

# Lessons Learned Review

**The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital**

May 2018

## About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care<sup>1</sup> promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.<sup>2</sup> We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk)

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<sup>1</sup> The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence.

<sup>2</sup> The Professional Standards Authority. 2015. *Right-touch regulation – revised*. Available at: [www.professionalstandards.org.uk/policy-and-research/right-touch-regulation](http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation) [Accessed: 14/05/2018].

**From the Chief Executive**



The Rt Hon Jeremy Hunt MP  
Secretary of State  
Department of Health and Social Care  
39 Victoria Street  
London  
SW1H 0EU

27 April 2018

Dear Secretary of State,

I am pleased to submit the Authority's *Lessons Learned Review* of the Nursing and Midwifery Council's handling of allegations against midwives working at Furness General Hospital. The review has been prepared in accordance with the Terms of Reference set out and approved in the Department of Health's letter of 16 March 2017.

This is to some extent an historical review. The tragic deaths of babies and in some cases mothers took place between 2004 and 2016. The passage of time however does not lessen the seriousness of the events as they unfolded nor the importance of learning from them. The NMC has made clear to us that it has done and intends to continue to do so.

We are grateful to the families who spoke to us and shared their experiences however painful it was. They generously allowed us to reflect their knowledge in this review. Many other witnesses provided us with valuable information including the Cumbria Police. We thank them.

These matters have already been subject to an investigation chaired by Dr Bill Kirkup CBE. We have relied substantially on his report and we are grateful for his personal assistance to us.

This Review recognises the many changes and improvements the NMC has made but I highlight here two areas where further consideration is needed; the NMC's approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency.

We are grateful to the NMC Chief Executive, the former and present Directors of Fitness to Practise and the many other members of NMC staff who assisted us.

Yours sincerely

A handwritten signature in black ink that reads "Harry Cayton".

Harry Cayton CBE  
Chief Executive

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# 1. Introduction

1.1 In February 2017, the Secretary of State for Health asked the Professional Standards Authority (the Authority) to undertake a 'lessons learned' review of the Nursing and Midwifery Council's (NMC) handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust).<sup>3</sup> The NMC supported that decision and welcomed the review.

1.2 The concerns arose between 2004 and 2014 and were the subject of an independent investigation conducted by Dr Bill Kirkup CBE<sup>4</sup> which found serious concerns about the clinical competence and integrity of the midwifery unit at Furness General Hospital (FGH). During that period there were several avoidable deaths of mothers and babies. The NMC received its first complaint about midwives at the hospital in 2009. It did not complete its work until July 2017.

1.3 Our terms of reference approved by the Secretary of State were:

'1. To review the handling by the NMC of the complaints against midwives in the University Hospitals of Morecambe Bay NHS Foundation Trust arising out of events in 2008 and later and, in particular:

- a) The NMC's approach to managing the complaints;
- b) The administration of the cases; and
- c) The relationship management with witnesses, registrants and other key stakeholders

2. To identify lessons for the NMC (and other regulators) about its handling of these cases and its approach to relationships with witnesses and other stakeholders.

3. In the light of the NMC's present procedures to make further recommendations if necessary for changes to its processes and approach.

The review will not look at the substance of the NMC's decisions or its panels' decisions on the facts of individual cases and whether to proceed with them. It will look particularly at matters of patient protection, the NMC's communications with families, including the NMC's handling of recent subject access and freedom of information requests.'

1.4 As our terms of reference make clear, this is a 'lessons learned' review which means that our review does not:

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<sup>3</sup> Letter from the Deputy Director – Professional Regulation, Department of Health to Harry Cayton CBE dated 17 February 2017.

<sup>4</sup> Dr Bill Kirkup CBE. (March 2015) *The Report of the Morecambe Bay Investigation*. Available at: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408480/47487\\_MBI\\_Accessible\\_v0.1.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf) [Accessed: 22/02/2018].

- Investigate further the events at FGH or make findings about them
  - Make any findings about midwives, individuals or organisations, other than the NMC, involved in the incidents and subsequent investigations at the Trust
  - Examine or make judgements on the decisions made by committees and panels of the NMC.
- 1.5 We have therefore concentrated on the processes and activities undertaken by the NMC in investigating and prosecuting the cases it identified and its approach to those with whom it worked. We have also looked at the way in which it handled a Subject Access Request (SAR) made by one of the parents who complained to the NMC about the midwives. We also make some general comments about the legal framework surrounding the fitness to practise process and its suitability for addressing the problems that existed at the Trust.
- 1.6 We discuss our process for carrying out the review at paragraphs 1.8-1.18 below. We thank colleagues at the NMC for their assistance to us. We are also grateful to the other individuals who gave up their time to speak to us.
- 1.7 For our understanding of the background to these events we have relied on the Report of the Morecambe Bay Investigation by Dr Bill Kirkup CBE published in March 2015 (the Kirkup report), together with reports by the Parliamentary and Health Service Ombudsman (the Ombudsman).<sup>5</sup> We have also taken account of Coroners' inquests into the deaths of three mothers and babies.

#### **How we carried out this review**

- 1.8 The review and its terms of reference were agreed in March 2017. At that point, we held an initial meeting with the NMC to discuss practicalities and had a preliminary discussion with Dr Kirkup.
- 1.9 We thought it important to take account of the experience of families who had been involved in the NMC's fitness to practise investigations and asked the NMC to identify those families. It made initial contact with those families, who were invited to contact us if they wished to do so. We took out advertisements in the local press and contacted a firm of solicitors who had represented several of the families. We recognise that many years have passed since the events that gave rise to the NMC's investigations and understand that some of the families involved did not wish or feel able to discuss the cases with us further.
- 1.10 We publicised our review on our website, and provided contact details for anyone who might wish to contribute to it.
- 1.12 We began our work in July 2017 having waited for the final fitness to practise case dealing with the concerns at the FGH to be concluded.
- 1.13 The NMC opened cases against 30 named individuals. Some of the individuals had more than one case opened against them. The NMC gave us access to 66

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<sup>5</sup> Listed at footnotes 15-19 below.

electronic case files which related to registrants employed by the Trust between 2006 and 2017. Two of these cases (and individuals) we did not consider to be relevant for the purposes of this review. Of the 64 remaining cases, a number were duplicates. We examined 51 cases in total. The NMC also provided us with access to an electronic file of documents which related to the Morecambe Bay cases but which were not case specific. It also gave us access to some paper files for the earliest period of investigation as not all documentation was available electronically.

- 1.14 In relation to its response to the SAR, the NMC gave us access to electronic copies of the original and redacted versions of the documents that it had provided. We discuss our process with respect to this aspect of our work at paragraphs 4.111-4.117.
- 1.15 We spoke to a number of individuals who had contacted us or who we thought could help. These included members of those families who wished to speak to us, Dr Kirkup, representatives of the NHS Trust, the Royal College of Midwives (RCM), the General Medical Council (GMC), the Care Quality Commission (CQC), Cumbria Police, one of the midwives affected by the investigations, a former member of the NMC's staff and one of the Kirkup investigation's expert advisors.
- 1.16 We invited the NMC to look at a sample of six files that we had reviewed so that it could itself identify any issues and tell us how the cases would be dealt with now under its revised and improved procedures that did not exist before 2014. The NMC provided a detailed and helpful response.
- 1.17 Following our review of the case files and interviews, we asked the NMC a number of questions for response in writing. We also interviewed members of the NMC's present staff.
- 1.18 We obtained legal advice where we considered it necessary.

### Concerns about the evidence

- 1.19 The NMC has assured us that we have seen all the papers available with respect to the Morecambe Bay cases. However, it should be noted that:
  - The standard of record-keeping at the NMC, particularly before 2014, was very poor and we cannot be sure that all documentation was in fact saved to the case files
  - We found documentation in our review of the SAR material that was relevant to the NMC's handling of the complaints and which was not included in the relevant case files. This raises the possibility that there is other material that we have not seen and that the NMC is not aware of
  - The NMC's poor record-keeping has also meant that it has been difficult for us to consistently ascertain whether documents existed, who saw them, whether they were discussed and, generally, what decisions were taken, by whom and the reasons for those decisions

- A number of file notes of decisions and telephone conversations were either not made or not saved
- Poor record-keeping was exacerbated by the staff turnover at the NMC in the years when it was looking at the cases, so that it was often not possible to clarify what happened or why decisions were taken, because the relevant staff had left
- The length of time that has elapsed since some actions were taken is too great for memories to be relied upon.

1.20 Despite this, we think that we have seen enough to support the conclusions we have reached in this report and the lessons we consider the NMC and others could learn.

### The structure of this report

1.21 We have adopted the following structure for this report

- In Section 2, we provide factual background about the history of concerns about FGH, the structure of midwifery regulation, the role of the NMC and its fitness to practise process
- In Section 3, we provide a narrative about the key cases that we looked at and a discussion of the families' concerns
- In Section 4, we set out our analysis of the NMC's approach to the cases and the families
- In Section 5, we look at the changes in the NMC and the key lessons that have been learned or are to be learned from these cases.

1.22 Inevitably this report discusses the actions of individuals and their effect on others. Since this review is intended to focus on lessons to be learned, we have taken the view that it would be inappropriate to name people who were directly involved in the events either as members of the families, midwives or staff at the NMC. We therefore use the following conventions:

- Parents are referred to as Mr and Mrs A etc
- Midwives are referred to as Midwife 1 etc
- Staff and former staff at the NMC are not individually identified, except for senior executive and non-executive members, who are referred to by their job titles.

1.23 As some families do not wish the identity of their baby to be revealed – even where it may already be known – we have avoided referring to gender. We have also not given the babies a pseudonym but instead refer to them with reference to their relationship with their parents. We acknowledge, given the material already in the public domain, that it may be possible for some to be identified, but ask that the families be afforded privacy so that the impacts of these sad events are not compounded by our efforts to learn from them.

1.24 The impact upon the families who lost babies and mothers has of course been immense. The families we spoke to hoped that lessons would be learnt by all those involved in maternity services so that other babies and their families are



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protected. Our review therefore examines the way in which the NMC responded to the complaints it received about poor care by midwives and considers how far improvements which it has already made address the concerns that we identify.

## 2. The factual background

2.1 In this section, we look at the background to the concerns, as established by the Kirkup report, and describe the regulatory system governing midwives, together with the NMC's structure and system for dealing with complaints.

### The concerns at FGH

2.2 The expert analysis quoted in the Kirkup report identified at least 20 instances of significant or major failures of care associated with three maternal deaths, ten stillbirths and six neonatal deaths at the FGH between 2004 and 2012. Of these, it suggested that a different result might have been expected in 13 cases had there been different care.<sup>6</sup>

2.3 The Kirkup report stated that the midwifery unit at FGH suffered from poor clinical knowledge, poor working relationships between different groups of staff, together with grossly deficient responses to adverse incidents. The midwives had developed a defensive culture that tended to support each other rather than identifying and acting on lessons from such incidents. The report said that the reactions of staff in the maternity unit were shaped by a denial that there was a problem. It found 'clear evidence of distortion of truth in responses to investigation' and of improper preparation of staff who were witnesses at an inquest. In addition, it found that there was a 'conflict of roles of one individual who inappropriately combined the functions of senior midwife, maternity risk manager, supervisor of midwives and staff representative'.<sup>7</sup> We note that concerns about the alleged distortion of the truth had been investigated by Cumbria Police, but no prosecutions followed.

2.4 In addition, the Kirkup report said that clinical governance systems generally in the Trust were inadequate and placed too great a reliance on inadequate internal investigations.<sup>8</sup> It also found that, by the time the report was published, the Trust had made significant strides to address the concerns.

### Other investigations

2.5 Many of these concerns were identified by an inquest in 2011<sup>9</sup> into the death of a baby at the FGH where the coroner identified areas of poor care and took the view that, in giving evidence, the midwives concerned were likely to have colluded. A further inquest in February 2018 heard of poor care involved in the death of a baby as late as 2016.<sup>10</sup>

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<sup>6</sup> Paragraph 1.7 of the Kirkup report.

<sup>7</sup> Page 8 of the Kirkup report, point 10.

<sup>8</sup> Page 8 of the Kirkup report, point 12

<sup>9</sup> Inquest touching the death of Mr and Mrs A's baby – 1-6 June 2011.

<sup>10</sup> Inquest touching the death of Mrs C's baby – 6 February 2018.

- 2.6 In July 2011, the NMC and CQC jointly undertook a review of the Trust to assess whether all the requirements regarding the arrangements then governing the statutory supervision of midwives were in place and were effective in supporting safe midwifery practice and in identifying and responding to poor and unsafe practice.<sup>11</sup> The review found that there was a focus by the Supervisors of Midwives at FGH (but not at the other maternity units within the Trust) on supporting midwives and their practice ahead of the purpose of statutory supervision – which is to protect mothers and babies. Recommendations were made to address these concerns. The review was followed up in June 2012 and a report published in July 2012.<sup>12</sup> The published report found that action to implement eight of the 15 recommendations had been completed and there was progress on a further six.
- 2.7 Cumbria Police had been approached by one of the families late in 2010 as a result of concerns about the actions of the Trust and the midwives. In July 2011, Cumbria Police opened a formal investigation into the Trust which looked at clinical concerns to see whether these met the threshold for criminal prosecution, together with the allegations of collusion by the midwives. The investigation into collusion was completed in April 2013 without charges being brought. The remainder of the investigation was completed in December 2013 also without charges being brought, though the case was not finally closed until the Kirkup report was published.<sup>13</sup>
- 2.8 Between December 2013 and February 2014, the Ombudsman published five reports of investigations into events at FGH. The first, in December 2013 made findings of poor clinical practice and about the quality of the local investigation.<sup>14</sup> The second (also in December 2013) found similar concerns about the quality of the local investigations carried out by the Trust and by the supervisors of midwives in that these investigations had failed to identify major concerns or account to parents.<sup>15</sup> The third (also December 2013) considered the role of the

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<sup>11</sup> Nursing and Midwifery Council (October 2011). *Review of University Hospitals of Morecambe Bay NHS Foundation Trust*. Available at:

[www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/nmc\\_review-of-university-hospitals-of-morecambe-bay-nhs-foundation-trust.pdf](http://www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/nmc_review-of-university-hospitals-of-morecambe-bay-nhs-foundation-trust.pdf) [Accessed: 24/04/2018].

<sup>12</sup> Nursing and Midwifery Council (July 2012). *Review of University Hospitals of Morecambe Bay Foundation Trust*. Available at:

[www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/final-morecambe-bay-extra-ordinary-report-20120907.pdf](http://www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/final-morecambe-bay-extra-ordinary-report-20120907.pdf) [Accessed: 22/02/2018].

<sup>13</sup> Interview with Cumbria Police.

<sup>14</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at:

[www.ombudsman.org.uk/sites/default/files/Midwifery supervision and regulation Mr M report.pdf](http://www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation%20Mr%20M%20report.pdf) [Accessed: 22/02/2018].

<sup>15</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Ms Q and Mr R about the North West Strategic Health Authority*. Available at:

[www.ombudsman.org.uk/sites/default/files/Midwifery supervision and regulation Ms Q and Mr R report 0.pdf](http://www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation%20Ms%20Q%20and%20Mr%20R%20report%200.pdf) [Accessed: 22/02/2018].

Strategic Health Authority in investigating the concerns.<sup>16</sup> The fourth (published in February 2014) found similar concerns and also considered that the Trust had not fulfilled its obligations to the parents under the Data Protection Act<sup>17</sup>. In the fifth report (published in December 2013), the Ombudsman recommended significant changes to the system for supervising midwives.<sup>18</sup>

- 2.9 The NMC received its first complaint against a midwife at FGH in relation to these concerns in February 2009. The last case that it considered was heard by its Conduct and Competence Committee (CCC) in June 2017.

### The Local Supervisory system for regulating midwives

- 2.10 The system for regulating midwives and responding to adverse events in place at the time is relevant background to this review. Until 2017, Local Supervisory Authorities (LSAs) (until 2012 the Strategic Health Authorities and, after that, NHS England) were responsible for the local regulation and supervision of midwives. The LSA Midwifery Officer (LSAMO) was responsible for appointing Supervisors of Midwives. The purpose of the supervisors was to protect women and babies by actively promoting safe standards of midwifery practice. They investigated adverse incidents, could make recommendations for improvements and could require midwives to undergo periods of supervised practice.<sup>19</sup> The system was intended to provide support and guidance to every midwife practising in the UK and to promote excellence in midwifery care. The NMC set the rules and standards for the functions of the LSAs.
- 2.11 The Ombudsman's reports found a series of flaws in the system for midwifery supervision at the FGH: reports were not sufficiently detailed, they were delayed, matters were not escalated to the LSAMO, there was little external scrutiny and there was a blurring of roles.
- 2.12 The system was abolished in 2017 following the Ombudsman's reports with the active support of the NMC and the Authority. The NMC now liaises directly with the senior officers at the relevant Trust if there are concerns about individual midwives.

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<sup>16</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: a report by the Health Service Ombudsman of an investigation into a complaint from Mr L about the North West Strategic Health Authority*. Available at [www.ombudsman.org.uk/publications/midwifery-supervision-and-regulation-report-health-service-ombudsman-1](http://www.ombudsman.org.uk/publications/midwifery-supervision-and-regulation-report-health-service-ombudsman-1) [Accessed 22/02/2018].

<sup>17</sup> Parliamentary and Health Service Ombudsman. *Investigation reports concerning the University Hospitals of Morecambe Bay NHS Foundation Trust*. Available at: [www.ombudsman.org.uk/sites/default/files/Investigations\\_concerning\\_Morecambe\\_Bay-report-140915.pdf](http://www.ombudsman.org.uk/sites/default/files/Investigations_concerning_Morecambe_Bay-report-140915.pdf) [Accessed: 22/02/2018].

<sup>18</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: recommendations for change*. Available at: [www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation\\_%20recommendations%20for%20change.pdf](http://www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation_%20recommendations%20for%20change.pdf) [Accessed: 22/02/2018]

<sup>19</sup> Nursing and Midwifery Council (2008). *Support for Parents: How the supervision and supervisors of midwives can help you*. Available at: [www.guysandstthomas.nhs.uk/resources/our-services/maternity/n-and-m-council-support-for-parents.pdf](http://www.guysandstthomas.nhs.uk/resources/our-services/maternity/n-and-m-council-support-for-parents.pdf). We understand this leaflet is out of date and is being removed.

## The NMC's role

- 2.13 The NMC is responsible for the regulation of nurses and midwives in the UK. It exists to protect the public and to maintain public confidence in the professions. It sets standards of education, training, conduct and performance and seeks assurance that education courses are equipping nurses and midwives with the skills and knowledge required. It admits nurses and midwives to its register so that employers and the public can check that someone is authorised to practise and where problems arise, it will investigate and, if necessary, act by removing them from the register or otherwise restricting their practice.
- 2.14 The NMC holds the largest register of any UK healthcare regulator, some 690,000 nurses and midwives and currently has an annual income in excess of £86 million. It employs over 400 staff.<sup>20</sup>
- 2.15 The NMC has had a difficult performance history. It cooperated with an investigation by the Authority in 2008 and with a Strategic Review by the Authority in 2012.<sup>21</sup> Problems in relation to its handling of fitness to practise cases were highlighted in those reviews and in each of our performance reports from 2009 to 2016. The Authority's performance reviews however also chart a steady improvement in performance across all the Standards of Good Regulation from 2014 onwards.
- 2.16 The Chief Executive of the NMC<sup>22</sup> has been very frank in saying to us that, until 2014 when changes following the Authority's 2012 Strategic Review had largely been implemented, the NMC was not in a state to address the concerns that arose in respect of the FGH.<sup>23</sup>

## The NMC's fitness to practise procedures

- 2.17 The NMC's structure and processes for dealing with fitness to practise matters changed and improved considerably since the first complaint was received in 2009.
- 2.18 Complaints and concerns about fitness to practise are handled by the NMC's Fitness to Practise Directorate. Since 2011, the procedure has been that complaints are initially reviewed by the NMC's Screening Team which considers whether there appear to be concerns that should be investigated. The team

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<sup>20</sup> Nursing and Midwifery Council, *Annual Report and Accounts 2016–2017 and Strategic Plan 2017–2018*. Available at: [www.nmc.org.uk/globalassets/sitedocuments/annual\\_reports\\_and\\_accounts/annual-report-and-accounts-2016-2017.pdf](http://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/annual-report-and-accounts-2016-2017.pdf) [Accessed: 22/02/2018].

