following the principles of good practice, which may include evidence of keeping up to date with their area of practice, or previous good character or history.
- Personal mitigation, eg periods of stress or illness, personal and financial hardship, level of experience at the relevant time, and level of support in the workplace.

Guidance on publication is given in [P]ublication of Fitness to Practise and Registration Appeal Outcomes (effective from August 2017, Amended by Deputy Director of Fitness to Practise: 30 January 2018).

Background to the charges

[15] The first group of allegations (Charges 1.1(a) to 1.4) related to the care given by the appellant to Patient A over the 9-10 June 2016 at various points. Concerns regarding this patient's care were initially investigated by the hospital following a formal written complaint and feedback document submitted by the patient and her husband on 26 August 2016. The complaint prompted a review of documentation and care of Patient A by the hospital, conducted primarily by Ms 2, the Inpatient Manager for the Maternity Unit. Within that role she was expected to answer complaints from women and their families and would be asked to carry out investigations into them.

[16] Patient B was admitted to the hospital on 6 September 2016 at 31+ weeks pregnant and gave birth to a pre-term baby on 7 September. She had had a high risk pregnancy. Concerns about the care provided by the appellant were brought to the hospital's attention following the submission of an internal incident report- called a "Datix" report- dated 7 September 2016, and completed by another midwife, Ms 5, raising concerns about the approach of the appellant.

[17] On 10 September 2016, Patient C, a non-English speaking female, gave birth to a full term stillborn baby. At that time all women who had a pregnancy that resulted in a stillbirth at the hospital had a multidisciplinary risk management review of their care, primarily by Ms 2. As a consequence of this review Ms 2 identified concerns regarding antenatal, labour, and post labour care by the appellant.

[18] During the review of the care provided by the appellant to Patient B Ms 2 identified further alleged failings to provide adequate care on 7 September 2016 to a fourth patient, Patient D. On the advice of HR the concerns she identified were not investigated internally owing to the volume of material already being investigated.

[19] Following completion of her investigation, Ms 2 produced a written report and recommended that the concerns relating to the appellant's care provision to patients A-C should be referred to a disciplinary hearing. The disciplinary hearing was chaired by Ms 1, the Clinical Services Manager for the Hospital. Ms 2 was the presenting officer. The disciplinary hearing resulted in a decision to dismiss the appellant. Following an appeal process that decision was upheld in November 2017.

Procedure prior to the FTPC hearing

Interim orders and additional charges

[20] The respondent received a referral concerning the allegations relating to Patients A-C on 17 February 2017. An interim conditions of practice order ("ICOPO") was imposed for a period of 18 months. Interim orders are reviewed every 6 months unless there is a material change of circumstances. An early review of the interim order was requested by the respondent in June 2017 following an alleged breach of the ICOPO. By a decision dated 15 June 2017 the respondent varied the ICOPO to clarify a potential misunderstanding.

[21] A second review took place at a hearing on 4 January 2018, raising concerns that the appellant had been acting unsupervised as a midwife to a private patient, in breach of condition 3 of the ICOPO, which provided:

> "At any time that you are employed or otherwise providing midwifery services, either remotely or face to face, you must place yourself and remain under the direct supervision of a registered midwife. Such supervision is to consist of working at all times under the direct observation of a registered midwife. "

The appellant accepted that condition 3 of the ICOPO had not been fully complied with, (and breached on 7 occasions) but maintained that the spirit and its objective had been. On 8 January 2018 the appellant's ICOPO was replaced with an interim suspension order, this being viewed as necessary for public protection pending the respondent's investigation. These admitted breaches led to the inclusion of charge 7 before the FTPC.

FTPC Hearing

[22] The respondent led 4 witnesses, Ms 2; Ms 1; Ms 4; and Ms 3, the administrative officer of the Private Midwifery service provider. The respondent also placed reliance on the signed statement of the respondent's investigation manager, Mr 6. No evidence was led from or statements produced for Patients A-D. A signed statement from a senior charge midwife, whom the appellant said she had asked to review her patient's notes for Patient C,

which had been given to Ms 2 during her investigation and which formed part of her investigation report was produced.

[23] The appellant gave evidence and led the evidence of Ms 5, a midwife at the hospital at the time of the allegations and who had completed the Datix report concerning Patient B. The committee notified its factual findings on 15 August, and reconvened on 2 September to address misconduct and impairment, having heard the live evidence of the appellant, read her reflective piece and considered parties' submissions.

Misconduct

[24] The committee was of the view that the appellant's actions fell significantly short of the standards expected of a registered midwife. She had breached multiple provisions of the Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) ("the Code"), departed from various policies which her employers had in place, and departed from the NMC's guidance on the standards of competency for registered midwives.

[25] The panel considered each of the charges individually in determining whether the appellant's actions were so serious so as to amount to misconduct in the circumstances. It concluded that all but 8 of the charges found proven fell seriously short of the conduct and standards expected of a registered midwife and amounted to misconduct.

[26] The finding in charge 6 that the appellant's actions were dishonest in relation to charges 1.2(i) and 3.4 was a serious attempt to create a misleading impression that she had previously discussed breastfeeding with Patient A, and had formally discharged Patient C. The panel noted that honesty, integrity and trustworthiness were the bedrock of the midwifery profession, and that the appellant had breached a fundamental tenet of the nursing profession in documenting information known to be incorrect.

