Section 29 Case Meeting

4 May 2022

157-197 Buckingham Palace Road, London SW1W 9SP

Joanna Esther Young

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Rebecca Senior, Senior Legal Reviewer, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority

In attendance
Fenella Morris QC, Counsel, 39 Essex Street Chambers

Observers
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Polly Rossetti, Policy Advisor, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and the statutory time limit for an appeal would expire on 4 May 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 9 March 2022.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the Panel dated 9 March 2022
- The Authority's Detailed Case Review
- Transcripts of the hearing dated Monday 6 December 2021-Thursday 23 December 2021 and Tuesday 8 March 2022-Wednesday 9 March 2022
- Counsel's Note dated 27 April 2022
- Exhibits
- The NMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

8. Background

8.1 The case was heard in conjunction with another registrant midwife (Registrant 2) who was struck off the register in relation to her involvement in the events

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

giving rise to the complaint. At the time both registrants were employed by Shrewsbury and Telford NHS Trust as Community Midwives ('**the Trust**').

8.2 The case concerned the treatment given to Mother A and her newborn, Baby A. The birth, on 26 April 2016 had been a home birth and appears to have been straightforward. Baby A developed chestiness and rapid breathing around 10 ½ hours after birth, consistent with signs of Group B Streptococcus.

8.3 Mother A called the Midwife Led Unit (MLU) at 15.00 and 18.30 raising concerns about Baby A. On both occasions she spoke to Witness 3. Mother A called again at 02.50 and spoke to Registrant 2. On the morning of 27 April 2016, witness 3 asked the Registrant to visit Mother A that morning. Mother A was on the case list for a different midwife but as she had other commitments that morning, the action was given to the Registrant.

8.4 The Registrant called Mother A at 9.03 on 27 April. When making the call, she was not aware of the discussions that had taken place between Mother A, Registrant 2 or Witness 3. The Registrant's account was that she was calling to arrange a time to visit and that she had not been told/had not heard the instruction from Witness 3 that she needed to visit Mother A that morning Mother A would not have known what matters she should tell a health care professional where relevant questions are not asked.

8.5 The charges against the Registrant relate to the actions/lack of action during the telephone call. Specifically, it was alleged, that she failed to: carry out a comprehensive triage assessment of Baby A; recognise the urgency of medical attention for Baby A or to make a contemporaneous record of her call with Mother A.

8.6 There was a further allegation that the non-contemporaneous record that was made was inaccurate – i.e., made after the event to support the Registrant's account and protect her from criticism following the death of Baby A. This was not proved.

8.7 The Registrant did not attend on Mother A until 12.30 on 27 April 2016. Before she arrived, Baby A went into cardiac arrest and was airlifted to hospital where she later died.

8.8 The Coroner's Inquiry took place in April 2017. The Inquiry found that Baby A died of Early Neonatal Group B Beta-Haemolytic Streptococcus Meningitis and Congenital Pneumonia. The expert evidence before the Coroner and the NMC Panel was that, by the time the Registrant became involved, the chances of survival were extinguished. The NMC case was that the trauma of the death would have been lessened if Baby A had been conveyed to hospital. Had this happened her parents would have been supported. They would not have faced the prospect of giving CPR to their baby who had been alive for just over 30 hours.

8.9 The Registrant attended and was represented at the hearing. She did not admit any of the charges.

8.10 Stage one of the hearing took place between 6 and 22 December 2021, with the Panel's decision on facts being delivered on 22 December 2021. The bulk of the allegations were found proved with the exception that the Registrant made

inaccurate records of her telephone calls with Mother A and that this conduct was dishonest. The hearing then adjourned until 8-9 March 2022. At the resumed hearing the Panel found the Registrant's actions amounted to misconduct but that her fitness to practise was not impaired.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

9.3 ***The Panel's approach to impairment***

9.4 The Members considered whether the Panel addressed all the matters relevant to a decision as to impairment, having regard to (i) its findings of fact, (ii) the other evidence before it, and/or (iii) the case law as to the correct approach to impairment.