<sup>21</sup> Professional Standards Authority 2016, *Strategic review of the Nursing and Midwifery Council*. Available at: [www.professionalstandards.org.uk/publications/detail/strategic-review-of-the-nursing-and-midwifery-council](http://www.professionalstandards.org.uk/publications/detail/strategic-review-of-the-nursing-and-midwifery-council) [Accessed: 24/04/2018]

<sup>22</sup> She became Acting Chief Executive in December 2011 and appointed to the role of Chief Executive in October 2012.

<sup>23</sup> Interview with the review team 9 January 2018.

conducts an initial risk assessment to consider whether the NMC should seek an interim order. An interim order restricts a registrant's practice pending a final decision if there is evidence that the registrant may be a risk to themselves or other people or there are other public interest reasons to do so. Such an order might suspend the registrant's registration or impose conditions with which the registrant must comply while practising.

- 2.19 The Screening Team can close a complaint or refer it for further investigation.
- 2.20 Until 2012, the majority of investigations were undertaken by external solicitors appointed by the NMC. Following a pilot in 2012, the majority of cases are now investigated by its in-house legal team. More complex cases are sent out externally. The investigation generally involves interviewing witnesses, contacting the employer for information, assessing the registrant's answers to the allegations (where these are available) and, where appropriate, seeking expert evidence. A report is then prepared summarising the allegations investigated and the results of the investigation. Until recently, that report recommended whether there was a case to answer against the registrant (that is, that there is evidence that the registrant did the actions complained about and, therefore, their fitness to practise may be impaired). We understand that a formal recommendation is no longer made.
- 2.21 Until 2016, the investigation report was considered by the Investigating Committee which decided whether or not there was a case to answer. Since 2016, this decision is taken by two Case Examiners, one of whom is a registrant and one of whom is not. The person or body making the complaint and any other interested parties are told the outcome.
- 2.22 During the period covered by this review, all cases where a case to answer had been found were heard by panels of the Conduct and Competence Committee<sup>24</sup> consisting of three people comprising at least one registrant and one lay person. Cases may be considered at hearings or meetings. The cases covered by this review were all heard at hearings, which are not unlike trials. The NMC is represented by a lawyer who presents the case and calls evidence and witnesses. The registrant may be represented and can challenge the witnesses and call their own. The person who has made the complaint, for example the patient or their relative, may be called to give evidence at the hearing as a witness. They are not represented because they are not a party to the case.
- 2.23 The panel decides first whether the facts alleged are proved. If they are, it considers whether those facts amount to misconduct or lack of competence. If it decides that there was misconduct or lack of competence, the panel considers whether the registrant's fitness to practise is impaired – in other words, are there concerns about the registrant's fitness to practise at the date of the hearing (as

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<sup>24</sup> Since July 2017, by the Fitness to Practise Committee.

opposed to the time when the events occurred). If it is, the panel decides what, if any, sanction should be imposed. The sanctions available to the panel are:

- A caution, which goes on the registrant's record for up to five years but does not restrict the registrant's practice
- Conditions of practice which might require a registrant not to undertake certain work, work under supervision and/or take further training for a set period of time
- Suspension for up to 12 months, during which the registrant must not work as a nurse or midwife
- A Striking-Off order, which means that the registrant is no longer on the register and may not practise as a nurse or midwife.

- 2.24 Where a panel has imposed conditions or a suspension, that sanction is usually reviewed towards the end of the period to see whether the concerns which led to the sanction have been addressed. The review panel can decide that the registrant is no longer impaired, extend the sanction or impose new sanctions.
- 2.25 In considering whether the registrant is impaired, the panel must consider any remediation that has been undertaken by the registrant (for example, training), together with any insight that the registrant shows (for example, an understanding of why the error occurred and why it should not happen again) and, based on this, assess whether there is a risk of repetition. It is thus possible, particularly where there has been a clinical error, that the registrant may have undertaken training and demonstrated insight so that there is little or no risk of repetition and the panel might find that the registrant's fitness to practise is not impaired and so no sanction is required.
- 2.26 The panel must also consider whether a finding of impairment is required to uphold professional standards (so a signal is sent to the profession that the conduct was not acceptable) or to maintain public confidence in the profession (so that the public can see that particularly serious conduct is taken seriously by the regulator).
- 2.27 The fitness to practise process does not exist to hold a full inquiry into all aspects of a case. It is directed at an individual's fitness to practise at the time of the hearing. This does involve findings of fact but these may not address the full situation, particularly if a number of different individuals are involved. Charges before a panel may not reflect all the concerns that are raised: they will only cover the matters where the regulator considers that there is a case to answer. The NMC recognises, as do we, that the purpose of the fitness to practise process and hearings may not always be fully appreciated or accepted by those making complaints or acting as witnesses, who may understandably have broader concerns.



## 3. The cases we considered and the families' concerns

- 3.1 In this section we describe the facts of the main cases considered by the NMC. These provide the evidence on which we base our findings. We also set out the concerns of the families we spoke to. We do not discuss every complaint. Our role is to review the lessons to be learned from the NMC's handling of the cases as a whole, not to consider each in detail.
- 3.2 The complaints considered by the NMC came from a number of sources:
- The families directly affected
  - Cumbria Police
  - The Trust
  - The NMC itself following discussions with the Kirkup review team.
- 3.3 As we have reported in Section 1, the NMC opened 64 complaints against 30 named individuals. Five families complained directly to the NMC about the care they had received. However, the complaints received from the Trust and those opened by the NMC involved looking at a considerably larger number of adverse incidents.
- 3.4 We have set out at [Annex A](#), a chronology of the main events that occurred while the NMC were considering complaints about the midwives at FGH.
- 3.5 The NMC received its first complaint in February 2009. It began an investigation into that complaint, but this was delayed between June 2010 and January 2014 due to a decision by the NMC to await the findings of an inquest and completion of a police inquiry. Between 2010 and 2014 further information became available and more complaints were received. A number of these were also closed either following an investigation or in error. In early 2014, the NMC conducted a review of all the complaints that it had received since 2009 and opened or re-opened a number of investigations. Further complaints were received after that both from families and the Trust. Following the Kirkup report, it met Dr Kirkup and sought and received information from that team and considered further complaints against individual midwives. The last of the 64 complaints was heard by the Conduct and Competence Committee in June 2017.

### **The investigation into the care provided to Mrs A and her child**

- 3.6 Mrs A's waters broke two days before the birth of their baby in October 2008. Mr and Mrs A attended FGH that evening. Midwife 1 was on duty, examined Mrs A and sent her home. Mr and Mrs A returned the next day and were seen by Midwife 2. Again, Mrs A was sent home. Mr and Mrs A said that they had told the midwives that they, and their older child, had been feeling ill with viral symptoms



and they were concerned that this might place the baby at risk of infection. They said that no action was taken to follow up these concerns. The midwives did not agree that they were told of the symptoms.

- 3.7 When contractions began early in the morning of the following day, Mr and Mrs A returned to the maternity unit and their baby was born quickly. Midwives 3, 4 and 5 and 6 were involved in the care either at the birth or in the subsequent period while Mrs A and her baby were at the FGH. There is a conflict of evidence as to the baby's state at birth. Mrs A collapsed shortly after the birth; it was established that she had an infection and antibiotics were administered to her, but not to the baby. The baby's temperature was found to be low, which can be an indicator of infection, and the parents told the local investigation that they observed other symptoms that concerned them. On the morning of the following day, Mrs A found her baby collapsed. The baby was transferred to the special care baby unit at FGH and subsequently to specialist units in other hospitals and died at nine days old of septicaemia. During this time, the observation records were lost.

#### *The local investigation*

- 3.8 In the period between the birth and immediately after their baby's death, Mr and Mrs A prepared a chronology of the events from their perspective. They supplied this to the Trust shortly afterwards, together with a series of questions about the quality of care provided and the outcome for their baby.
- 3.9 Midwife 7, the maternity risk manager and a supervisor of midwives, began an internal investigation shortly after the incident but, on receipt of Mr and Mrs A's concerns, the Trust instructed an independent midwife to investigate. That independent investigation concluded that there had been a failure to monitor the baby, and a failure to recognise the signs of infection and therefore to treat it at an earlier stage. This investigation made recommendations for the Trust but was not intended to, and did not, identify concerns about the practice of individual midwives.<sup>25</sup>
- 3.10 Midwife 7 resumed her investigation and undertook a root cause analysis of the events which was completed in January 2009. She subsequently carried out an investigation for the Local Supervisory Authority (completed in May 2009). Midwife 7 did not identify significant concerns about the midwifery care provided to Mrs A. In the absence of the care records, the analysis relied on the recollections of the midwives and tended to blame the paediatricians at the hospital. It did not engage with the initial independent report. Midwife 7's report was shared with Mr A, together with copies of statements made by the midwives to the investigation.
- 3.11 Mr A believed that there were discrepancies between the various midwives' statements and his own and his wife's recollections. He was concerned that there

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<sup>25</sup> *External Investigation into Serious Untoward Incident at Furness General Hospital: (Mr and Mrs A's baby) 2008.*

was an attempt to cover up the events. A review of Midwife 7's root cause analysis was commissioned by the Trust from Midwife 8, who was independent of the Trust.<sup>26</sup> That report did not identify problems with Midwife 7's report. However, it is notable that the NMC's Midwifery Team, which was separate from its Fitness to Practise team, had concerns about the root cause analysis which were not noted in Midwife 8's report.<sup>27</sup> A meeting involving the Trust, the NMC and Mr and Mrs A to discuss the root cause analysis was held in November 2009 and there appears to have been agreement that it was flawed.<sup>28</sup>

#### *The 'NMC shit' email*

- 3.12 In 2009, Mr A was informed by the Trust of a data breach involving his personal information. In response to enquiries he made in late 2010, it appeared that, in the context of the NMC investigation, Midwife 3 had caused an email to her from Midwife 4 to be sent to an incorrect email address. The email was headed 'NMC shit' and included a document which contained information about Mr A's complaint. It was suggested that it contained Midwife 4's statement for the investigation by the NMC, though we note that this was denied by Midwife 4 who told us that the document did not contain any of her response. Mr A was concerned that this was an attempt by the midwives to ensure that the accounts sent to the NMC were consistent.
- 3.13 The Trust had held an investigation about the data breach. Midwife 4 said that she had sought to provide Midwife 3 with a template to help her write her own statement, rather than to collude over their recollections. Material from the Trust on the NMC's files suggests that a representative of the CQC looked at the documents, though it is not clear in what context, and noted that there was no evidence of similar wording or phrases between the two statements.<sup>29</sup>

#### *Mr A's complaints*

- 3.14 Mr A made his first complaint to the NMC in February 2009 following the independent midwife's investigation<sup>30</sup> for the Trust. It concerned the care provided to his wife and child.
- 3.15 It took the Trust four months to provide the NMC with the identities of the midwives involved. The Trust was also slow to provide their statements to the NMC. In July 2009, the NMC raised complaints against midwives 3, 4, 5 and 6.
- 3.16 In July 2009, Mr A raised his concerns about the investigation by Midwife 7 and the discrepancies in the midwives' statements, providing a detailed analysis of his concerns. He sent this to the NMC.

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<sup>26</sup> Independent Report Local Supervising Authority Midwifery Office Report for North West Strategic Health Authority, June 2010.

<sup>27</sup> File note of discussion between the NMC's Midwifery Advisor and Midwife 8 dated 1 July 2010.

<sup>28</sup> Report of meeting prepared by the NMC's Midwifery Advisor dated 1 December 2010.

<sup>29</sup> Email dated 15 November 2011 to Mr A.

<sup>30</sup> See footnote 24.

- 3.17 The NMC sent details of the allegations that it was considering to Midwives 3, 4, 5 and 6 in July 2009. These were very general and did not distinguish between the different midwives and their roles – for example, on the evidence available, it appeared that Midwife 3 had been involved in the aftercare, but not the birth of the baby, but the allegations covered failures at the birth. The midwives' responses to the allegations were received in August 2009 and the complaint was considered by the Investigating Committee in September 2009. It was referred to external lawyers for investigation. The investigation was limited to the failure to identify that the baby had an infection and to the midwives' poor record-keeping.
- 3.18 Statements were taken by the external lawyers from Mr and Mrs A in late 2009. The statements were signed in May 2010. The chronology they had prepared was referred to in the statement signed by Mr A as 'Exhibit 2'.
- 3.19 The investigation was completed in May 2010 and the report recommended that there was no case to answer against the midwives. This appears to have been based strongly upon the statements of the midwives, the local investigations and the Trust's own statements. The discrepancies raised by Mr A were not addressed.
- 3.20 The report was not considered by the Investigating Committee because the inquest into the death of Mr and Mrs A's baby was announced and the NMC decided to wait to see whether there were findings at the inquest which were relevant to the complaints.
- 3.21 In the meantime, Mr A had contacted the NMC's Midwifery team about his concerns about Midwife 7's 2009 investigation. The NMC's midwifery adviser shared these concerns. She met Mr and Mrs A and the Local Supervisory Authority Midwifery Officer and flaws were identified in the investigation by Midwife 7. The adviser told the Fitness to Practise team that it was important that the Investigating Committee should be made aware of the doubts about the robustness of Midwife 7's investigation when it considered the complaint.
- 3.22 In January 2011, Mr A informed the NMC about the 'NMC shit' email and made it clear that he was concerned that there might have been collusion over the statements given to the NMC by Midwives 3 and 4. He was informed that he would need to make a new formal complaint for this to be considered. Mr A was upset at being required to fill in more forms when he had already provided the information. Eventually, in March 2011, new complaints were opened by the NMC. It is clear that the NMC intended that the investigation should consider all aspects of Mr A's complaints.

- 3.23 In April 2011, the NMC appears to have decided<sup>31</sup> that the original complaints should be considered by the Investigating Committee. A note was prepared which was intended to reflect the concerns of the NMC midwifery adviser.
- 3.24 The inquest into the death of Mr and Mrs A's baby took place in June 2011. The coroner was strongly critical of the care provided and suggested that the midwives had 'colluded' over their evidence.<sup>32</sup> The NMC postponed the Investigating Committee's consideration of the complaints to study the coroner's findings.
- 3.25 In July 2011, a group of the NMC's Fitness to Practise team members discussed Mr A's complaints and the inquest. They considered that the cases suggested concerns which were not suitable for individual fitness to practise cases but showed major cultural problems at FGH. They proposed that a recommendation should be made to the Investigations Committee that the cases should be closed, the Trust should be referred to the CQC and the midwifery unit put into special measures.<sup>33</sup> This was intended to be discussed with the then Director of Fitness to Practise. We saw no record of the outcome of this discussion but it appears that the NMC took the view that the decision should await further information about the police investigation that had by then been instigated.
- 3.26 The investigations concerning the treatment of Mr and Mrs A's baby and collusion, were put on hold while the police investigation was continuing. The NMC continued to investigate two aspects of the 'NMC shit' email: the data breach and the offensiveness of the title.
- 3.27 In June 2012, Mr A sent the NMC a number of documents and emails that he had obtained from the Trust which, he considered, supported his concerns about possible collusion between the midwives and within the Trust over the evidence given at the inquest.<sup>34</sup> Complaints were opened against a number of midwives in June 2012. However, nine of these were closed, apparently on the basis that new ones would be opened (or made part of existing complaints) and then expedited.<sup>35</sup> These then appear to have been forgotten until they were re-opened in April 2014 following the general review of the Morecambe Bay cases. By that time, at least one of the midwives was no longer on the register. Those that were taken forward in 2012 were referred to new external lawyers for investigation. The lawyers were asked to re-investigate the matters that had been looked at by the previous lawyers. The lawyers recommended further investigation of the original allegations and asked whether a complaint should be raised about Midwife 7 and her investigatory reports. The NMC did not raise such a complaint. In any case, none of the investigations were commenced until 2014 when the police investigation ended.

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<sup>31</sup> Email chain dated 8 April 2011 but there was no record of the reason.

<sup>32</sup> Inquest touching the death of Mr and Mrs A's baby – 1-6 June 2011.

<sup>33</sup> File note of meeting of members of the Fitness to Practise team dated 21 July 2011.

<sup>34</sup> Letter from Mr A to the NMC 11 June 2012.

<sup>35</sup> Letter of 22 June 2012 to Mr A.

- 3.28 In January 2013, the Investigating Committee decided that there was no case to answer against the midwives in respect of the 'NMC shit' email, at least as regards the data breach and the offensiveness of the title because the breach was an isolated incident and had been dealt with by the Trust and the offensive title was not serious enough to amount to misconduct. The external lawyers' report suggests that further investigation of the collusion concerns might take place following conclusion of the police investigation. While Midwives 3 and 4 were subject to investigation in respect of wider allegations of collusion, we saw no evidence that the facts in relation to this email were investigated further.
- 3.29 In September 2013, the Kirkup investigation was set up. In December 2013, Cumbria police informed the NMC that it was no longer pursuing allegations against individuals. Between December 2013 and February 2014, the Ombudsman published its reports.<sup>36</sup>
- 3.30 In January 2014, the NMC held a major internal review<sup>37</sup> of all the information that it had about all the FGH cases and referred the issues raised by Mr A in respect of the care of his wife and baby to external lawyers for further investigations. In the course of these investigations, further complaints were raised about:
- Midwives 1 and 2 about their alleged failure to act on information about Mrs A's illness
  - Midwife 7 about her supervisory investigations
  - 14 Midwives in respect of 'dishonesty and collusion' over evidence given at the inquest.
- 3.31 The external lawyers provided their report in July 2014. The Investigating Committee considered that report in November 2014 and decided that:
- There was a case to answer in respect of the clinical care provided by Midwives 1 and 2 in the days before the birth
  - There were cases to answer in respect of Midwives 3, 4 and 6 in respect of the care provided during and/or after the birth
  - There was no case for any midwife to answer in respect of the collusion allegations.
- 3.32 Cases where it was determined that there was a case to answer were referred to a panel of the CCC. The concerns about Midwife 7 were left for further investigation.
- 3.33 The NMC's in-house legal team then began to prepare the cases for hearings before the CCC. The NMC's intention was that all the cases would be heard together. However, because of the complexity of the cases and defence arguments that the publicity surrounding the cases could lead to unfairness, the

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<sup>36</sup> See footnotes 15-19 above.

<sup>37</sup> Documents dated 10 January 2014 on the NMC files.

CCC held a case management meeting in July 2015, which was adjourned until October 2015. At that meeting, the panel decided that:

- The cases in respect of Midwives 1 and 2 would be heard separately from those in respect of Midwives 3, 4 and 6
- The publicity did not mean that there could not be a fair hearing.

### *Midwives 1 and 2*

- 3.34 The cases of Midwives 1 and 2 were heard in March and April 2016. Mr and Mrs A were called as witnesses. A second statement was taken from them in early 2016. Their statements from 2010 were not put before the panel. Nor was the chronology that Mr A had prepared in 2008, which was referred to as 'Exhibit 2' in his 2010 witness statement. We could find no trace of this chronology prior to the hearing in any of the files that we examined even though there were a number of copies of the 2010 statement referring to it. We do not know whether it was ever received from the external solicitors who took that statement.
- 3.35 At the hearing,
- Midwife 1 denied that Mr and Mrs A had mentioned that she was feeling ill and that she had not had that conversation with them
  - Midwife 2 said that Mrs A had simply told her that she had a headache and this was recorded in the notes and that this did not trigger any obligation to take further action
  - In submissions, the defence suggested that Mr and Mrs A had not mentioned that they had told the midwives of the illness until the inquest in 2011
- 3.36 Mr A sent the chronology to the NMC in the course of the hearing. This provided supporting evidence that, in 2008, he and his wife recalled telling the midwives of the infection. The NMC did not consider that, overall, this would materially add to its case and did not put the chronology before the panel.
- 3.37 The panel found that Mr and Mrs A were honest witnesses and had mentioned Mrs A's illness to people at the hospital but could not be satisfied that those people had been Midwives 1 and/or 2. It relied on the records made by the midwives as decisive. It decided that there was no case to answer for Midwife 1 because it could not be satisfied that she was the person that Mr and Mrs A had talked to about the illness. The facts were not proved for Midwife 2.
- 3.38 Mr A told us and the NMC that he and Mrs A found the process of giving evidence extremely stressful and upsetting. He was also distressed about being required by the panel Chair to refer to their child not by name but as 'Baby A'. This he refused to do.