Impairment

[27] The panel went on to consider whether, as a result of its findings on misconduct, the appellant's fitness to practise was currently impaired. It concluded that it was. The panel noted that the concerns had related to both the appellant's clinical midwifery practice, as well as her behaviour.

Sanction

[28] The committee considered that the appellant's actions were serious, had exposed patients to a significant risk of harm and had not demonstrated the care and compassion necessary for midwifery practice. Allowing the appellant to maintain NMC registration would put the public at a continued risk of harm, and would undermine public confidence in the profession and in the NMC as a regulatory body. Considering all of these factors, the appropriate and proportionate sanction was that of a striking-off order.

Alleged delays once hearing commenced

[29] The appellant contends that a significant delay occurred between lodging of the allegations in February 2017 and their determination in September 2019.

From the papers, transcripts and submissions before this court the following key steps in the timeline for the purposes of this appeal have been identified:

- The allegations relating to patients A-C were referred to the respondent on 17 February 2017.
- The respondent's initial investigation commenced and was concluded in January 2018. Following consideration by the Case Examiners, of *inter alia* potential breaches of the ICOPO, discussed above, further investigations by an investigation panel were recommended by the Case Examiner.

- The case was referred to the Fitness to Practice Committee by September 2018 by which time charge 7 was introduced (it appears that charges relating to Patient D were also added during further investigation).
- The original FTPC hearing was set down for 7 days-12-15 and 18- 20 February 2019. At the commencement of the hearing certain preliminary issues, in particular regarding disclosure, arose. Discussions over these matters continued over the next few days, during which the panel identified potential grounds for recusal of one its members. On the 5th day the hearing re-convened with a new panel member, and also a new Legal Assessor and legal secretary. Thereafter a motion was made for the appellant to discharge the remaining 3 days available and assign a further 10 day diet at which she would, for diary reasons, be represented by new counsel. This motion was said to be on the appellant's instruction and following advice given. The motion was granted and a further diet commencing on 7 May including 7-10, 20-22 May was assigned.
- Evidence was heard on 7-10 and 20-22 May. The hearing reconvened on 12 August at which oral submissions in support of written submissions already lodged were made. The hearing was then adjourned until the afternoon of 15 August, on which date the panel issued its findings on the facts. It was anticipated that additional dates would be required to address impairment and on the appellant's unopposed application the hearing was continued to 2-5 September 2019 to allow time to consider the factual findings and to address impairment and sanction aspects of the hearing.

Submissions

[30] Detailed written submissions were made by both parties and taken account of by the court. A table narrating the appellant's challenges in respect of each charge proven and the respondent's response was also produced. What follows is a summary of the key issues. The grounds advanced by the appellant tended to overlap, the same point being advanced in respect of a number of grounds.

Submissions for the appellant

Ground of appeal 1-Breach of article 6 ECHR

[31] Two complaints were made: that the manner in which they were conducted rendered the proceedings unfair and that the proceedings did not conclude within a reasonable time. It was submitted that in subjecting the appellant to proceedings to determine whether she had been dishonest, the NMC had failed to respect requirements 1 and 3 of article 6 of the ECHR.

[32] By virtue of the use of regulatory proceedings, and the lack of primary evidence relied upon by the respondent, the appellant had been deprived of the opportunity to have witnesses against her examined. The application of civil standard of proof was unfair in respect of allegations of dishonesty.

[33] There had been a breach of the "reasonable time" provision of article 6. The matter was referred to the respondent in 2017 but a hearing did not take place until February 2019. Delays were exacerbated by piecemeal disclosure of documents which the appellant's counsel objected to at the outset of the hearing. The unfairness was compounded by the NMC's request of its own witness, Ms 2, to search for and provide some of the non-disclosed documents. Once commenced the hearing in itself had been delayed due to adjournments

for further documentation, recusal, and witness availability amongst other reasons. It had ultimately been heard over a period of 7 months with various breaks. The respondent sought three extensions to interim orders.

[34] The appellant was deprived of the right of continuity in a public hearing, guaranteed by section 6(1) of the Human Rights Act 1998. The membership of the committee had changed during the course of the hearing on grounds of recusal. This was in addition to a change of Legal Assessors and secretary in mid case. The new panel member had not been present during the opening exchanges. There was no adequate public scrutiny afforded of the advice given to the committee by the Legal Assessor. Changes in her legal representation in the course of the hearing had also denied the appellant continuity. The lack of continuity in the panel membership and in legal representation resulted in an inability to deal with the hearsay nature of the evidence of Ms 2, and her apparent giving of expert evidence which were challenged on the appellant's behalf.

[35] By releasing a full list of charges to the press on 15 February 2019, with no statutory requirement to do so, and by including reference to the serious allegations of dishonesty in advance of the hearing, the respondent artificially created high public interest, and in so doing breached the Nolan Principles (otherwise, The Seven Principles of Public Life; The Ethical Standards Expected of Public Office-Holders).

Ground two – procedural unfairness

[36] Five specific complaints were made: (a) failure to obtain the primary evidence; (b) admissibility of evidence given by Ms 2; (c) discrimination; (d) withholding of evidence; and (e) assessment of expert evidence.

Primary evidence

[37] The NMC had a duty to investigate cases properly- *Professional Standards Authority for Health and Social Care* v *Nursing and Midwifery Council and X* [2018] EWHC 70 (Admin) at Para 65. The primary evidence (the four patients, doctors and senior charge midwives involved in their treatment) in support of the allegations was not led. The appellant was accordingly prevented from cross-examining such witnesses. It was suggested that witnesses B and C made no complaints, and the complaints of witness A would not have withstood scrutiny. It was submitted that other than Ms 2's speculation as to the import of the absence of clinical notes, and in the absence of any corroborative evidence from any other source, the NMC could not get a case off the ground other than in respect of inadequate record keeping.

