AIMS For a better birth...

Clare Fisher - the Welsh witch-hunt

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AIMS Chair Beverley Beech reports

Clare Fisher qualified as a midwife in October 1993 and in 1994 came to work in Carmarthen. Following the arrival of Gillian Harris (Head of Midwifery) at Carmarthenshire NHS Trust Clare was subject to a series of investigations, comments and general bullying. In 1998 she made a formal complaint. Other midwives questioned the wisdom of this.

Six weeks later Clare found herself 'suspended from duty'. She did not return to the Trust for 22 months. In that time the midwives she worked with were informed that they should not contact her. Her Named Supervisor of Midwives neither contacted her nor offered any support during this period. When Clare was finally reinstated the Trust offered no reason for her suspension - and UNISON insisted that her fellow staff be informed that there had been no disciplinary procedures involved despite this enforced and prolonged absence.

In 2003 an NHS client, who was 35 weeks pregnant and had yet to write her birth plan, alleged that 'she feared' that Clare would not accept her wish for a hospital birth and believed that this had happened to other women. There followed a supervisory investigation to look at the home births under taken by two midwifery teams. In reality it was a trawl through Clare's case notes (25 of the 30 notes examined were Clare's). The women who supported Clare were never interviewed, despite writing to say they wanted to be involved with the investigation. No evidence was produced supporting the allegation or that any other women had similar experiences, but despite this the investigation concluded that there was 'gross misconduct and gross negligence and that Clare should not be allowed to work within the community or in isolation.'

A disciplinary hearing was to be held on the 17th April 2004, however Clare was off sick with stress and she notified the Trust that she could not attend and, furthermore, was still awaiting the documentation.

Carole Bell (Acting Head of Midwifery) forwarded the 'investigation file' to Gillian Harris who was on secondment to Health Professions Wales (HPW) who then forwarded it to Jean Keats (also at HPW) who had also been appointed to sit on the Trust's Disciplinary Hearing. The conflict of interest in these two roles does not seem to have occurred to Jean Keats - who suggested to the LSA that if Clare did not attend the disciplinary hearing she should be suspended from practice and reported to the Nursing and Midwifery Council (NMC), clearly having made a decision well ahead of the hearing.

Around this time Clare was told by her Union that the Trust intended to sack her and if they did so she

would lose her pension rights and was advised to resign and the Trust would pay her in lieu of notice. The Trust assured her that this would then be the end of the matter. Clare formally resigned on 29th April 2004. She intended setting up as a midwife in independent practice - but before she could do so she received a letter from Dr Robyn Phillips (HPW) (May 7th 2004) stating that she was suspended from practice with immediate affect, and that her practice had been referred to the NMC.

On the 6th July 2004 the NMC held an Extraordinary Meeting of the Preliminary Proceedings Committee. The Committee concluded that 'it was not necessary to direct the interim suspension of your practice' and wrote to Clare informing her of this two days later. She was also told that the Committee would notify the LSA and understood that her suspension would be lifted. On the 12th July Robyn Phillips, despite being told by Clare that the suspension was lifted, wrote to her stating that the suspension was still in force (as she had not, allegedly, heard from the NMC). It was not until the 26th July that Robyn Phillips informed Clare that her suspension was lifted. Shortly afterward Clare miscarried her 6th baby, after five healthy pregnancies, an event which she believes was caused by the stress.

Around this time Carmarthenshire NHS Trust midwives were accepting an award from Princess Anne for 'promoting normality' in Wales. Clare who had attended more home births than any other midwife in the area was not invited and only found out about it afterwards.

After repeated requests for a meeting, and a threat to go to the press, on the 10th August 2004 Clare and her partner met with HPW. She wanted a full and frank discussion of why she had been referred to the NMC and why they failed to lift her suspension appropriately. Clare presented a list of questions but they were not answered. Instead HPW claimed that this meeting was 'to provide supportive supervised practice and ongoing contact with a named supervisor of midwives.' Following this meeting Dr Phillips immediately began taking steps to replace Chris Withey, who was Clare's Named Supervisor of Midwives and with whom she had a good relationship, with Jean Keats - the supervisor who had only recently recommended to the LSA Clare's referral and suspension.

Chris Withey eventually withdrew as Clare's Named Supervisor - 'on advice received from HPW'. Dr Phillips then attempted to impose Supervised Practice on Clare - but was told by the NMC that she was not empowered to do so. Instead - and with her appointment as LSA MO made public in the October NMC magazine - Jean Keats was appointed as Clare's Named Supervisor of Midwives, yet another conflict of interest. Dr Phillips failed to acknowledge that the Named SoM she was appointing had been so directly involved in the previous referral - and Mrs Keats has since stated that she was simply unaware that the midwife to whom she was now Named Supervisor was the same midwife that she had only recently recommended for suspension from practice and referred to the NMC.