- 3.39 These cases were completed seven and a half years after the events took place, six years after the possible concerns could have been identified from Mr A's witness statement and two years after they were in fact raised.
- 3.40 Following the hearing, the Authority looked at this case under its powers under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended). This enables us to refer cases to the High Court if we consider that the decision was insufficient to protect the public. We were concerned about:
- The failure to provide the panel with the contemporary chronology prepared by Mr & Mrs A
  - The panel's approach to the naming of Mr and Mrs A's child
  - The cross-examination of Mr and Mrs A.
- 3.41 The NMC agreed that the panel could have been more sensitive. It did not agree that its decision not to provide the chronology to the panel was wrong. The NMC considered that although the chronology may have supported the evidence on one aspect of the case, overall, it would not support and/or might have undermined its case in other respects. Taking all the circumstances of the case into account and bearing in mind the relevant case law, the Authority decided that the decision was deficient, but was not insufficient to protect the public.

#### *Midwives 3, 4 and 6*

- 3.42 Midwife 6 was out of the country in May 2016 when the hearing was to take place. Her case was heard separately on her return. The cases in respect of Midwives 3 and 4 were begun then and adjourned until June 2016 when, because of scheduling difficulties, the two cases were heard separately. Both were found to have committed misconduct and their fitness to practise was impaired. In September 2016 Midwife 3 was suspended from the register for nine months because, although the clinical concerns had been remediated, there were public interest grounds for finding impairment. In October 2016 Midwife 4 was struck off.
- 3.43 Midwife 3's fitness to practise was reviewed in May 2017 and was found no longer to be impaired.
- 3.44 When the case of Midwife 6 was heard, in January 2017, the NMC offered no evidence to the CCC with the result that no case to answer was found. The panel accepted that the expert evidence and other circumstances of the cases made it clear that it was appropriate for the NMC to offer no evidence in these circumstances and that there was no case for Midwife 6 to answer.
- 3.45 These cases were completed almost eight years after the events took place and more than seven years after the complaints were made.

### *Midwife 8*

- 3.46 Mr A considered that the NMC ought to have considered whether Midwife 8's report into the adequacy of Midwife 7's analysis raised concerns about Midwife 8's fitness to practise. The NMC told him<sup>38</sup> that it had asked the Kirkup team whether it had identified any specific concerns about Midwife 8's report, that none had been suggested and that it had decided not to open any fitness to practise complaint against her. It told him that it had reviewed this decision in August 2016. The NMC reviewed the matter again in July 2017 and decided that its original decision was correct. We saw that the NMC had asked the Kirkup team for information about individual midwives whose practice might be of concern and the team did not refer to Midwife 8. It appears that this may have been explicitly discussed in a meeting with the team. We saw no evidence that the Kirkup team had any concerns about Midwife 8.
- 3.47 The team considering whether or not to raise the complaint at the NMC did not look at the original report by Midwife 8<sup>39</sup> even though the report was in the NMC's possession and had been since 2010. It relied on the fact that no concerns had been received from the Kirkup team.
- 3.48 The review in July 2017<sup>40</sup> again did not look at Midwife 8's original report even though it had been included in the material sent to Mr A as part of his Subject Access Request in late 2016.

### *Mr A's other concerns*

- 3.49 Mr A raised concerns with the NMC about its handling of the cases through the whole period, particularly about the prolonged length of time, the lack of information that he was given about progress and what he perceived to be the NMC's failure to take action to satisfy itself that the midwives were fit to practise while it was looking into the complaints. There were frequent discussions with the Chief Executive and senior staff by email, over the telephone and in person. The previous Chair and the current Chief Executive met with Mr A and apologised for the time taken to progress the cases. Mr A also raised concerns with the Secretary of State for Health.
- 3.50 After the hearings, Mr A continued to be concerned about what he perceived to be the NMC's failings in these cases and the approach the NMC had taken to the Authority's criticisms of the cases of Midwives 1 and 2. He made a Subject Access Request (SAR) under the Data Protection Act 1998 in respect of the information held by the NMC relating to him and his child. He was dissatisfied with the NMC's handling of that request.

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<sup>38</sup> Letter of 8 September 2016 from the then Director of Fitness to Practise to Mr A.

<sup>39</sup> This is made clear in the initial advice dated 22 May 2015 and in subsequent advice, including that dated 17 July 2017.

<sup>40</sup> Advice dated 17 July 2017.



- 3.51 Mr A told us<sup>41</sup> that, when he first complained to the NMC, he was not familiar with the NMC or professional regulation so he did not think of it in terms of making complaints about specific individuals. He thought he was simply alerting them to a serious incident and he expected the NMC to take it seriously and investigate. He said he was concerned about the care provided, the disappearance of medical records and possible dishonesty. As time progressed he became increasingly concerned about the NMC's handling of the cases against the midwives involved in his baby's care.
- 3.52 He told us that, for him, the biggest issue 'wasn't that people made mistakes because you know people do make mistakes and even if there is a tragic outcome it doesn't automatically mean that people need to be referred to the professional regulator'. However, it seemed to him that a set of things had gone wrong, statements had been made by the midwives that he and his wife 'knew were incorrect' and records went missing. He was concerned people were being dishonest, that they were not learning from his baby's death and the same thing could therefore happen to other people.
- 3.53 Mr A told us that he 'thought it nonsensical' for the NMC to have sent an identical set of allegations to every midwife and expect midwives on the night shift, for example, to comment on allegations in relation to things that had happened on the day shift.
- 3.54 He told us that he and his wife had hoped the NMC would take their baby's death seriously but it 'felt hopeless and that they were just following a process for the sake of following it. It felt like nobody really cared about what they were doing. Nobody understood that there might be mothers and babies at risk and it was like an administrative process that nobody really cared about'. He felt that the NMC's 'lack of speed or sense of urgency' contributed to that sensation.
- 3.55 Mr A told us he had wanted to know what was being done and how they were making sure that mothers and babies were safe. He repeatedly made this argument not because he was being 'vindictive' but because he 'was genuinely concerned that some of the things that had happened ... might happen again'.
- 3.56 Mr A said he found the whole process including when hearings took place 'far worse than I could have imagined'. He had not realised that he and his wife would be subjected to cross examination in a manner which he felt attempted to discredit them. They had no one representing them and no-one supporting them to refute statements made against them. He said, 'it just feels like a very unfair process that people can actually base a case and their arguments on trying to discredit a bereaved family and there is nobody there who is supporting the family or arguing or saying hang on a minute that's not true ... It was a horrible, horrible process and no wonder, no wonder, people don't want to go through it'.

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<sup>41</sup> Interview with the team, September 2017, from which the following paragraphs are taken.

- 3.57 He told us he was particularly upset by the assertion at the hearing by the defence barrister that the first time he and his wife had first mentioned telling the midwives that she had felt unwell was at the inquest, when in fact they had made a record of that in the chronology they prepared whilst their baby was still in hospital. He could not understand either why the NMC had insisted the chronology was not needed in evidence. The consequential media coverage was also very hard for the family to bear causing his wife to feel unwell.
- 3.58 Mr A thought the NMC process might be improved, 'if the midwife might acknowledge you and express some words of sympathy... in a humane system the first thing the barrister would say is we are very grateful to Mr [A] for coming. We know it's hard for him and we would like to express on behalf of those involved how sorry they were. That's what humans do.'
- 3.59 Whilst he had found some people within the NMC were kind, he told us he thought there was no proper emotional support and no representation for the family. He had discovered some of the earlier verdicts by reading it in the media although later the then Director of Fitness to Practise sent him email updates.
- 3.60 He was upset by what he saw as the attitudes displayed towards him, especially the monitoring by the NMC of his online communications. He thought the NMC was unduly concerned about its reputation instead of responding to him as a bereaved person who had been forced by circumstances into having to complain and in the face of inadequate investigations, having to pursue them over many years. It had taken a heavy toll on him and his family. He failed to understand why the NMC would not share the report that it had commissioned from a senior barrister (see paragraph 3.77) openly as he had been led to expect or why they had so heavily redacted information in response to his Subject Access Request.
- 3.61 Mr A has a background in the safety industry. His experience is evident in the way that he approached the identification and analysis of problems and his complaint to the NMC.

### **The investigation into the care provided to Mrs B and her baby**

- 3.62 In July 2008 Mr B's wife died in childbirth from amniotic embolism, which is a rare condition with a 50:50 survival rate. Their baby was brain damaged during the birth and died shortly after. The local investigation found there had been no failures of care. Mr B's recollection differed significantly about the events that took place during labour. The inquest held in July 2009 into both deaths made no criticism of the care provided by the midwives. It noted that there was a discrepancy between the recollections of Mr B and of the midwives but the coroner appears to have preferred the evidence of the midwives.

- 3.63 These findings were contradicted by the Ombudsman's investigation carried out following a complaint by Mr B. The Ombudsman concluded,<sup>42</sup> with the benefit of clinical advice, that Mrs B's condition, if properly treated, need not have been fatal, and that there were major failures in care provided to the baby, whose heart was not monitored during the delivery. The failures were not identified in the Root Cause Analysis undertaken by Midwife 7. The Ombudsman also criticised the failure of the supervisors of midwives to question the adequacy of a root cause analysis carried out by the Trust, which did not identify the concerns about the care provided to Mr B's child and suggested that a supervisory investigation was unnecessary.
- 3.64 The NMC received information from Cumbria Police about the death of Mrs B and her child in November 2012. That information included a statement from Mr B, which gave a different account of the birth from that given to the coroner by the midwives who provided the care. Mr B also complained of disrespectful behaviour by the midwives at the inquest including 'high fiving' each other after the verdict.
- 3.65 The NMC opened a case in November 2012 against Midwife 9, who had been in charge at the birth, and referred the case to external lawyers for investigation. That investigation concentrated only on the failure of Midwife 9 to call for help when Mrs B was taken ill in labour; it did not look at the care provided to her baby. Mr B was not contacted for any statement to be taken, nor was clinical advice sought. Relying on the findings of the inquest, the statements of Mr B to the police and the local investigation, the report recommended that there was no case to answer. It considered that, given the other statements, there was little to be gained from speaking again to Mr B. The Investigating Committee agreed with the recommendations in July 2013.
- 3.66 Mr B became aware of the NMC investigation through the Trust and asked to be involved in it. Despite being told by the NMC's case officer that he would be interviewed, he was never approached. He made a complaint himself to the NMC in August 2013 with specific allegations about the failure to monitor his son's heart rate, the care records going missing and the midwives' behaviour at the inquest. In October 2013 the NMC refused to re-open the complaint on the basis that the conduct of Midwife 9 had already been investigated.
- 3.67 However, in January 2014 and following publication of the Ombudsman's report, Mr B made further complaints to the NMC and the case against Midwife 9 was re-opened, together with cases against six Supervisors of Midwives including Midwife 7. The allegation against the supervisors was that they should have identified the flaws in the root cause analysis and challenged it so that a supervisory investigation could have been undertaken; however, the NMC's

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<sup>42</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at: [www.ombudsman.org.uk/sites/default/files/Midwifery\\_supervision\\_and\\_regulation\\_Mr\\_M\\_report.pdf](http://www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf) [Accessed: 22/02/2018].

external lawyers were not instructed to consider this allegation but only to investigate whether the decision not to undertake a supervisory investigation was the right one.

- 3.68 Internal legal advice prepared in January 2014<sup>43</sup> considered whether the clinical concerns about Midwife 9 could be taken forward given that the Investigating Committee had decided there was no case to answer in July 2013. The advice was that, since Midwife 9 had been informed that the events at the delivery were being investigated and that the complaints had been dismissed, the NMC was prevented by its legislation from re-opening the investigation. This was notwithstanding that the initial investigation failed to look at the clinical failures identified by the Ombudsman. The advice suggested that the NMC could only reconsider the original complaint if an allegation arose about a different incident where the original complaint was relevant.
- 3.69 The decision to close the case concerning Midwife 9 was taken at Screening stage on 11 August 2014. An instruction was given not to inform Mr B of this until the cases against the supervisors had concluded.<sup>44</sup> When Mr B was told in November 2014 about the outcome of his complaint against Midwife 9, the reason given for the delay was that 'new allegations or new evidence may have been identified that would have required us to further consider [Midwife 9's] fitness to practise'.<sup>45</sup>
- 3.70 The other cases were closed with no case to answer. This was because the Investigating Committee considered that there was no evidence that the root cause analysis was inadequate; and there was insufficient evidence about what had and had not been discussed at the meetings.
- 3.71 In respect of Midwife 7, the external lawyers' initial recommendation was one of no case to answer. However, due to concerns about her practice identified by the Kirkup investigation team, this recommendation was not put to the Investigations Committee and further investigation was carried out (paragraphs 3.102-3.108 below).
- 3.72 No investigation was carried out into Mr B's complaint about the behaviour of the midwives at the inquest.

### **The investigation in to the care provided to Mrs C and her baby**

- 3.73 In March 2016, Mrs C's baby died having suffered brain damage during birth. Midwife 4 was the labour co-ordinator at the time. Midwife 10 was also involved in the birth. The NMC became aware of the matter in the context of the proceedings against Midwife 4 surrounding her involvement in the birth of Mr and

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<sup>43</sup> Advice dated 30 January 2014.

<sup>44</sup> Email dated 22 September 2014.

<sup>45</sup> Letter to Mr B dated 13 November 2014.

Mrs A's baby. In June 2016 the Trust referred both midwives to the NMC. The Trust had, itself, suspended Midwife 4.

- 3.74 Midwife 4 had been under investigation by the NMC for almost seven years in relation to the death of Mr and Mrs A's baby. No restrictions had been placed on her practice during that period. On receipt of the Trust's report, in June 2016, the NMC obtained an interim suspension order preventing Midwife 4 from practising.
- 3.75 In October 2016, Midwife 4 was struck off the register as a result of failures in her care for Mr and Mrs A's baby. Accordingly, the complaint against her in respect of Mrs C and her baby could not be investigated further.
- 3.76 Mrs C did not make a direct complaint to the NMC because she was aware that the NMC was investigating the case, but the NMC did contact her during its investigation. The NMC did not notify Mrs C when Midwife 4 was struck off the register and Mrs C learnt of this through media reports. Mrs C complained to the NMC about its handling of this case and, in particular, why the NMC acted so quickly to restrict the practice of Midwife 4 following Mrs C's baby's death yet had failed to do so following Mr and Mrs A's baby's death.
- 3.77 The NMC asked a senior barrister to review whether the NMC ought to have sought an interim order restricting the practice of Midwife 4 at an earlier stage. The NMC told Mr A that 'at no stage during the numerous review and investigations which took place was the threshold for applying for and imposing an interim order passed.'<sup>46</sup> It also told him that the 'purpose of this review is to identify lessons for the future'. It has not, however, published the barrister's report, which it regards as subject to legal professional privilege. The Information Commissioner upheld this decision in August 2017.<sup>47</sup> We discuss this further at paragraphs 4.99-4.103 below.
- 3.78 The Case Examiners reviewed the case against Midwife 10 in March 2017 and decided that, in the light of the remediation and insight shown by Midwife 10, there was no case to answer against her.

### **The investigation into the care provided to Mrs D and her baby**

- 3.79 Mrs D gave birth to a baby in 2004. The baby showed no signs of life at birth, but was revived. The baby died 27 hours later. Mrs D had suffered from high blood pressure throughout her pregnancy and it was known that the baby was large. Midwife 11 was in charge at the birth. The coroner's inquest in 2013 found that the care given by Midwife 11 was poor, including failures to properly risk assess the birth, to monitor the foetal heart rate properly and to adopt appropriate positions for the birth. There were also concerns that Midwife 7's supervisory report was inadequate and that Midwife 7 may have misled Mrs D about the care given. Mrs D did not discover that she might have cause to complain to the NMC

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<sup>46</sup> Email from NMC to Mr A of 8 September 2016.

<sup>47</sup> Information Commissioner's Office case reference FS50677575, 7 August 2017.

until contacted by the police, several years later. An inquest into her baby's death was then held<sup>48</sup> and the Kirkup investigation was starting. She became aware that Midwife 11 had been involved in another birth four years later, where the baby was stillborn. She then discovered, through the media, that the Trust had suspended Midwife 11. In January 2014, following the inquest and at the suggestion of her solicitor, she complained to the NMC about Midwife 11.

- 3.80 The NMC had already opened a complaint against Midwife 11 following a referral by the Trust in November 2013. This arose out of further untoward events in 2013 investigated by the Trust and involved failures to manage high risk births appropriately, to identify low foetal heart rates, to gain consent or to escalate emergencies and poor record-keeping. The Trust suspended Midwife 11 from practice. The NMC obtained an interim suspension order in January 2014. Midwife 11 informed the NMC that she had decided to retire from practice. She was subsequently struck off by a panel of the Conduct and Competence Committee.
- 3.81 The NMC decided not to include Mrs D's case in its case against Midwife 7 because it considered that it was likely that Midwife 7 would be able to show that the quality of her reports had improved since 2004 and the evidence available did not demonstrate dishonesty.
- 3.82 Mrs D explained<sup>49</sup> that when she and her husband first lost their baby, they accepted the Trust's explanation that it was 'just one of those things, babies die'. She said that they had simply asked whether there was any procedure that could be changed to stop it happening to another family. At the time they were told there was not but it is clear to her now that there was.
- 3.83 Following her complaint to the NMC, a solicitor for the NMC interviewed her. Mrs D told us it was 'quite harrowing when you have gone through something, do you know what I mean, nine and a half years earlier and you have grieved as a family and you have grieved as a mother for something that has happened...'
- 3.84 Mrs D told us 'It was a very, very traumatic time. But we, we had kind of dealt with it and tried to move forward but it kind of opened up old wounds, and then to find out that they had lied to us and, you know, that the basic things that should have happened, that the NMC should have picked up on, that – I just found incredible ...and I couldn't understand why – the NMC are there to protect the public but also to protect their registrants and I get that' but she found it hard to understand why the NMC did not check that the registrants were fit to practise.
- 3.85 When the midwife eventually apologised in her letter to the NMC it had meant more than anything. 'All I wanted was for her not to practise and deliver another baby ... I don't want her not to have a life and be miserable for the rest of her life because she didn't go to work that day and think, oh I think I'll kill this woman's

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<sup>48</sup> Inquest touching the death [Mrs D's baby] September 2013.

<sup>49</sup> All quotations taken from an interview between Mrs D and the review team October 2017.



baby by not doing my job properly. I don't think for one minute that any of it was an intentional thing but she had been a dripping tap for – she must have been a dripping tap before she delivered [my baby]...I always said she lives with that every day you know...in the very beginning I thought no midwife goes into work to deliver a baby and it dies. That must be a hell of a shock for somebody....'.

- 3.86 Mrs D found herself propelled into media coverage and 'everybody knew my business'. She understood that there were a lot of charges but felt the NMC had not kept her in the loop. 'I mean, [the midwife] had admitted all the charges in a letter and basically told them she wasn't going to a hearing ... six months before and they never even shared that with us. So I still went down to London and still relived that day in a room full of people which was – it's harrowing to relive and relive again and again and again. It's like knocking a scab off a cut and never letting it heal'. Mrs D also highlighted the profound impact on her other children, including media intrusiveness and the length of time the investigations took, which spanned their childhood. It caused them to re-grieve and 'feel robbed'.
- 3.87 Mrs D found the NMC 'very matter of fact' to deal with. She had had to initiate contact with them to find out information. No-one had really been allocated to support her. She had been given a named contact but did not always manage to get that person when she called. Letters were 'guarded' but 'pleasant enough'. She could not recall receiving any expression of sympathy for her loss. The panel however had been 'lovely ...really nice'. The midwife was not present and was not represented so Mrs D did not get asked many questions. After the hearing however it was 'just kind of like well once you had given your evidence it was just like that – away, go, that's it, gone'.
- 3.88 Mrs D chose not to go to London to hear the decision but was given only about five or so minutes notice before it was 'all over the press', which was very hurtful: 'I think they thought about themselves and their own reputation. They didn't keep us in the loop whatsoever and the process was so long and drawn out'.
- 3.89 Mrs D said that the NMC had not contacted her about Midwife 7. Following the death of her baby, Mrs D had met with Midwife 7 during a 'listen to mother' session at the Trust with her bereavement counsellor. She thought that the midwife had 'lied to her' about the need to monitor the baby's heartbeat. The NMC, when investigating the complaint, did not ask Mrs D or the bereavement counsellor for a statement about what she thought was dishonesty. She had understood there could not be a hearing when a midwife retired. She did not even know there had been a hearing until after it was held when she discovered it in her local press.
- 3.90 Mrs D felt that not only the midwife but also 'a catalogue of organisations including the NMC' had let them down that night. From her perspective the NMC had been 'very, very quiet ... almost like shrouded in secrecy. They are a regulator ... so there should not be any shroud of secrecy there...people should know what they are doing and how they do it I think and it isn't like that at all'.