Challenges to the admissibility of hearsay and expert evidence given by Ms 2

[38] The transcript for 14 February records an exchange between the panel and the legal assessor in which legal advice was given with regard to the admissibility of evidence. The committee's decision together with the Legal Assessor's advice on how Ms 2's evidence should be treated was plainly wrong and did not accord with the approach specified in *El Karout* v *Nursing & Midwifery Council* [2019] EWHC 28 (at paragraphs 96-99 and 128) and *Ogbonna* v *Nursing and Midwifery Council* [2010] EWCA Civ 1216. The appellant had not been offered the chance to cross-examine Patient A, nor indeed had any evidence been led from her; and separately Ms 2's evidence that there had been a complaint from Patient B during a phone call was uncorroborated.

Discrimination during the application of Rule 31

[39] It was submitted that as a midwife in Scotland, she had been subjected to standards

and processes different from those applied by and regulating the NMC's obligation of fairness and relevance in the assessment of admissibility and weight to be attached to evidence under Rule 31 in England and Wales.

Withholding of documentation

[40] The NMC merely presented documents it deemed appropriate: complete patient notes were not produced and certain documentation was missing. During the evidence of Ms 2 she made reference to a notebook of the appellant's of which the panel requested sight. This was not produced by the respondent and the panel referred in their decision to the fact that the appellant did not produce it thus reversing the burden of proof. It specifically stated (at page 34 of the decision) that "The panel did not have a copy of your notebook, nor did you produce it during evidence." A subsequent FOIA request by the appellant disclosed that the NHS Tayside Trust had destroyed the notebook.

Incorrect assessment of expert evidence

[41] In evaluating the opinion evidence given by Ms 2 the panel only considered the weight to be attached to this evidence. The panel should have considered whether the evidence met the test for admissibility of expert evidence. Had they done so the evidence would not have met the test of impartiality. By presenting that evidence the respondent was in breach of the duties imposed upon it by the Nolan Principles and the requirement of utmost probity.

Ground 3- Balance of Probability

[42] A number of complaints were made under this ground: (a) the assessment of Ms 2's evidence; (b) burden of proof; (c) expert evidence; (d) the legal assessor's advice; and (e)

approach to dishonesty. Some of these have been noted already in reference to other grounds.

[43] It was submitted that drawing from the content or lack thereof in patient records an inference that certain care was not given was a leap which no reasonable committee properly advised as to the law, and considering the facts, could reasonably have made. Ms 2 had no actual knowledge of the circumstances relating to the clinical care provided to the patients, and had not spoken to patients A, C or D. Her evidence that she had spoken with Patient B was not supported by documentation. There was no evidence she had spoken to any of the doctors involved or had followed up with the Midwifery Team Leader or midwives on duty at relevant times.

Legal assessor and finding of dishonesty

[44] The Legal Assessor incorrectly advised the committee of the process to be engaged in assessing objectively the appellant's conduct. He failed to consider *Ivey* v *Genting*, [2017] UKSC 67 or *Royal Brunei Airlines Sbd* v *Tan* [1995] 2 AC 378. The approach in *Ivey* should have been followed. It was submitted that given the appellant's sub-standard noting and record keeping the overwhelming probability relating to the respective notes underlying the charges of dishonesty emanating from Charges 1.2.g and 3.4 was that she had been careless in noting them, not that she had intended to mislead anyone reading the notes later to cover up want of performance. The panel should have accepted that submission.

Ground 4-sanction

[45] The decision on sanction was wrong, unfair, excessive and disproportionate.

Impairment

[46] The panel failed to address current impairment, as it should have done, rather than historical allegations of impairment as alleged by the NMC.

Disregard of mitigating factors

[47] The panel erred in dismissing mitigation regarding the appellant's health condition, recognised as a disability (*Davies* v *Scottish Courts and Tribunal Service* [2018] UKET 4104575/2017), and acted in a discriminatory manner as outlined under The Equality Act 2010. It failed to recognise that the alleged incidents occurred over a period of 4 night shifts and one single ante-natal visit in a career spanning 11 years. It failed to recognise that Ms 4 was incorrect in her evidence that she had not been provided with a copy of the ICOPO and thus wrongly came to the conclusion that the appellant had intentionally breached it over a four-month period. The panel failed to recognise that insight and remorse had been demonstrated and erred in attaching insufficient weight to this.

Sanction

[48] The panel failed to ensure that all other potential options of sanction were explored before ordering strike off.

[49] The Legal Assessor's advice made no reference to the important consideration of mitigation at all sanction levels as outlined in *Wisniewska* v *Nursing and Midwifery Council* [2016] EWHC 2672 (Admin) (27 October 2016), para 20, and directed the panel only to a Sanctions Guidance document, SAN-1 which failed to reflect *Wisniewska*.

Submissions for the respondent

[50] Counsel for the respondent submitted that the appeal should be refused.

