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Midwifery lecturer Sarah Davies reports on the NMC's case against Deborah Purdue

Deborah Purdue: Independent Midwife with 25 years experience - struck off the register by the Nursing and Midwifery Council.

'She is an experienced midwife with good knowledge, skills and competence. She has a totally unblemished record' - the words of the Local Supervising Authority Midwifery Officer (LSAMO) in her report at the conclusion of a supervisory investigation (March 2006) of Deborah Purdue's practice following one birth in July 2005 where the baby, having been born in hospital under medical care, died shortly after birth.

The supervisory report was sent to the Nursing and Midwifery Council (NMC) in May 2006. Debs was not suspended from practice, and continued to work as a midwife, both in hospital and independently, for the next three and 3/4 years. On 20th March 2009, following a Fitness to Practice hearing, the NMC issued a striking off order - to protect the public.

Midwifery supervision

Supervision is required by British law, and its purpose is 'to protect women and babies by actively promoting a safe standard of midwifery practice.'1 Every midwife has a Supervisor of Midwives (SoM) with whom she has an annual review, where her practice is reviewed and any educational needs identified. Supervision of midwives has a very important role to play when there is an adverse outcome; investigating and putting safeguards in place if poor practice is identified; encouraging the midwife to reflect on her care and learn from the experience; supporting the midwife so that she can continue to practice safely and competently, and often, supporting the bereaved parents.

Local supervisory processes in Deborah Purdue's case

Six days after the death of the baby, on 25th July 2005, Debs and the second midwife, her independent midwife partner, were invited to a meeting. This subsequently proved to be, rather than the supportive debriefing meeting that the midwives expected, the first step of evidence-collecting in a supervisory investigation. The NMC2 (page 5) states 'midwives under investigation [...] should be informed about the supervisory investigation before it commences.' Debs' own SoM wrote a formal complaint on 2nd September pointing out that the process so far had breached the provisions outlined in the Standards and Guidance for Supervisors of Midwives. Her complaint was upheld by the LSAMO, who wrote on 22nd

September :

'As you are already aware I share your concerns (...) I will go through the issues with both supervisors - it has certainly made me think about providing specific training around investigation for super visors in the future.'

The initial meeting having been discounted, a new investigation was instigated, led by a different SoM, who wrote a report on 6th October 2005. There followed three months of emails between Debs and the LSAMO, followed by a meeting on 5th January 2006 to gather further evidence regarding Debs and her par tner IM's career history, cases attended and to review previous case notes.

Referral to the NMC

On the 20 March 2006, nine months after the death of the baby, Debs had a meeting with the LSAMO. She was told the LSA investigation was now complete, and that she was being referred to the NMC. In her report to the NMC (sent over two months later) the LSAMO says that she had 'been advised' to refer the case to the NMC. There is no indication in the letter as to the source of the 'advice'. In the letter to Debs informing her of her referral, there are sections of the Midwives Rules[3] quoted under the heading 'Breach of Midwives Rules and Standards' but no specific allegations. The letter concludes with the statement that the LSAMO does not intend to suspend Debs from practice.

The LSAMO's decision not to suspend Debs at this point indicates that she did not feel that Debs constituted a danger to the public. There had been one adverse outcome in 25 years and in the words of the same LSAMO in the same report to the NMC: 'She is an experienced midwife with good knowledge, skills and competence. She has a totally unblemished record.'

Referral to the NMC is a serious event, usually related to continuing lack of competence despite supervised practice, where 'over a prolonged period of time a registrant makes continuing errors or demonstrates poor practice'[3] or because of 'serious professional misconduct.' The NMC[2] (page 3) cites the most common examples as:

- Physical or verbal abuse
- Theft
- Deliberate failure to deliver adequate care
- Deliberate failure to keep proper records

There was no such issues in Deb's pratice

LSA Guidance, South of England[4] on page 5, section 5 states: 'The NMC will not normally become involved in a case if it is not demonstrated that considerable measures have already been taken to tackle the situation at a workplace level (...) the NMC's role is to protect the public from registrants whose fitness to practice and whose situation cannot be managed locally. (...) Reporting a case of unfitness to practice to the NMC is appropriate to the extent that public protection may be compromised.'