- 3.91 Mrs D would like the NMC to be far more responsive when complaints are made and keep families in the loop constantly, even if they do not have anything to tell them and just say ‘it might not feel like we are doing anything but we just thought we would touch base with you. So it doesn’t feel like you are just a statistic, because that’s exactly how I felt’.

### **The investigation into the care provided to Mrs E and her baby**

- 3.92 Mrs E and her baby died in the ambulance on the way to FGH in 2008. The pregnancy was complicated since Mrs E was diabetic and suffered from high blood pressure. It appears that she attended an antenatal appointment where she ought to have been seen by an obstetrician but was not. Records of her blood pressure were not taken. She collapsed at home a week later and died.<sup>50</sup> Midwife 7 undertook a root cause analysis of the death.
- 3.93 This case was referred to the NMC by the Kirkup Inquiry team as part of its concerns about Midwife 7.<sup>51</sup> Expert evidence obtained by the NMC suggested that there were material flaws in her root cause analysis and was included in the cases against Midwife 7.<sup>52</sup> Mr E was not informed of the investigation. The NMC made attempts to trace his whereabouts<sup>53</sup> but, when information was received, no letter was sent informing him that a hearing was to take place.

### **The investigation into the care provided to Mrs F and her baby**

- 3.94 Mrs F had had a difficult previous birth. For this baby, she was induced but there were significant problems and it appears that she was not adequately cared for in the process. The baby was large and the delivery attempts caused her considerable pain. Her baby was stillborn. It is clear from the inquest report that the care Mrs F received was inadequate through the use of inappropriate techniques for the birth, failure to monitor the foetal heart rate and to escalate concerns properly<sup>54</sup>. Midwife 11 was the midwife in charge at the birth.
- 3.95 Mrs F complained to the NMC in December 2013 and her case was investigated by external lawyers.
- 3.96 The cases of Mrs D and Mrs F were included in the consideration of the other matters raised by the Trust by the NMC. The matters were referred to the CCC and Midwife 11 was struck off in May 2015.

### **The investigation into the care provided to Ms G and her baby**

- 3.97 In 2008, Ms G’s baby was born brain damaged. She was under the care of Midwife 11. Following settlement of a claim against the Trust, Ms G complained

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<sup>50</sup> Police report April 2012.

<sup>51</sup> Letter from the Kirkup team to the NMC dated 24 April 2015.

<sup>52</sup> Expert report for the NMC dated 12 May 2017.

<sup>53</sup> Email from tracing agents to NMC – 31 May 2017.

<sup>54</sup> Inquest touching the death of [Mrs F’s baby], July 2009.



to the NMC in April 2015. The NMC opened an investigation but closed it following the decision to strike off Midwife 11 in respect of the other cases.

- 3.98 While the NMC did inform Ms G that there were ongoing cases against Midwife 11, and of the outcome of those cases, we could find no record of the NMC telling her that, if Midwife 11 were to be struck off, then it could not investigate her complaint further.

### Concerns about Midwife 7

- 3.99 The Kirkup report identified a major concern in these cases about the quality of the local investigation reports. Many of these were undertaken by Midwife 7 who was the Maternity Risk Manager at FGH and one of the Supervisors of Midwives. Her investigations involved a number of cases and we set out below the concerns about her investigatory practice as they arose. These were:

- Her investigations were inadequate and failed to identify failings, which meant that that learning was not identified and applied and poor practice continued
- She contributed to a culture of lack of openness and honesty about failings in care, and a perception of cover up and collusion amongst the midwives
- She was alleged to have misled families

- 3.100 The concerns raised with the NMC were:

- By Mr A, throughout 2009, about the quality of the LSA report written by Midwife 7, and media reports he shared with the NMC about the maternity unit at FGH
- By the NMC Midwifery Team in 2010 about that report
- The complaint made by Mr A in June 2012 alleging that Midwife's 7's report for the LSA was dishonest and that she had guided the midwives' responses to the local investigation, the NMC investigation and the inquest, including preparing a set of model answers
- About her report on the death of Mrs B and her baby, which was included in the material provided to the NMC by Cumbria Police in 2012
- By Mrs D in October 2013 who said that Midwife 7 told her in 2005 that there had been no failings of care in relation to the birth of her baby, when Midwife 7 knew this was not the case
- The Ombudsman's report relating to Mr B's complaint published in December 2013 which was critical of the conflicts in Midwife 7's role
- Mr B's complaint in January 2014
- The Kirkup investigation and report.

- 3.101 Midwife 7 retired from practice in March 2012 but remained on the NMC's register.

- 3.102 In June 2012 the NMC opened a complaint against Midwife 7 along with other midwives, following Mr A's complaint about collusion over the inquest into the death of Mr and Mrs A's son but, as described at paragraph 3.27, immediately closed it. This appears to have been an administrative error, but it was not corrected. The NMC does not seem have responded to a recommendation the following month from its external lawyers that one should be opened.
- 3.103 Following its review of the cases in early 2014, the NMC decided that there should after all be an investigation into Midwife 7. It opened a complaint which covered the allegations of collusion in respect of the inquest and the concerns about the investigation reports prepared by Midwife 7 relating to Mr and Mrs A's baby. In April 2014 a further complaint was opened in respect of Mr B's concerns. In October 2014, following discussions with the Kirkup team about the wider governance concerns at FGH and the receipt of further material, one was opened about her other investigative reports. Ultimately these three cases were treated jointly by the NMC.
- 3.104 As we have set out above, the Investigating Committee found that there was no case to answer in respect of the concerns about 'collusion', while the NMC's external lawyers did not investigate the concerns about Midwife 7's supervisory report in Mr B's case and initially recommended that there was no case to answer. It was not until June 2015, when the Kirkup report was published and further information received from the Kirkup Investigation team, that a full investigation into the standard of the supervisory reports was begun. Nine supervisory reports were considered by an expert. The investigation took time because of difficulties obtaining information from the Trust, and because there was considerable discussion with the expert who was instructed to advise.
- 3.105 The complaints were considered by the Case Examiners in December 2016. They decided that there was a case to answer in respect of seven of the reports and referred Midwife 7 to the CCC.
- 3.106 In April 2017, the case was reviewed, as is normal practice, by a lawyer at the NMC. That lawyer noted a number of evidential problems with the expert's review of some matters and that there was evidence that would support charges of dishonesty, though these might need further investigation. Thought was also being given to whether it might be possible to resolve the case by way of a consensual panel determination (CPD). Under this arrangement, the registrant admits the charges and agrees a sanction. The proposal is considered by the CCC which can approve the agreement or not. If the agreement is approved, a full fact-finding hearing is not required.
- 3.107 The NMC decided that its aim should be 'focused case management for the best outcome to be reached by June 2017 given the age and history of the case'.<sup>55</sup> We understand this to mean that the priority was to have the case completed. The final charges related to the inadequacy of the root cause analyses and

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<sup>55</sup> Internal email dated 6 April 2017.

supervisory reports carried out by Midwife 7 in respect of four families: Mrs A and child, Mrs B and child, Mrs F and her child, and Mrs E and her unborn child. They did not include charges about collusion (because there was no sufficient evidence of other collusion, or realistic prospect of obtaining sufficient evidence of collusion to give rise to a case to answer) or dishonesty to the parents.

- 3.108 The hearing was scheduled for June 2017. Following discussions with Midwife 7's representative, a CPD was reached with Midwife 7. Under this, she admitted the majority of the charges and agreed that she ought to be struck off. Under the NMC's arrangements, the referrers of the complaint (that is, the family or other people who referred the case to the NMC) are offered the opportunity to comment on the agreement. The agreement was not reached until the Friday of the week before the hearing was due. The referrers were contacted on the Friday afternoon and had until the Monday lunchtime to make comments. Mr A and Mr B raised concerns (a) at the short notice and (b) they were not told what the charges were so could not properly comment. Their comments were put before the Committee considering the CPD agreement. The CPD was accepted by the Committee on the Tuesday afternoon and Midwife 7 was struck off.
- 3.109 This case was completed eight years after Mr A first raised concerns about the adequacy of Midwife 7's investigations and five years after Midwife 7 had retired.

#### Other information available to the NMC

- 3.110 Our examination of the files showed three other pieces of information about the Midwifery Unit at FGH in the NMC's possession.
- 3.111 The first was an internal email dated 30 September 2011, which referred to information that the CQC had received from a 'whistle-blower' which alleged that midwives at the FGH were incompetent, destroying records in order to disguise incompetence and preparing dishonest reports. The email indicated that the CQC was taking this forward. The CQC was unable to tell us what, if any, action it took following this referral<sup>56</sup>. The NMC could show us no evidence that it had made any attempts to follow this up with the CQC.
- 3.112 The second was a report of 22 cases investigated by Cumbria Police where there had been significant untoward events at the FGH. This was provided to the NMC by Cumbria Police in April 2012.<sup>57</sup> The report identified the families and the midwives involved in the care. Seven of these cases had arisen after 2009. The midwives included a number who were the subject of complaints already opened by the NMC. We could find no evidence of the NMC taking any action on this information when it arrived. Indeed, it appears to have chased Cumbria Police for the information in December 2013<sup>58</sup> and received the information again.

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<sup>56</sup> Interview with the review team, September 2017.

<sup>57</sup> Email from Cumbria Police to the NMC dated 17 April 2012.

<sup>58</sup> Email from NMC to Cumbria Police dated 9 December 2013.

- 3.113 The NMC looked at this information as part of its review of the cases in early 2014 and, in some cases, considered that more information would be needed from the police. The NMC told us that the scope of the review was to consider the police documentation and the Ombudsman's reports, and to review and identify the position with all open and closed cases. It was not intended to produce an investigation plan for future conduct of the cases, and did not purport to do so. Consideration as to what further information should be sought would be set out in any subsequent investigation plan. We could not identify any consideration being given by the NMC as to whether new complaints needed to be opened or investigated.
- 3.114 The NMC told us that it had had considerable correspondence with the Trust about the fitness to practise of its midwives working there and provided us with a schedule of the correspondence. That correspondence did not appear to us to seek information directly about most of the cases raised by the police or about all of the midwives concerned.
- 3.115 In July 2012, Mr A sent the NMC the results of a Freedom of Information Act disclosure from the Trust<sup>59</sup> about the claims raised against it in respect of the midwifery unit at FGH. That information showed that 19 claims had been notified in respect of events from 1 January 2009 and that there had been a sharp rise in claims in respect of untoward incidents after 1 January 2007.

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<sup>59</sup> Letter to Mr A from the Trust dated 18 July 2012.

## 4. The NMC's approach to the cases and the families

4.1 In this section we discuss the issues that we have identified in the handling of these cases by the NMC and from which lessons can be learned. We look at:

- Record-keeping
- Identifying the key concerns and investigating the complaints
- The management of the cases
- Looking at concerns beyond the individual cases
- The length of time taken
- Communication with the families
- Transparency
- Problems with the legal framework of fitness to practise in the context of these concerns.

### Record-keeping

4.2 As we described at paragraph 1.19, the NMC's record-keeping was poor before 2014. While documents sent to the NMC before that time appear usually to have been saved to the system, together with letters and emails sent by the NMC to witnesses, registrants, the Trust and others, we found that other matters – particularly internal discussions and instructions – were not consistently recorded or saved. So it is difficult to understand how or why case management decisions were taken. It also appears that matters considered in other parts of the organisation were not always saved in relevant fitness to practise files. We considered that we did not see full records of:

- Internal conversations where instructions may have been given or decisions taken about the handling of complaints
- Discussions between NMC staff and its external lawyers
- Discussions between NMC staff and complainants, witnesses, registrants or their representatives – frequently there are emails from these individuals referring to conversations but no NMC record of them<sup>60</sup>
- Some instructions sent to external lawyers, particularly case presenters, and discussions with them about the charges to be put and the presentation of the cases
- Telephone conversations and meetings, particularly with senior members of the NMC's executive.

4.3 This poor record-keeping created a risk of a lack of continuity in approach and/or of ongoing understanding of a case, particularly when (as we saw here) cases were handled by several individuals in succession. Subsequently, it made it difficult for us or the NMC to establish what happened in the past.

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<sup>60</sup> For example, among many, email of 15 October 2009 from Mr A.

- 4.4 We have reported in our annual performance reviews on the NMC's inadequate record-keeping and steps taken by the NMC, with some success, to improve it. In these cases, we noted significant improvements in record-keeping in the years after 2015.
- 4.5 However, records of internal discussions and decisions about case management, and discussions with the NMC's lawyers and those representing the registrants were still missing from the files of the cases of Midwives 1 and 2 in the spring of 2016. There were no records of any discussions around the chronology that had been attached to Mr A's 2010 witness statement. We saw emails where he raised the matter and mentioned telephone conversations with the lawyer involved, the then Director of Fitness to Practise and the Chief Executive. However, the emails recording this do not appear on the case file. We found them as part of the documentation disclosed following Mr A's Subject Access Request. Similarly, we did not see clear records of the internal discussions around the decision to offer no evidence against Midwife 6: there is legal advice setting out the reasons for offering no evidence that were given to the panel, but no record of any approval or sign-off for that advice, though we do not question the appropriateness of that advice. In respect of Mrs C, we noted that there were references in emails to telephone conversations without records of the content of those.
- 4.6 We noted that the discussions in respect of Midwife 7, in 2017, were significantly fuller and the reasons for decisions were clearer and easy to follow. However, in their responses to our questions, the NMC provided us with reasons for decisions taken which had not been apparent to us from the files.

### **Identifying the key concerns and investigating the complaints**

- 4.7 We identified occasions where the NMC did not identify issues or act on information that could have been followed up. This is serious because:
- The investigation does then not address all the possible concerns
  - It may mean that matters are missed when considering whether an interim order is needed
  - Registrants may not be fully aware of the case against them
  - Risks to patient safety may not be addressed.
- 4.8 We found the following problems:
- A lack of clinical knowledge in both its Fitness to Practise teams and its external lawyers
  - Over-reliance on local investigatory reports
  - Failing to engage with the points raised by the families
  - Failing to engage with the information provided by Cumbria Police.

### *Clinical knowledge*

- 4.9 In our audit report in 2009, we recommended that the NMC put in place a mechanism for staff to have access to expert advice on acceptable nursing and midwifery standards. Early clinical input should ensure that the regulator investigates the right issues, and can assess the seriousness of the clinical concerns and so identify and manage any risks to patients posed by individual registrants.
- 4.10 The NMC obtained expert clinical advice in the majority of cases which were taken to the CCC, but not until after the initial investigation had been completed. The allegations were therefore formulated without the benefit of early clinical advice, and the expert was asked to comment on allegations which had been formulated by lawyers rather than to identify the practice concerns which required investigation. Clinical advice should have been obtained at an earlier stage so that the correct concerns about registrants' practice were identified and investigated.
- 4.11 This knowledge is also likely to be helpful when dealing with employers and those commenting on individual cases. The Trust's Head of Midwifery told us: 'I was dealing with screening people, or investigating managers, or fitness to practise investigators who have no midwifery background or knowledge. And I think that's the real gap in the NMC as well, that actually some of what we experienced might not have happened if we had actually had the midwifery practitioners doing that screening or the investigation'.<sup>61</sup>
- 4.12 Early clinical advice ought to have identified that:
- Mr and Mrs A said that they had told 'the midwives' that they were unwell and, therefore, that this should have triggered action from the midwives – this could have been identified when the statement from Mr and Mrs A was taken in 2009 and someone with clinical expertise would be likely to have done so, but the concern was not formally raised until 2014
  - There were discrepancies and problems with the supervisory reports prepared by Midwife 7 in respect of Mr and Mrs A's baby and the death of Mrs B and her baby – these were not raised by the NMC until 2014
  - There were significant clinical concerns in respect of the deaths of Mr B's wife, which were identified by the Ombudsman, who had clinical advice
- 4.13 The NMC told us that the bulk of complaints that it receives do not require expert clinical advice. We agree that, unlike the ones we have been considering in this report, many complaints about nurses do not require expert advice. It has also suggested that the points above did not uniquely require clinical advice. That may be so, but clinical expertise would have been more likely to identify them and we note that those without clinical expertise did not do so: neither the NMC

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<sup>61</sup> Interview with the review team, October 2017.



nor its external lawyers identified those cases when early clinical input should have been obtained.

- 4.14 The NMC has told us that it has in the past employed clinical advisers in its Fitness to Practise Directorate. These, however, have left the organisation and the NMC has been unsuccessful in recruiting to the posts. It has made alternative arrangements to ensure that clinical advice remains available by using its clinical case examiners (separately from their statutory decision-making role). It recognises that this is not ideal and plans to recruit for the posts again. Where a need for clinical advice is recognised, the advice is generally sought at the screening stage and so would be available on the file to external firms and to the internal investigation teams, but it can be requested at any time.

#### *Reliance on local supervisory reports*

- 4.15 Great reliance was placed on the local supervisory reports prepared under the old statutory arrangements, particularly in the early years of the investigations. These were made by statutory bodies with statutory powers and duties. Local reports and investigations generally are an important part of clinical governance and a source of learning from adverse incidents. When done appropriately, they can be of significant assistance to the NMC, as was the case in respect of Midwife 11, where the Trust's 2013 investigation into her provided the basis for the NMC obtaining an interim order suspending her from practice and for her subsequent striking off.
- 4.16 However, it would appear that, at least until 2013, the NMC was not able to rely on frank reports from the Trust. Dr Kirkup told us that the NMC, and the other regulatory and oversight bodies, had problems identifying the concerns at FGH because all they had to rely on was the very limited and, as we have seen, often inaccurate information given by the Trust. However, he also told us that there was a sense of disbelief within his Investigation Team that no individual or organisation had identified what was going on at FGH as it was readily apparent from clinical records and the local investigation reports. He thought that the NMC needs to have 'some ability [to uncover things] every now and again when the Trust is trying to pull the wool over your eyes.'<sup>62</sup>
- 4.17 We recognise that, in the bulk of cases whether involving midwives or other clinicians, local investigation reports will provide powerful evidence about the facts of untoward events. However, the NMC had evidence and concerns about the quality of the reports in 2010 from Mr A and these concerns were shared by the Midwifery Team to the extent that they reviewed the system at FGH with the CQC in 2011. These concerns do not appear to have been shared with external lawyers investigating the case of Mrs B and her child. Moreover, while the external lawyers investigating the case of Mr and Mrs A took statements from them and referred to those statements in evidence, there is no evidence that they engaged with the concerns raised by Mr A about the quality of the local reports,

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<sup>62</sup> Interview with the review team June 2017.



the alleged inconsistencies involved or how far those might have affected the reliability of those reports. Reliance was also placed on local reports by the external lawyers looking at Midwife 4's care of Mrs C.

#### *The evidence from the families*

- 4.18 The NMC appears not to have engaged properly with the families affected by the events either to seek information or to address the concerns that were raised. Examples include:
- Mr B was not interviewed by the external lawyers who, in effect, dismissed his concerns. This was a significant omission because the Investigating Committee decided that there was no case to answer on the basis of the investigation report and the NMC then decided that it could not re-open the case when the Ombudsman's decision<sup>63</sup>, supporting Mr B's concerns was published
  - Mr A's evidence identifying discrepancies between the various statements made by the midwives never seems to have been addressed properly because no one seems to have examined those statements to see whether discrepancies existed and, if so, how serious they were
  - The NMC did not address the substance of a complaint by Mr A when considering whether or not to open a complaint but to rely instead on the absence of concerns from the Kirkup team
  - The NMC did not contact families identified to the NMC by Cumbria Police in April 2012 for their recollections
  - The allegation that Midwife 7 might have been dishonest to some of the families was not properly addressed until it was too late to explore the case properly.
- 4.19 There also appears to have been a lack of familiarity with the detail of the evidence that the families provided. This is illustrated particularly by the episode of Mr A's chronology, the absence of which appears not to have been noticed. Nor was the content of his witness statement of May 2010. We discuss this in more detail at paragraphs 4.27-4.36.
- 4.20 Generally, the approach taken by the NMC's investigations appears to have been based on seeking information from the Trust about cases and seeking expert advice on that. While this is important evidence, the experience and evidence of the families is also important in identifying any discrepancies or concerns that might have arisen. The approach by the NMC meant that concerns raised by the

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<sup>63</sup> Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at: [www.ombudsman.org.uk/sites/default/files/Midwifery\\_supervision\\_and\\_regulation\\_Mr\\_M\\_report.pdf](http://www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf) [Accessed: 14/05/2018].

families, some of which were supported by subsequent investigations, were not addressed.