9.5 In terms of the findings of fact, the Panel had found that the Registrant's failings were in 'basic midwifery practice' (i.e. triage/assessment/prioritising/recognising an emergency). The Panel found the failings to be significant. The Members noted that the Panel had found that the failings were not attributable to systemic problems in the Trust. As part of its decision on misconduct, the Panel found that the Registrant's actions fell seriously short of the conduct and standards expected of a midwife.

9.6 The Members discussed the Panel's approach to impairment on public protection grounds. The Members noted that the Panel had found a low risk of repetition in the light of the Registrant's actions since the events, including training. The Members considered that it would be difficult to disturb this assessment. The Members concluded that there was sufficient evidence before the Panel to justify its findings that the Registrant was not impaired on public protection grounds.

9.7 The Members went on to consider the approach to impairment on public interest grounds. This involved a discussion of whether the Panel's findings at the facts and misconduct stage were adequately considered as part of this assessment. The Members also discussed whether the Panel had had regard to the NMC's guidance on 'Insight and Strengthened Practice' as part of their assessment.

9.8 As outlined at 9.5, the Panel found the Registrant's failings to be 'fundamental' failings in midwifery practice which were a serious departure from standards. Having made these findings, the Members were concerned that the Panel did not provide clear reasons for its decision that the Registrant was not impaired on public interest grounds. The Members considered that the Panel were required to give clear reasons in this regard. The Members also had concerns that the Panel may not have considered the NMC's guidance as part of its assessment.

Poor reasoning

9.9 The Members noted that the Panel referred to '*specific circumstances of this case*'[2] and lack of subsequent fitness to practise issues in determining that a finding of impairment was not required. The Panel did not specify what the specific circumstances were. The Members considered that the Registrant's conduct was serious. Whilst it was acknowledged that this was a single clinical incident, the Members considered that it was made up of several basic failings. Moreover, the Members noted that the Panel had not accepted that the environment at the Trust was a relevant as the failings were basic and fundamental. The Members also did not consider a lack of subsequent concerns to be a factor which should be afforded weight when considering whether a finding of impairment is required to uphold public confidence and standards. The Members felt that the Panel had taken irrelevant matters into account in their reasons at the impairment stage.

9.10 The Members also discussed whether the finding of no impairment on public interest grounds was open to the Panel, despite poor reasons. The Members concluded that there was a disjuncture between findings that the misconduct was a serious in that it was basic failings in midwifery practice and the conclusion that no finding of impairment was required to uphold public confidence and standards. The Members were concerned that the Panel had failed to grapple with its earlier findings that the misconduct represented fundamental failings in the care of a new-born baby. The lack of explanation caused the Members concern as to whether the Panel had properly considered whether public confidence would be undermined by a finding of no impairment.

Conclusion on insufficiency for public protection

9.11 The Members concluded that the Panel's decision to find the Registrant not impaired on public interest grounds was insufficient for public protection in the following respects: the Panel took into account irrelevant matters at the impairment stage; the Panel failed to give adequate reasons in relation to the question of whether there was impairment on public interest grounds, firstly given the fundamental nature of the failings and secondly because the Panel failed to address the NMC guidance that was before them. This led the Members to be unsure whether the Panel took the correct approach.

10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power

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[2] Transcript 9 March 2022 page 6 line 11

under Section 29 and refer this case to the High Court of Justice of England and Wales.

06/06/22

Alan Clamp (Chair) **Dated**

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Panel of the Nursing & Midwifery Council
The Registrant	Joanna Esther Youn
The Regulator	Nursing & Midwifery Council
NMC	Nursing & Midwifery Council
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 9 March 2022
The Court	The High Court of Justice of England and Wales
The SG	Regulator’s Indicative Sanctions Guidance