Ground 1

Length of proceedings

[51] The complaint was lacking in specification, and was in any event unfounded. The overall length of proceedings gave rise to no concern over compliance with article 6. The proceedings concluded on 5 September 2019. The overall period- a decision 7 months after the initial listing and 31 months from receipt of the complaint- was reasonable, particularly when regard was had to the complexity of the case, the conduct of the parties and what was at stake for the appellant. The February and August adjournments were at the appellant's request. Each stage of the procedure was article 6 compliant. The initial investigation took 11 months, which was entirely reasonable in the circumstances. The procedure then went to the case examiners who ordered further inquiry into the alleged breach of the interim order. A period of 8 months for consideration and inquiry by case examiners was also reasonable in the circumstances. It was acknowledged that there was a delay after the case returned from the case examiners but not such as to constitute a breach of the reasonable time requirement. During the 12 months between referral to the FTPC and the final determination there were four callings of the case: the abortive hearing in February 2019; the actual hearing in May 2019; oral submissions in August 2019; and the impairment and sanctions hearing in September 2019. The February and August hearings were adjourned to later dates at the appellant's request.

Release of details of charges to the press

[52] On 14 February 2019 the charges had been read to the committee and were accordingly in the public domain. In accordance with the respondent's then guidance (Publication Guidance, August 2017 (as amended) at para.20), details of the charges were

provided following a request from a journalist. Given the FTPC proceedings were public, it was submitted that it was entirely appropriate that details of the charges were provided.

Ground 2

Assessment of expert evidence

[53] Any opinion evidence given by Ms 2 was admissible. The committee took a careful and discriminating approach to Ms 2's evidence. It formed a favourable impression of Ms 2 contrary to the view it reached about the appellant. Weighing the evidence, and assessing what conclusions to draw from it, is quintessentially the function of the committee (eg *C* v *Gordonstoun Schools Ltd* 2016 SC 758 at para. 56). A careful, detailed and discriminating decision was given, setting out conclusions which were open to the committee and giving clear reasons for doing so. There was no basis on which this court could properly interfere with the conclusions.

Failure to obtain the primary evidence

[54] In short, the fact that further witnesses, in particular the patients concerned, did not give evidence caused no real prejudice to the appellant and did not render the proceedings unfair. That Ms 2 did not directly observe the events with which the charges are concerned was accepted by her in cross-examination (p284 of the Bundle). That did not mean that there was a general insufficiency of evidence. There was no submission by the appellant that the patients themselves be required to give evidence. Given that the vast majority of the charges related to a failure to properly document events, and given the concessions made by the appellant in her own evidence, it was submitted that the patients' evidence would have been of no assistance to the FTPC.

[55] *Professional Standards Authority for Health and Social Care* v *Nursing and Midwifery Council and X* [2018] EWHC 70 (Admin) offered no assistance to the appellant. No point of principle was established by it and the facts, concerning when the NMC could properly offer no evidence, were not analogous to the present case.

Admissibility of hearsay and expert evidence of Ms 2

[56] Having regard to the Civil Evidence (Scotland) Act 1988, s2 and Rule 31(1), hearsay evidence was admissible in proceedings before the committee. Although at the outset of proceedings an objection was stated to the admissibility of any evidence by Ms 2 that was properly characterised as expert (that is, opinion) evidence, no such objection was in fact taken during her evidence. Despite this the matter was returned to in submission under reference to *Kennedy* v *Cordia (Services) LLP* 2016 SC (UKSC) 59. It was accepted that Ms 2 had given skilled evidence that would assist the FTPC and that it was based on a reliable body of knowledge or experience. The objection was that she lacked knowledge and understanding of the day to day demands on a practising midwife. Her understanding "may be out of date" since she accepted, for example, that it had been some time since she herself had delivered a baby. It was accepted that she was a Registered Midwife. Given her evidence about a continuing involvement in the provision of care and her role as the line manager for the senior charge midwives, the committee was entitled to conclude that she was qualified to comment on the expectations of a midwife in the position of the appellant.

[57] Counsel for the appellant had attacked Ms 2's impartiality, on the basis that:

> "[she] pursued an investigative and prosecutorial role against the [appellant]. This was her role through the NHS Tayside Disciplinary process. She had come to a concluded view before the current procedure was begun. She is entirely partial as a result .., and any opinions she provides are necessarily biased and stem from an Investigatory process I say was flawed."

It was submitted that the committee did not accept that characterisation of Ms 2's evidence, a view that it was entitled to reach. Accordingly Ms 2 was both qualified and sufficiently independent to provide opinion evidence.

Discrimination during the application of Rule 31

[58] The basis for the assertion that the appellant was somehow treated differently because she practised in Scotland has not been clearly articulated.

Withholding of Evidence

[59] The appropriate approach for a person in the position of the appellant to take was that outlined in *Holton* v *General Medical Council* [2006] EWHC 2960 (Admin), namely to require the regulator to make records available and if it does not do so, seek a direction from the committee. In the present case, the records were sought and produced and an adjournment allowed a period for them to be considered. In relation to the notebook, it was not clear what prejudice the appellant suggested this caused. Whatever its import, the availability or otherwise of a notebook (prepared by the appellant and which was not available to the NMC) would not justify the allowance of the appeal.

Ground 3

Burden of Proof

[60] Read fairly and as a whole it was clear that the committee properly directed itself upon, and applied, the burden of proof. There was no reversal of the burden of proof.

Expert Evidence

[61] To the extent that the appellant sought to rely upon discrepancies or inconsistencies in Ms 2's evidence, it was for her counsel to deal with such points in cross-examination. In

any event, the points identified by the appellant were not material to the overall conclusion of the committee.