- 4.21 We were also concerned that the complainants in these cases were not given the opportunity to see the responses to the allegations from the registrants. In the two cases where this was relevant (Mr A and Mr B), there were major differences of recollection between the families and the midwives. Giving the families the opportunities to see the responses of the registrants would have enabled them to identify any further discrepancies of recollection as to facts. The NMC has told us that, in the cases that went before the CCC, it did not have responses which could be shared with the families. This is correct. However, in others, notably the early ones by Mr A, the midwives did provide responses to the NMC and it is not clear to us why these could not have been shared.

#### *Information from Cumbria Police*

- 4.22 The Fitness to Practise team also missed the significance of other information that was provided. In 2012 Cumbria Police provided the NMC with a list of cases where there were concerns about the care of patients.<sup>64</sup> The NMC appears to have taken no action on the list for almost two years when, as the police told us,<sup>65</sup> the point of providing the information was to enable the NMC to consider whether urgent action ought to be taken. A number of midwives' names appear on the list who were already the subject of complaints and some of the events were relatively recent. These included Midwife 9, who was involved in the care of Mrs B and whose practice was never fully investigated, and Midwife 11, who was suspended by the Trust in 2013 following two adverse incidents and an examination of her practice by the Trust.
- 4.23 When those cases were considered as part of the review of all the cases, the view seems have been taken that the NMC should await further information from Cumbria Police. We saw no record of the police being asked for this information. However, in our view, the information already sent by the police was sufficient for the NMC to have sought the records of the cases directly from the Trust. It could also have sought contact details for the families. We saw no evidence that it considered doing so.

#### **Management of the cases by the NMC**

- 4.24 From our examination of the files, we found that, particularly before 2014 there was only limited understanding of what the cases were about and the issues they raised. There also appears to have been poor communication between the NMC and its external lawyers. We noted that case managers changed frequently and, possibly hindered by poor record-keeping, did not always understand the history or substance of the cases. The NMC's case management system was inadequate and we were told that it did not have the capacity to enable links

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<sup>64</sup> Email from Cumbria Police to the NMC 12 April 2012.

<sup>65</sup> Interview with the review team, August 2017.

between cases to be noted. There appears to have been poor communication of the concerns of the Midwifery team to the Fitness to Practise team. Our interviews with those members of the team who were case officers confirmed that they were not particularly expected to have an understanding of the details of the case or take a view as to the issues. They also spoke of heavy caseloads at the time. These points must go some way to explain why there seems to have been little engagement among NMC staff about the various points raised by Mr A or understanding about their implications.

- 4.25 This meant that opportunities to pursue potentially serious concerns were missed so that these were either not investigated or the investigation was significantly delayed.
- 4.26 We look below in detail at two examples where we considered that the NMC failed to keep a clear history of the cases in mind or identify links between cases and identify some more general examples of poor case management.

*The chronology prepared by Mr & Mrs A*

- 4.27 The handling of the chronology prepared by Mr and Mrs A in November 2008 is a matter of considerable concern. This chronology was referred to as 'Exhibit 2' in the witness statement signed by Mr A in May 2010. As we have said at paragraph 3.34 we could find no trace of the chronology on the NMC's files prior to March 2016 when Mr A sent the NMC a copy of it. We found copies of the witness statement on several files at the NMC prior to that date, but the exhibit was attached to none of them. We saw no evidence that anyone at the NMC had noticed its absence, or tried to find it or even felt that it might contain information that was relevant to any of the cases. This suggests a lack of interest in the evidence that complainants can provide.
- 4.28 The 2010 witness statement, in which Mr A also mentioned that he and his wife had 'told the midwives' of their illness, was not included in the papers in the case of Midwives 1 and 2, where it was directly relevant. This may have been because a second statement specifically covering the events involving Midwives 1 and 2 had been taken in early 2016.
- 4.29 At the hearing, defence counsel suggested that Mr and Mrs A had not mentioned that they had told the midwives of their illness until the coroner's inquest in 2011. Mr A was surprised that the chronology referred to in his May 2010 witness statement was not before the panel because this would have rebutted this point. He sent a copy to the NMC during the hearing.
- 4.30 The chronology in our view provided relevant evidence because Mr A mentions that he and his wife told 'the midwives' of the infection on the face of his 2010 witness statement and the chronology provides support for that. This chronology is also mentioned in the independent report commissioned by the Trust in 2008, a copy of which was in the NMC's possession.

4.31 Mr A was concerned that the allegations by the midwives' defence had not been challenged by the NMC, and he raised the question with the then Director of Fitness to Practise. He indicated in an email written immediately after a conversation with her that he had understood her to say that the first time that the NMC had seen this chronology had been when he produced it during the hearing. She told us<sup>66</sup> she recalls saying this and believed it to be the case at the time that she said it. There is no record of anyone at the NMC seeking or providing an explanation of what had happened to the chronology. Mr A's direct question to the NMC<sup>67</sup> about this was never answered.

4.32 The Authority asked the NMC about the chronology when it reviewed the cases of Midwives 1 and 2 following the panel's decision. The NMC wrote to us:<sup>68</sup>

'We gave active consideration to the inclusion of this in the bundle of documents. We decided not to include it because;

- There was nothing to indicate when it was made
- It did not support the evidence of Mr [A] in our case against [Midwife 2] The chronology referred to the "the midwife" on 25 October 2008 being told that Mrs [A] was unwell. It made no mention of a second midwife being present and also being informed
- The chronology did not identify the midwives whom Mr and Mrs [A] had spoken to on either 25 or 26 October 2008'.

4.33 In a letter to the Secretary of State for Health,<sup>69</sup> the NMC wrote 'we considered the inclusion of Mr [A's] near contemporaneous statement. We decided not to present this to the panel as our view was that it did not provide new evidence, given that it did not name the individual midwife and it was not clear when it was made.' We note that the chronology is clearly dated 8 November 2008. We understood the NMC's statements to mean that the NMC had the chronology at the time that it was preparing the bundles for the panel.

4.34 The NMC was unable to provide us with a definite answer as to what happened to the chronology. No one was able to say definitively when it first had possession of the chronology. The NMC has told us<sup>70</sup> that it agrees that there is a significant likelihood that the chronology was lost at an early stage and that the first time that it came to its notice was when Mr A presented it at the hearing. The NMC told us that the 'active consideration' given to including it in the bundle had certainly taken place when it was provided by Mr A, and, therefore, after the bundle had been in the panel's possession. It was unable to say whether such consideration had been given before that. We found no documentary evidence to suggest that consideration had taken place earlier or that anyone had noticed the

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<sup>66</sup> Email to the Authority, 27 October 2017.

<sup>67</sup> Email from Mr A of 11 March 2016.

<sup>68</sup> Letter from NMC dated 20 May 2016.

<sup>69</sup> Letter from the Chief Executive of the NMC dated 27 June 2016.

<sup>70</sup> Letter to the Authority of 29 March 2018.

absence of the chronology before Mr A provided it. This is despite it being referred to on the face of the witness statement of May 2010.

- 4.35 The NMC further told us that it had decided not to provide the chronology to the panel because it considered that the document might overall have undermined the case. Our terms of reference do not permit us to comment on this view. It indicated that its point about the date of the document was that it was created after the events rather than contemporaneously. We noted that the document was completed less than three weeks after the events took place.
- 4.36 We consider that this episode suggests, at the very least, poor record-keeping by the NMC and, if we are correct that the absence of the chronology was not noted until Mr A provided it, a lack of familiarity with the documents or a failure to enquire after what might have been an important, near contemporaneous piece of evidence. We comment on how the NMC dealt with this matter in its responses to the Authority and the Secretary of State at paragraph 4.130 below.

#### *Allegations of collusion and dishonesty*

- 4.37 We looked closely at the allegations concerning possible collusion or dishonesty by the midwives. We noted that the Kirkup report found 'clear evidence of distortion of the truth in responses to investigation' and 'inappropriate distortion in the preparation for an inquest, with circulation of what we could only describe as 'model answers''.<sup>71</sup> These allegations are serious and it is incumbent on a regulator to investigate them, if only because honesty is a key responsibility of all health care professionals. In these cases, moreover, the allegations were that the dishonesty was aimed at covering up poor care. There is, thus, a clear link between the concerns and patient safety. We note that Cumbria Police decided not to prosecute these cases. The police would have had to bear in the mind the criminal standard of proof (beyond reasonable doubt). The NMC panels use the civil standard of proof (more likely than not) and it is, in theory, possible, that a panel might have found an allegation proved to the civil standard which would not have reached the criminal standard.
- 4.38 We make no allegations against any individual and we do not suggest that any individual ought to have been found to have been dishonest or colluded under the civil standard of proof. Our focus is on how the NMC investigated the allegations. We also recognise that there are often difficulties in proving dishonesty and collusion and these were present here.
- 4.39 There were three strands of concerns:
- Individual midwives were alleged to have been dishonest in the accounts they gave to local investigations and in their responses to NMC inquiries
  - Some midwives were alleged to have colluded to present distorted evidence to the coroner's inquest into the death of Mr and Mrs A's baby

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<sup>71</sup> Kirkup report, page 8, point 10.

- Midwife 7 was alleged to have been dishonest to individual parents when discussing the causes of the babies' deaths and in her supervisory reports.

#### Allegations of dishonesty by the midwives

- 4.40 We could not see evidence that the NMC had properly engaged with all the evidence available to it about dishonesty among the midwives in respect of local investigations until 2014. There appears to have been no analysis of the alleged discrepancies in their statements or the disparity between those statements and the recollections of Mr and Mrs A and Mr B. No attempt was made to follow up the allegations of the whistle-blower to the CQC.
- 4.41 The concerns about collusion raised in respect of the 'NMC shit' email were never addressed in that we saw no evidence that the NMC had actually sought a copy of the email and the attachment. This appears to be because the external lawyers only investigated concerns about the offensiveness of the title and the data breach because they considered that the collusion issues should wait until the police investigation had been completed. The complaints were closed after the first two issues had been dismissed by the Investigating Committee and the remaining concerns were not identified in the review of the cases in 2014. Again, we make it clear that we have no evidence to suggest that collusion would, in fact, have been found.

#### Alleged collusion over the inquest

- 4.42 The NMC's external lawyers looked in detail at the evidence supplied by Cumbria Police in respect of the allegations of collusion at the inquest. The Investigating Committee concluded, on what appears to have been a thorough investigation, that there was no case to answer against any of the individual midwives identified by Cumbria Police. That investigation, however, was limited to the information obtained by the police. We did not see other evidence that was available (for example, statements made for the 2008/09 investigations into the deaths of Mr and Mrs A's baby) being checked also for discrepancies which might have supported the allegations. We recognise, however, that all of the evidence was available to Cumbria Police.

#### Alleged dishonesty to the families

- 4.43 The first time the question of dishonesty to the families was properly addressed was in 2017 when the NMC's lawyer reviewed the case against Midwife 7. She noted possible instances of dishonesty by Midwife 7 towards Mr A and Mrs D and proposed further investigation in order to bring charges. The lawyer's view was that, if dishonesty could be established, this would put Midwife 7's inadequate investigations in a different light, namely that it could be inferred that she was covering up poor practice in all of the investigation reports which were found to be inadequate.



- 4.44 These concerns were not pursued by the NMC. The NMC told us that there would have been difficulties proving what had been said in conversations that might have taken place some years before and that there could have been abuse of process arguments which may have been successful and would have delayed the hearing significantly. It decided that it was not proportionate or appropriate to pursue the point because it considered that it had sufficient evidence to support a striking-off from the register for Midwife 7.
- 4.45 Concerns about dishonesty and collusion were highlighted by the Kirkup report. They were matters which the NMC ought to have investigated because, if correct, they would seriously affect the registrant's fitness to practise. It had material as early as 2010 which does not appear to have been investigated adequately and which was not identified as part of its review of the cases in 2014 or following discussions with the Kirkup team. We have no basis on which to suggest that the allegations would have been found proved, but it is regrettable that the NMC's investigatory failings meant that these questions were never formally explored.

#### *Other case management problems*

- 4.46 We also noted that the concerns about the quality of supervisory reports do not seem to have been effectively communicated to the Fitness to Practise team and, therefore, did not inform their or their external lawyers' assessment of the evidence available.

#### **Looking at concerns beyond individual cases**

- 4.47 In these cases, we observed that the NMC tended to concentrate on the substance of the cases and whether they, as individual cases, could be proved but did not consider whether information from one case might impact on others or that there might be wider public protection concerns.
- 4.48 We have already noted that the NMC did not engage soon enough with the allegations of dishonesty that were raised in many of the cases, that its Midwifery Team's concerns were not effectively considered by its Fitness to Practise Team and that the list of cases provided by Cumbria Police in 2012 was not examined until 2014. In addition, we were surprised that the concerns about the supervisory reports did not trigger questions about the quality of the care provided by the midwives at FGH both generally and in the individual cases where the supervisory report may have been deficient. In those cases which had not been referred by the families or the Trust and where Midwife 7's supervisory reports were criticised; no consideration was given as to whether the fitness to practise of any of the midwives involved in the direct care should be examined.
- 4.49 The NMC has argued that it did not have evidence which would reach the high threshold needed in order to obtain interim orders against any of the midwives. Our terms of reference preclude us from commenting on this. However, we would observe that it did not appear to have taken steps to see whether further

evidence existed in the light of the information that it had received from Cumbria Police and from Mr A and Mr B.

- 4.50 We also noted the legal advice about whether the clinical concerns about Midwife 9 in Mr B's complaint could be re-opened. The Ombudsman, of course, had identified those concerns. The advice was that, even though Midwife 9's actions at the time had not been properly investigated, it was not possible for the NMC to re-open the case. The advice does not appear to have considered the public protection concerns that might still exist about Midwife 9 or have noted that her name appears in connection with a number of the cases which concerned Cumbria Police. No consideration appears to have been given as to whether it might have been appropriate to look further at her practice.
- 4.51 The concerns about FGH involved questions of attitude and culture which were outside the NMC's remit but which were within the remit of both the Trust and of the CQC. We noted that on 21 July 2011 a group of NMC staff did indeed identify wide failings within FGH and that addressing them was substantially beyond the scope of the fitness to practise process. The group appears to have been proposing radical solutions, including the closure of the unit, referral of the problems to the CQC or placing the unit in special measures. The issues were left for discussion with more senior colleagues. There is no record of such a discussion.

#### The length of time taken

- 4.52 The length of time taken to deal with the cases is an obvious concern. It took more than eight years between the first complaint being received by the NMC and the final fitness to practise hearing. Untoward incidents involving registrants complained about were occurring until 2016. The NMC itself agrees that the delays were a failing and has apologised for them.<sup>72</sup>
- 4.53 The RCM told us that the situation as a whole was, understandably, very stressful for all midwives (and other health professionals) at FGH. It told us that 'the process being so lengthy that was a huge issue for our registrants, who at the time were trying to continue to work under extreme stress, they went a number of years without any communication from the NMC and we understand that that was in relation to the pause in the investigation when the police investigation began. But that did cause a lot of stress for our members, because obviously there was no communication for a long time. It was quite stressful at the outset in terms of the registrants that were initially referred all had exactly the same allegations to answer whether they were involved in a specific episode of care or not. So, on a lot of those, responses were not applicable because they had generic allegations sent out to them. So, that was quite stressful for them'.
- 4.54 As part of this review, one midwife who had been subject to NMC fitness to practise proceedings shared with us her experience, including that of appearing

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<sup>72</sup> Letter from NMC to the Authority of 5 October 2017.

at a hearing of the CCC. It was clear that this registrant remains devastated by the outcomes for the families in these cases, and has been through an exceptionally difficult time. Her main concern was the amount of time it took the NMC to conclude the proceedings.<sup>73</sup>

4.55 In these cases, the delay had the following effects:

- Registrants who were subsequently suspended or struck off the register continued to practise
- Registrants retired or otherwise lapsed from the register which meant that their conduct could not be investigated by the NMC and they could not be required to provide evidence
- It caused memories to be questioned, particularly in the case of Midwives 1 and 2
- It added pressure for the NMC to complete cases rapidly in the latter stages, which may have impacted on the quality of its investigation and decision-making
- It affected the reputation of the NMC as an effective regulator.

4.56 There were three main reasons for the slow progress:

- The NMC's failure to identify the key issues in the early years
- Delays caused by the NMC putting its investigations on hold while the inquest and the police investigation took place and
- The timescales involved in the fitness to practise process.

#### *Failure to identify the issues*

4.57 The fact that the NMC and its external lawyers did not identify key issues from information in its possession from Mr A, Mr B and Cumbria Police when they were received meant that:

- The question of whether Midwives 1 and 2 should have taken more action about Mrs A's illness was not identified until 2014, over four years after it should have been apparent
- The clinical concerns raised by Mr B were not addressed at all
- Possible concerns about Midwife 9 were not fully investigated
- The concerns about Midwife 7's supervisory reviews were not addressed until 2014
- The concerns about Midwives 3, 4, 5 and 6 needed to be reinvestigated in 2014 to address the flaws in the previous work.

4.58 We recognise that the NMC's work was hampered by the fact that the Trust was slow to answer its requests for information and, at times, indicated a confidence in its registrants' fitness to practise that was subsequently shown to be

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<sup>73</sup> Interview with the Review Team, September 2017.

misplaced. It may well also be that there would have been some delay because of the police investigation. However, if the NMC was not properly aware of the issues it ought to have been investigating then it was not in a position to press the Trust on its concerns or to engage properly with the police about what it could investigate. We cannot estimate how long a proper investigation would in fact have taken but identifying the issues properly would undoubtedly have meant that the NMC might have been able to take earlier action on some cases and to have picked up cases more quickly once the police investigation had been completed.

### *External investigations*

- 4.59 The work on the initial complaints by Mr A was held up for three and a half years because the NMC decided to put its decisions on hold for two investigations:
- Between June 2010 and June 2011 because of the inquest into death of Mr and Mrs A's baby and
  - Between July 2011 and December 2013 because of the police investigation.
- 4.60 Between June 2010 and June 2011, no work was done on Mr and Mrs A's complaints. During the police investigation work was done on aspects of the 'NMC shit' email and on Mr B's complaints.
- 4.61 There are a number of reasons why regulators postpone fitness to practise investigations for external events such as these:
- Their investigations might prejudice police inquiries
  - The police and coroners have stronger investigatory powers and this can provide improved evidence for the regulator's own proceedings
  - The outcome of the investigations might affect decisions by the regulator
  - If there is a criminal conviction this means that the regulator can rely on the fact of the conviction as proof of the facts, and this can considerably shorten the regulators' own processes.
- 4.62 However, there are risks associated with such delays and we note that the GMC did not delay its own investigations into the doctors at FGH because of these investigations.<sup>74</sup>

### *The inquest*

- 4.63 The inquest simply looked at the causes of the death of Mr and Mrs A's baby. The coroner made it clear that he had no objection to other investigations being undertaken while he was preparing for the inquest.<sup>75</sup> We saw no written decision

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<sup>74</sup> Interview with the GMC and the Review team, August 2017.

<sup>75</sup> Letter from the Coroner to NMC dated 4 March 2011.

or reasoning behind the NMC's decision to postpone consideration of the cases until the inquest was completed. We do not think that it was necessary for it to do so: it was investigating whether the midwives concerned were fit to practise, not why Mr and Mrs A's baby died.

- 4.64 We recognise that the coroner's report in this case raised some significant concerns for the NMC. However, these concerns should have been apparent from the material already submitted to the NMC by Mr A. We do not think that the fact of the inquest should have prevented the NMC from looking at the fitness to practise of the individuals complained about, the discrepancies in their statements and the problems with the supervisory reports.

