Neutral Citation Number: [2019] EWHC 28 (Admin)

Case No: CO/2392/2018

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/01/2019

Before :

MR JUSTICE SPENCER

- -

Between :

KATHYRN AMANDA JORDAN EL KAROUT	**Appellant**
- and -	
NURSING AND MIDWIFERY COUNCIL	**Respondent**

- -
- -

The Appellant appeared in person

Mr Loran (instructed by **the NMC**) for the **Respondent**

Hearing dates: 18th October and 5th November 2018

- -

Approved Judgment

Mr Justice Spencer :

Introduction and overview

1. This is an appeal pursuant to Article 38 (1) of the Nursing and Midwifery Order 2001 against the decision of the Nursing and Midwifery Council's ("NMC's") Fitness to Practise Committee ("the Panel") contained in a notice of decision letter dated 23rd May 2018, in which the Panel determined that the appellant's fitness to practise as a midwife was impaired by reason of her misconduct, and that the appropriate sanction was an order striking her off the register. This decision was made at the conclusion of a hearing lasting seven days, from 14th to 22nd May 2018, at which the appellant was represented by counsel, Ms Emma Shafton and the NMC were represented by counsel, Mr Christopher Harper.

2. In short the allegation was that on the ward where she worked the appellant had stolen packs of dihydrocodeine tablets prescribed for patients to take home when discharged from hospital after giving birth, and had falsified medical records to facilitate and conceal the thefts. It was alleged that the appellant had stolen dihydrocodeine in this way in relation to seven patients, although the Panel found the allegation of theft proved in relation only to five of the seven.

3. The relevant events took place in June and July 2015. The delay of nearly three years before the disciplinary proceedings were heard arose in part because there were criminal proceedings which did not conclude until March 2017. The appellant was tried in the Crown Court for the offences of theft alleged in relation to two of the patients. She was acquitted by the jury.

4. The appellant had some 20 years' experience as a midwife, with no previous findings of misconduct. She was employed as a Band 6 midwife by Brighton and Sussex University NHS Trust from September 2014 until her dismissal on 6th November 2015. In 2014, a year or so earlier, there had been a series of episodes of the theft or disappearance of dihydrocodeine within the maternity unit. There was no suggestion that the appellant was responsible. In November 2014 the Trust introduced a new procedure for the withdrawal and administration of dihydrocodeine by requiring that it be stored and treated as a controlled drug. A procedure was put in place which required two midwives to sign out the medication from the controlled drugs cupboard.

5. Dihydrocodeine is an opiate based strong painkiller. It was commonly prescribed for patients "to take out" ("TTO") when discharged home, along with paracetamol and ibuprofen. In the controlled drugs register, kept in the drugs cupboard, a record had to be made of the date and time when the medication was withdrawn from the store, the patient's name and the amount given. Two signatures were required, one "given by" and one "witnessed by". The balance of the drug remaining in the store after each withdrawal was required to be recorded. The procedure did not require that both midwives signing for the medication had to be present when it was actually given to the patient. But both had to be present when it was withdrawn from the store. Nor did the medication have to be handed to the patient by the midwife signing as "given by" rather than "witnessed by".

6. The TTO medication had to be authorised and prescribed by a doctor, on a printed form headed "discharge note and prescription", commonly referred to as a TTO form. This listed the drugs the patient was to take home. The procedure was that a copy of the form should be handed to the patient, and another posted to the patient's GP. A copy should also be attached to the patient's notes and a further copy given to the hospital pharmacy. It was a feature of the evidence before the Panel that these requirements were not always observed, and the Panel did not base their findings upon any shortcomings in the completion of TTO forms.

7. The thefts of dihydrocodeine alleged to have been committed by the appellant spanned a period of a fortnight or so between 20th June and 6th July 2015. On Saturday 20th June the appellant had just returned to work from an extended period of sick leave. Suspicion first fell on the appellant on 1st July when it was discovered that one of the patients about to be discharged home, Patient A, did not have in her pack of TTOs the dihydrocodeine which the appellant had signed out in the drugs register and had purportedly given to the patient along with paracetamol and ibuprofen. This was discovered after the appellant had gone off duty from the night shift during which the dihydrocodeine had been signed out. After a thorough search the missing dihydrocodeine could not be found.

8. Over the next few days an investigation was carried out, overseen by the manager of maternity and gynaecology services, Ms 3. In the controlled drugs register six other patients were identified for whom the appellant had signed out dihydrocodeine as part of their TTO medication. Each of these six patients was telephoned at home to establish whether she had in fact received and taken home dihydrocodeine as part of her TTO pack. In each case the response was that no dihydrocodeine had been given. The results of this investigation were rather sketchily reported in a document described as an "audit". The dihydrocodeine which should have been given to these other women, Patients B, C, D, E, F and G, had been signed out on dates between 20th June and 30th June. The appellant was not alerted at that stage to the investigation that was now in progress.

9. On 6th July Patient A was readmitted to hospital for further treatment. She was discharged the same day, again without dihydrocodeine as part of her TTOs. Again, however, the appellant had signed for the withdrawal of dihydrocodeine for Patient A.

10. Following this the police were informed. Ms 3 and her colleague Ms 1, a lead midwife who had also taken part in the exercise of telephoning the patients, made witness statements to the police on 9th July. On 10th July 2015 the appellant was arrested by the police at the hospital, on the ward where she worked. She was searched. In her handbag the police found an empty torn packet of dihydrocodeine tablets. The box was labelled for Patient B who had been discharged from hospital on 24th June. The dihydrocodeine had been prescribed for her as part of her TTO medication but she did not want it. It was common ground that the appellant had failed to return the unwanted pack of dihydrocodeine to the drugs cupboard. Her case was that she had put the packet in her back pocket, and because she was distracted by her duties she had forgotten to return the packet before the end of her nightshift. It was only as she was driving home that she realised she still had the packet in her possession. In a panic she

had thrown the tablets away but retained the box in her handbag and had forgotten thereafter that she still had it.

11. Following her arrest the appellant was suspended from her employment on 10th July. On 1st September 2015 the NMC received a referral from her employers about her fitness to practise. On 15th September 2015 the NMC notified the appellant that the investigation was being referred to the Case Examiners for consideration. However, the NMC investigation was put on hold until the conclusion of the police investigation.

12. For reasons which are unclear the police investigation and subsequent prosecution were unduly protracted. Following her acquittal in the Crown Court on 27th March 2017, the matter was investigated further by the Case Examiners. On 29th December 2017 the case was referred to the Fitness to Practise Committee.

The charges

13. The charges were framed as follows:

> That you, a registered midwife;
>
> 1) Between 20 June 2015 and 6 July 2015
>
> a) Incorrectly signed and/or countersigned that TTO medication consisting of dihydrocodeine had been given to one or more of the Patients on the dates listed in Schedule 1 in the controlled drug record book;
>
> b) Your actions above were dishonest in that you deliberately falsified the records of one or more of the Patients listed in Schedule 1 to make it appear as though they had been given dihydrocodeine when they had not in fact been given this medication;
>
> 2) Stole medication that was recorded as being given to one or more of the Patients listed in Schedule 1;
>
> AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Schedule 1

Patient A	30 June 2015
Patient A	6 July 2015
Patient B	24 June 2015
Patient C	22 June 2015
Patient D	20 June 2015
Patient E	27 June 2015
Patient F	30 June 2015
Patient G	27 June 2015

14. At the conclusion of the hearing the Panel found Charge 1(a) proved in relation to Patients A, B, C, D and G, but not proved in relation to Patients E and F. The Panel found Charge 1(b) proved in relation to Patients B, C, D and G, but not proved in relation to Patients A, E and F. The Panel found Charge 2 proved in relation to Patients A, B, C, D and G, but not proved in relation to Patients E and F. The Panel decided that as a result of this proved misconduct the appellant's fitness to practise was currently impaired. Having considered the aggravating and mitigating factors, the Panel decided that the only appropriate sanction was a striking-off order. An interim suspension order was made for a period of 18 months to allow for the possibility of an appeal.

The grounds of appeal

15. The appellant filed her notice of appeal on 18th June 2018, now acting in person. With the notice she submitted "initial grounds of appeal" indicating that she intended to lodge amended grounds and a final skeleton argument when the relevant documentation and transcripts were available.

16. In the event she did not file amended grounds, but she served a very full skeleton argument dated 26th September 2018. That document runs to 17 closely typed pages with occasional headings but no paragraph numbers. In the respondent's skeleton argument, dated 4th October 2018, Mr Loran has helpfully distilled the appellant's grounds of appeal into the following propositions, which I am content to adopt by way of outline:

Ground 1:

That the NMC contravened Article 6 of the European Convention on Human Rights ("ECHR") in that (i) there was an unreasonable delay before the substantive hearing was held (ii) the appellant did not have a real opportunity to present her case or challenge the NMC case (iii) there was no presumption of innocence and the Panel were not impartial.

Ground 2 :

That the NMC contravened Article 23.1 of the Universal Declaration of Human Rights in that the appellant is unable to obtain favourable employment and has suffered financially as a result of the striking off order.

Ground 3:

The Panel was biased or attributed undue weight to the evidence of the NMC's witnesses and/or attributed insufficient weight to the appellant's evidence.

Ground 4:

The Panel's decision to strike off was disproportionate and the Panel failed to give a thorough and proper explanation for their reasons at the sanction stage.

17. Whilst these four grounds capture the essence of most of the appellant's complaints, there are very many individual complaints within the documents she has submitted (the initial grounds and the final skeleton argument) which I shall address as necessary.

The appeal hearing

18. I heard the appeal on 18th October 2018. The appellant appeared in person and presented her arguments clearly and forcefully. The respondent was represented by counsel, Mr Loran, whose submissions were also clear and focussed. At the start of the hearing the appellant provided me with a further document headed "Personal Statement". Oral submissions occupied a whole court day. I invited the appellant's assistance in developing the many points set out in her skeleton argument. Towards the end of the hearing the appellant produced yet a further document relating principally to the legal definition of dishonesty in the criminal context. I reserved judgment.

19. Soon after the oral hearing, on reviewing all the material, and in particular the full transcript of the seven day hearing, I was concerned that there was one aspect of the proceedings before the Panel which had not been sufficiently addressed in the appeal, either in oral or written submissions, and upon which I required further assistance from the parties. This related to the admissibility of the hearsay evidence on which the charges in respect of Patients D, E, F and G was based. I set out my concerns in an e-mail to the parties and invited their written submissions, with a view to a further short oral hearing confined to that single issue. It was not possible to convene such a hearing until 5th November 2018. I received further oral and written submissions from the appellant and from Mr Loran on the hearsay issue, which I shall address in detail later in this judgment.

The legal framework

20. The test to be applied in determining this appeal, derived from the general provisions governing appeals in the High Court, is set out in CPR 52.21(3):

> "The appeal court will allow an appeal where the decision of the lower court was-
>
> a) wrong; or
>
> unjust because of a serious procedural or other irregularity in the proceedings in the lower court."

21. Thus it is for the appellant to persuade me that the decision of the Panel to strike her off the register was wrong or unjust because of a serious procedural or other irregularity in the proceedings before the Panel. This clearly involves examination of

the correctness of the Panel's decision to find the charges proved and then, quite separately, the correctness of the decision to impose the ultimate sanction of striking off.

22. As to the approach in relation to disciplinary appeals of this kind, I adopt Mr Loran's summary of the helpful analysis by Cranston J in *Cheatle v GMC* [2009] EWHC 645, at [12]-[15]:

> (a) The appeal is not confined to points of law but neither is it a de novo hearing.
>
> (b) The court's function is not limited to a review of the Panel's decision, and in relation to findings of fact the court is entitled to exercise its own primary judgement on whether the evidence supported such findings. However, the court will not interfere with a decision unless persuaded it was wrong.
>
> (c) In relation to findings which reflect a professional judgement concerning standards of professional practice and conduct, the court will exercise distinctly secondary judgement and give special place to the judgement of the professional body as the specialist tribunal entrusted with the maintenance of the standards of the profession.