Libellous notes

Clare had been concerned that the hand of Gillian Harris was behind these referrals despite HPW's denial. Her suspicions were confirmed when she received copies of the documents that had been forwarded to the NMC. They contained a libellous and dishonest handwritten note stating that 'She

[Clare] had attend [sic] and signed the attendance form, lied to the investigating officer'. Clare recognised the distinctive handwriting as Gillian Harris's. This note only came to light the day before the hearing so Clare asked the NMC for copies of all the papers relating to her case as the copies forwarded to her by HPW and the copy held in their archives did not contain the note. Clare wrote to Dr Phillips asking her to investigate the author of the statement which she failed to do, so Clare wrote directly to Gillian Harris asking her to confirm her authorship. Despite a draft copy letter that is held in HPW archive denying her involvement, Gillian Harris did eventually write to confirm that she had added the hand written comment. There was no apology - instead she accused Clare of failing to draw attention to the matter at an earlier stage.

Planning ahead?

The NMC declined to proceed with the case against Clare but on the 7th September Robyn Phillips wrote to the NMC case officer asking her to confirm that 'all aspects of Ms Fisher's practice were considered in total when reaching a decision to decline to proceed' and asking for a copy of the specific advice given by the NMC to Clare

On 17th December 2004 Robyn Phillips telephoned the NMC to ask if the transcripts of the Interim Suspension Hearing and the Investigations Committee Hearing had been destroyed and if not, asked them to ensure that they were kept because HPW 'may have occasion to request them.'

VBAC at home

In June 2005 Clare under took the care of Jenny Traves, a woman expecting her second baby after a previous caesarean. She went into spontaneous labour and after two hours the baby's heartbeat dropped significantly, with further decelerations. Clare did a vaginal examination and recommended immediate transfer by ambulance, she informed the hospital that she was bringing in a woman with a VBAC labour with fetal bradycardia. The crash team was not awaiting her arrival and instead, after receiving a verbal handover from Clare, Jenny Traves was taken into a side ward to be assessed. The midwives failed to pick up the fetal heartbeat with an abdominal transducer so they broke the waters, which were clear (indicating perhaps that the baby was OK), attached a fetal scalp electrode which recorded the baby's heartbeat for 15 minutes. 20 minutes after admission a doctor arrived, took off the scalp electrode, used a scanning machine and declared that he could not find a heartbeat and ordered a crash caesarean. The baby was stillborn. Jenny shared her story in AIMS Journal Vol: 21 No:1 page 22.

The following morning Jean Keats phoned Clare to inform her that she was conducting an investigation and required the case notes. Clare, meanwhile, was primarily concerned about the health of her client and her client's par tner - and attended the hospital every day to support them. During the transfer to hospital Clare had left the case notes in the woman's home - but had provided hospital staff with a full verbal handover. The family returned home - asking for time to grieve. After the funeral Clare collected the case notes and forwarded them to Jean Keats - and these were received by her on June 30th 2009.

HPW had insisted that Jean Keats be appointed as Clare's supervisor, despite Clare's objections, and the principles of supervision require that a named supervisor of midwives should not investigate the practice of 'her' midwife. Nonetheless, Jean Keats was undertaking the investigation. Once more she failed to recognise the conflict of interest - and indeed she also failed to provide Clare with alternative supervisory support until after the conclusion of her investigation, some three months later.

Yet again, Clare was referred to the NMC and the first interim hearing of the NMC was held in January 2006 and adjourned. The next hearing was held in Cardiff in March 2006 and Clare was accused of failing:

1. to provide evidence of continuing professional development.
2. to send a completed set of midwifery records to Jean Keats
3. to keep a contemporaneous record of Jenny Traves' labour
4. to provide hospital staff with Jenny Traves' records
5. to send Jenny Traves' record to Jean Keats.

There were nine further hearings, over 19 days, the last on 1st May 2008. Despite the conflicting evidence, Jean Keats contradictory responses and corroboration of Clare's statements by Jenny Traves, Clare was found guilty of charges 2 and 4 and given a five year caution.

The hearing was a travesty of justice with a panel that was clearly biased against the midwife. In the last two hearings Eunice Foster (due regard midwife) repeatedly fell asleep but the hearing continued despite this matter being raised with the legal assessor who took no action. Clare alerted the Chief Executive's office at the NMC and they took no action either. Jenny Traves, herself a registered nurse, spoke very fluently and effectively in the hearings, her testimonial, however, was disregarded and she was accused of speaking out because of her alleged friendship with Clare, despite having had no contact for a year after the funeral of her baby and only becoming aware of the disciplinary case from reading newspapers.