Dishonesty

[62] There was no dispute about the approach to be taken to dishonesty between the parties. The appellant's counsel concurred in the approach set out by the NMC's Presenting Officer. The Legal Assessor's advice on the point was a short but appropriate summary of *Ivey*. It is clear from the terms of the decision that the committee considered and applied that advice.

[63] No error in law having been identified in the approach of the committee and there being a clear and comprehensible explanation of their decision for which there was a basis in the evidence, the court should not interfere with the conclusion.

Ground Four: sanction

[64] In all the circumstances, but in particular in light of the findings of dishonesty and working in breach of conditions that had been imposed by the respondent, the sanction of striking off was within the range of possible sanctions that the committee could reasonably impose. There was no proper basis on which this court should interfere with that conclusion.

[65] The committee adopted the proper approach to identifying the correct sanction, namely, it started with the lightest sanction and worked up; and properly explained why all sanctions short of striking off were insufficient and why the sanction of striking off was necessary to maintain public confidence in the profession.

Analysis and decision

Delay

[66] As counsel for the respondent submitted, where a breach of the reasonable time guarantee is asserted, the first question for the court is whether the period of time that has elapsed is *prima facie* sufficient to give rise to a real concern as to whether article 6 has been complied with. This is a matter which must be judged according to the individual circumstances of the case, looking to the length of the proceedings as a whole. Factors which will be relevant even at the stage of a examination of the period which has elapsed will include the nature and complexity of the proceedings, the conduct of parties, and what is at stake. If the circumstances appear to raise a *prima facie* case, these factors will of course require more detailed assessment. Looking at them in the round for the moment, the overall period from the making of the complaint to the respondent to decision by the committee was 31 months, a period which the court does not consider raises a *prima facie* concern of unreasonableness. Even if we had reached the opposite conclusion, a closer examination of the relevant factors would have shown that the time period could not be described as unreasonable. The matter was one involving a degree of complexity, requiring investigation and decision making as to procedure, and formulation of appropriate charges. During the proceedings two hearing dates were adjourned at the request of the appellant. The panel considered it would be in the interests of fairness to the appellant to grant those adjournments, even in the face of opposition, having regard to what was at stake for her. It is true that a few days were lost at the outset of the original proceedings because of disclosure issues, but this made a small contribution to the lapse of time in all the circumstances. Accordingly we do not consider that there is any merit in this point.

[67] Associated with this point the appellant sought to argue that she had been prejudiced by (a) substitution of a panel member and (b) a change in her legal advisers leading to a lack of continuity. There is no merit in either of these points. Both arose during the first few days of the original hearing in February 2019 when disclosure issues were being addressed. It was on perusing the full papers at that stage that a recusal issue arose in respect of one panel member and a new member was introduced on day 5. However no substantive proceedings had yet taken place. Counsel for the appellant was invited to make submissions, declined to do so and stated himself content with the substitution. As to the change of representation this is a matter for the appellant herself, and those she instructed. It is true that the first week was lost to disclosure issues but it is not apparent why these had not been raised in advance of the hearing. It was said to be as a result of this that counsel then asked for the case to be adjourned for a new counsel to start the case, since the remaining time would not be sufficient to conclude matters and it was proving difficult to find a further space in counsel's diary. Leaving aside how it can be that dates for the continuation of proceedings in which counsel had already participated should not take priority over cases in which he was yet to appear, this is again a matter for the appellant and her advisers. It is apparent that the original 10 days allocated would never have been sufficient to conclude the proceedings and the appellant's advisers share responsibility for this fact.

[68] Several further matters might usefully be disposed of at this point. First, the argument was advanced that the advice of the legal assessor lacked scrutiny, yet without pointing to any alleged detriment to the appellant (the issue of whether the correct legal principles were followed by the panel will be dealt with separately). The fact is that the

advice was tendered openly and recorded, and both parties were asked whether they had any submissions to make in respect of this, and neither did.

[69] Second, the appellant complains of the disclosure to the press of details of the charges at a point where the hearing had not progressed beyond the reading of the charges, and where no press or public were present. Again the appellant does not point to any alleged detriment. In any event, the issuing of this information was in accordance with the panel's published guidance on the issue of publication which states (para 20) that "Once the charges have been confirmed to the panel on the day of the hearing, these will be available upon request". The charges were read and confirmed on 14 February and the statement was issued the following day.

[70] Third, the Nolan Principles have no bearing on the issue here: what is at issue is the fairness of the proceedings.

[71] Fourth, the appellant's arguments relating to the Equality Act are misguided: the issue is whether the panel gave due consideration to the fact that the appellant was suffering from a medical condition when assessing her conduct; and again when considering mitigation.

[72] Fifth, although there seems to have been a disclosure issue at the outset of the first hearing, the missing papers were supplied and counsel appeared satisfied that disclosure had been made and the case could proceed. The appellant has not pointed to any problems caused by missing documentation other than her comments in relation to a notebook. The appellant raised an issue in relation to a personal notebook of hers in which she had previously stated that she had made certain relevant entries relating to patients, citing two points, (i) a general unspecified unfairness and (ii) an assertion that the panel's treatment of this issue showed that they inverted the onus of proof.