23. More general guidance on the proper approach of the court in an appeal such as this where findings of fact are challenged, is to be found in the decision of the Privy Council in *Gupta v General Medical Council* [2002] 1 WLR 1691, at [10]:

> "… [These] appeals are conducted on the basis of the transcript of the hearing… In this respect these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that this first instance body enjoys an advantage which the appeal does not have, precisely because that body is in a better position to judge the credibility and reliability of the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from various professional conduct committees, the [court] must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility

> or reliability of the evidence before such a committee, the [court], duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to facts reached by the committee…."

24. This approach has been consistently followed, for example by the Court of Appeal in *Southall v General Medical Council* [2010] EWCA Civ 407, where Leveson LJ said, at [47]:

> " … First, as a matter of general law, it is very well established that findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are virtually unassailable (see *Benmax v Austin Motor Co Ltd* [1955] A.C. 370); more recently, the test has been put that an appellant must establish that the fact-finder was plainly wrong (per Stuart-Smith LJ in *National Justice Cia Naviera SA v Prudential Assurance Co Ltd (The Ikarian Reefer)* [1995] 1 Lloyd's Rep 455 at 458). Further, the court should only reverse a finding on the facts if it "can be shown that the findings… were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread" (per Lord Hailsham of St Marylebone LC in *Libman v General Medical Council* [1972] A.C. 217 at 221F more recently confirmed in *R (Campbell) v General Medical Council* [2005] 1 WLR 3488 at [23] per Judge LJ)".

25. As to the approach of the appeal court where the challenge is to the sanction imposed by the Panel, the principles were helpfully distilled by Cranston J in *Cheatle (supra)* at [33-35]:

> "33. The seminal decision on sanction is *Bolton v Law Society* [1994] 1WLR 512, where Sir Thomas Bingham MR endorsed the principle that it would require a very strong case to interfere with a sentence imposed by a disciplinary committee, which is best placed for weighing the seriousness of professional misconduct. That a sanction might seem harsh, but nonetheless be appropriate, could be explained by the primary objects of sanctions imposed by disciplinary committees. One object was to ensure that the offender did not repeat the offence; the other, indeed the fundamental, objective was to maintain the standing of the profession (at pp 518-9).
>
> 34. *Bolton* has been endorsed on numerous occasions since it was decided, although in *Ghosh v General Medical Council* [2001] 1 WLR 1915 Lord Bingham said that while the court would accord an appropriate measure of respect to the judgment of the committee as to the sanction necessary to maintain professional standards and provide adequate protection to the public, it would not defer to its judgment more than was warranted by the circumstances. The court could decide

> whether a sanction was appropriate and necessary in the public interest, or excessive and disproportionate (at [34])."

26. The overall position is helpfully summarised in the notes at CPR 52.21.1 in The White Book (Civil Procedure) 2018: "Where all material evidence has been placed before the disciplinary tribunal and it has given due consideration to the relevant factors… the court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal which was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed": see *Council for the Regulation of Health Care Professionals v GMC* [2004] EWCA Civ 1356; [2005] 1WLR 717, at [78].

27. The powers open to the court on this appeal are set out in Article 38(3) of the Nursing and Midwifery Order 2001. The court may:

    (a) dismiss the appeal;

    (b) allow the appeal and quash the decision appealed against;

    (c) substitute for the decision appealed against any other decision the Panel could have made;

    (d) remit the case to the Fitness to Practise Committee to be disposed of in accordance with the directions of the court.

28. These then are the broad legal principles which apply in this case. I shall refer to other authorities in analysing the individual complaints made by the appellant in relation to discrete aspects of the case. First, however, it is necessary briefly to summarise the way in which the misconduct allegations were put, the evidence to support them, the appellant's case in response, and the conclusions of the Panel.

Patient A

29. Patient A gave live evidence. She had made a witness statement to the police less than a month after the relevant events. She was due to be discharged on 1st July 2015. The appellant was on duty the previous night. It was common ground that the appellant had given Patient A her TTO medication, in a green bag, probably around 5 a.m. Patient A was adamant that the bag contained only paracetamol and ibuprofen. There was no dihydrocodeine. The appellant was equally adamant that there was dihydrocodeine in the bag as well. It was common ground that she had signed out the dihydrocodeine from the drugs cabinet overnight. The issue, therefore, was whether the appellant had failed to give Patient A the dihydrocodeine because she had stolen it, or whether Patient A might have been given it but somehow it had been innocently mislaid.

30. It was common ground that the green bag containing the TTOs had been placed on the window sill near Patient A's bed. When the appellant went off duty at 7.30 a.m. she told the next midwife, Ms 2, at handover that she had given Patient A her TTOs including dihydrocodeine. At around 8 a.m. Ms 2 gave Patient A some dihydrocodeine on the morning drug round. One of the Panel members queried why

the dihydrocodeine from her TTOs would not have been used, if she had received it, which Ms 2 said was a good question.

31. Later that morning, when the time came to discharge Patient A, it became apparent that she did not have any dihydrocodeine in her green bag of TTOs. A very thorough search was conducted of her property, her bedside drawers and her bedding. There was an equally thorough search of the drugs cupboard. The dihydrocodeine which should have been in her TTOs was nowhere to be found. Ms 2 informed the lead midwife, Ms1, who oversaw further searches.

32. Patient A's discharge was delayed whilst a further prescription of dihydrocodeine was obtained from the hospital pharmacy. In the end she left without it at 1.30 p.m. because she was tired of waiting. She had to obtain dihydrocodeine from her GP, but she was in pain for some time in the interim. It was this episode which precipitated the investigation then overseen by the ward manager, Ms 3. The appellant was not asked at the time for an explanation, when the matter would have been fresh in her mind.

33. The appellant was still unaware of the suspicion which had fallen upon her when Patient A was readmitted on 6th July. The appellant attended to her catheterization. She signed out more dihydrocodeine that day for Patient A, but Patient A was adamant she never received it. Nor did she expect to receive any more dihydrocodeine as she already had it prescribed by her GP. Again, the allegation was that the appellant must have stolen the dihydrocodeine withdrawn from the drugs cabinet and signed for as administered.

34. In her own evidence the appellant recalled dealing with Patient A on both occasions. On 1st July she told Patient A she would be going home with all three medications. She had put the dihydrocodeine in the green bag along with the other two. She remembered the second occasion, 1st July, because it was the day of the Brighton bus crash. There were no green bags that day because they had run out, but she remembered giving Patient A the dihydrocodeine she had withdrawn.

35. Counsel for the appellant drew attention to various discrepancies in the detail of the witness accounts of Patient A, Ms 1 and Ms 2. She pointed out that on 1st July the TTO containing the pain killers would have been lying around on the window sill for several hours until discharge. She queried why, if she had stolen it, the appellant would have volunteered to a group of midwives at the handover that she had given dihydrocodeine to Patient A if she knew full well she had not done so, and when this could so easily be checked. It was not suggested that Patient A (or any other patient) was deliberately lying, but the Panel should not underestimate the impact of emotion in trying to remember such details soon after giving birth.

36. The Panel would have had all these points well in mind, and others too. For example, in her police witness statement Patient A had said, in describing the midwives' insistence on searching her property for the dihydrocodeine, "I remember saying I was *pretty* sure I had not received codeine." The Panel nevertheless preferred the evidence of Patient A to the evidence of the appellant. The Panel found Patient A "consistent, measured, clear and … compelling in her evidence that she did not receive dihydrocodeine. She had a good recall of her stay on the ward and her interactions with [the appellant] as her midwife. The Panel found her to be both credible and reliable in her evidence."

37. By contrast, in relation to the evidence of the appellant, the Panel's conclusion, on Charge 2, theft, was:

> "You claimed that you gave the dihydrocodeine to Patient A but she denied receiving it. The Panel preferred the evidence of Patient A which it found compelling and it did not believe your claim. Accordingly on the balance of probabilities the Panel feels satisfied that you stole it and this charge is found proved. "

38. Accordingly the Panel also found Charge 1(a) proved, in that the appellant had incorrectly signed and/or countersigned that TTO medication consisting of dihydrocodeine had been given to Patient A when it had not been. The Panel found that allegation proved in relation to both 30th June and 6th July. They were satisfied that it was the appellant who had given Patient A her TTOs on both occasions and satisfied that on neither occasion was Patient A given dihydrocodeine.

39. The Panel was not satisfied that Charge 1(b) was proved, deliberate falsification of the records of the patient to make it appear that she had been given dihydrocodeine when she had not. This was on the technical basis that the Panel had to construe the charge as meaning the <u>records of the patient</u>, rather than more broadly <u>any</u> hospital records. Although the appellant had countersigned the controlled drugs book for dihydrocodeine which had not in fact been given to the Patient, Charge 1(a), there was no evidence that she had made any corresponding entry in the patient notes for Patient A.

<u>Patient B</u>

40. Patient B did not give live evidence. Her witness statement, dated 30th August 2017, was agreed. Like Patient A, Patient B had given evidence at the Crown Court trial. There must, therefore have been a police witness statement made much nearer the time of the relevant events, but that did not feature in evidence. The Panel only had this comparatively recent statement. The appellant, would of course, have had access to Patient B's police statement had it been relevant to make use of it.

41. The issue in relation to Patient B was very different from Patient A. Patient B was due to be discharged on 24th June 2015. She was a consultant obstetrician by profession. She had declined dihydrocodeine on several occasions during her stay at hospital. In her witness statement she said:

> "5. On the Tuesday evening (same date, 23 June 2015) about 10 or 11pm, I was given more paracetamol and ibuprofen. I was again offered something stronger and again I declined.
>
> 6. <u>At this time</u>, the nurse said she would help me with my discharge medication, which is also known as a TTO. There was a bag with paracetamol, ibuprofen and an anticoagulant that I needed. There was no discussion about me getting anything stronger. My recovery had been fine and I still did not require any stronger pain killers." (emphasis added)

42. There was no dispute that it was the appellant who gave Patient B her discharge medication. The nursing notes showed that the appellant had attended Patient B at 23.40hrs on 23rd June. She indicated in the notes that she had given her TTOs. The appellant signed the drugs register to indicate that she had withdrawn dihydrocodeine at 00.15hrs on 24th June.

43. The appellant's case was that when she took the TTOs to Patient B (including dihydrocodeine) Patient B said she did not want dihydrocodeine. The appellant did not press the point, knowing that Patient B was herself a doctor and was well able to make an informed choice. The appellant's evidence was that she removed the box of dihydrocodeine from the TTO bag and put it on the bed where she continued attending to the discharge paperwork. Having her hands full, she then put the box in the back pocket of her trousers so that she had her hands free "to tidy her tray table, pour her some water, get everything set up so that when I left the room she would be able to reach everything and she was comfortable" (see transcript, page 358). The box remained in her pocket. She was distracted thereafter with other tasks and it went out of her head completely. She still had the box in her pocket when she left the hospital at the end of her shift.

44. The appellant acknowledged that the correct procedure would have been to return the box to the drugs store and record in the register that it had been returned. It was not until she was driving home that she realised the box was still in her pocket. She had just finished the night shift and needed to get back home to her children to get them to school. She was tired. She had been in trouble over the amount of sick leave she had taken and had visions of taking the tablets back and having her practice questioned. She made the decision to dispose of the tablets. When she got home she ripped the box in half. She put the tablets in a waste bin near where she parked the car. She kept the box because it had confidential information on it, Patient B's details. For that reason she did not want to throw the box away. She put it in her handbag and forgot about it. The box was still in her handbag when she was arrested by the police nearly two weeks later on 10th July.