#### The Cumbria Police investigation

- 4.65 The formal police investigation opened shortly after the inquest was completed, in July 2011 (though Cumbria Police had been aware of the concerns since late 2010). There were a number of meetings and some email correspondence between the police and the NMC about the investigation. In assessing the NMC's reaction to it, we are hampered by the lack of clear notes of meetings or discussions to provide a clear thread. We saw no formal legal advice discussing whether or not the investigations should be put on hold, though we accept that discussions were held with external lawyers and that their advice was followed.
- 4.66 From our examination of the papers and discussions with Cumbria Police, it appears that:
- Cumbria Police did not wish to reveal material to the NMC that might find its way to the registrants – the NMC had made it clear that, if it received information relevant to a complaint, then it would disclose that to the registrants concerned
  - The NMC understood that the police did not think it was appropriate for them to interview witnesses, other than Mr A, and particularly not the registrants (though the NMC has no power to interview registrants) but that the police had no objection to it investigating the “NMC shit” emails and, when it arose, Mr B's case. The NMC's external lawyers advised that this was as far as it was appropriate to go
  - At meetings with Cumbria Police in 2011 and 2012, the NMC indicated that it would find evidence from the police useful in order to assess whether it needed to take action to protect the public
  - Cumbria Police provided information to the NMC in April 2012 about more than 20 cases where they considered that there were concerns about the midwives that should be investigated
  - In November 2012, Cumbria Police provided information about Mr B's concerns.
- 4.67 Cumbria Police told us that ‘we were really concerned that reports of the same midwives who we had the cases sitting in front of us were still practising at the

hospital' and 'I decided that the safeguarding was going to have to trump the investigation at that point, because I felt I have to give some information on these cases to the NMC'. They were clear to us that their expectation was that the NMC would use the information provided in April 2012 to seek more information from the Trust to enable it to continue its investigations and, if necessary, take action to restrict midwives from practising. The NMC took no action on this and we do not know whether it was even sent to their external lawyers either at the time or when Cumbria Police re-sent the information a year later.

- 4.68 On receipt of the material in respect of Mr B's complaint, the NMC opened a case against Midwife 9. It did nothing to progress the cases which were already open but continued to wait for the police investigation to conclude. This was contrary to the police's expectation. Cumbria Police told us that it was 'constantly' telling the organisations involved that the police investigation was going to take years and 'no way' did they want to hold up any other body's investigation, particularly as there were safeguarding concerns. The NMC started its work again in January 2014, once the police investigation had been closed.
- 4.69 From our review of the papers, it is not clear to us that the NMC understood the approach that Cumbria Police were taking. In our view, there was scope for the NMC to investigate the wider fitness to practise of the midwives concerned (for example by seeking information from the Trust or from the families) and the police expected them to do so at the time the information was sent. We saw no evidence that the NMC considered doing so. This was an opportunity missed, given that some of the midwives identified by the police were subsequently involved in adverse events at FGH.
- 4.70 This delay meant that registrants continued to practise who may not have been safe to do so and that the investigation into Mr A's complaints was delayed by at least 30 months. We note, in particular, that untoward incidents involving two of the registrants noted on Cumbria Police's list took place after the NMC had received the information from the police and that those midwives were subsequently struck off (one for incidents that took place after that list had been received). We recognise that the NMC was in correspondence with the Trust frequently over this period and sought assurances about the Trust's view of the practice of the midwives and, indeed, that the Trust indicated that it had no concerns about the registrants. We cannot say whether an investigation would have provided sufficient evidence to justify the NMC in seeking an interim order restricting those midwives' practice. However, we saw no evidence of the NMC seeking direct evidence from the Trust about the events referred to in the police reports.

#### The NMC's investigations process

- 4.71 Fitness to practise cases require a period of investigation, an opportunity for the registrant to respond to the allegations, and (where cases are referred on to a hearing) a legal process in preparing for the hearing. Additional delays can be



caused for a variety of reasons, such as difficulties obtaining evidence or tracing witnesses, or in scheduling hearings at a time when all witnesses can attend. This means that, however effectively the case is managed, the process is unlikely to be quick. In looking at these cases, we considered whether there were delays which were avoidable.

- 4.72 We found initial delays in the NMC's process in identifying the midwives. The NMC is not necessarily able to identify a registrant from a complaint but needs to contact the employer in order to obtain the relevant Personal Identification Number and confirmation that the registrant was, in fact, involved in the care complained of. The Trust was very slow to respond to these requests and needed considerable chasing by the NMC. We do not criticise the NMC for this delay.
- 4.73 Following this, the process for investigating allegations takes time. It will frequently depend upon the availability of witnesses and their willingness to co-operate. The NMC sets timescales for investigations. We noted that, in a number of the cases, the external lawyers requested extensions of the usual timescales, for example because of difficulties in obtaining information from the Trust, contacting witnesses and obtaining appointments and signed statements from witnesses and in obtaining approval for experts to be instructed and then following discussions over the detail of those reports.
- 4.74 We have not been able to review the external lawyers' files, so it is impossible for us to tell whether the time taken to investigate the individual complaints was reasonable or not. We noted that it took six months between Mr A's witness statement being taken by the lawyers and the time Mr A signed it. This appears to be too long. After 2014, we noted significantly improved reports from the external lawyers which provided evidence of continual activity and we doubt that it would have been possible to reduce significantly the length of time that the investigations took at that point.
- 4.75 There was a delay of 16 months between the Investigating Committee's decisions to refer the cases of Midwives 1, 2, 3, 4 and 6 to the CCC in November 2014 and the hearings of the CCC, which did not begin until March 2016. This was because it was necessary to deal with a number of points that had been raised by the defence about whether it would be possible to hold a fair hearing, given the delay and the publicity surrounding the cases. There were also arguments about whether the cases should be heard together or separately.
- 4.76 The CCC originally met to consider the arguments in July 2015 and adjourned until October 2015 to enable them to be fully addressed. Once its decisions were made, fresh hearings had to be scheduled and the final hearings did not begin until March 2016, with the case against Midwife 6 heard in January 2017 (because she was out of the country).
- 4.77 As we have said, the process for assessing fitness to practise is likely to take a long time where, as here, facts are disputed and expert evidence is needed.

Indeed, the Government is looking to address this in its plans to reform the regulation of health care professionals. While the NMC cannot be criticised for the structural problems with the process or the problems that it faced in dealing with the Trust, its own failure to identify key matters to be investigated and its decision to postpone work because of external investigators were the key reasons behind the length of time taken to deal with these cases.

### Communication with the families

4.78 We have set out our concerns (paragraphs 4.18-4.21) about the way in which the NMC engaged with the concerns raised by the families. We now look more closely at the way in which the NMC kept them informed of progress and provided support where they were witnesses. All of the families suffered the loss of the child, mother or both, or significant harm. As the NMC's Chief Executive and everyone else we spoke to accepted, the cases were terrible, life-changing tragedies for the families. It is understandable that those families will want to understand what went wrong and to have any problems addressed so that they do not happen again. It is also the role of the NMC to investigate and take action to ensure that the public is protected.

#### Mr B

4.79 In Mr B's case, the NMC failed to carry out the initial investigation of the complaint adequately so that it considered that it was unable to open it again in the light of the Ombudsman's report. Moreover, the way in which the NMC communicated with Mr B fell well below acceptable standards of treatment. Our concerns are:

- When Mr B tried to raise his concerns himself, he was met with a confusing response<sup>76</sup> and, ultimately, a refusal to open a complaint on the grounds that the decision had already been taken by the Investigating Committee
- When the case was re-opened in early 2014 together with Mr B's other concerns, the NMC took almost seven months to act on its internal legal advice that it could not look again at the clinical aspects of the complaint
- When that decision was taken, it was also decided not to inform Mr B of this until the Investigating Committee had come to a conclusion on his other complaints
- When he was informed of the decision about the clinical case, he was told that it had been delayed because 'new allegations or new evidence may have been identified that would have required us to further consider [Midwife 9's] fitness to practise.'<sup>77</sup>

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<sup>76</sup> The emails of 9 August 2013 between Mr B and NMC, for example, suggest uncertainty on the NMC's part about whether he could raise a complaint or not.

<sup>77</sup> Letter to Mr B dated 13 November 2014 setting out the Investigating Committee's decision.

- 4.80 The correspondence that we have seen from the NMC to Mr B is confusing and cannot have been helpful to him. There are frequent long gaps where there is no evidence that he was being given information about progress. At no point does anyone seem to have recognised that he is a bereaved husband and father, that his recollection of the events ought to have been investigated properly by the NMC or that he was entitled to be taken seriously by the NMC.
- 4.81 We were particularly concerned by the way in which the NMC communicated with Mr B after it had re-opened the clinical complaint against Midwife 9 and then closed it again. The NMC was unable to provide us with a reason for the instruction to delay telling Mr B about this decision. There is no documentary evidence to support its statement to him that the delay was because it was awaiting further information. It has told us that it is not unusual for additional information to come to light in cases involving a number of different parties before a complaint is considered by the Investigating Committee. We accept that, but it is hard to see how this would have applied to Mr B's complaint because it had been closed at screening on the basis that the Investigating Committee had already taken a decision on it and the legal advice was that the whole events at the birth of Mr B's child could not be re-opened. The matters being considered by the Investigating Committee were not connected to the birth. The NMC agrees that the treatment of Mr B was unacceptably poor. It did not give him a full picture of the handling of this complaint. The NMC never explained to Mr B that its original investigation had been flawed and never apologised to him for this.

#### *Mr A*

- 4.82 The handling of Mr A's complaints raised similar concerns. As we have said, he provided regular and significant contributions to the NMC. The concerns he identified about the clinical practice, the distorted responses to investigations and the inquest were supported by the Kirkup report. Yet we found little evidence of the NMC or its external lawyers seriously engaging with the points that he raised or using them to question the accounts given by the midwives concerned.
- 4.83 We found that the information provided to Mr A in response to his requests for information about progress, particularly before 2014 was confusing and contradictory.
- 4.84 The first time that Mr A was given any information about the substance of the complaints that the NMC was taking forward was following the Investigating Committee's decisions in November 2014.<sup>78</sup> This information was provided to him in a number of letters about each of the registrants about whom he had raised a complaint or where he was noted as an interested party. Those letters reproduced the Investigating Committee's decisions, based on the allegations considered by the external lawyers. It cannot have been easy to correlate these

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<sup>78</sup> Letters to Mr A setting out the Investigating Committee's decision in respect of each registrant of 13 November 2014.

to the allegations that he had asked to be investigated. We were not surprised that he remarked that he 'did not find them easy to understand'.<sup>79</sup>

- 4.85 We found that the way the NMC provides reasons for the decisions by the Investigating Committee and also by Case Examiners is likely to be difficult for complainants to follow. This is because the decision is simply pasted into the letter to the complainant. The decisions are written following a report of the investigation and relate to that investigation. Any complainant reading them will have no information as to the intervening history, why some matters raised were not investigated, or how other matters were linked to the existing complaint. This does not assist the complainant to understand or have confidence in the process.
- 4.86 Mr and Mrs A were witnesses at the hearing in respect of Midwives 1 and 2. We have quoted Mr A's views of his experience at paragraph 3.56. We note that the panel was not provided with the chronology that supported his statement that he and Mrs A had told 'the midwives' of her illness. Mr A was, however, generally complimentary about the support that he received from the NMC in preparation for that hearing and at the hearing. From the documents we have seen, we agree that the NMC made strong efforts to provide appropriate support. Mr A told us that Mrs A also found the experience distressing.
- 4.87 Giving contested evidence is inherently distressing; however, it is not possible to deny registrants whose careers are at risk the right to cross-examine witnesses robustly. However, the fact that this happens and the manner in which it is sometimes done is a significant problem with the fitness to practise process and we consider this at paragraphs 4.132-4.136 below.
- 4.88 Further concerns arise in respect of the Consensual Panel Disposal (CPD) in the case of Midwife 7 where she admitted a number of charges and agreed that she should be struck off. The NMC's rules require that referrers of complaints are consulted about the appropriateness of a CPD. In this case, the agreement as to the wording of the CPD was reached on the Friday before the hearing was due to begin. Mr A, Mr B and Mrs F, who were interested parties, were informed of the proposal that afternoon and asked for their comments by the following Monday. The charges which Midwife 7 had accepted were not disclosed.
- 4.89 In our view, it is unreasonable to expect families to comment on CPDs in this limited amount of time. Ten days had been set aside for the hearing and it would have been possible to delay the start of the hearing in order to give the referrers adequate time to consider the CPD. We also consider that it would have been open and transparent to allow them to understand the charges particularly where, as here, significant matters that they had raised were not included. We note that, in error, the charges were made available to the press before the families saw them.

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<sup>79</sup> Email from Mr A to the NMC 16 November 2014.

## The NMC's approach to Mr A

- 4.90 Mr A had close contact with the NMC throughout these cases and was a vigorous critic of it as a body. He made a Subject Access Request for the information held about him by the NMC. We discuss the approach the NMC took to that request at paragraphs 4.104-4.128 below.
- 4.91 We looked at the following documents as well as those on the complaints files:
- Briefings to the Chair and Chief Executive and Council members about correspondence and meetings with him and events that he was attending
  - Copies of documents showing that the NMC monitored his Twitter feed, gathered quotes from him in the press and set up Google Alerts about him
  - Internal email discussions about how to 'handle' him and his complaints from a corporate communications point of view
  - Internal email discussions about the media reporting of individual complaints
  - Internal email discussions about communicating with him
  - Other email discussions where his name appears to have come up as a possible speaker at an event or as an individual with an interest or a contribution to make
  - A very small number of moderately offensive comments about him between some members of staff.
- 4.92 It is clear from these documents that he was regarded as someone who was hostile to the NMC corporately and who needed to be handled with considerable care. In one Council briefing he is referred to as 'a high profile individual'. This is understandable. He has written a book,<sup>80</sup> speaks regularly about his experience and is a regular user of Twitter. As is his right, he makes occasional trenchant comments about the NMC and its Chief Executive. We can understand that the NMC would wish to inform itself of what he is saying publicly about it and that, given his high profile, its Chair and Chief Executive would wish to be briefed about him.
- 4.93 In our view, the documents that we saw generally demonstrated a professional approach to Mr A. We would, however, make the following observations:
- There are a very small number of emails between staff members which suggest that they found Mr A a nuisance to deal with, were disrespectful about him and gave the impression that he was not seen as someone who had lost a child or had anything helpful to give to their investigations. The then Deputy Director of Fitness to Practise apologised to Mr A for the unprofessional tone of some of these, though others were not disclosed to Mr A.

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<sup>80</sup> *[Mr and Mrs A's son]'s Story: Uncovering the Morecambe Bay scandal* (2015).

- The internal documents indicate a very cautious approach towards dealing with Mr A and a nervousness about the tactics of approaching him.<sup>81</sup>

4.94 By the end of the process, the NMC's relationship with Mr A had broken down. We asked the NMC for its reflections on this.<sup>82</sup> The NMC noted that Mr A had had significant levels of contact with staff there at all levels, including the Chief Executive. It recognised the tragic experience that Mr A had had and apologised to him for the delay. The Chief Executive said 'what we failed to do, and when we did it was too late, was manage his expectations. So it was clear to me at the beginning of 2014 he had expectations we wouldn't be able to meet. And six years had passed and the die was set'. She suggested that, amongst other things, 'we could have taken every opportunity to remind him what we could and couldn't do, and to make it clear that the thing that he wanted, which I believe was the big systemic review and investigation, was never going to be delivered by this organisation.' We do not believe that Mr A was asking the NMC to do that. We think that Mr A was asking the NMC to look at serious and evidenced concerns about the competence and conduct of the midwives at the FGH and whether they were safe to practise. We do not think that it was unreasonable for him to expect that the NMC would do so. The problem was that the NMC did not take proper account of his concerns, did not communicate well with him and was not open with him about the problems with their investigations in the early years.

#### *Other families involved*

- 4.95 We have set out the experiences of other families at paragraphs 3.73-3.98 above. They show a picture of individuals whose interest in the cases was not seen as a priority by the NMC. They were not kept well-informed of progress or of the status of cases. The comments that we have quoted from two of the families attest to the fact that they found the NMC's processes opaque and unhelpful. While there were examples of individuals at the NMC providing helpful and supportive advice and information and some sympathetic and thoughtful letters, most of the communication appeared to us to be impersonal and did not engage with the real concerns of the families. They were infrequent and showed no evidence that the NMC was considering the impression that it was giving to those families. It is understandable that the families were disappointed in the NMC as a regulator.
- 4.96 The NMC gave the impression to the families that they were of limited relevance to its fitness to practise process. We found that:
- Information and concerns raised by the families were ignored
  - There was no attempt to play back the families' concerns to them, so that the NMC could be sure that it understood them
  - The NMC did not seek to cross-check registrants' responses with the families

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<sup>81</sup> For example, internal emails – document numbers 58278198, 5193557, 5192658, 5192244.

<sup>82</sup> Interviews with Chief Executive and Director of Fitness to Practise, January 2018.



- Due weight was not placed on evidence provided by the families
- Correspondence with the families was confusing and irregular
- The NMC has not been transparent with the families about why matters went wrong or about its processes.

4.97 The NMC has argued that it could not have been transparent with the families because, until 2014, it was not in a state to recognise what had gone wrong. This may be the case but at no point after 2014 has it done so. For example, the flaws in the original investigation of Mr B's complaint must have been apparent in 2014 but he was never told about them. The flaws in the investigation of Mr A's cases must have been apparent when the NMC reviewed the cases in 2014 but it has never been open about them to Mr A. Despite Mr A's requests, he was never told in writing what had happened to the chronology. Given this continued failure to be open with the families, we cannot say that members of the public raising complaints with the NMC will feel confident that their concerns are being addressed or treated with an appropriate level of respect or that the NMC will be frank with them where things go wrong. This will apply even if the investigation carried out by the NMC in fact addresses all the concerns.

### **The transparency of the NMC as an organisation**

4.98 We considered two matters which are relevant to the transparency of the NMC as an organisation:

- The request for advice on whether it ought to have sought an interim order in respect of Midwife 4 at an earlier stage
- The Subject Access Request from Mr A.

#### *The review of whether an interim order ought to have been sought*

4.99 As we have mentioned, the NMC commissioned a review from a senior barrister as to whether it had missed opportunities to seek an interim order restricting the practice of Midwife 4. We commend the NMC for commissioning this review which shows an intention to review its actions and learn lessons from them.

4.100 Mr A asked, when he heard that the report had been commissioned, whether he would be able to see the report. The NMC did not provide a clear answer to that. He asked again when he was told that it had been received. The NMC offered him the opportunity to see a copy of the report in private, provided that he kept it confidential. Mr A did not agree to that condition. As mentioned at paragraph 3.77 above, the NMC also informed him what conclusions the senior barrister reached. The Information Commissioner has said that the NMC's 'brief description of the conclusion accords with that advice'.

4.101 A journalist sought disclosure of the report under the Freedom of Information Act. The NMC refused to provide the report and this approach was endorsed by the Information Commissioner. We understand that the matter is being considered by

the Information Tribunal and that the Tribunal's decision awaits the publication of this Review.

- 4.102 In the light of the NMC's assertion of legal professional privilege, it would be inappropriate for us to discuss the content of the report or to opine on the legal position. The NMC has the right to refuse to publish information if it is covered by an exemption under the Freedom of Information Act, though it is not compelled to do so. We note that it has a written policy covering its approach to such requests.
- 4.103 It would have been very difficult for Mr A to comply with the requests to keep a private examination of the document confidential. He comments frequently on the events at FGH and the NMC and it could, practically, have been difficult to keep his knowledge of the findings of the report separate. Following the litigation, we would suggest that the NMC reconsider whether, in fact, there would be any danger to it in publishing the report and whether it should, in fact, do so. If the matter, is covered by privilege, it is obviously entitled to rely on that. However, organisations are able to publish documents even if they are covered by privilege. The NMC told Mr A that the purpose of the review was to 'identify lessons for the future'. The NMC might improve its transparency and public confidence in its willingness to learn if it did publish the document.

#### *Mr A's Subject Access Request*

- 4.104 On 14 September 2016, Mr A submitted a Subject Access Request (SAR) to the NMC seeking disclosure of material held by the NMC in respect of him and members of his family.
- 4.105 The NMC noted that the request potentially covered a very significant amount of correspondence and paperwork covering 35 fitness to practise cases, 20 registrants and around 10,000 emails. The documentation also included information about a very significant number of other individuals (registrants, NMC staff and many other people) who had rights under the Data Protection Act. Other documents were covered by legal professional privilege and it would be entirely proper for the NMC not to disclose these. It was clearly a complex task to provide documents that complied with Mr A's rights while respecting the rights of others. Many documents required significant redaction to protect those rights. The NMC decided to instruct solicitors to undertake the detailed work required to comply with the request.
- 4.106 The solicitors wrote to Mr A asking if he was able to narrow down his request and pointing out that there might be difficulties if Mrs A did not give her consent to her data being included in the request, because many documents referred to 'Mr and Mrs A' and it would be impossible to redact these in a way which protected Mrs A's identity. There does not appear to have been a response from Mr A to that request. No attempts appear to have been made to chase a response or, indeed, to correspond with Mrs A separately to seek her consent.