(i) Counsel for the appellant had been unaware of the existence of the notebook until it was referred to in passing during the proceedings, which would seem to be odd if the appellant considered it to be of value in her case. In any event, steps were taken to try to locate it by both sides. The appellant apparently contacted those who had acted for her in the earlier proceedings in which the book had been produced asking for a copy, but it seems that this was not forthcoming. Counsel thereafter stated "I entirely accept that the NMC have investigated the appropriate avenues and it may be that within the timescale of this hearing the notebook is simply not going to turn up". No further submission was made. Furthermore, during the discussion which had taken place, counsel noted that the notebook was relevant only to the care of patient C. In the course of the appellant's evidence she was asked about the notebook and whether she used it for any of her patients and she said "no". She said it mostly contained passwords and the like. However she then said it contained one blood pressure reading but could not say whether it was for one of the patients whose care the panel was addressing. Thus it appears that the notebook was of no relevance to the case, and even if the patient in question was one of those to whom the case related patient details are meant to be recorded in medical records not private notebooks. There were in any event inconsistencies in the appellant's position about this, she having said elsewhere in her evidence that she used individual bits of paper to record some entries, and specifically in relation to patient C. No issue of unfairness in our view arose from the fact that the notebook could not be located.

(ii) The appellant asserts that the panel inverted the burden of proof, citing in support of this the one reference to the notebook in the panel's findings, as follows:

> "In a meeting with NHS […] on 15 November 2016 you stated that you documented notes regarding Patient C in your own notebook, rather than Patient C's maternal

> records. The panel did not have a copy of your notebook, nor did you produce it during evidence."

It is impossible to view this as a general indication that the panel inverted the onus of proof, especially when they specifically recognised in terms at page 31 that the onus lay on the NMC, and impliedly recognised this throughout in the way they approached whether or not individual charges had been established.

[73] Sixth, the appellant complains that the panel applied the standard of proof on a balance of probabilities rather than beyond reasonable doubt. It is quite clear that the former is the appropriate standard and the panel did not fall into error in this.

[74] Seventh, the appellant asserts that the advice of the legal adviser as to dishonesty whilst referring to the test in *Ivey* v *Genting*, [2017] UKSC 67 failed to acknowledge the root of that test in *Royal Brunei Airlines Sbd* v *Tan* [1995] 2 AC 378, with the result that the panel failed to apply *Ivey* as they should have done, and assess dishonesty on an objective basis. It was a little difficult to follow this submission, since the passage from *Ivey* quoted by the assessor comes from a paragraph in which the test in *Royal Brunei* is referred to. In the latter Lord Nicholls, pointed out that

> "The only answer to these questions lies in keeping in mind that honesty is an objective standard. The individual is expected to attain the standard which would be observed by an honest person placed in those circumstances. It is impossible to be more specific."

[75] The assessor, making reference to *Ivey* read a passage which identified the importance of asking whether the conduct would be considered dishonest according to the standards of ordinary decent people, which is the benchmark against which the panel proceeded to assess the issue. We see no error in the advice given or the approach taken by the panel.

[76] Eighth, the appellant made a submission that she was discriminated against in the application of Rule 31 of the 2011 Rules, arising from the fact that the issue of admissibility of the evidence of Ms 2, a matter to which we are about to turn, could not have been determined in advance of the proceedings at an interim hearing, as can be done in England and Wales or in Scottish proceedings which involve judicial case management. However, the argument misunderstands the point. The point is not that a decision on admissibility would not be open to a panel in Scotland, the only issue is as to the stage at which this can be done. There is accordingly no merit in this argument.

[77] We turn to the remaining arguments which relate essentially to questions of the nature and admissibility of evidence led before the panel. One of these issues related to the fact that the NMC did not call the patients in question or the medical or nursing staff who had been involved in their care, thus depriving the appellant of the opportunity to examine these witnesses. This argument was also addressed under reference to *Professional Standards for Health and Social Care* v *Nursing and Midwifery Council, X* [2018] EWHC 70 (Admin) on the basis that the failure to call these witnesses was a breach of the duty to investigate cases properly. There is a broader point about the nature of the evidence led, relating to the most substantive point addressed in the appeal, relating to the evidence of Ms 2, and we deal with it in that context. So far as these discrete points are concerned, however, it was a matter for the NMC to decide what evidence to call in support of its case. If the appellant or her advisers thought that there would be benefit to her in calling other witnesses she could have done that herself. There were several ways in which the evidence from these witnesses could have been secured. She could have arranged for signed statements to be taken by her agents; she could have asked the NMC to arrange this with a view to seeing whether the evidence might be agreed; she could have called the witnesses herself. As to the second

point, that case involved an appeal by the professional body against a decision of the committee of the NMC that there was no case for her to answer against *X* in respect of an allegation that her fitness to practise as a nurse had been impaired by reason of misconduct, in respect of possible non accidental injuries to a baby in her care. The issue was that the decision not to proceed had been taken without proper inquiry; that no evidence had been placed before the panel at all; and that the committee wrongly concluded that it could uphold a submission of no case to answer at the instigation of the NMC without having heard any evidence. It is difficult to see an analogy with those circumstances and those of the appellant, and far less so with the obiter remarks in para 65 of the case, which were referred to by the appellant. The appellant in the course of making the submission about the failure to call the patients or other witnesses made reference to article 6(3) ECHR which of course has no application in the present circumstances.

[78] That leads us to the remaining issue, relating to the evidence of Ms 2. It is worth setting out some detail of the background to this submission. At the start of the original hearing in February 2018 counsel for the appellant indicated that he had a matter he wished to raise about the admissibility of the evidence of Ms 2, that might be appropriate to address as a "preliminary submission" before she gave evidence. He did not state what that submission would be, even in summary, and no notice of it had been given. The panel decided not to hear the submission on the basis that it could be heard at a later stage (p158).