45. In the course of giving this evidence-in-chief about the conversation with Patient B which had prompted the appellant to remove the box of dihydrocodeine from the TTOs, counsel for the NMC interrupted to point out that the appellant's evidence conflicted with Patient B's agreed (and therefore unchallenged) witness statement. The appellant's counsel disagreed. The Panel adjourned to enable counsel to discuss and resolve the matter. When the hearing resumed the Panel was informed of the outcome of the discussion. The appellant's counsel maintained that when paragraphs 5 and 6 (quoted above) were read together they *could* be interpreted as indicating that the refusal of a stronger painkiller and the discharge conversation took place at one and the same time, relying on the words at the start of paragraph 6 "at this time" as the link. Counsel for the NMC disagreed with that interpretation and said he would make submissions upon it, but he accepted that his opponent's construction was a legitimate alternative interpretation. In fact he did not return to the matter in his closing submissions. The appellant's counsel, in her closing submissions, contended that paragraphs 5 and 6 of Patient B's statement were "largely in line" with what the appellant had said.

46. The appellant's account in relation to Patient B's dihydrocodeine was challenged and probed in cross-examination at considerable length, and to powerful effect. The Panel

took the view that the appellant's evidence was at odds with the evidence of Patient B (in her agreed witness statement) that when she was given her TTO medication there was no discussion about getting anything stronger. The Panel concluded:

> " In the face of this clear and unequivocal statement by Patient B which you had agreed, the Panel did not accept your claim that you had offered Patient B the dihydrocodeine that you had signed out for her but that she refused it and you forgot to sign it back into the controlled drugs cupboard."

Charge 1(a) was therefore proved.

47. In relation to Charge 1(b), dishonest falsification of patient records, the Panel concluded:

> "… you gave an account that you had accidentally removed this medication from the ward. The Panel did not accept your account. It is further noted that the records were not amended by you to show what had happened to this medication."

Charge 1(b) was therefore proved as well.

48. In relation to Charge 2, theft, the Panel concluded:

> "… it is accepted by you that the torn, empty packet of dihydrocodeine was found in your bag when you were searched by the police on 10 July 2015. The Panel rejected your explanation of how this packet came to be in your possession. The Panel did not believe your description of how you panicked when you found that you had forgotten to put the dihydrocodeine back in the controlled drugs cupboard and that you had thrown away the contents but kept the packet for reasons of patient confidentiality. Not only did the Panel not believe your assertion that Patient B had declined your offer of dihydrocodeine but your claimed behaviour would have been completely at odds with the experienced and conscientious midwife you claim to be. Furthermore, if you had really reflected on the issue of patient confidentiality you had ample opportunity to dispose of the packet as confidential waste."

Accordingly the Panel found the charge of theft proved in relation to Patient B.

Patient C

49. Patient C gave live evidence. She had made a witness statement dated 13th October 2017. She had not been a witness at the Crown Court trial. She was due to be discharged on 23rd June 2015. The appellant was on duty the previous night. She signed out dihydrocodeine for Patient C at 22.00hrs on 22nd June. The appellant had also made an entry in the nursing notes at 22.00hrs. The entry read: "Started discharge for tomorrow. Postnatal info pack gone through. TTOs and community midwife handover form given".

50. The appellant's case was that she had given patient C her TTOs at that time, including dihydrocodeine. Patient C's evidence was that she did not want dihydrocodeine and was not given it. Patient C had worked as a pharmacy technician and therefore knew about drugs. She was adamant she had been given no dihydrocodeine. The appellant's case was that although she now had no recollection of Patient C, she must have given her dihydrocodeine because the register showed that she had withdrawn dihydrocodeine for her from the drugs cabinet.

51. Patient C's witness statement was very brief. She gave the information over the telephone when she was asked to provide a statement. She said she had not taken any oral painkilling medication in hospital and had never asked for any. She said in her witness statement that although she had said she needed no painkillers to take home she was given some paracetamol anyway, and may have been given ibuprofen. She corrected this in her oral evidence. She said that the person she spoke to on the telephone who took her witness statement had misunderstood (not misrepresented) what she was saying. In her oral evidence she expanded on the details of receiving the paracetamol. She said that when the time came for her to leave hospital, a member of staff had put it on top of her duffle bag. The member of staff had paracetamol in her hand and said she might as well take it with her anyway. She took the box home and still had it in the medicine cupboard at home. She was sure there was no dihydrocodeine. She did not like taking tablets because she found them difficult to swallow. She was also breast feeding at the time, and would definitely not have wanted to take dihydrocodeine. In cross-examination she accepted that it was possible that she had been given TTO medication by one member of staff then given paracetamol by a different member of staff.

52. She was adamant in cross-examination that she had received no phone call about this matter except the call from the man who took her witness statement. That conflicted fundamentally with the evidence of Ms 3, the maternity ward manager. Her evidence was that on 6th July 2015 she had phoned Patient C at home who had told her that she had only taken paracetamol home: "I don't like to take drugs". Patient C agreed in cross-examination that it was a long time ago and she could not remember everything. The only midwife whose name she could remember was "Ruth". She did not remember the appellant. She said that if she had found when she got home that she had been given dihydrocodeine, she would have contacted the hospital to inform them of the error.

53. In her own evidence the appellant said she would have used a green bag to give the TTOs. She certainly did not put a single box on a duffle bag. All she could say was that she must have given Patient C dihydrocodeine because that is what she had signed for in the register.

54. In her closing submissions the appellant's counsel suggested that if Patient C could be so wrong about not receiving an earlier telephone call, she could be equally wrong about other details. She was doing her best, but she was not asked to provide a witness statement until more than two years after the events she was recalling.

55. The Panel found Patient C to be a compelling witness. She gave clear evidence that she had not been given dihydrocodeine and was very clear in her recollection as to why she had refused it. She had a clear understanding of the difference between dihydrocodeine and paracetamol. There were matters she was unable to recall but that

did not undermine the credibility and reliability of her evidence. In relation to Charge 1(a):

> "…The panel determined that you had incorrectly signed the TTO medication for Patient C as consisting of dihydrocodeine in the controlled drug record book on 22nd June 2015 "

The charge was therefore proved.

56. In relation to charge 1(b) the Panel determined that in the patient care notes "…you falsely stated that the TTO medication was given when this was not the case". Charge 1(b) was therefore proved as well.

57. On Charge 2, theft in relation to patient C, and in relation to Patients D and G, the Panel noted that the appellant had signed out the dihydrocodeine TTOs from the controlled drugs cupboard and had completed patient care notes to show that this had been given to the patients when it had not:

> "…The dihydrocodeine was not given to any of the patients and the proper inference that is made by the Panel, which is corroborated by the fact that you were found in possession of Patient B's empty dihydrocodeine box by the police, is that you stole the dihydrocodeine. Therefore, on the balance of probabilities the Panel find this charge proved in relation to Patients A, B, C, D and G."

Patient D

58. Patient D did not give evidence and there was no witness statement from her. The case against the appellant was based entirely on hearsay evidence. Patient D was discharged from hospital on 20th June 2015. The nursing notes showed that the appellant attended her at 10.15hrs and again at 12.45hrs where the entry includes "TTOs given". The drugs register records that the appellant withdrew dihydrocodeine from the drugs cupboard at 12.45hrs, coinciding with the entry in the nursing notes. No TTO form was located. Patient D was one of the witnesses spoken to over the telephone as part of the "audit" carried out by Ms 3.

59. According to her witness statement to the police, dated 9th July 2015, Ms 3 spoke to Patient D on 6th July "as a welfare call", because she was listed as having received dihydrocodeine on 20th June. Ms 3's statement read: "She told me over the phone that she had not received any." The entry in the audit schedule was to the same effect: "Phoned 6/7/15 by [Ms 3]. [Patient D] confirmed TTO not received." In her oral evidence Ms 3 explained that the entry in the schedule was compiled from other notes she had made.

60. In her oral evidence Ms 3 confirmed that it was she who had spoken to Patient D. She added that this was a patient who had a normal delivery, so there was no reason for her to have had dihydrocodeine. In his closing submissions, counsel for the NMC pointed out that in the nursing notes there was an entry at 11.00hrs (not made by the appellant): "Feeling well, no analgesia required".

61. In her own evidence-in-chief the appellant said she had no recollection of Patient D, as she only had the notes to work from. 20th June was her first day back at work after sick leave. She agreed that the notes indicated "Small tear, not sutured. Minimal blood loss. Feels and looks well. Six hour discharge". She said she had no particular recollection of giving the TTOs on this occasion. But if the patient required tinzaparin (which was included in her TTOs), she would have needed a doctor to come and sign for it, and the doctor might have decided to include a prescription for painkillers as well (transcript, page 364). If a patient is given analgesia to take home she does not have to use it. It is a prescription "as needed". The appellant thought it would be perfectly reasonable for a doctor to write her up for dihydrocodeine. She, the appellant, would not have questioned it if the doctor had written a prescription for dihydrocodeine as well as paracetamol and ibuprofen so that the patient could take it home and use it if she needed it, even if she had a normal birth.

62. In cross-examination the appellant said she was happy that she had signed out Patient D's dihydrocodeine and had given it to her: "Yes, Yes, absolutely". If she had signed an entry to say she had given it, then she had given it.

63. In his closing submissions counsel for the NMC pointed out that there was no clinical need for Patient D to have dihydrocodeine. He invited the Panel to treat that as some supporting evidence that Patient D had not in fact received dihydrocodeine.

64. The appellant's counsel submitted (page 467) that, on the NMC's case, she would have had to doctor a TTO form before withdrawing the dihydrocodeine "very opportunistically… whilst dealing with things outside of work and her personal life and a busy shift". She must have thought "Right, I'm now going to doctor a TTO form. I've found an opportunity here. We have someone with no clinical need. I'm going to doctor the form, hope my colleague doesn't realise, and then withdraw the medication and steal it within the space of a few hours. Was that really plausible?"

65. The Panel noted that the evidence in relation to Patient D was hearsay evidence. However, Ms 3 had spoken with Patient D on the telephone as part of her audit and Patient D had informed her that she did not receive dihydrocodeine. The patient care records stated that Patient D was issued with TTO medication. The controlled drugs book recorded that the appellant had signed out 28 dihydrocodeine tablets for Patient D on 20th June. Ms 3's evidence was consistent with her police statement given as part of the enquiry and her evidence given to the Panel. Ms 3 clearly recalled speaking to Patient D and the Panel accepted her evidence in relation to Patient D. Therefore Charge 1(a) was proved.

66. Likewise, the Panel found that Charge 1(b) was proved, in that the appellant had falsified the patient care notes on 20th June to show that TTO medication had been given including dihydrocodeine.

67. In relation to Charge 2, theft, the Panel found that the appellant had signed out dihydrocodeine from the controlled drugs cupboard for Patient D's TTOs and had completed patient care notes to show it had been given when it had not. The Panel was satisfied that the proper inference was that dihydrocodeine had not been given to Patient D (or to Patient C or Patient G) which was corroborated by the fact that the appellant was found in possession of Patient B's empty dihydrocodeine box. The proper inference was that she had stolen the dihydrocodeine in each case.

Patient G

68. Patient G did not give evidence, nor had she made a witness statement. The case against the appellant was based wholly on hearsay evidence. Patient G was due to be discharged on 27th June 2015. The nursing notes showed that the appellant attended at 15.00hrs and signed to indicate she had been given her TTOs. Again, no TTO form was found. The appellant's was the second signature in the register for withdrawing dihydrocodeine for Patient G at 16.10hrs. The first signature, as giving the dihydrocodeine, was in fact Ms 2.

69. Ms 3 gave evidence that she had spoken to Patient G by telephone on 8th July, the day before Ms 3 made her first witness statement to the police. Her witness statement said: "I asked if she had taken home any dihydrocodeine, she said she hadn't as she was breastfeeding and definitely didn't want to take any". In the audit schedule the entry read "Phoned by [Ms 3], message left. Spoke on the 8/7/15 to [Patient G], confirmed that she only took home paracetamol and ibuprofen."

70. In cross-examination Ms 3 was asked, in relation to Patient G, whether it was safe to take dihydrocodeine when breast feeding. The answer was that they did give dihydrocodeine to breast feeding mothers. She also confirmed that Patient G's delivery had not been a normal birth, the implication being that a stronger painkiller would have been appropriate as there had been an episiotomy.