Val Beale, (Local Super vising Authority Midwifery Officer (LSAMO) South West) the NMC witness presented herself as an expert at home births and skilled at examining case notes; but cross examination by Clare's barrister, Barbara Hewson, revealed that she had little, experience of home birth and was no expert in handwriting analysis. It was Val Beale who contended that Clare may have written the case notes, 'but not these' because they were too comprehensive and too neat, implying that the delay in handing them over was because they were being re-written - despite the mother confirming that she watched Clare write them up. The panel could easily have resolved this by asking Clare to produce three other case files for comparison the next day, they failed to do so.

Following the conclusion of Clare's case Professor Paul Lewis wrote to the NMC expressing his concern about the proceedings:

1. The unsympathetic nature of the panel's approach to Jenny Traves and her partner and the assumption that she was in some way in cahoots with Clare.
2. That the Council's solicitor took a view that was at odds with the advice and information given by

the NMC around 'the ownership of records', what a Supervisor of Midwives could ask for and the audit of the PREP standard.

3. That the panel lack the degree of impartiality necessary for the hearing to be judged as fair
4. That the final charges were more about a breakdown in the relationship between Clare and Jean Keats and he seriously questioned Jean Keats' objectivity and ability to continue as an LSAMO.
5. That the panel member who fell asleep (Eunice Foster) and the Chair of the panel (Betty Rush), should be suspended from any further hearings until a review of this case has been carried out by the NMC.

As far as we know there has been no response to this letter from the NMC.

This is a damning indictment of the proceedings by a Professor who is Chair of the NMC's Strategic Conduct and Competence Committee. At the outset of the interim proceedings Professor Lewis had hoped to give evidence on behalf of Clare but the NMC file notes show that they strenuously objected to this on the grounds of the potential adverse publicity that may arise. Instead Professor Mavis Kirkham appeared as a defence witness on behalf of Clare. The NMC did not provide any expert witness independent of HPW's investigation/process.

Complaint to the Ombudsman

On 25th October 2006 Clare made a complaint to the Ombudsman about HPW and their maladministration.

The Ombudsman's report is damning. He found that: 'The investigation undertaken by Jean Keats was not an appropriate investigation for the purposes of NMC Rule 5 and concluded that 'I have identified serious flaws in the investigation and the process conducted by HPW and these flaws amount to maladministration. It is evident that this has caused injustice to Ms F in that she was not given the opportunity to comment on the investigation into her fitness to practise, and explanation put forward on her behalf by way of mitigation was ignored, she was denied any avenue of support during the investigation and at the conclusion of the process she was not notified of her right to appeal the suspension. These failures undoubtedly aggravated what was an already stressful situation. Therefore I uphold her complaint.'

The Ombudsman recommended that Clare receive £5,000 compensation for HIW's maladministration. It is a pittance in view of the number of years she has been victimised and the length of time she spent on suspension without any remuneration. The NMC panel refused to adjourn an additional few days pending the publication of the Ombudsman's report - despite having already taken over two years to deal with these proceedings.

Post-partum haemorrhage

In August 2008 Clare was contacted by Jane Hood. She was 39 weeks pregnant and was very anxious about the forthcoming birth because of the bullying tactics employed by the NHS staff. She determined

to find an independent midwife, or give birth on her own.

Clare agreed to care for her and on the 4th September 2008 arrived at Jane's home after being told that Jane was in early labour. Jane had a spontaneous delivery of a baby boy in a pool at home but two hours after the birth she lost around 250mls of blood. An hour later she had a further loss and Clare advised that she transfer to hospital, she refused. Clare spoke with a colleague about using syntometrine (because of the risk associated with raised blood pressure which Jane had normally, but it was fine during the labour) and after discussion administered it. Jane repeatedly refused to move to hospital. At 13.30 Clare spoke with a supervisor of midwives whose only advice was that she should bring Jane into hospital (expecting her to bully Jane into agreeing). Finally, Jane agreed to go in. Clare had her records with her when she gave a full verbal handover to the staff - and she did not see NHS staff making their own records at this point. Jane was then under the care of the hospital staff and Clare had no further input into her care. Their management of Jane was poor, she had a further bleed, and they failed to monitor her properly. There is no evidence that this was investigated.

Two days later Clare received a letter stating that there would be 'an overview' of Jane's emergency admission to Singleton Hospital. Clare repeatedly asked for clarification of precisely what the concerns were but, yet again, she did not receive a reply until the case was referred to the LSAMO - Gillian Harris.

Clare complained to the LSA about Sian Passeys review and the subsequent investigation carried out by Gwyneth Singh (a supervisor of midwives at the Trust). Her complaint was lodged with Gillian Harris on April 2nd 2009 - it has still not been resolved. But when Clare met with Joy Kirby (who was investigating her complaint) on October 7th 2009 and asked whether Sian Passey's review had been on behalf of the hospital or the LSA Joy Kirby - some ten months after the incident that was being investigated - was unable to provide clarification.