[79] It is worth noting at this stage that prior to the hearing a Case Management Form dated 23 November 2018 was returned on behalf of the appellant. The form asks that the registrant "Please set out below the details of any points of law or legal arguments you intend to raise in respect of your case and any of the Nursing & Midwifery Council's evidence which you say is inadmissible in these proceedings, with reasons". This section of

the form was left blank. There is a question which stated "Are you intending to rely on any expert evidence?" The response on the form was "No". At the outset of the first hearing counsel indicated that part of the basis for a request to adjourn was that it was intended to obtain an expert witness, but that was departed from on the same day when it was explained that there was no intention to lead any expert evidence. The terms of NMC guidance on the use of expert witnesses is also relevant. The Guidance states that the NMC will usually instruct an expert if "we need specialised knowledge or expertise that we cannot obtain locally".

[80] It was against this background that the evidence of Ms 2 was led before the panel. During the hearing, and prior to the evidence of Ms 2, an indication was made that there was to be an objection on the basis of her experience and the suggestion that she was not an expert. However, it was agreed between the parties that the panel should hear her evidence to decide her level of expertise and specialisms before deciding on the application itself. No indication was given of the general nature of the objection relating to her expertise; and there was no suggestion that her evidence was being objected to on the basis of alleged partiality arising from her involvement in the internal disciplinary investigation.

[81] The objection which was eventually made related to the "admissibility of [Ms 2's] evidence in so far as it contains expert evidence". It was acknowledged that her evidence as to the investigation which she conducted, the statements taken, interviews conducted for the disciplinary hearing at which she was presenting officer, and the entries in the various medical records were all admissible as factual evidence (appendix p1444). However, any aspects of her evidence which did not address matters of fact, and strayed into opinion failed to satisfy the test for admissible expert evidence as set out in *Kennedy* v *Cordia*, para 44 of which set out a four part test. It was accepted that parts i and iv were met: the evidence

would assist the tribunal and there was a reliable body of evidence to underpin the expert evidence. However counsel invited the panel "to consider carefully whether [Ms 2's] evidence in these areas meets the *Kennedy* criteria in respect of part ii, whether the witness herself had the relevant expertise, and part iii whether she was impartial. As to the first of these it was acknowledged that she possessed a detailed knowledge of policy and procedure, but had not been involved in day to day midwifery since September 2016. As to the second matter, the witness pursued an investigative and prosecutorial role against the appellant through the internal disciplinary process, and had reached a concluded view before the current procedure began. She was a partial witness and her opinion evidence stemmed "from a flawed disciplinary process". The nature of any defects in the process was not specified. From the nature of the cross examination of the witness it appears to be based on (i) the mere fact of her involvement in the internal investigation; (ii) the assertion that others may also have been at fault but were not charged; and (iii) issues over whether she had misinterpreted certain of the medical records, which is, if not a matter of fact, a matter of fact and inference.

[82] The presenting officer submitted that the witness gave evidence as to fact as well as some opinion evidence. As to the latter she clearly had the necessary qualifications. It was unfounded to call the witness partial and there was no evidence of "a flawed investigatory process". There is no evidence of her exaggerating or fabricating things to make out the trust's case. She based any opinions offered, using her knowledge and experience, on her assessment of the notes and also what was said to her by the appellant.

[83] The advice given by the legal assessor was that, the evidence having been admitted, the matter was essentially one of weight. There was no method by which the admissibility of the evidence could have been addressed in advance. The witness was competent to give

evidence of fact. It was for the panel to determine whether the witness demonstrated sufficient evidence that she was skilled in respect of the questions that were asked of her. In such circumstances it was for the panel to determine whether or not it would be satisfactory to find matters proven on the basis of that evidence. No comment was made on this advice.

[84] The panel accepted that the issue was essentially one of weight to be given to the evidence. It was submitted that it was wrong to do so, under reference to para 51 of *Kennedy* v *Cordia* that "the requirement of independence and impartiality is in our view one of admissibility rather than merely the weight of the evidence". We accept, of course, that the question of partiality raises a question of admissibility of evidence, and that circumstances may arise, even in proceedings such as these, where the matter arises very sharply as a point of admissibility. A partial witness is not a witness who can give opinion evidence. It would be reasonable to conclude, from the way the assessor referred to the inability to address the admissibility of the evidence in advance and the fact that the evidence had already been led, that the assessor was looking at the issue of admissibility in a somewhat narrow, technical way, but that the advice to consider whether it would be satisfactory to find matters proven on the basis of that evidence would encompass an assessment of whether the witness had demonstrated a partiality such that her evidence could not be taken into account. It seems clear to us that the panel, in accepting that advice, was not suggesting that, even if they found partiality to be established, they would feel able to rely on the opinion evidence of the witness and simply place her partiality in the balance when assessing the weight to be given to her evidence. The panel assessed Ms 2 and found her:

> "to be a credible and reliable witness. Her evidence was balanced, fair and consistent, even under cross-examination. She demonstrated a high level of professionalism, appeared very familiar with the documentation in use at the Hospital, was an experienced midwife, and gave evidence regarding the Hospital's midwifery standards and practices. Although Ms 2 worked in an operational

> management role at the time, she is a registered midwife and continued to support the team clinically when necessary. The panel was therefore of the view that Ms 2 was well placed to give evidence regarding your conduct and the standards of care expected from a midwife at the Hospital. The panel did not accept all of her evidence. For example, it considered that to expect the recording of consent for the examination of the perineum in the intrapartum period was perhaps a 'platinum' standard of recording and the panel was aware of current midwifery practice in today's busy NHS."