71. In her own evidence the appellant agreed that she had made the entry in Patient G's notes an hour before the dihydrocodeine was signed out in the drugs register. This time she was signing it out nearer to the time that the patient was actually leaving hospital. As far as she was concerned, Patient G went home with whatever was on the TTO form including dihydrocodeine (page 375). In cross-examination she insisted that if she had signed it out in the drugs book and it was in the patient's notes, she had definitely given it to the patient.

72. In her closing submissions the appellant's counsel made the point that there was certainly a clinical need for dihydrocodeine but this was a purely hearsay account, potentially multiple hearsay.

73. The Panel were satisfied that the appellant had incorrectly signed the drug record to indicate that dihydrocodeine had been given to Patient G on 27th June. They took into account Ms 3's witness statement in which she had said that she telephoned patient G and recalled the patient saying she was breastfeeding and definitely did not take any dihydrocodeine home as part of her TTO. The Panel noted that Ms 3 was clearly able to recall the conversation in her evidence. Charge 1(b) was therefore proved. The Panel were also satisfied that by indicating in Patient G's notes that she had given the TTO to Patient G when she had not, she had falsified the patient notes. Charge 1(a) was therefore proved as well.

74. As in the case of Patient D, because the Panel were satisfied that the dihydrocodeine which had been signed out was not given to any of the patients A, B, C, D and G the proper inference, corroborated by the fact that she was found in possession of Patient B's empty box, was that she had stolen the dihydrocodeine.

Patients E and F: the unproved charges

75. The other two patients in respect of whom the evidence was almost entirely hearsay were Patient E and Patient F. The Panel were not satisfied that any of the charges were proved in respect of these two patients, because the Panel were not satisfied that it was proved that these patients had not received their dihydrocodeine. It is important to note the basis on which the Panel reached that conclusion.

Patient E

76. In relation to Patient E, dihydrocodeine was signed out at 10.15hrs on 27th June. The appellant had made an entry in Patient E's notes that TTOs were given. The notes indicated that analgesia had been given as prescribed. She made another entry in the patient notes at 12.30hrs indicating that Patient E was ready to go home.

77. In the audit schedule there was an entry that Patient E had been "phoned at home", but there was no indication of who it was that had spoken to her. The entry stated that she was asked what medication she was sent home with. She said only paracetamol and ibuprofen, as painkillers. She said that she wished she had had something stronger for when she was in a lot of pain. The audit schedule also recorded that Patient E was contacted on 27th July (as requested by the police) to see if she was prepared to talk to the police. She agreed to do so, but apparently nothing came of that. Had she made a witness statement to the police, that would have been disclosed.

78. There was no mention of any phone call to Patient E in Ms 3's witness statement to the police dated 9th July, but in her oral evidence Ms 3 told the Panel that she had spoken to Patient E. On closer questioning in cross-examination it emerged that Patient E had not wanted to come to the phone at first because she was in a lot of pain. Ms 3 had spoken to Patient E's husband or partner. The phone was then passed to Patient E herself. She was crying down the phone when they started talking. Ms 3 asked her "Well about your pain relief, do you not have enough pain relief, what have you got?" She went through what she had. Ms 3 asked her in terms if she had some dihydrocodeine, and described the box. Patient E replied that she had no dihydrocodeine and had actually sent her husband out to get some more pain relief (page 265).

79. In cross-examination Ms 3 remembered that Patient E had actually said "I've sent my husband off to Asda to go and get something stronger." Ms 3 said it was a really upsetting phone call to be involved in. When pressed she was not sure that it was Patient E's husband who was referred to rather than some other family member. She denied that she was exaggerating the distress of Patient E in the conversation. She admitted that the only record there was of the conversation was the audit schedule.

80. In their reasons the Panel noted that Ms 3 had not recorded in her police statement who it was that had spoken with Patient E, and the details in her witness statement were not recorded in the audit report. The Panel could not therefore be satisfied as to what had been said by Patient E.

Patient F

81. The evidence in relation to Patient F was similarly unsatisfactory. Patient F was due to be discharged home on 30th June. She was seen by the appellant at 22.00hrs. At some

point that night the appellant signed out dihydrocodeine for Patient F from the drug cupboard. The entry is not timed. It appears in the register immediately before the entry for Patient A, which was also not timed. In the audit schedule the entry gives no detail of the conversation with Patient F said to establish that she had not received her dihydrocodeine. The entry merely reads "…on discussion with the woman she did not receive this drug".

82. In her witness statement to the police dated 9th July 2015, Ms 3 said that she knew her colleague Ms 1 had spoken with this patient to establish if she had received any dihydrocodeine. Ms 3's statement gave no information as to the content of that conversation. In her oral evidence Ms 3 told the Panel (page 266) that it was Ms 1 who had spoken to patient F.

83. Ms 1 said in her witness statement to the police dated 9th July 2015 that she had telephoned Patient F to find out whether she had actually had her dihydrocodeine. Her husband answered the telephone. She introduced herself, apologised for disturbing them and said she just wanted to know what medication had been taken home the previous evening. Her husband said: "I think she had paracetamol and ibuprofen." She asked him whether she thought Patient F had taken home any dihydrocodeine. He said "I'm pretty sure not but I'll go and ask her." He came back a few minutes later and said: "No, definitely not, just paracetamol and ibuprofen." That was the end of the conversation.

84. In her oral evidence Ms 1 confirmed that she had not spoken directly to Patient F, but only to her partner. She thought she had made a written report, for her manager, of everything she had found in her investigation, but no such document was produced. The only evidence of the conversation was her witness statement and the very general entry in the audit schedule.

85. In their reasons the Panel noted that Ms 1 had only spoken to Patient F's husband and not to Patient F herself, and that the only evidence was her husband's report of what Patient F had said. The Panel could not be satisfied as to the accuracy of what was said by Patient F and accordingly the charge was not proved.

The hearsay issue

86. The striking feature of the NMC's case against the appellant was that of the seven allegations of stealing dihydrocodeine, four depended entirely on hearsay evidence to establish that the patient had not received the dihydrocodeine prescribed for her. In relation to patients D, E, F and G the only evidence that the patient had not received dihydrocodeine as part of her TTO medication came from the audit conducted by Ms 3 and her colleagues in which these and other patients were telephoned at home, on the pretext of a welfare call, in order to ascertain whether they had been given dihydrocodeine as part of their TTO medication.

87. The procedure which had been followed for the audit was explained by Ms 3 in her oral evidence. There were three of them who made phone calls to patients. Having identified from the drugs register the patients for whom the appellant had withdrawn dihydrocodeine from the drugs cupboard, those patients were telephoned. It was in the nature of welfare call: "We had a template that we could work to, but we did not double up on the conversations. We knew what we were going to say. We kept it very

brief. It was a welfare conversation, so we could look at the results after and evaluate the outcome." (page 260). The notes from the individual calls were brought together to compile the audit schedule. She and the others who made the calls sat down together with the notes. She had a computer and put the information into the schedule, taking the entries from their written records.

88. Although all seven patients, A, B, C, D, E, F and G, were contacted by telephone in this way, and although the police were presumably supplied with all these details, only Patients A and B made witness statements to the police. They were the only patients to give evidence at the Crown Court trial. Ms 3 and Ms 1 also gave evidence at the trial. The fact that the appellant was acquitted by the jury of stealing the dihydrocodeine prescribed for Patients A and B - precisely the allegation she faced in these disciplinary proceedings - obviously did not preclude the Panel from reaching a contrary conclusion. This was not least because the standard of proof was different: the criminal standard of proof beyond reasonable doubt in the Crown Court, the civil standard of proof on the balance of probabilities in the disciplinary proceedings. However, the fact of her acquittal was not altogether irrelevant. As a matter of common sense and common fairness the Panel were obliged to proceed with greater caution in differing from the jury's conclusion on the very same allegations of theft, particularly in view of the serious consequences of such a finding for the appellant's career as a midwife. Although as a matter of law the standard of proof remained the civil standard, it is well established that the more serious the charge alleged, the more cogent is the evidence needed to prove it: see *R v H* [1996] A.C. 563. The Panel were so advised by the Legal Assessor, although no reference is made to it in their reasons.

89. The "investigation" conducted by Ms 3 and her colleagues in relation to these seven patients, based solely on replies in "welfare" telephone calls, could never have been a proper foundation in itself for disciplinary proceedings whose outcome could jeopardise the appellant's whole career as a midwife. The investigation was conducted principally for the benefit of the Trust as her employer, to determine whether she should be dismissed from her employment.

90. Against this background it is instructive to see how it came about that the alleged theft of dihydrocodeine prescribed for the five other patients (apart from Patients A and B) came to be the subject of these disciplinary proceedings. Among the documents in the appellant's bundle for the appeal, is a series of email exchanges between Ms 3 and the NMC's Case Officer soon after the appellant's acquittal in the Crown Court, including the following rather unattractive email from Ms 3, bemoaning the appellant's acquittal:

> "Dear Hamida, Please find enclosed the letter I received from the court case. Unfortunately they found her not guilty based on the evidence from only two ladies. Please do remember we dismissed her on the grounds of gross misconduct using substantially more evidence we pulled together. Do let me know the next steps in regards to her registration."

91. It is clear that this is what prompted further attempts to secure the co-operation of the five other patients in order to strengthen the misconduct case against the appellant. As a matter of common sense, the greater the number of patients who said they had not

received and taken home their dihydrocodeine, the more improbable would be the coincidence that this was all a mistake, and the stronger the misconduct allegations would become. There was nothing necessarily wrong or improper in such a course of action, but it must be remembered that two years had now elapsed since the relevant events, and it was incumbent on the NMC to ensure that the case was presented fairly. In the event, only one of the other five patients was prepared, belatedly, to be a witness: Patient C. The other four, Patients D, E, F and G, declined to co-operate, in circumstances I shall explain later.

92. This then is the context of the hearsay issue. It is extremely regrettable that no consideration seems to have been given by the NMC initially in framing the charges, or by counsel or the Legal Assessor at the hearing, to the *admissibility* of the hearsay evidence from these four patients, as opposed to the *weight* to be attached to that hearsay evidence. The distinction is very important, and has been emphasised in the authorities.

93. The leading case is *Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216. One of the disciplinary charges of misconduct against the midwife in that case raised allegations which were centrally dependent upon the evidence of a particular witness, a team leader. The evidence was adduced before the relevant committee (the equivalent of the Panel in the present case) in the shape of a written statement from this witness, in the face of objection by Mrs Ogbonna asserting that it was unfair for it to be admitted since she had no opportunity to cross-examine the witness. The committee nevertheless admitted the statement and found that charge proved, and two other charges as well.

94. On appeal to the High Court, Nicola Davies J concluded that the admission of the team leader's evidence under charge 1 was unfair and that the committee's decision on that charge was in consequence unsustainable. She further held that the committee had plainly taken account of its charge 1 finding, as well as its charge 2 and 3 findings, in further finding, as it did, that the midwife was guilty of misconduct and that her fitness to practise was impaired. The judge held that the committee's error in relation to charge 1 tainted its findings of misconduct and impairment and therefore its overall decision to strike the midwife off the register. She accordingly allowed the appeal.

95. The NMC appealed against that decision but the Court of Appeal upheld the conclusion of Nicola Davies J in relation to charge 1. Central to the argument was the wording of rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 which provides:

> "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…"

The committee, in deciding to admit the evidence, had correctly identified the key issue as one of "fairness". They recognised the prejudice to the midwife if the evidence were to be admitted without her having the opportunity to cross-examine the witness, but reminded themselves it would be for them to decide what weight to attach to the

statement. They considered it would be prejudicial to the NMC to exclude the evidence, particularly when the team leader was the only witness to some of the matters set out in the charges. They therefore concluded that, on balance, considering the prejudice each party would suffer by an adverse decision, they ought to admit the statement whilst reminding themselves that they might later need to treat it with caution.