Jane Hood had written an open letter stating that she was 'astonished that [the case] is being reviewed without asking me anything about what occurred. She was never interviewed and despite her reminder in this letter that she 'requested a copy of my notes in writing on October 1st 2008, and on two further occasions, but have still received nothing.' [Note: Her initial request resulted in a demand for £35 for the notes, which the Trust cashed in November, but it took a letter to the Information Commissioner before the notes were sent, in February.

In December 2008 Peter Higson, Robyn Phillips, Gillian Harris and Jean Keats met to discuss the 'Supervisory Review' In the space of three months the 'overview' had become a 'Supervisory Review which Clare still had not had an opportunity to consider and comment upon. They decided that 'advice would be sought from the NMC and a supervisory investigation would be under taken in the time factor suggested by the NMC.'

Later that month Professor Paul Lewis sent an email to Gwyneth Singh expressing his concern at Healthcare Inspectorate Wales' (HIW) (formerly Health Professions Wales) continued failure properly to follow procedures and engage with Clare stating: 'I would urge that caution is given to ensure that due

process is properly followed.'

On the 29th December 2008 Gillian Harris made a file note of a telephone conversation with Christina McKenzie at the NMC in which she gave the erroneous impression that Clare was not engaging with the supervisory process at all. But Christina wrote in an email to Clare that following discussions with the LSA it was her understanding that there was no LSA investigation underway - yet Gwyneth Singh had been appointed to conduct precisely such a supervisory investigation some eighteen days earlier.

On the 23rd January 2009 Clare finally received a copy of the 'Overview of Care' and noted that she was the only individual named in the whole document, everyone else was referred to by initials.

On the 30th January 2009 Clare met with Gwyneth Singh. She had received the original copy of the 'Overview of Care' - and acknowledged that this was the basis of her investigation, and Maggie Davies (a consultant midwife and super visor at the same Trust provided Mrs Singh with support). Clare was supported by Professor Paul Lewis, Kay Cotter (her named supervisor of midwives) and Simon Dunn from UNISON. At the meeting Clare was given a copy of Jane Hood's notes to peruse. Clare had been asking for a copy since before Christmas and Jane had been asking for her notes since October 2008 and was still awaiting a copy. Clare still does not have a copy of the notes, despite Jane Hood giving written permission for Clare to have a copy.

During the meeting Clare outlined her actions during the birth, justified her clinical decisions and provided Gwyneth Singh with the relevant documentation.

The report should have been completed within 20 days of the incident. It took over three months, more than six months after the clinical incident that was being 'investigated'. Clare was contacted in writing on 11th December, the other midwives involved were not asked to attend an interview until February - and yet Gwyneth Singh had initially informed Clare that her report must be forwarded by early January, in line with NMC requirements. Jane Hood had written a supportive letter about Clare but she was not interviewed.

On the 23rd March 2009 Gwyneth Singh produced her report and two days later Clare received a letter from Gillian Harris stating that in view of the fact that Clare had a five year caution against her registration she was referring her to the NMC. The NMC then compiled a list of 20 allegations, all of which are hotly disputed.

On the 8th July 2009 an Interim Hearing Panel met to consider whether Clare should be suspended from practice or impose a Conditions of Practice Order. They decided that neither action was appropriate. On the same day there was an Investigations Panel hearing which decided that the case needs 'further solicitors' investigation.'

On the 2nd April 2009, within the ten day deadline for appeal, Clare wrote to the LSA making a complaint about Gwyneth Singh's investigation. On the 23rd April Clare received a letter stating that Joy Kirby (LSA Midwifery Officer, East of England) had been appointed to investigate her complaints, the results of

this investigation are eagerly awaited.

Since then Clare has attended a woman at home and was meant to be supervised. She made repeated phone calls to her supervisor informing her that the woman was in labour but the supervisor did not respond to the calls until the following day, after the woman had successfully given birth. Clare is now being blamed for attended a birth without supervision and yet another investigation has been instigated.

In 15 years as a midwife in Wales Clare has been prevented from working for approximately 4 of those years. In that time there have been nine investigations (three referrals to the NMC, two referrals to the NHS fraud squad, and a recommendation of Supervised Practice (presently under appeal)). The sum total of findings against her are that she did not send her Named Supervisor of Midwives, Jean Keats, a set of client notes (despite offering in writing to meet with her to do so - in a letter that Jean Keats forgot that she received until it was subsequently found archived at HIW); that Clare did not send her patient records for 16 days after a request (despite the fact that they were at the client's house, that the client had post operative complications, and that Clare waited until after the funeral to return them.)

Ironically, the manager, Gillian Harris, whom she reported for bullying and harassment at Carmarthenshire NHS Trust in 1998 subsequently became LSA MO at HPW - at which point Clare's problems at LSA level began. Over that period Clare had no problems when working within the NHS midwifery sector in London, or the nursing sector in general.