- 4.107 The then Deputy Director of Fitness to Practise told us that he had a conversation with Mr A in November 2016. From that, he understood that Mr A was interested in what the documentation showed about 'the NMC's culture'. In response to this the Chief Executive and the then Director of Fitness to Practise waived their rights under the Data Protection Act so that Mr A could see the full extent of their correspondence. We commend them for doing so.
- 4.108 The NMC told us that the solicitors<sup>83</sup> looked at material which underwent three stages of review. Documents where the legal reviewers had queries for the NMC to resolve were reviewed by the NMC and the NMC made the final decision as to how the document should be redacted. There followed a final check by the solicitors before the documents were disclosed to Mr A. The NMC has told us that it takes responsibility for the decisions taken.
- 4.109 More than 1500 documents were disclosed to Mr A in a redacted form. Some of these included several different emails in one document. The then Deputy Director of Fitness to Practise wrote to Mr A to apologise that some of the comments in some documents appeared disrespectful to him. In subsequent correspondence, he identified four documents which fell within this category.<sup>84</sup>
- 4.110 Mr A was concerned that a number of the documents were very heavily redacted. Indeed, some pages were blank apart from his name.

#### Our review

- 4.111 The NMC provided us with access to an electronic folder containing copies of the original documents plus the redacted versions as sent to Mr A.
- 4.112 We were assured by the NMC that these were all the documents that were forwarded to its solicitors for advice. We were also assured that these were the complete documents that had been discovered from their database using what appeared to us to be reasonable criteria. In our review of other documents, we noticed some which appeared to refer to Mr A by implication but we recognise that these did not contain his personal data and so would not have been picked up and did not need to be disclosed.
- 4.113 The documents that we received were not in a form that was easy for us to review. Not all of the redacted documents (and very few of them in category 3 below) were clearly linked to the original documents and there was a delay while the solicitors provided us with the information that we needed. Apart from the initial instructions, we saw no information about discussions that might have been had between the NMC and the solicitors and no reasoning as to why individual redactions had been made. In particular, we were not shown any document from the solicitors or the NMC which described the approach or the principles guiding the redaction of the documents.

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<sup>83</sup> NMC's response to our questions, December 2017.

<sup>84</sup> Email to Mr A dated 21 December 2016.

4.114 We initially reviewed all the documents to divide them into categories. These were:

1. Publicly available information (such as news reports, Twitter conversations and other matters)
2. Correspondence which was directly related to individual complaints, most of which we had seen on the complaints files and much of which had been sent to Mr A as the complainant
3. Documents which we had not seen on the files, most of which were internal to the NMC which referred to communications with Mr A, discussions about him and other matters where his name was mentioned (for example, as an attendee at a conference).

4.115 We looked at a sample of the documents in categories 1 and 2 to satisfy ourselves that the redactions appeared to be broadly appropriate. We looked at every document in category 3. We then set out our understanding of the law relating to SARs and invited the NMC to comment on its reasoning for redacting some documents.

#### Our approach in reviewing the documents

4.116 We are not experts on the law governing SARs and Data Protection. It is not our role to rule on whether individual redactions complied with the law. The Information Commissioner exists to do that and it would be wrong for us to make judgements which are properly the function of that office. Any opinions that we express below should be treated as informed opinions, not as definitive statements as to whether or not the NMC carried out its duties appropriately.

4.117 In looking at the documents, however, we took into account:

- Our general understanding of the law and what is regarded as good practice, which informed our opinions on individual documents
- The NMC's instructions to its solicitors that it wished to be as transparent as possible
- The NMC's understanding of Mr A's wish to get a picture of the 'culture of the NMC'
- The practicalities involved in redacting the information, and
- The content of the documents themselves.

#### Our understanding of the law

4.118 Our understanding of the relevant law and good practice is as follows:

- Information under a SAR must be provided in an intelligible form or with an explanation – so, if a decision is taken to redact a document to the extent that only the portion relating directly to that individual is included, then

explanation is needed about the context as to why the personal information was being held. The NMC has told us that, having taken legal advice, it is satisfied that it complied with this

- Where the information reveals personal information about other individuals then the information need not be disclosed unless there is consent or it is reasonable to do so. It is likely to be reasonable to do so where the individual is a senior public figure, such as a Minister or senior member of the organisation. Where it is not reasonable, the organisation should consider whether the information could be redacted so that the information could be disclosed without identifying the other individual
- Where information is included in a document which is not personal information, but is not subject to the exemptions and where other individuals' personal information can be redacted, it is regarded as best practice not to redact the document further
- It is good practice to consider the principles of Freedom of Information as well as the Data Protection Act when considering a request.

4.119 We also bore in mind that there is often no single right answer in these circumstances and that organisations have a significant level of discretion as to how much information they provide to individuals. In that context, we noted the NMC's stated desire to act transparently.

#### What we found

4.120 We found that the documents that we looked at in categories 1 and 2 above appeared to have been appropriately redacted. Those within category 2, in particular, contained substantial personal information about registrants and other third parties which it would have been entirely inappropriate to disclose.

4.121 We also found a number of minor errors in the redactions and matters which had not been properly picked up in the work. In the context of the large number of documents that were considered, we did not think these were significant or failed to disclose information of importance to Mr A.

4.122 We had, however, concerns about the approach taken to documents in category 3, which contained much more information that was internal to the NMC and included draft documents, reports to its Council, internal discussions about the PR handling of individual cases and some general emails.

4.123 We raised these concerns with the NMC and asked for its comments. The NMC assured us<sup>85</sup> that all redactions were made following legal advice and provided some limited explanations where we asked for them. We have taken these into account in our comments below.

4.124 We noted two documents which were disrespectful of Mr A which were not disclosed. These were emails which, in our judgement, referred to his personal

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<sup>85</sup> NMC's response to the Authority's questions, December 2017.

data. These contained low-level, in one case puerile, disrespectful comments about him between members of staff at the NMC. The NMC told us that the decision not to disclose the documents was made by one of its legal advisers. We do not accept the NMC's comments that it was not clear that Mr A was being referred to in one of the documents. In the other, we disagree that it was not possible to redact the information so that the members of staff concerned were not identifiable. We consider that it is regrettable that these were not disclosed, given Mr A's interest in the culture of the organisation.

- 4.125 We also noted a number of documents where, in our view, insufficient information about the context was given. In one letter to the Secretary of State for Health, the name and address of the Secretary of State had been unnecessarily redacted along with much other content and, in our judgement, there was entirely insufficient context given to enable Mr A to understand why the document had his name in it. In another document, the only part that was sent to him contained the two words of his name so it was impossible to understand the context. In a number of others, it appeared to us that the NMC could have revealed either the whole document or significantly more of it without compromising others' personal information.
- 4.126 We were perplexed by this because the documents involved were innocuous and did not reveal anything that should reasonably have caused the NMC embarrassment. Many of the documents were corporate documents, including information which, in our view, could have been disclosed without breaching the NMC's other obligations or its right to legal professional privilege.
- 4.127 We commend the approach of the Chief Executive and then Director of Fitness to Practise in waiving their own rights under the DPA. It tangibly demonstrated a wish to be transparent and this should be recognised. However, we consider that the NMC and its solicitors might have been able to achieve greater transparency by:
- Making further efforts to contact Mr A about refining his request
  - Making further efforts to establish whether or not Mrs A was content to waive her rights under the DPA
  - Addressing more closely some individual documents and considering whether it would be possible to provide more information without breaching other peoples' rights.
- 4.128 The NMC's approach may have complied with the law. However, it appears to us that it would have been possible for the NMC to have provided significantly greater context by a more nuanced approach to redaction. There were a relatively small number of documents where this could have been appropriate. We considered that, had there been a commitment to transparency throughout the organisation, the documents could have been redacted in a more proportionate way. This would have provided greater confidence in the NMC's statements that it wished to be a transparent organisation.



- 4.129 We link our comments in this section to the points we made about the NMC's approach to the families in paragraphs 4.78-4.97. We identified there that the NMC has not disclosed the problems that arose with its handling of the cases, even though it has told us that it agrees that there were 'failings' in its handling of the cases, particularly before 2014.<sup>86</sup> This is not consistent with the NMC's aim to be a transparent organisation.
- 4.130 We also noted that the NMC failed to address the history of what had happened to the chronology in its correspondence with Mr A which suggests either disrespect for him or a reluctance to be open about what had happened to it. Its correspondence with us and with the Secretary of State was capable of being understood as saying that the NMC had given full consideration of whether to include the chronology at a stage well before the point that Mr A provided it. We could see no evidence of the NMC seeking to satisfy itself as to what had happened about the chronology at the time, even though Mr A had raised the question with the Chief Executive directly.<sup>87</sup>
- 4.131 The NMC also refused to disclose the report it commissioned from the senior barrister. In our view, public confidence is likely to be greater in organisations which are transparent and admit mistakes.

### The fitness to practise system

- 4.132 The Kirkup report suggested that there were significant clinical and cultural concerns about the midwifery unit at FGH. After its investigations, the NMC found concerns about the fitness to practise of the midwives proved in four cases. Of those, one midwife was struck off 11 years after the first concerns about her practice arose, a second was struck off five years after she had retired and a third was suspended for nine months even though the panel found that there were no longer any concerns about the safety of her practice. The fourth was struck off having also retired. Interim Suspension orders were imposed on three midwives (two of whom were subsequently struck off). Further avoidable deaths occurred while the NMC were considering the complaints.
- 4.133 Our review of these cases has strengthened our view that the fitness to practise process is not well suited, of itself, to deal with the range of concerns that arose at FGH. Immediate problems of clinical competency and problems of culture and attitude should be addressed by the employer so that swift action can be taken to address the concerns. The CQC is the body in England that should deal with problems that arise out of systemic failings within the Trust or employer. The Authority has recently published its views on the future of fitness to practise in the context of possible reform of the regulation of health care professionals.<sup>88</sup>

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<sup>86</sup> NMC response to our request to examine cases – 5 October 2017.

<sup>87</sup> Email from Mr A to the NMC of 11 March 2016.

<sup>88</sup> Professional Standards Authority 2017, *Right-touch reform*. Available at: [www.professionalstandards.org.uk/latest-news/latest-news/detail/2017/11/23/authority-releases-special-report-on-regulating-health-workforce](http://www.professionalstandards.org.uk/latest-news/latest-news/detail/2017/11/23/authority-releases-special-report-on-regulating-health-workforce) [Accessed: 24/04/2018].

The NMC cannot itself be expected to take full responsibility for dealing with all of these concerns.

4.134 The fitness to practise process was originally developed by the professions to deal with very serious allegations of the sort that we saw in these cases – often involving dishonesty or serious clinical malpractice. The registrant’s career was at stake and, inevitably and rightly, strong protections were needed to ensure fairness. This has resulted in the following features:

- It is adversarial – the vocabulary is one of ‘allegations’, ‘prosecution’, ‘defence’ and ‘sanction’ – and owes a lot to the criminal law
- It is lengthy which, as the RCM and the families told us, adds to the distress for all concerned – the NMC, when it considered the cases that we referred back to it considered that, even with its improved processes, it was still likely to take up to nine months for most of the investigations to be completed and that hearings would take even longer
- It does not encourage regulators to look at the whole picture of a registrant’s practice which means that wider concerns may be missed
- Registrants inevitably feel that they are being held to account and their livelihoods are at stake and this encourages a defensive approach
- It involves hearing and testing the witnesses’ evidence which caused, as we have seen, significant distress to the families and registrants
- It tends to focus on a single incident or group of incidents – if that incident is not proved then there is no further examination of the registrant’s fitness to practise. It is not unusual for facts not to be proved because of prosecution failings, because witnesses fail to turn up or for other technical reasons which have nothing to do with the registrant’s actual fitness to practise
- There is a very high bar before an interim order can be obtained against a registrant who may be a risk to patient safety
- It encourages a legalistic approach to complaints – we saw a number of excellent legal analyses of cases which focussed on whether facts could be proved and the likely outcome; they did not consider wider fitness to practise questions about the registrant or the culture at the hospital.

4.135 None of these features are conducive to addressing concerns early or encouraging an open culture. While there will continue to be cases where the facts are such that a process of this sort is the only reasonable approach, we hope that future reforms will encourage regulators and employers to work together so that, where it is possible and appropriate, concerns are addressed locally and resolved quickly. Regulators should not automatically put complaints into the fitness to practise process where a more proportionate approach will protect the public. We discuss these matters further at paragraphs 5.50-5.52.

## 5. Changes at the NMC and lessons

- 5.1 The NMC received the first concerns about the midwifery unit at FGH in February 2009. It completed the last of the cases in June 2017. Formal sanctions were imposed against four midwives, one of whom had retired in 2012. Cumbria Police identified seven cases which had arisen since 2009 where it had concerns about the care. The Trust received 19 claims in respect of untoward events which arose after 2009 (some of these may have been the same as those investigated by the police). From our study of the files we were aware of at least two further untoward incidents and one death under the care of midwives who were already under investigation after 2013.
- 5.2 We do not know whether any of these could have been prevented but, in our view, before 2014 the NMC did not take credible information which it received about the midwives at the FGH seriously or take action to satisfy itself that the midwives were fit to practise. Its handling of the cases before 2014 generally was frequently incompetent. Even after that:
- Cases took longer to be investigated than was necessary causing distress to families and registrants
  - The full range of the conduct allegedly involved – clinical concerns, collusion and individual dishonesty – was not fully explored
  - The families we spoke to were dissatisfied and our study of the files showed that all of the bereaved families were unhappy with aspects of the way in which they were treated or their cases handled by the NMC.
- 5.3 In our view the major problems were:
- The NMC's record-keeping was poor
  - Individuals did not analyse cases properly or consider the implications of them
  - Information from third parties or elsewhere in the NMC was not properly analysed or acted upon
  - The NMC did not take information from the families seriously or engage with them properly
  - When criticised or asked to provide information, the NMC adopted a defensive approach, even if it intended to be transparent
  - The fitness to practise system itself is unsuitable for dealing with a number of the concerns noted in the Kirkup report.
- 5.4 We recognise that the NMC faced several problems dealing with the cases. The Trust was, during the early years of the period, facing significant challenges. It did not assist the NMC to identify problems with midwives' practice. The CQC was in the early stages of its life and, as the Kirkup report noted, was also not best placed to assist the NMC. The NMC itself was, as our audits at the time and

as the Chief Executive herself recognised, not in a position to deal competently with those cases at least until 2014.

- 5.5 In this section we consider how the NMC has addressed the issues and identify the lessons that can be learned.

### **The NMC**

- 5.6 The NMC has changed significantly during the years covered by this Review, partly in response to the Authority's reviews and also of its own initiative. It participated fully in changes to the system for midwifery supervision and implemented these. The NMC's Chief Executive also told us that, in her view, it was not until 2014 that the NMC could be regarded as beginning to address the concerns that we have identified. We have borne this in mind in looking at the lessons we have identified in this review and in assessing how far our concerns still apply to the NMC.

### *The NMC's analysis of the cases*

- 5.7 We invited the NMC to look at six of the cases that troubled us and identify where its handling had gone wrong and how it addressed the problems that it identified. These were all cases that were opened in 2012 or earlier. The NMC provided a full and frank response to us and it was clear from our correspondence that it fully accepted a number of the criticisms that we make above. It was clear that it had looked at the cases openly and in considerable detail. It noted that the cases showed:

- Record-keeping failures
- Failures to identify key concerns and assess risk
- Lack of clarity in decision-making
- Internal communication failures
- Poor communication with families.

### *Further action taken by the NMC*

- 5.8 The NMC also pointed to a number of areas where it considered that it had changed its structures in ways that would meet the concerns. These are:

- The High Profile Cases Unit
- The Employer Link Service and more flexible ways of working with Trusts
- The Risk and Intelligence Unit
- Improved support for witnesses
- The Public Support Service.

- 5.9 We looked at the High Profile Cases Unit, the Employer Link Service and the Risk and Intelligence Unit, and spoke to members of the NMC Fitness to Practise team.

### *High Profile Cases Unit*

- 5.10 The High Profile Cases Unit was established in 2014. It oversees the work on cases which fit particular criteria which make it likely that they will be complex or controversial. The aim appears to be to ensure that such cases receive the right level of handling and that appropriate briefing about them is provided to senior members of the NMC executive. The team seeks to provide strong case management and holds regular meetings to discuss progress on cases and the issues that arise. Some cases are run directly by the team. Others are run by other teams but in close liaison with the unit.
- 5.11 It is clear that the FGH cases would now fall within its remit because the criteria for cases suitable for the unit includes cases involving maternal or baby deaths. The team told us that they have significantly greater ownership of cases than was the case previously, that they are aware of the issues and liaise closely with case managers, internal and external lawyers over the investigation of the cases.
- 5.12 We noted that this team had been responsible for handling the latter stages of the Morecambe Bay cases. We saw an improvement, albeit with some significant limitations, in the handling of those cases in the later years. In particular, the cases against Midwives 7 and 11 showed improved analysis and record-keeping.

### *Employer Link Service*

- 5.13 The NMC established its Employer Link Service (ELS) in 2016, following a recommendation in the Francis Report. We were told that the ELS aims to establish relationships with employers so that employers can be more open with the NMC and better aware of when it needs to report incidents. The ELS meets regularly with other stakeholders, such as the CQC with the aim of establishing relationships to share information and intelligence and feeding this back within the NMC.
- 5.14 We were impressed by the ELS team which appeared to have a clear understanding of its purpose. We considered that there was potential for it to:
- Establish relationships with Trusts so that Trusts report concerns to the NMC, understand the work of the NMC and work with the NMC where there are concerns about registrants
  - Bring intelligence to the NMC if it becomes aware of concerns about culture or other issues within a Trust
  - Establish relationships and share intelligence with other stakeholders, such as the CQC.
- 5.15 We received positive views about the ELS from the Trust, though the representative of the CQC that we spoke to felt that there was scope for more

work at local level between the CQC and NMC<sup>89</sup>. We noted that the Service has a relatively small staff covering the United Kingdom.

### *Risk and Intelligence Unit*

- 5.16 In 2017, the Risk and Intelligence Unit (RIU) was added to the ELS. It exists to analyse information from fitness to practise cases and elsewhere to identify trends and risks and to relay these to the rest of the NMC. Like the ELS, we consider that it has the potential to be a source of information about trends and about individual areas of practice where risks may be emerging.

### *Individual members of staff*

- 5.17 We spoke to individuals in the NMC who had been involved as case managers and lawyers for the cases we looked at. They were unanimous that there has been a change in their roles, that their workload has been reduced and that they have greater ownership of cases. They spoke to a major culture change within the NMC and of being better supported and trained and with much greater access to guidance.
- 5.18 We were also pointed to examples of significantly more nuanced approaches to potential fitness to practise cases. We noted one where the NMC is clearly working closely with the relevant Trust to address and manage risks arising out of concerns about an individual midwife's fitness to practise. We found this encouraging.

### *The Public Support Service*

- 5.19 The NMC is in the process of establishing a Public Support Service (PSS) and has appointed a Head of that Service. It told us that the aim of that service is to:
- Improve the information available to the public about the fitness to practise process
  - Explain to complainants how the process works and deal with concerns that they may have
  - Identify good practice and provide advice to the Fitness to Practise directorate about improvements to the service provided to public complainants and
  - Support witnesses before panel hearings.

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<sup>89</sup> Interview with the team, October 2017.