96. In the Court of Appeal it was argued on behalf of the NMC that the criterion of fairness to which rule 31(1) refers can be fully and satisfactorily met by the consideration that it will always be open to a tribunal, having admitted a statement, then to make a careful assessment of the weight that it should attach to it, which it was suggested, was what the committee had done.

97. The Court of Appeal firmly rejected this argument. Rimer LJ said, at [23] and [25]:

> "[23]…That submission appears to me to overlook the point that the criterion of fairness referred to in 31(1) is relevant to whether the statement should be admitted at all: the rule expressly required the decisions as to the exclusion of the hearsay statement to be governed by considerations, inter alia, of fairness. In that context, the NMC should perhaps be reminded that it was seeking to adduce Miss Pilgrim's statement as the sole evidence supporting the material parts of charge 1 when it knew that evidence was roundly disputed and could not be tested by cross-examination. It was, moreover, seeking to adduce it in support of a case that it was promoting, whose outcome could be (as in the event it was) the wrecking of Mrs Ogbanna's career as a midwife, a career which had lasted over 20 years. I should have thought it was obvious that, in the circumstances, fairness to Mrs Ogbonna demanded that in principle the statement ought only to be admitted only if she had the opportunity of cross -examining Miss Pilgrim upon it. …
>
> 25. What the judge did in her judgment was what the CCC failed to do, namely to consider and assess the fairness, in the particular circumstances she described, of admitting the witness statement at all. She concluded, for the reasons she gave, that its submission was unfair. As I interpret her judgment, her reasoning was focused on the particular facts of the case. It did not purport to lay down any more general principle than the need for a proper consideration to be given to the criterion of fairness when the question of the admission of a hearsay statement under rule 31 arises."

98. Thus, the Court of Appeal upheld the quashing of the findings on charge 1, and directed that charge 1 could not be re-opened against Mrs Ogbonna. Moreover, because the evidence on charge 1 may have influenced the committee's decision on charges 2 and 3, and therefore their conclusion on fitness to practise and sanction, the Court of Appeal quashed the decision overall, but directed that the trial of charges 2

and 3 alone be remitted for a rehearing afresh before a differently constituted panel of the Committee.

99. This approach to the distinction between *admissibility* and *weight* was followed and applied in another NMC case, *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). The nurse in that case faced disciplinary charges which depended upon the evidence of witnesses who were not called to give evidence but whose written statements were admitted. The case was further complicated by the fact that the nurse did not attend the hearing and would not therefore be in a position to cross-examine either witness in any event. The panel found that the appellant's fitness to practise was impaired by reason of misconduct and suspended his registration for a period of 12 months. He appealed to the High Court.

100. In a very thorough analysis of the relevant legal principles, Mr Andrew Thomas QC, sitting as a judge of the High Court, reviewed the relevant authorities from the criminal jurisdiction where the principles are now clearly established by the decision of the Supreme Court in *R v Horncastle* [2009] 2 Cr App R 15. This and subsequent cases illustrate the need to undertake a careful balancing exercise before admitting such evidence, especially in a case where the statement of the absent witness is the sole or decisive evidence on a charge.

101. Mr Andrew Thomas QC considered the decision of the Court of Appeal in *NMC v Ogbonna* and also the decision in *R (Bonhoeffer) v GMC* [2012] IRLR 37 in which the Court of Appeal held that *Ogbonna* did not lay down a general rule that there always had to be good and cogent reasons for the absence of the witness; all such cases are fact-sensitive, and the test is the requirement of fairness. Important factors may be a history of animosity between the parties, a conflict of factual evidence, and the degree of impact which the evidence would have on the registrant's career. At [45] the judge continued:

> " For the purposes of this appeal, the relevant principles which emerge from the authorities are these:
>
> 1.1. The admission of the statement of the absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness *before* admitting the evidence.
>
> 1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in balance, but it will not always be a sufficient answer to the objection to admissibility.
>
> 1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.
>
> 1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up

> the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively there would be some means of testing its reliability.
>
> In my judgment, unless the Panel is given the necessary information to put the application in its proper context, it will be impossible to perform this balancing exercise."

102. Applying the guidance in these authorities to the present case, it is necessary to examine in some detail the way in which this hearsay evidence was approached at the hearing in counsel's submissions, in the advice from the legal assessor, and in the Panel's ultimate decision.

103. At the very outset of her closing submissions, counsel for the appellant (Ms Shafton) said this (page 456 C-F):

> "We are dealing with seven patients. The first things, Sir, that I invite you and your colleagues to do is to put from your mind Patients D, E, F and G. Effectively I am inviting you not to consider them at all when considering the charges. Why do I ask you to do that? These are hearsay accounts; none of the witnesses have been even approached, it would seem, in this case to provide evidence to you; none of them have made statements in these proceedings. Not only are their accounts hearsay as my learned friend concedes, in numerous cases multiple hearsay, and not only that but anonymous hearsay in some cases as we are dealing with family members or other individuals - a male was described in relation to Patients E or C - with no information about their identity, not even their name. I submit that the circumstances in which these hearsay accounts were collected, recorded and presented to you, the Panel, was so unsatisfactory that the accounts are fundamentally unreliable, <u>it would be unfair to rely upon them and therefore no weight should be attached to them.</u> In order to substantiate my request to you that no weight should be placed on the account of those four patients, I refer to section 4 of the Civil Evidence Act 1995. The reason why I do that is because the Act of Parliament very helpfully sets out six factors that panels such as you should take into account when considering what weight to give to the hearsay evidence…"(emphasis added).

104. Pausing there, the first thing to note is that Ms Shafton was not here specifically addressing the issue of *admissibility* as opposed to *weight*. She identified the issue of unfairness, but submitted only that because it was unfair to rely on the statements no weight should be attached to them. She did not address the critical distinction between admissibility and weight. Nor did counsel for the NMC. Nor did the Legal Assessor in the advice she gave to the Panel, as I shall explain.

105. Second, although Ms Shafton went on to address the Panel on the shortcomings of the hearsay evidence by reference to the factors identified in section 4 of the Civil Evidence Act 1995, those were factors which, by definition, went to the weight rather than the admissibility of the hearsay evidence. This is because section 1(1) of the 1995 Act provides in stark terms:

> "s.1(1) In civil proceedings, evidence shall not be excluded on the ground that it is hearsay."

Thus, all hearsay evidence is *admissible* in civil proceedings. Section 4 of the Act is headed "Considerations relevant to weighing of hearsay evidence", and provides:

> "s.4(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.
>
> (3) Regard may be had, in particular, to the following-
>
> a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;
>
> b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;
>
> c) whether the evidence involves multiple hearsay;
>
> d) whether any person involved had any motive to conceal or misrepresent matters;
>
> e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;
>
> f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."

106. Ms Shafton made detailed submissions in respect of each of these factors. She submitted that the evidence of these other four patients, D, E, F, and G, was crucial evidence in the case. It was not supplementary but went to the very heart of the issues. Importantly, she submitted, at page 456H:

> "There is no reason … why the NMC could not have produced the original maker of the statements in this case and that really is the nub of it. We have heard no evidence about any attempt made to contact the witnesses. It certainly would have been reasonable to do so in the circumstances. The patients were all identified by name; there is not a vast time that has elapsed

> between them originally being spoken to by the hospital and today that would have really resulted in any insurmountable difficulty in them being spoken to, a witness statement taken, signed and then being produced to give evidence… We also know that there was a police investigation in this case and mutual assistance could have been sought from the police in terms of obtaining the contact details of the individuals. Patient B and Patient C gave their statements in late 2017, so they were certainly contacted not that long ago. Why could the same not have been done for the remaining patients? We have not heard any evidence about any unavailability or unwillingness to co-operate. It simply seems that no effort at all was made to try and get evidence from them in documentary form. These are serious allegations, Sir, as I am sure you and your colleagues fully appreciate as an experienced Panel with potentially serious consequences for the Registrant. Therefore, when considering what weight should be placed upon those four patients. I ask you to consider all of those points and whether it would have been reasonable in this case and practicable to produce the original maker, the four patients as it were, to give evidence in the same way that Patients A to C have."

107. At the conclusion of Ms Shafton's submissions, counsel for the NMC, Mr Harper, was permitted to respond to the hearsay point. He said, at page 471F:

> "You were taken through section 4 of the [Civil] Evidence Act in relation to hearsay. The first subsection of that deals with the practicality of getting in touch with witnesses who could in any other circumstances give live evidence and it was put to you, based on the evidence as it stood at that point, that the NMC had effectively made no efforts to contact these witnesses, had stood by and allowed their evidence to go in as hearsay. That I entirely accept on the basis of what my learned friend had available to her was a fair analysis of what she had. I did not anticipate the extent to which that point was to be made and raise this at this stage. <u>Efforts were made to contact those other patients; they were unsuccessful</u> and so those patients were not part of these proceedings with the exception of Patient C who was brought into those proceedings, as you know, having been contacted for the first time after a long time. She was part of that process and was brought into these proceedings. <u>The other witnesses, attempts were made and they were unsuccessful.</u> To that extent only I intend to correct that point. Everything else that was said about the reliability of the evidence of course I make no comment on, my learned friend has made her submissions and you will balance it, but it was just on that one factual point." (emphasis added)

108. Regrettably, although there is no suggestion that Mr Harper intended to mislead the Panel, the information he gave, quoted above, was not entirely accurate and

potentially gave a misleading impression. Among the documents contained within the appellant's bundle for this appeal hearing there was a series of internal NMC notes or memoranda, detailing repeated attempts to make contact with the hearsay witnesses.

109. The first note, dated 25th September 2017, made by the Case Officer, recorded that Ms1 proposed to contact the patients "to check if they will engage with the NMC". On 28th September there was a note that Ms 1 had made numerous attempts to contact Patients C, E and G but had received no reply. She had, however, succeeded in contacting Patient D who had agreed to speak to the NMC but asked that they wait a few days because she was on annual leave. On 4th October 2017 there was a message that calls had been made to Patients C, D, E and G, all of which rang out and went to voicemail. Messages were left for each person asking if they could call back. On 6th October 2017 there was a note that calls were made again to Patients C, D, E and G. All four calls rang out and went to voicemail. On 9th October there was a note that calls were made to Patients E and G but there was no reply from either. On 9th October there was a call to Patient D and a message was left on her voicemail asking her to call back. On 10th October there were calls to Patients D, E and G but there was no reply and each call diverted to voicemail.

110. On 10th October a call was received from Patient D. She said that she declined to give a statement to the police at the time: "…what would be required of her from an NMC perspective was explained and she asked for a couple of days to think about it and will the call me back to let me know her decision either way".

111. On 13th October there was a call to Patient D. There was no reply and the message was left on voicemail asking her to call back as a matter of urgency to confirm if she was willing or unwilling to be a witness and to provide a statement to the NMC. The note continued: "…from speaking to her previously I strongly suspect that she is unwilling to engage any further".

112. The position in fact, therefore, was that contrary to the information the Panel were given, all four of the hearsay patients had been "contacted". One of them, Patient D, had said she would think about providing a statement to the NMC but did not return further calls. The other three hearsay patients were contacted, but by their lack of any response, it was obvious that they did not wish to be involved as witnesses. That should inevitably have prompted the question: why not? For example, might it be that they were no longer sure of what they had originally said when they asserted they had not taken home any dihydrocodeine?