[85] It is apparent from the finding that the witness was balanced, fair, and consistent and demonstrating a high degree of professionalism, that the panel rejected the submission that the witness was biased. In our view they were right to do so. There was no basis in the evidence to consider that she was partial. The fact that the appellant did not agree with Ms 2's interpretation of certain medical records, or the inferences she drew from them, does not make her a partial witness. The fact that she might have been mistaken about these does not make her a partial witness. The fact that she had been directly involved in the internal investigation equally does not make her a partial witness. She had not been involved previously with the appellant and was not her line manager. She was an independent senior employee asked to conduct an internal inquiry and having the relevant expertise to do so. The fact that she reached conclusions about that inquiry does not make her a partial witness, so long as it appears that those conclusions represent the bringing to bear of her expertise, objectively, to a particular set of facts. The reaching of conclusions does not make a witness an advocate for one side or the other or render her partial.

[86] As to her experience, she had been a registered midwife since 2000. At the time of giving evidence she had recently taken on the role as a senior midwife of practice development in the hospital and medical school concerned, having previously been in an operational management role in maternity services working in collaboration with a multidisciplinary team to issue a safe delivery of person centred midwifery care. During

that period she had been involved in clinical practice, and when not directly delivering care, was writing guidelines, and writing protocols. Prior to that she had been seconded to a national programme of work, Leading Better Care, designed to enable teams and leaders to manage care safely. Prior to that she held a consultant midwife post and had held several research midwifery posts. She had also been seconded at one point as a university lecturer involved in the training of midwives.

[87] It is clear that she was well qualified to tender opinion evidence. It must be borne in mind also that she was not giving evidence to a lay body. She was giving evidence to a specialist tribunal who could and did bring their own expertise to bear on the issue. The matters at issue were not complex, factually or otherwise. It should also be noted that of the 61 counts against her, the appellant admitted 14 of them; and the panel found another 12 to be established largely on the basis of admissions which she herself had made in evidence. A further 31 were established, and in the vast majority of these the basis for this was to be found in the medical notes and the rejection of evidence given by the appellant. In only about 12 instances is the evidence of Ms 2 specifically referred to, and only seldom in respect of her opinion. It occasionally rejected Ms 2's evidence as proposing an unduly high standard. The panel therefore approached the issues in a discriminating manner as one would expect from a speciality tribunal. When the panel went on to consider misconduct and impairment it did so separately and sequentially, relying on its own professional judgment, the Code, and relevant authorities.

Sanction

[88] The panel heard and accepted the advice of the legal assessor and bore in mind that any sanction imposed by it must be appropriate and proportionate and, although not

intended to be punitive in its effect, may have such consequences. It had careful regard to the Sanctions Guidance ("SG") published by the NMC; and identified a number of aggravating and mitigating factors. The mitigating factors were identified and discussed. On the issue of the appellant's health, it noted that there was some evidence that the appellant had displayed symptoms of the health condition averred by her around the time of the events, but concluded, as they were entitled to do on the evidence, that there was nothing to suggest that this would have impacted on her ability to practise safely and effectively as a midwife. The respondent's own guidance on sanctions notes that personal mitigation, such as a matter of health, may be less relevant than within the criminal justice system since sanctions in regulatory proceedings are to protect the public and not to punish the individual. The panel highlighted both the aggravating and mitigating factors at the outset of its consideration on sanction and it is in our view a reasonable assumption that it had these in mind at every step of the process it then embarked upon.

[89] The submission that the panel failed to ensure that all other potential options of sanction were explored before ordering strike off is simply incorrect. It considered each of the options open to it in order of increasing severity. In view of the seriousness of the case, it decided that it would be neither proportionate nor in the public interest to take no further action. The appellant's misconduct was not at the lower end of the spectrum, in view of the seriousness of the case it would be neither proportionate nor in the public interest to impose a caution order.

[90] With regard to the imposition of conditions the committee was of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in the case given there were multiple, serious and wide-ranging concerns in respect of clinical midwifery practice, as well as serious concerns regarding attitude and

conduct. The appellant had failed to satisfy the committee that the conduct would not be repeated. The committee had found the appellant to have been dishonest on two occasions, and to have also tailored her evidence before it, in attempt to disguise the true nature of events. It also took account of its finding that the ICOPO had been breached, which it considered to be of the utmost seriousness. The committee determined that placing a conditions of practice order would not adequately address the seriousness of this case, the severity of the conduct and the appellant's limited level of insight, nor would it sufficiently protect the public, or satisfy the public interest considerations.

[91] The committee was of the view that the findings in this particular case demonstrated that the appellant's actions were serious as the misconduct involved four patients, two instances of dishonesty, and working in breach of an ICOPO. The appellant had exposed patients in her care to a significant risk of harm and had not demonstrated the care and compassion necessary for midwifery practice. The committee considered that allowing the appellant to maintain NMC registration would put the public at a continued risk of harm, and would undermine public confidence in the profession and in the NMC as a regulatory body. Considering all of these factors, the appropriate and proportionate sanction was that of a striking-off order. We do not consider that the appellant has identified a basis upon which we would be entitled to interfere with the decision on sanction. In all the circumstances the appeal must fail.