## Lessons from this review

- 5.20 We now look at the lessons that we think can be learned from the review and consider how far they have been addressed by the NMC. Although these lessons are drawn from our examination of these particular cases, we have drafted the lessons widely because we think that they contain points for all regulators to bear in mind.
- 5.21 In what follows, we have attempted where possible to indicate where we consider that the NMC has already addressed the concerns and to set out areas which we think that it still needs to address. We are cautious in doing so because we only looked at a very small number of cases in the context of the NMC's overall caseload. Where relevant, we have drawn on learning from our own performance reviews to lend weight to our views.
- 5.22 We also stress that many of the initiatives that the NMC has adopted are relatively new. We have not had the opportunity to see them working in practice or to assess their effectiveness. We would raise two caveats about these. The first is that the initiatives have involved establishing new units and teams. This may well be appropriate, but there is a danger that those units may become isolated and not properly integrated into the organisation. It is essential that the good practice in the High Profile Cases Unit and the forthcoming Public Support Unit is replicated across the NMC so that their culture becomes the norm and that the work of the Employer Link Service and the Risk and Intelligence Unit continues to be communicated to and relevant to the work of the rest of the organisation. Secondly, many of the problems that we noted rely on the identification by individuals of issues of concern and taking appropriate action on those. The NMC needs to monitor the work of these teams as they develop.

## Record-keeping

*Accurate and complete record-keeping is essential to keep sight of the issues in a case and its development and to enable the organisation to maintain a full audit trail of actions.*

- 5.23 In our view, the NMC has taken significant steps which have, broadly, addressed the record-taking concerns. However, by its nature, record-keeping is only as good as the individuals keeping the records and we continued to see occasions where record-keeping could have been better right up to the conclusion of the cases. The NMC may wish to consider whether there are ways in which it can monitor or encourage staff further to maintain complete records of documents, conversations and decisions on the relevant files.

## Identification of the issues

*Those analysing and investigating complaints need to have the time, expertise and support, including access to clinical advice to enable them to identify the concerns properly and to follow them through.*

- 5.24 We found significant improvements in the investigation and analysis of complaints, particularly in respect of the later cases. There appears to be greater ownership of cases and the new teams established by the NMC, particularly the High Profile Cases team, have the potential to deal more consistently with cases and identify the wider issues.
- 5.25 Ultimately there will be no substitute for an intelligent analysis of a complaint by staff who have the time, skills and access to the right advice to ensure that the right concerns are identified and taken forward. This means that the NMC needs to ensure that staff:
- Have the right expertise
  - Are properly trained and supported
  - Have access to expert advice, particularly clinical advice
  - Are able to manage and criticise the work of external lawyers.
- 5.26 We conclude that the NMC has made significant steps to address the problems that we have identified. It may wish to consider whether:
- Its arrangements for obtaining clinical advice either internally or by its external lawyers in fact ensure that that such advice is obtained in the cases where it is needed
  - Further training or support needs to be given to ensure that staff looking at cases continue to be able to identify and investigate any wider concerns about registrants' practice where there is evidence to suggest that the concerns may go beyond a single case.

## Working with third party investigators

*Regulators should work closely with other investigators and regulators to ensure that, so far as possible, they are able to act to protect the public and unnecessary delays are not caused by other investigations.*

- 5.27 The NMC told us that, in 2011, it had no guidance on what approach should be taken when there were external investigations. Such guidance now exists. Its starting position is that, in all cases, the investigation should take place without delay. There must be clear and compelling reasons for an investigation to be put on hold and the case owner will need to record why doing so is considered to be in the public interest. Such reasons might include prejudice to the external

investigation, practicality and efficiency. The guidance makes clear that the NMC must liaise with the third party investigator and confirm their position in writing.<sup>90</sup>

- 5.28 The existence of this guidance is an important step. However, each case is different and the approach to be taken will vary with the individual facts. They will all require thoughtful analysis by properly supported staff who are familiar with the cases and the issues and who communicate clearly with the third party investigators. We have not seen further examples of cases where there have been third party investigations and so have not had the opportunity to see how they work in practice. In line with our view on analysing the issues, we think that the NMC is in a significantly better position to reach appropriate decisions than it was in 2012. The NMC may wish to ensure that it is satisfied that its staff are properly familiar with its guidance and that decisions are made at the appropriate level.

### Looking beyond the individual cases

*Regulators should ensure that their processes enable them to take account of all available and relevant information about cases and that intelligence is properly shared.*

- 5.29 The NMC has told us that the Employer Link Service and the Risk and Intelligence Unit are likely to provide considerably greater intelligence for the Fitness to Practise team. Those teams have access to wider intelligence and have the potential to inform the work of the Fitness to Practise team. The NMC has also made improvements to its ability to share information within the organisation.
- 5.30 We did not look closely at these new teams but we agree that, in principle, they should address many of the problems we saw. We refer to the caveats set out in paragraph 5.22 because it is essential that the units remain relevant to the work of the NMC and fully integrated in its organisation. As we have suggested in the previous lessons, their success will depend up on the staff making up these teams and in the leadership and guidance they receive. The overall approach appeared to us to be appropriate. The NMC may wish to monitor the work of these teams to ensure that they provide right level of information to the rest of the organisation.
- 5.31 The NMC may also wish to consider whether it is appropriate to examine lessons from fitness to practise cases to see whether they provide information which should lead to changes to its rules or where it or other bodies might issue guidance. We understand that learning from the FGH cases is being fed into its review of education standards for midwives and we found this encouraging.

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<sup>90</sup> NMC response to our questions.

## Working with others

*Regulators must work with others in the health and care system to address concerns about patient safety.*

- 5.32 Since 2011, the NMC has entered into Memorandums of Understanding with other regulators in the system. We also saw some strong examples of it working closely with Trusts and other regulators which suggest that this lesson has to a great extent been taken on board. We consider that the Employer Link Service has the potential to achieve strong relationships with key stakeholders including Trusts and the CQC, though we note the points raised by the CQC about there being greater scope for working together at local level. The ELS has a relatively small staff.
- 5.33 We therefore consider that the NMC has taken strong steps to address this lesson. It may wish to monitor the work of the ELS to satisfy itself that the service has sufficient resources to manage its work and is able to ensure that relations on the ground are strong enough.
- 5.34 In addition, there remains a concern about what the NMC's position should be if a Trust or other regulator is failing to recognise a problem and whether it has powers to protect the public adequately in those circumstances. The Government is currently considering reform to the regulatory system for health and care professionals. It and the NMC may wish to consider whether any further powers are needed which are proportionate and would better enable the NMC to address concerns about the practices of individual registrants.

## The treatment of the families

*Regulators must engage with patients and service users, ensure that they are informed of the process and progress, and analyse and take their evidence seriously if they are to properly identify problems and hold public confidence.*

- 5.35 The NMC recognised that its communications with the families were poor, sporadic and often confusing. It has made major improvements to its work in providing support to witnesses at hearings and it also began steps, before this review was announced, to establish the Public Support Service.
- 5.36 We saw some evidence of improvements in the regularity with which complainants were contacted after 2014. We also considered that the NMC provided considerable support for witnesses appearing in front of panels and we commend that. The Public Support Service has yet to be fully established and we are not in a position to judge how its work will affect that of the NMC.
- 5.37 Our review of the cases suggested significantly more serious concerns. The cases that we saw suggested to us that, culturally, the NMC does not recognise the value that patient and family evidence provides or that patients and families

have an interest in cases which, as a regulator, it needs to take seriously. It was not frank and open with them. There are some specific points it needs to consider.

### *Information for complainants*

- 5.38 The families we spoke to told us they knew little about the NMC's process. While the NMC's website provides information for those referring a complaint it did not appear to us to be tailored well towards patients who might not be familiar with the process. We understand that the new Public Support Service will be reviewing this information.

### *Sharing registrants' responses with complainants*

- 5.39 We produced policy advice to regulators in 2009<sup>91</sup> where we made it clear that, in our view, the benefits of sharing registrants' responses with complainants outweigh the risks.
- 5.40 The NMC told us that, following publication of the policy paper, it did adopt a process for sharing initial responses. Where it is aware of a registrant's position on the facts of the allegation, and a patient/family member is likely to be able to comment and/or provide evidence on a material point, it ensures that it obtains their evidence during its investigation process. It suggested that routinely sharing responses to complaints with the complainant could add delay. It mentioned that many registrants include their response to the local investigation and it may not be appropriate for the NMC to reveal this since its rules only permit it to disclose the response to the NMC. It told us that it followed its legislation which set out the times when it must inform complainants of particular findings or facts.<sup>92</sup>
- 5.41 We consider that, on the latter point, the NMC may be taking an unnecessarily restrictive view of its rules. The fact that the registrant has sent the response to the local investigation to the NMC suggests that it is part of the registrant's response to the NMC and so could be disclosed. We are also not convinced that addressing discrepancies when interviewing complainants later is sufficient. Complainants may not be able to identify all the clinical concerns that might exist, but they are in a good position to say what did and did not happen. A registrant may well provide an account which suggests that good practice was followed, but if that is shown to a complainant, the complainant's recollections may well suggest this was incorrect and this may indicate further clinical concerns. Early identification of such disputes might suggest further areas of investigation and would enable case examiners to be better informed. It will also provide complainants with greater confidence that they are being taken seriously and have a part in the system.

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<sup>91</sup> Professional Standards Authority (2009). *Handling complaints: sharing the registrant's response with the complainant*. Available at: [www.professionalstandards.org.uk/publications/detail/handling-complaints-sharing-the-registrant-s-response-with-the-complainant](http://www.professionalstandards.org.uk/publications/detail/handling-complaints-sharing-the-registrant-s-response-with-the-complainant) [Accessed: 14/05/2018].

<sup>92</sup> Interview with the Director of Fitness to Practise, January 2018.

### *Mr A*

- 5.42 We understand that the NMC accepts that setting Google Alerts on Mr A was taking its monitoring of him too far. It told us that guidance has been issued to its communications team. We recognise that representatives of the NMC, including the Chief Executive spent a significant amount of time in correspondence with Mr A and that apologies were given both for the delay and the experience that Mr A had while in front of the panel as a witness.
- 5.43 We think that it is important that the NMC should consider, from Mr A's point of view, how its actions have looked and whether it can work with him to gain further learning about providing support to complainants and, in the process, demonstrate that it has learned lessons.

### *The Public Support Service (PSS)*

- 5.44 The establishment of the PSS has the potential to be hugely positive and could be crucial in assisting the NMC to address the very serious concerns we have identified. In the light of our examination of these complaints we suggest that it ought to look at the following matters urgently:
- The information given to the public about the fitness to practise system
  - How the NMC ensures that it properly understands the concerns of patients and families and addresses them
  - Ensuring that people who have an interest in cases are kept in touch with key decisions and, where appropriate, consulted about them.
  - Communication of decisions to complainants – in particular, we think that there needs to be greater empathy shown to complainants who have lost loved ones and more accessible explanations of decisions reached at the various stages
  - Dealing honestly and openly with complainants.
- 5.45 The NMC has yet to demonstrate tangibly that it has properly addressed the need to deal appropriately with patients and families who complain. This is the key area where we consider that work needs to be done. The Public Support Service may provide it with the opportunity to achieve this, particularly if it addresses the points that we have raised above. We should stress, however, that it will be essential that this culture is properly embedded throughout the NMC as whole. The formation of the new service will be pointless if the approach taken by people dealing on a daily basis with patients, families and their complaints is not radically changed.



## Transparency

*Regulators should aim to publish as much as they legitimately can so that they can improve public confidence through transparency.*

- 5.46 The NMC said it wished to be a transparent organisation. We saw examples of it demonstrating transparency. It was frank to us about the mistakes that it made with the cases before 2014. The Chief Executive and then Director of Fitness to Practise waived their rights in providing their emails to Mr A unredacted. However, it was not frank about mistakes that arose in its handling of the complaints to either Mr A or Mr B. Its approach to the bulk of the Subject Access Request material and to the report from the senior barrister was, in our view, not transparent.
- 5.47 The NMC told us that taking a different approach to the SAR would have significantly added to the costs of an already expensive operation. It considered that it had complied with its legal obligations and did not appear to accept that any other approach would have been appropriate.
- 5.48 In our view, transparency involves being open about mistakes, demonstrating learning and can include providing information even where the organisation is not required to do so or where a more restrictive approach is permissible. The NMC's registrants owe a duty of candour and the approach that the NMC took to Mr A's chronology and to the SAR did not convince us that the NMC was applying that duty to itself.
- 5.49 We consider that the NMC needs to look critically at its approach to providing information to the public in a way which goes beyond its published guidance and which actively attempts to be as open as it legitimately can without damaging its own or other people's rights.

## Flaws in the fitness to practise system

*Regulators should work closely with employers and other stakeholders to deal with concerns which can be remedied without fitness to practise procedures and should avoid those processes where this can be done without compromising patient safety or the public interest.*

- 5.50 The NMC also told us that it felt that the system and legislation covering fitness to practise was not fit for purpose. It did not provide us with examples of how the system should be changed to improve it, though it has now made submissions about this in its response to the Government's consultation paper on the future of

regulation.<sup>93</sup> It has also launched a consultation on changes to its fitness to practise process<sup>94</sup> which we hope this review will inform.

5.51 We recognise the difficulties of this particular scenario where the employer was part of the problem and the CQC was not in position to take strong action. This has changed and protocols and Memorandums of Understanding are in place with the key stakeholders. However, our view is that, for the future, when concerns of this sort are raised, regulators should:

- Seek information from the employer about the registrant's practice generally and whether there are any other concerns which ought to be addressed
- Analyse the information from the employer critically and, if necessary, look directly at the other information available
- Consider with the employer whether it is possible to address those concerns by action at the local level without the need for regulatory procedures and, if so, monitor progress with the employer
- If there are concerns about the employer, involve the CQC at an early stage to address those concerns
- Only use the fitness to practise process where it is clear that the employer is not taking satisfactory action or the employer does not have the levers to do so or if there are concerns about deep-seated incompetence, behaviour or attitudes which call into question whether the registrant should remain in the profession.

5.52 We saw evidence that the NMC is beginning to approach cases in this way and we commend this. What will be crucial is for the NMC to do so in a way which keeps families and patients properly informed and maintains their confidence and which does not mean that serious cases are treated inadequately.

### Finally

5.53 The NMC has made major changes to its organisation and processes in the years covered by this review. As our performance reviews have recognised in recent years, its processes, structures and arrangements for record-keeping have improved significantly. Its support for witnesses before panels appeared to us to be strong. We consider that the changes, particularly in respect of the new teams that have been established, have the potential to reduce the risk of many of these concerns arising again. It is important that the NMC monitors and provides support for the work that it is undertaking in respect of:

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<sup>93</sup> The NMC response to the consultation was in their recent Council papers – [www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2018/council-papers-jan-2018.pdf](http://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2018/council-papers-jan-2018.pdf) Item 8, p.37 [Accessed: 14/05/2018].

<sup>94</sup> Nursing and Midwifery Council consultation on changes to fitness to practise function, *Ensuring patient safety, enabling professionalism*. [Online] Available at: <https://www.nmc.org.uk/about-us/consultations/current-consultations/ensuring-patient-safety-enabling-professionalism/> [Accessed: 24/04/2018].

- Ensuring that there is proper identification of issues by its staff and external lawyers and that action is taken where risks are identified
- Improving relationships with Trusts and other regulators
- Identifying intelligence and wider learning from cases.

5.54 However, in our view, the NMC needs to address very serious concerns about the way in which it deals with families and patients and whether it is a transparent, open organisation. It needs urgently to review and improve:

- Its engagement with patients and families who complain so that it engages with their evidence, provides appropriate information to them, keeps them informed and dealing openly with them
- Its approach to transparency about its errors and its approach to individuals.

5.55 Taking these actions forward will need energy and commitment and will require some cultural change within the organisation. These matters are serious and need to be addressed urgently if the NMC is to maintain public confidence in it as a regulator. The Authority will be monitoring and reporting on progress as part of its annual performance reviews of the NMC.

## Annex A: Chronology of the main events surrounding the NMC's handling of the FGH midwives' cases

Date	External events	NMC Work
2004	Death of Mrs D's baby. Midwife 11 involved in care.	
2005	Death of Mrs E and her baby. Concerns about Midwife 7's root cause analysis.	
2008	Deaths of Mrs B and her baby and the babies of Mr and Mrs A, Mrs F and Mrs G.  Independent investigation into the death of Mr and Mrs A's baby.	
2009	Inquests into deaths of Mrs B and her baby, Mrs F's baby and Mrs G's baby.  Jan-July: Root cause analysis and LSA report by midwife 7.  Aug: 'NMC shit' email sent.  Between 2009 and 2012, 7 further incidents subsequently investigated by Cumbria Police.	Feb: Complaint by Mr A. The NMC's first indication of concerns.  July: Complaints opened against Midwives 3, 4, 5, and 6.  Sept: Complaints referred to external solicitors.  Oct: Mr A raises concerns about the LSA report.
2010	March: Midwife 7 retires.  June: Inquest into the death of Mr and Mrs A's baby announced. LSA report reviewed by Midwife 8 at request of NMC.	May: Witness statement signed by Mr and Mrs A.  June: Work on Mr A's complaint placed on hold.  July: NMC midwifery team identify concerns in Midwife 8's report.

Date	External events	NMC Work
	Nov: Mr A seeks more information about the 'NMC shit' email.	Nov: Mr A identifies discrepancies in midwives' accounts.  Inadequacies in LSA report identified by Trust, NMC and Mr and Mrs A.
2011	June: Inquest into the death of Mr and Mrs A's baby.  July: Cumbria Police investigation commences.	Jan: Mr A complains to NMC about the 'NMC shit' email.  June: NMC considers inquest findings.  July: NMC notes concerns about culture at FGH.  Sept: Investigations put on hold because of police investigation.
2012		April: Cumbria Police provide a list of cases that concern them. Mr A provides further information about possible collusion.  May: Case opened in respect of 'NMC shit' email.  June: Cases opened in respect of alleged collusion at the inquest and either closed immediately or put on hold.  Nov: Cumbria police refer cases of Mrs B and her baby to NMC.  Dec: NMC Investigating Committee closes 'NMC shit' email cases in respect of the data breach and offensive title.
2013		Jan: Mr B's case in respect of Midwife 9 referred to external lawyers.

Date	External events	NMC Work
	<p>April: Police decide to take no action in respect of allegations of collusion.</p> <p>Sept: Kirkup Investigation established.</p> <p>Dec: Police investigation concluded.</p> <p>Ombudsman publishes reports in respect of Mr B's concerns.</p>	<p>July: No case to answer for Midwife 9 in respect of Mr B's case.</p> <p>Aug: Mr B complains about Midwife 9.</p> <p>Oct: Mr B's complaint closed. Complaints opened in respect of Midwife 11 following media report.</p> <p>Dec: Trust refers Midwife 11 to NMC in respect of other incidents.</p>
2014	<p>Feb-April: Ombudsman publishes further reports in respect of Mr A's concerns.</p>	<p>Jan: Interim order obtained against Midwife 11.</p> <p>Jan-April: NMC reviews all FGH cases and reopens some cases which had been closed, including those of Mr B.</p> <p>Investigations into Mr A's complaints resume.</p> <p>April: Complaints opened in respect of Midwives 1 and 2.</p> <p>Oct: Further case opened in respect of Midwife 7.</p> <p>Nov: Investigating Committee takes no action in respect of allegations of collusion but refers Midwives 1, 2, 3, 4 and 6 to the CCC.</p>
2015	<p>March: The Report of the Morecambe Bay Investigation published ('the Kirkup report')</p>	<p>April: NMC consults Kirkup team about its concerns about individual registrants.</p>



Date	External events	NMC Work
		<p>May: Midwife 11 struck off the register.</p> <p>July: Pre-meeting of CCC in respect of Midwives 1, 2, 3, 4 and 6 adjourned.</p> <p>Oct: Resumed meeting of CCC to deal with defence concerns and case management.</p>
2016	<p>March: Death of Mrs C's baby.</p> <p>April: Midwife 4 suspended by the Trust.</p>	<p>Feb: New statements taken from Mr and Mrs A in respect of Midwives 1 and 2.</p> <p>March-April: CCC hearings in respect of Midwives 1 and 2. No case to answer and no misconduct found.</p> <p>May-June: CCC hearing in respect of Midwives 3 and 4.</p> <p>June: Interim order in respect of Midwife 4 following death of Mrs C's baby.</p> <p>Sep: Midwife 3 suspended.</p> <p>Oct: Midwife 4 struck off.</p> <p>Dec: Case Examiners refer Midwife 7 to the CCC.</p>
2017	<p>Coroner announces inquest into death of Mrs C's baby.</p>	<p>Jan: No case to answer found in respect of Midwife 6.</p> <p>May: Midwife 3's case reviewed: no longer impaired and suspension lapses.</p> <p>June: Midwife 7 struck off the register.</p>

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