113. In relation to hearsay, the advice given by the Legal Assessor was as follows (see page 473A-D):

> "If I look at the hearsay point first of all, you have been referred to section 4 of the Civil Evidence Act. I would invite you to consider the Rule 31 of the Fitness to Practise Rules and what that says in relation to hearsay evidence is that hearsay evidence may be admitted and the test is in relation to the relevance of the evidence and the fairness. Neither counsel argued that the evidence is not relevant. Where there may be some issue is to the weight which should be attached to the evidence and what the fair approach to that evidence is. So, you have heard [Ms

> 3's] evidence and you have also see the advance audit. A number of criticisms have been made of the advance audit and I think on behalf of the NMC it is accepted that it is hearsay and in some cases multiple hearsay. You may wish to consider the case of *Thorneycroft* - I apologise if I am not fully citing the reference to that - and one of the factors you may wish to consider in deciding the weight of the evidence is whether it is the sole or decisive evidence on certain charges. If it is the sole and decisive evidence on certain charges, then great care should be considered in looking at the audit alone and saying that the charge is made out, and again I have invited you to consider each of the charges separately and I would again emphasise that the approach should not be taken that because the charge is made out in respect of A, it is more likely that in respect of say, for example, F to have occurred just because you have decided that the charge is made out in relation to A and that is just an example."

114. In their reasons for the decision the Panel made the general observation in respect of the hearsay evidence:

> "The Panel also reminded itself that in relation to Patients D, E, F and G… the only evidence given by them was hearsay contained in the statements of Ms 3. It took this into account when considering the overall weight to be attached to statements attributed to these patients."

115. In relation to Patient D, where the charge was found proved, the reasons stated:

> "The Panel noted that evidence in relation to Patient D was hearsay evidence. However, Ms 3 stated that she had spoken with Patient D on the telephone as part of her audit. Patient D had informed her that she did not receive dihydrocodeine. …Ms 3's evidence was consistent with her police statement given as part of the enquiry and her evidence given to the Panel. The Panel noted that Ms 3 clearly recalled speaking to Patient D and the Panel accepted M3s evidence in relation to patient D. Therefore the Panel agreed that charge 1(a) is proved in relation to Patient D. "

116. In relation to Patient G, the reasons stated:

> "The Panel determined that in relation to Patient G you did incorrectly sign in the controlled drug record book that TTO medication consisting of dihydrocodeine had been given to her on 27 June 2015. The Panel in reaching this decision took into account the police statement of Ms 3 in which she stated that she telephoned Patient G asking if she had taken home any dihydrocodeine. She recalled that Patient G stated that she was breastfeeding and definitely did not take any home (sic) dihydrocodeine as part of her TTO. The Panel noted that Ms 3

> was clearly able to recall this conversation in her evidence. Therefore charge 1(a) is proved in relation to Patient G."

117. In relation to Charge 2, theft of the medication in relation to Patients A, B, C, D and G, the reasons stated:

> "The dihydrocodeine was not given to any of the patients and the proper inference that is made by the Panel, which is corroborated by the fact that you were found in possession of Patient B's empty dihydrocodeine box by the police, is that you stole the dihydrocodeine. Therefore, on the balance of probabilities the Panel finds this charge proved in relation to Patients A, B, C, D and G."

118. As already explained, this hearsay issue was not clearly ventilated in the grounds of appeal, or in the appellant's skeleton argument or in the respondent's skeleton argument. Nor was it addressed in oral submissions at the hearing on 16th October. When I reflected upon the matter, having re-read the entire transcript of the disciplinary hearing and the material in the appellant's own bundle, it became clear that this potentially important point had been overlooked. I gave directions for further written submissions to be lodged by the parties in relation to the following issues:

> "1. In the light of the authorities, and in particular *NMC v Ogbonna* and *Thorneycroft v NMC,* before considering its *weight* should the Panel have first determined the *admissibility* of the evidence, pursuant to Rule 31, i.e. whether it was fair to admit the evidence, which was the only evidence that the patient did not receive dihydrocodeine? If no such determination was made, was this a serious procedural irregularity and/or may it have resulted in a wrong decision? The advice given by the Legal Assessor focused only on the *weight* to be given to the evidence, and that was reflected in the Panel's reasons…: "It took this into account when considering the overall weight to be attached to statements attributed to these patients." Is Rule 18(7) relevant to these issues?
>
> 2. In the presenter's reply to the closing submissions of counsel for Ms El Karout…, it was stated that unsuccessful attempts were made to contact the other patients, i.e. D, E, F and G. However, in the appellant's bundle… is an e-mail chain which shows that Patient D *was* contacted and spoken to on 10th October 2017. What is the significance of this factual error?"

119. In response, in her written submissions dated 1st November 2018 on the hearsay issue, the appellant contended that there was indeed a serious procedural irregularity in failing to determine the admissibility of the hearsay evidence of Patients D, E, F and G before any question of weight was assessed. Nor were the Panel provided with accurate information about the lack of response from those four patients. Given the seriousness of the consequences for the appellant, namely the ultimate sanction of striking off, the findings of the Panel overall should be quashed.

120. At the further hearing on 5th November 2018 the appellant developed these submissions. She explained that counsel who had represented her, Ms Shafton, had not been provided with the documentation relating to the NMC's attempts to engage with the hearsay witnesses. She submitted that without the evidence of the four hearsay patients, and in particular Patients D and G in respect of whom the allegation of theft was found proved, the Panel would not necessarily have reached the other findings they did.

121. In his skeleton argument in response on this issue, dated 31st October 2018, Mr Loran submitted on behalf of the NMC that the admissibility of the hearsay evidence was never challenged at the hearing by counsel representing the appellant, and that to take this admissibility point now would involve a complete change of position from that taken before the Panel. He also submitted that such a challenge is outside the scope of the appeal hearing as set out in the grounds of appeal and the appellant's final skeleton argument. Mr Loran (who did not, of course, appear at the hearing before the Panel) pointed out that before the charges were read and put to the appellant the Chair of the Panel asked if there were any preliminary matters and nothing was raised (page 145G-H). The only issue which arose was some necessary redaction of the bundle. Mr Loran submitted that as no objection was taken to the hearsay evidence of these four witnesses going before the Panel, there was no need to make an application to admit the evidence and no need for the Panel to consider the issue of admissibility. He submitted that the appellant cannot now be permitted to contend that the evidence should never have been admitted, or that some unfairness arises from its admission.

122. As to the authorities of *Ogbonna* and *Thorneycroft*, Mr Loran submitted that in neither of those cases was the registrant represented before the Panel, and there was a clear duty in consequence to ensure fairness by testing the crucial evidence of the hearsay witnesses. By contrast, in the present case the appellant, who was represented, chose not to object to the admissibility of the hearsay evidence. He submitted that where there was no dispute as to the admissibility of the hearsay evidence, Rule 31 was not actively engaged.

123. Mr Loran submitted that in any event the Panel plainly had in mind the potential unfairness of the hearsay evidence. The submission by the appellant's counsel, Ms Shafton, that the Panel should attach no weight to the evidence of the four patients D, E, F and G amounted in practical terms to the same thing as not admitting the evidence at all. By rejecting the evidence in respect of Patients E and F the Panel demonstrated that they had weighed the hearsay evidence properly and fairly.

124. As to the impact on the charges generally if the hearsay evidence of Patients D and G was wrongly admitted, Mr Loran submitted that this still left intact the charges in respect of Patients A, B and C. The overall picture would have remained "largely the same" in that the appellant had been found to have falsified patient records and stolen medication on a number of occasions. Thus the decisions on impairment and sanction should remain the same.

125. In his oral submissions at the further hearing on 5th November 2018, Mr Loran helpfully drew attention to the Rules, and in particular Rule 24 which sets out the order of proceedings at the initial hearing. He submitted that the Panel had clearly considered the evidence in respect of Patients A, B and C separately and did not base their conclusion in relation to Patients A, B and C to any extent upon their findings in

respect of the hearsay evidence of Patients D and G. Accordingly the result overall would have been the same even if the hearsay evidence had not been admitted.

The hearsay issue- discussion and conclusion

126. I remain very troubled by the admission of the hearsay evidence in respect of Patients D, E, F and G. For the reasons I shall shortly explain, I am firmly of the view that had the issues of admissibility and weight been properly analysed and separated, as required on the authority of *Ogbonna* and *Thorneycroft*, the Panel could not possibly have reached a proper conclusion that it was "fair" to admit the evidence. It follows that the Panel's findings in relation to Patients D and G must be quashed. The proceedings were thereby rendered unfair through a serious procedural irregularity. For that reason I am also satisfied that the findings as a whole cannot stand, because it cannot safely be assumed that the Panel would necessarily have found the other allegations of misconduct proved, or would necessarily have reached the same conclusion on the issue of impairment of fitness to practise, or on the issue of sanction. It follows that the appeal must be allowed and the matter remitted for hearing before a differently constituted Panel, with all the allegations of misconduct in relation to Patients D, E, F and G deleted from the Charges and edited out of the witness statements and other evidence.

127. I am satisfied that although the appellant had not advanced this hearsay point herself in the grounds of appeal, there was a general complaint that the proceedings had contravened Article 6 ECHR. In her final skeleton argument she relied in particular on the requirement that the person accused must have a real opportunity to present his or her case or challenge the case against them.

128. I do not accept Mr Loran's submission that because the appellant's counsel had not formally challenged the admissibility of the hearsay evidence, as opposed to making submissions on its weight, the Panel were entitled to move straight on to assess its weight without determining its admissibility. As *Ogbonna* and *Thorneycroft* make clear, they are distinct and separate issues. The advice of the Legal Assessor failed to make this clear. In the passage already quoted she paraphrased Rule 31 as providing that "…hearsay evidence may be admitted and the test is in relation to the relevance of the evidence and the fairness… Neither counsel argues that the evidence is not relevant. Where there may be some issue is to the weight which should be attached to the evidence and what the fair approach to that evidence is…". The Legal Assessor specifically referred the Panel to the case of *Thorneycroft*, but there is no suggestion that the Panel were provided with the report or transcript of the case, from which the crucial distinction between admissibility and weight would have been apparent. The consequence was that the Panel's attention was never directed to the requirement, as a matter of law, that they must first determine admissibility as a question of fairness before considering the question of weight.

129. There are several reasons why the Panel would have been obliged to find that the hearsay evidence in relation to patients D, E, F and G was inadmissible. First, it was not even a case where reliance was placed on a properly recorded witness statement from any of these four patients. All four of them had declined to engage with the process. The hearsay evidence was the oral response which each of them purportedly made to an enquiry by Ms 3, or in the case of Patient F by Ms 1, over the telephone. There was no audio recording of the conversation. There was no precision in the

noting of the conversation. Although Ms 3 spoke of a template, there was no "script" produced to show exactly what was to be said in each conversation to ensure consistency in the questions asked. Whatever contemporaneous note may have made of any of the conversations had not apparently been preserved, which was extremely poor practice. The sketchy composite audit schedule was the sole eventual product of the all important telephone calls.

130. Second and equally important, even if the Panel could fairly and properly rely on the accuracy of what the Patient was reported as saying, the context of the telephone conversations was very different from the formal setting of a request for information which might be used in disciplinary proceedings with the career of a midwife at stake. Ms 3 described the approach as making "welfare calls". Understandably she and her colleagues, in making phone calls to new mothers recently discharged from hospital, would not have wished to disclose the true purpose of the call. But there is a world of difference between, on the one hand, an off-the-cuff response to a question about medication amid general conversation in a welfare call and, on the other, a considered response to a very specific request for information, ensuring that the patient knew and understood the importance of the consequences of her answer. The very fact that none of the four patients had been willing to engage with the process of giving evidence may itself have been an indication that they were unsure of the detail of the medication they had been given. At no point in their reasons did the Panel advert to this aspect of the very informal context of the questioning and its possible impact on the reliability of the hearsay evidence from the patients on such an important issue; the Panel's focus was solely on whether Ms 3 had reliably recollected what had been said.

131. Third, this hearsay from the telephone conversations was the sole and decisive evidence to prove each of the charges relating to these four patients. It was the sole evidence that the dihydrocodeine had not been supplied to these patients and taken home. Unless that was proved, all the charges in relation to these four patients would have failed.