The question must be asked: why was a midwife with an 'unblemished record', and no period of

supervised practice, referred to the NMC by the LSAMO in the first place?

Different treatment for independent midwives?

The LSAMO's report continues: 'the situation has been made more complex by the fact that the midwives are independent practitioners. I have grappled with the realisation that if the practitioners were employed within a Trust then they may have been advised to undergo supported or supervised practice and/or disciplinary action.' The same report, however, recommends that the second midwife in the case, also an independent midwife, 'is placed on a formal programme of supervised practice in accordance with the LSA guidance.'

The report adds: 'It seems particularly harsh that as a tier of punitive/remedial action is missing (by the very fact that they (sic) are independent) that they (sic) now face referral to the regulatory body.' (The second midwife organised her own supervised practice and completed it with assistance from the Trust nearest to her home).

The NMC Fitness to Practice process: inefficient and unaccountable

On the 30th May 2006, Debs' case was referred to the NMC. On 24th October 2006, almost five months later, the first investigating committee (IC) met. There were four further ICs held and the NMC heard the case on 3rd to 7th November 2008. Evidence from the initial, discounted meeting was requested - this would be inadmissible in a court of law and so was successfully challenged. Proceedings were subsequently adjourned until March 16th 2009. The panel decided against passing an interim suspension order, justifying its decision with the words : 'Amongst the factors we bear in mind are (1) the amount of time that has elapsed since the allegation and (2) the fact that there is a degree of supervision in place to protect the public.' Therefore the Council decided in October 2008 that Debs could continue to practice and was not, by implication, a danger to the public. She had been practising as a midwife for the whole course of the investigation, since July 2005, and continued to do so until March 2009, when the Conduct and Competence Committee (CCC) reached its final decision.

The CCC first considered various sanctions:

1. No action: decided against, as 'facts too serious'
2. Caution: decided against, as 'facts too serious'
3. Conditions of practice order : decided against, as 'the panel was satisfied that there was no practical method of implementing the sanction' due to the fact that she was self employed; however, a 'conditions of practice order' had been applied in three earlier cases involving independent midwives.
4. Suspension order : decided against, as 'misconduct was so serious that it was not appropriate or in the public interest to do so.' Therefore Debs was struck off the register.

Serious misconduct?

Deborah was found guilty of:

1. Failure to carry out proper fetal heart (FH) rate auscultation
2. Failure to conduct an early vaginal examination
3. Allowing 'Patient A' to get into the birthing pool after there had been several readings of the fetal heart rate outside normal parameters.

The CCC panel consisted of: two lay people, a barrister and a retired hospital administrator with no knowledge of midwifery (court transcripts). The other was a midwife, with nine years experience; a labour ward manager in a consultant obstetric unit. Because he was the only panel member with midwifery experience, his opinions went unchallenged. If the NMC hearing had been a court of law, expert witnesses would have pointed out:

In relation to finding 1) The NICE guidelines5 (the panel's standard for 'proper' FH monitoring) are guidelines not rules. The NICE guideline on timing of auscultation of the FH is not evidence based. There was confusion during the hearing because the guidelines were changed between the incident and the hearing.

In relation to finding 2) Many expert midwives would not conduct an early VE when the labour appeared to be normal. There are other less intrusive ways to assess labour, including maternal observation and abdominal palpation.

In relation to finding 3) 'Allowing 'Patient A' to get into the pool': the language used gives some indication of the mindset of the panel

In conclusion

- The only midwife on the panel came from a hospital background: his perspective is not shared by midwives who have extensive experience of out-of-hospital birth.
- The panel were indeed in a position to impose conditions of practice if they had judged this necessary.
- Debs practised safely for nearly four years during this process. Both the LSAMO and the NMC judged that she was not a danger to the public during this time.

This sad case brings into question the constitution of the NMC and its competence to protect the public. Moreover, the lengthy and inefficient process which culminated in the striking off order, and the consequent stress and suffering inevitably endured by the practitioner, cannot be ethically defensible.

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