132. Fourth, there was an obvious consequent unfairness if the hearsay evidence were admitted, in that the Panel would then inevitably rely upon the greater accumulation of examples of patients who had not received their dihydrocodeine as rebutting any suggestion of innocent coincidence. This is demonstrated by the Panel's express finding that the charge of theft was proved in relation to patients A, B, C, D and G because "the dihydrocodeine was not given to any of the patients" and the "proper inference" was that the appellant had stolen it in each case, which was "corroborated" by the fact that she was found in possession of Patient B's empty box.

133. It follows that had there been no mention of Patients D, E, F and G at the hearing (as should plainly have been the case), it is impossible to say that the Panel's overall conclusion in relation to Patients, A, B and C, would necessarily have been the same. Put another way, the fact that the Panel wrongly found the charges proved in relation to Patients D and G may very well have reinforced, improperly and unfairly, their conclusion in relation to Patients A, B and C.

134. As already explained, Mr Loran submitted that because the Panel found the charges in relation to these three patients proved quite independently, the overall conclusion would have been no different; the appellant would still have been found to have stolen

dihydrocodeine in relation to those three patients, and that was sufficient to amount to the misconduct alleged, and to impair her fitness to practise. I cannot accept that submission. The whole shape of the case presented to the Panel would have been different. That was precisely why the NMC went to such lengths to include four more patients.

135. I should also make some observations on the procedural shortcomings which contributed to the unfair admission of the hearsay evidence. Mr Loran rightly drew attention to Rule 24, which prescribes the way in which the initial hearing of an allegation must be conducted. "Initial hearing" means "the first substantive hearing of an allegation", and that was the status of the hearing before the Panel which began on 14th May. Rule 24 (1) provides that, unless the Fitness to Practise Committee determines otherwise, the initial hearing of the allegation shall be conducted in prescribed stages.

136. The first or "preliminary stage" is prescribed by Rule 24(2), which provides that the Chair shall: (a) ask the registrant (if present) to confirm her name and personal identification number; (b) ask for the charge to be read out; and (c) ask whether the registrant wishes to make an objection to the charge on a point of law. Rule 24(3) provides that where the registrant makes an objection to the charge the Committee: (a) may hear representations from the parties (if present); (b) shall deliberate in private and announce its decision to those parties present as to whether it will uphold the objection; and (c) shall give reasons for its decision.

137. In the present case, the transcript shows that once the appellant had confirmed her name, the Chair asked whether there were any preliminary matters before the charges were put, to which the response from counsel for the NMC was "None that need trouble the Panel, Sir, no". The Chair did not ask the prescribed question, namely whether the Registrant wished to make any objection to the charge on a point of law. Had he done so, the issue of admissibility of the hearsay evidence may quite possibly have been flagged up for consideration. It certainly should have been, because the Schedule referred to in the charges set out the details of Patients D, E, F and G, and if their hearsay evidence was inadmissible their names should have been deleted from the Schedule and they should not have featured in the case any further.

138. It should also be noted that Rule 18 provides for the holding of a "preliminary meeting" before any allegation is considered by the Committee at a hearing if, in the opinion of the Committee or the Chair of the Committee, such a meeting would assist the Committee to perform its functions. Rule 18(6) provides that at the preliminary meeting the Legal Assessor may give a preliminary opinion for the purpose of resolving questions of law or admissibility of evidence. Rule 18(7) provides that notwithstanding paragraph (6), decisions as to whether or not any evidence is to be admitted at the hearing shall be taken by the Committee considering the allegation.

139. Again it is regrettable that the critical issue of the admissibility of this hearsay evidence was not flagged up early enough to have been considered at a preliminary meeting, so that the appropriate prominence could have been given to that issue from an early stage.

140. For all the reasons I have explained, I am quite satisfied that the findings of the Panel in relation to Patients D and G must be quashed and that consequently the findings in

relation to patients A, B and C must be quashed as well. However, as in *Ogbonna* itself, it must be for a fresh Panel to re-hear the allegations in relation to Patients A, B and C, untrammelled by the inadmissible hearsay evidence. Only the Panel can decide whether the admissible evidence is sufficient to prove those charges.

141. In his oral submissions, Mr Loran suggested that the Panel's starting point must have been their rejection of the appellant's explanation for failing to return Patient B's unwanted box of dihydrocodeine to the drugs cupboard; once the appellant was disbelieved on that, the Panel were entitled to rely on that finding in evaluating her evidence on the other charges as well. This is certainly the approach counsel for the NMC encouraged in his presentation of the case. It is significant that counsel's cross-examination of the appellant built up to Patient B as the climax: see page 400C-408F. His closing submissions were structured in the same way: see page 453D-454F. For this reason I have had to examine very closely the Panel's approach to the charges relating to Patient B.

Concerns in relation to Patient B

142. I am troubled about two separate aspects of the Panel's approach to the evidence relating to Patient B. Their reasons included the following:

> "In relation to Patient B although the Panel did not hear from her, the Panel noted that her statement had previously been agreed by you and accordingly the Panel found no reason to reject any part of her statement… Patient B said in her statement that while an in-patient she was asked on several occasions whether she needed anything stronger than paracetamol or ibuprofen but always declined. When she was given her TTO medication by you it contained paracetamol, ibuprofen and an anticoagulant. There was no discussion about getting anything stronger. She did not need anything stronger. <u>In the face of this clear and unequivocal statement by Patient B which you had agreed, the Panel did not accept your claim that you had offered Patient B the dihydrocodeine that you had signed out for her but she refused it and you forgot to sign it back in to the controlled drugs cupboard.</u> You accepted that you signed out this medication in accordance with the entry in the controlled drugs record. Therefore the Panel found charge 1(a) proved in relation to Patient B." (emphasis added)

143. This view of the supposed conflict between Patient B's witness statement and the oral evidence of the appellant clearly weighed heavily with the Panel in rejecting the appellant's account. The problem is that Patient B's witness statement was very far from "unequivocal", on what turned out to be the critical issue, namely whether there was a conversation at the time the TTOs were offered in which Patient B reiterated that she did not want dihydrocodeine. As already explained, when this potential conflict between Patient B's witness statement and the appellant's evidence-in-chief was first raised by counsel for the NMC, he eventually accepted that on one interpretation of the statement there was no conflict and he thus accepted, very properly, that the meaning was equivocal: see paragraph [45] above. I fail to understand in these circumstances how the Panel could properly have reached the

conclusion they did, quoted above, that there was no such discussion about and refusal of dihydrocodeine at the point of handing over the TTOs.

144. This witness statement made by Patient B, dated 30th August 2017, was the only statement put in evidence. It was very poorly drafted. As already observed, because Patient B had been a witness at the Crown Court trial there must have been a much earlier police witness statement, but this was never produced for the Panel. The appellant told me during the course of her oral submissions that the reason why Patient B's statement had been agreed, rather than requiring her to attend for cross-examination, was that in the Crown Court Patient B had agreed entirely with the appellant's version of events. This is borne out to an extent by an answer the appellant gave in cross-examination (at page 405):

> Q. … do you accept that by not owning up to it at that point it calls into question the explanation you give two weeks later?
>
> A. The explanation I gave two weeks later corresponded exactly with what the client said at the time, and she was interviewed totally independently of me."

145. The second matter of concern in relation to Patient B is a question asked of the appellant by one of the Panel members at the end of the appellant's evidence. At page 414E the Panel member asked:

> "Q. You were also asked another question, what else did you have in the back pocket? You said the handover sheet.
>
> A. Mm mm.
>
> Q. Do you consider the handover sheet as confidential information?
>
> A. Yes, I do."

The implication of this line of questioning, as I read it, was that if the appellant had the handover sheet in her back trouser pocket as well as Patient B's box of dihydrocodeine tablets, she was likely to have retrieved the document from her pocket before the end of the shift and hence been alerted to the presence of the box as well. Thus the credibility of her account was further undermined.

146. The difficulty is that this was to misunderstand, or misconstrue, the evidence which the appellant had actually given about her back pocket. At page 400F, in cross-examination, there was the following exchange during questioning about Patient B:

> "Q. What else do you store in your back pocket when you are at work?
>
> A. A handover, sometimes my phone, but it tends to be on the right side. Sometimes nothing…
>
> Q. Do you know if anything else was in the pocket that day?
>
> A. No. "

Thus the premise of the Panel member's subsequent question may well have been entirely false.

147. In their reasons the Panel rejected the appellant's explanation of how Patient B's packet of dihydrocodeine came to be in the appellant's possession. The Panel did not believe her description of how she panicked when she found she had forgotten to put the dihydrocodeine back in the controlled drugs cupboard, and had thrown away the contents but kept the packet for reasons of patient confidentiality. "Not only did the Panel not believe your assertion that Patient B had declined your offer of dihydrocodeine, but your claimed behaviour would have been completely at odds with the experienced and conscientious midwife you claim to be. Furthermore, if you had really reflected on the issue of patient confidentiality you had ample opportunity to dispose of the packet as confidential waste."

148. I am acutely aware of the limits of this court's entitlement to interfere with the Panel's assessment of the appellant's credibility on this crucial part of her account and I am not prepared to do so to the extent of quashing their findings and prohibiting a re-hearing of the charges relating to Patient B. The Panel had the benefit of hearing and seeing the appellant give evidence. Whilst these two concerns I have raised would not, therefore, of themselves justify reversing the findings of the Panel in relation to the credibility of the appellant's explanation in relation to Patient B, they reinforce my conclusion that, looked at as a whole, the impact of wrongly admitting the hearsay evidence of patients D, E, F and G cannot be confined to the discrete charges wrongly found proved in respect of patients D and G. The Panel plainly looked at the evidence in the case in the round in rejecting the proposition that so many patients could be mistaken in believing they had not been given dihydrocodeine as part of their TTO medication. Furthermore, the Panel clearly regarded the finding of Patient B's empty packet in the appellant's handbag as the clinching evidence to refute such a proposition. In their reasons the Panel relied on this "corroboration" as part of the justification for the "proper inference" that the appellant had stolen the dihydrocodeine issued for all five patients, A, B, C, D, and G.

Other grounds of appeal

149. In view of the conclusion I have reached in relation to the hearsay issue, which requires that the appeal be allowed to some extent at least, I propose to address the remaining grounds of appeal only briefly. My overall conclusion is that they do not provide any basis for allowing the appeal entirely and outright, rather than remitting the matter (as already explained) for a more limited re-hearing before a differently constituted Panel, confined to the allegations in respect of Patients A, B and C. I shall therefore consider only briefly each of the broad grounds of appeal summarised at paragraph 16 of this judgment. I have nevertheless considered carefully all the points raised by the appellant in her written and oral submissions.

Delay

150. Article 6 ECHR requires that proceedings be brought and concluded within a reasonable time. It is well established that there is a high threshold before it can be said that the period of delay is so unreasonable as to breach an individual's convention right under Article 6: see example, *Langford v Law Society* [2002] EWHC 2802 (Admin). In that case the delay was around 6 years. As in the present case, there was a

police investigation and a Crown Court trial. The question is whether there has been "inappropriate or unreasonable delay" in relation to the proceedings against the appellant. The chronology rehearsed at the start of this judgment demonstrates that there has not been unreasonable or inappropriate delay. It was proper to await the outcome of the police investigation and the criminal trial. The decision to refer the case to the Fitness to Practise Committee was made on 29th December 2017. The substantive hearing was held in May 2018. The NMC investigation and adjudication process was completed within 14 months after the conclusion of the police investigation. That was by no means unreasonable.

151. The appellant specifically complains that the evidence of Patient C was much less reliable because of the long delay. She had not made a statement to the police. Her first statement was made over two years after the relevant events, on 13th October 2017. This was plainly a factor to be taken into account in evaluating her evidence but it does not provide support for the conclusion that Article 6 has been breached.

Lack of opportunity to put her case or challenge the NMC's case

152. The appellant was, reluctantly, somewhat critical of her counsel's performance, by comparison with the forcefulness of her counsel at the Crown Court trial. I reject any suggestion that the appellant was incompetently represented by Ms Shafton. Having read and re-read the entire transcript of the hearing, it is plain that Ms Shafton presented the appellant's case vigorously, skilfully and attractively. For the reasons I have already explained, it is regrettable that the admissibility of the hearsay evidence was not directly challenged but that was a failing common to both counsel and the Legal Assessor as well; it does not affect my overall assessment.

153. There is a complaint that the Panel failed to challenge the weaknesses in the NMC's case, and the decision in *McDaid v NMC* [2013] EWHC 586 (Admin) is cited. However, that was a case where the registrant was unrepresented and did not appear at the hearing. Different considerations apply in that situation. In the present case it is evident from the transcript that the Panel examined the evidence of each witness very carefully, and probed and tested the evidence by questioning of their own.

154. There is a complaint that witnesses could have been but were not called by the NMC, in particular the midwives Laura Spicer and Marie Hornsby. There was no obligation on the NMC to call any particular witness. Although the appellant was forbidden to contact witnesses while she was still employed by the Trust, once she was dismissed in November 2015 there was no such restriction. It was open to her, and her advisers, to approach any witness and call such a witness if appropriate. The appellant cites the decision of the High Court in *Suddock v NMC* [2015] EWHC 2612 (Admin), and suggests that the judge in that case criticised the panel for failing to ensure that witnesses were not "cherry picked". Although that was a complaint made in the appeal, the judge rejected it and stressed that the NMC was under no obligation to call witnesses who might have supported the appellant's case: see [42]. There is no evidence that Laura Spicer could have added anything which would have assisted the appellant. When pressed in oral submissions, the appellant was not sure that Marie Hornsby would have benefited her case. Nor is there any suggestion that "Ruth" could have assisted the appellant's case.

155. The appellant made many submissions on the credibility of witnesses and the adequacy of the "audit". I have covered these points already. I have upheld the main complaint of inability to challenge the NMC's case and it has been covered in my decision in relation to the hearsay issue.

156. Another criticism made by the appellant was that Patient C had complained that the person taking her witness statement had "misrepresented" the facts". That is a misquotation from the transcript (page 222). In fact Patient C said that the person who drafted the statement had "misinterpreted", not "misrepresented", what she had said.

Presumption of innocence and impartiality of the Panel

157. The appellant complains that the Panel did not proceed on the basis of the presumption of innocence, particularly when she had been acquitted in the Crown Court. I have already addressed this point. The law is quite clear. The standard of proof is the balance of probabilities: see s.60A Health Act 1999. The burden of proof to establish the misconduct charges remains on the NMC. This was made quite plain in the Legal Assessor's advice to the Panel. The reasons stated specifically that the Panel were aware that the burden of proof rests on the NMC and that the standard of proof was the civil standard, namely the balance of probabilities.

158. As already observed the Panel did not expressly refer in their reasons to the advice properly given by the Legal Assessor that although the standard of proof is the balance of probabilities, the more serious the charge alleged the more cogent the evidence needs to be to prove it: see *R v H* [1996] A.C. 563. In view of the seriousness of these charges, and the acquittal of the appellant in Crown Court, it is somewhat surprising that the Panel did not advert to this advice in their reasons and did not acknowledge the need for particular cogency of the evidence before finding proved the charges of theft, with all the implications for sanction and the appellant's career. The Panel at the re-hearing would be well advised to have this firmly in mind, and to ensure that it guides their decision making. But the absence of any explicit reference to it in this Panel's reasoning does not in itself fatally undermine their decision.

Loss of employment opportunity

159. The complaint is that the sanction of striking her off the register means that the appellant can no longer work as a midwife or a nurse, which breaches her rights under Article 23.1 of the Universal Declaration of Human Rights. Because the appeal is being allowed and the matter remitted for hearing by another Panel, the question of sanction will have to be revisited in the event that there is again a finding of impairment of fitness to practise. As a matter of principle, however, provided the sanction is proportionate there cannot be a breach of this convention right. Sanctions are not intended to be punitive, but they may have that effect. The NMC's overriding duty is to protect the public, and that has to take precedence over the circumstances of any individual nurse or midwife. By analogy, in the context of solicitors, see: *Bolton v Law Society* [1994] 1 WLR 512, at 519, per Sir Thomas Bingham M.R.:

> "Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the

> exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. [A solicitor] can often show that for him and his family the consequences of striking off or suspension would be little short of tragic…..All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be person of unquestionable integrity, probity and trustworthiness…. The reputation of the profession is more important than the fortunes of any individual member..."

Attributing undue weight to the NMC's witnesses and insufficient weight to the appellant's evidence

160. I have covered many of the appellants individual points already in reviewing the findings of the Panel. The essential complaint is that the appellant disagrees with the Panel's assessment of the witnesses and their assessment of her own evidence and credibility. For the reasons explained at the outset of this judgment, on the authorities this is a very difficult complaint to sustain. I have identified my concerns in relation to certain aspects of the evidence but particularly in relation to Patient B.

161. Part of the appellant's complaint is that the appellant did not give sufficient weight to her circumstances. She had not hidden from management the fact that she was taking codeine for a long standing medical condition (endometriosis). The appellant argued forcefully that it made no sense that she would have stolen 200 dihydrocodeine tablets prescribed for these seven patients when she already had a prescription from her doctor. The appellant feels strongly that this was not taken into account by the Panel. In addition to looking after her three children she had caring responsibilities for her father, who is very unwell, and all on top of holding down a responsible job. It made no sense that she should steal dihydrocodeine tablets. There was no serious suggestion that she was stealing them to sell them on the black market.

162. These were all strong points which had to be weighed in the balance against the strength of the circumstantial evidence against her, and the Panel's conclusion in relation to her credibility as a witness on the key issues. She will be able to advance these points with equal if not greater force at the re-hearing.

163. In summary, the following seemed to me to be particularly relevant points on the evidence:

(1) In relation to Patient A: in her most contemporaneous account, her witness statement, she said only that she had been "pretty sure" at the time that she had not received her dihydrocodeine; there was a long period when, on the appellant's account, the dihydrocodeine would have been lying about on the windowsill; if the appellant had just stolen Patient A's dihydrocodeine, it would be odd to tell her colleagues on handover at 8 a.m. that she had given Patient A that medication when it could be so easily checked.

(2) In relation to Patient B, no-one appears to have addressed the significance of the fact that the empty packet found in the appellant's handbag was torn. If the

appellant had simply stolen the tablets, it would be strange enough that she brought the incriminating evidence of the empty box into work at all, but even stranger that she should have torn the empty box.

(3) In relation to Patient C, there was no properly recorded contemporaneous account from her; Patient C was adamant that she had not been telephoned by Ms 3, or any other staff member, as part of the "audit", and she was plainly wrong about that. Her witness statement was not made until October 2017, well over two years after the relevant events.

Disproportionate sanction of striking off, and inadequate reasons

164. Again, because the question of sanction will be revisited in any event, should the fresh Panel find the allegations of misconduct and impairment of fitness to practise proved, it is unnecessary to consider these grounds of appeal in any detail. The complaint is that the sanction of striking off was too drastic having regard to the appellant's long and unblemished record of service as a midwife over a period of 20 years. There is a complaint that the NMC's sanctions guidance is still imprecise in identifying where on the spectrum of dishonesty a particular case should be placed. The appellant cited two recent decisions of the High Court where this omission was highlighted, with strong recommendations by the judge in each case that the sanctions guidance should be revised and refined accordingly: see *Watters v NMC* [2017] EWHC 1888 (Admin) (Cheema-Grubb J) and *Lusinga v NMC* [2017] EWHC 1458 (Admin) (Kerr J), see postscript at [103]-[104].

165. I make no further observation on the appropriate sanction in this case save to make the obvious point that for a midwife to steal drugs on the ward where she is working must inevitably be regarded as a very serious matter, whatever the motivation.

Dishonesty

166. In her oral submissions at the conclusion of the appeal hearing, and in the further document she then produced, the appellant sought to argue that somehow the Panel may have fallen into error in interpreting the requirement of dishonesty for the purpose of Charge 1(b) and the charge of theft, Charge 2. The gist of the complaint is that the Panel applied the wrong test, particularly in view of the appellant's acquittal in the Crown Court of charges requiring proof of dishonesty.

167. The advice given by the Legal Assessor to the Panel was as follows (at page 474C):

> "…The appropriate case that is now cited in regulatory proceedings and has been approved as such is the case of *Ivey Genting Casinos(UK)Ltd* [2017] UKSC 67 and that is whether, by ordinary standards, a defendant's mental state would be characterised as dishonest. It has been suggested that a simple way of looking at this is looking at all of the facts and circumstances including the Registrant's state of mind then considering whether the NMC have proved dishonesty."

Paragraph 74 of the Supreme Court's judgment in *Ivey* was quoted in full,

and then following passage from the NMC guidance on dishonesty:

> "When making decisions on charges involving dishonesty, panels of the Fitness to Practise committee look at whether or not the conduct took place, and if so, with what state of mind. Any dispute over whether a nurse or midwife behaved dishonesty usually means that the Panel's findings will depend on what conclusions they can draw about the nurse or midwife's state of mind from the basic facts. This means the panel needs to consider: what the nurse or midwife knew or believed about what they were doing, the background circumstances, and any expectations of them at the time, whether the panel considers the nurse's or midwife's actions were dishonest, or whether there is evidence of alternative explanations, and which is more likely."

In my view that advice accurately reflects the position in law.

168. Charge 1(b) required proof of dishonesty. The Panel's reasons stated:

> "In relation to dishonesty the Panel noted the clear patient care records made by you. The Panel also considers that in each case you knew you had not given all the TTOs as you had not given the dihydrocodeine they were supposed to contain. The Panel found that these records were dishonest. On each occasion when you had recorded that you had given the TTOs, you had not noted that they did not include the dihydrocodeine. You stated that you were a midwife whose practice it was to amend records when they contained inaccuracies. Accordingly the Panel found that your actions were dishonest in that you deliberately falsified the records of Patients B, C, D and G by falsely implying that all the TTO had been given."

169. There is no indication in this reasoning that the Panel failed properly to apply the advice they had been given. A finding that the appellant had deliberately falsified patient care records would almost inevitably result in a finding of dishonesty in Charge 1(b).

170. As to Charge 2, theft, the simple issue was whether the appellant had or had not stolen the dihydrocodeine prescribed for each of the relevant patients, A, B, C, D and G. The Legal Assessor gave the correct advice on the elements of theft. It is difficult to see how the Panel could have reached any conclusion other than that the appellant had stolen the dihydrocodeine once the Panel were satisfied that she had not given the dihydrocodeine as shown in the records she had created. In relation to Patient B, the simple issue was whether the Panel was satisfied, on the balance of probabilities, that her explanation for possessing the box of dihydrocodeine found in her handbag on 10th July was false. If they were sure it was false, it was a proper inference that she had stolen the medication. Again, there is nothing in the Panel's reasoning to indicate that they failed properly to apply the legal advice they had been given.

Conclusion

171. For all the reasons I have given the appeal is allowed to the following limited extent already indicated (see paragraph [126] above):

(1) The appeal is allowed, and the decision to strike off the appellant from the Register is quashed.

(2) The case is remitted to the Fitness to Practise Committee, for the charges to be re-heard by a differently constituted Panel, in accordance with the following directions of the Court.

(3) Schedule 1 to the charges shall be amended to delete all reference to Patients D, E, F and G

(4) No evidence shall be admitted in relation to Patients D, E, F and G, and all reference to those patients shall be deleted from the witness statements and other documents placed before the Panel.

172. I shall consider any consequential matters arising from this judgment, including the issue of costs, when this judgment is handed down in court on Friday 11th January 2019. The parties must serve brief written submissions on any such consequential matters by 2pm on Thursday 10th January 2019.

173. Although it is not within the court's power so to direct, I consider it to be of the utmost importance that the appellant is again represented by counsel at the rehearing of the charges before the new Panel. I trust that the arrangements which enabled her to be represented at the original hearing will be extended accordingly.