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PSA's Lessons Learned Review: The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practice at the Furness General Hospital

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In May 2018 the Profesional Standards Agency (PSA) published a Review which highlights the lessons learned about the Nursing and Midwifery Council's (NMC) handling of investigations into the clinical c ompetence and integrity of the Midwifery Unit at Furness General Hospital (FGH) following concerns raised by, amongst others, the parents, the Cumbria police and the Kirkup Report (The Report of the Morecambe Bay Investigation chaired by Dr Bill Kirkup, CBE, published in March 2015). This Review makes a harrowing read. It is about 16 babies and 3 mothers who died. It highlights a catastrophic sequence of events where, effectively, no-one took responsibility to investigate concerns and to stop bad practice. It is quite clear that poor clinical practice had been witnessed where babies and women died who need not have died, and that some of the deaths occurred after it was discovered that there was a problem in this unit, including in the years after the Kirkup Report was published.

This Review concentrates on the NMC's *"approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency."* The Review is long and detailed and describes a time line from 2004 to 2017. I recommend that it is read in its entirety to understand the full failure of all the systems and organisations involved; you may find that you form a different view from that of the many press reports which have been made about various aspects of the many failures.

Section 2 of the Review describes the factual background, and how and when concerns were raised at the FGH. It describes the investigations and the inquests, and the involvement of the NMC and Care Quality Commission (CQC). Cumbria Police investigated clinical concerns which they passed to the NMC and the Ombudsman published reports of investigations, forwarding them to the Strategic Health Authority. The NMC received its first complaint about midwives at the hospital in 2009 and yet it did not complete the process of evaluating these complaints until *July 2017*, when the Conduct and Competence Committee heard the last of them - 64 in total. The time line in the Appendix of the Review makes for excruciating reading.

This section also describes the Local Supervisory System and the reasons for its subsequent abolishment in 2017, as well as changes to the NMC's Fitness to Practice system.

Section 3 details the babies and mothers who died and the consequences for the families. The names of the families and the midwives are not released, although they have been in the public domain many times. There is much shocking information about the deaths, the terrible experiences the parents have endured (including not being believed or having had their own evidence not being accepted in the investigations), the useless investigations, the disrespectful midwives and above all the failure of the NMC to ensure the Fitness to Practice of midwives. The midwives, too, were subjected to intense and unnecessary pressure over many years as the NMC failed in their responsibilities to undertake a timely and fair investigation. What was not made clear in most of the media reports was how widespread the failures were. Failures were by no means isolated to the midwifery department - the obstetric team and indeed the Trust management all bear responsibility for these unnecessary deaths.

In 2012, a Freedom of Information Act question about the Midwifery Unit at FGH disclosed that 19 claims had been notified to the NMC in respect of events from 1 January 2009 onwards and that there had been a sharp rise in claims in respect of untoward incidents after 1 January 2007. And yet 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 by the midwives was undertaken by the NMC. Nine supervisory reports were considered by an expert. The investigation took such a long time not least because of difficulties obtaining information from the Trust and the NMC. These included supervisory reports carried out by a midwife in respect of four families. The midwife subsequently admitted her mistakes and agreed that she ought to be struck off. This case was completed eight years after a parent first raised concerns about the adequacy of the midwife's investigations and *five years after the midwife had retired.*

Section 4 of the Review focuses on the NMC's *"approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency"*, and what can be learned.

The Review has a series of comments and criticisms about what they found at the NMC but one of the most significant is the one highlighting its lack of clinical knowledge. This is even more profound given that the NMC argued the point with the investigators, maintaining that they didn't need midwifery clinical advisors. The Review finds that there was a lack of understanding of what the cases were about and why the issues had been raised. This was combined with poor record keeping and communication by the NMC to create a situation which led to disaster.

The Trust's Head of Midwifery (in Morecambe) told the investigation

: *"I was dealing with screening people, or investigating managers, or fitness to practice 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."*

The Review also finds that the NMC did not engage properly with the families affected by the events, either in asking them for information, keeping them informed or indeed addressing their concerns. Rather than looking beyond the individual cases, it was found that too much emphasis was put on trying to win the case rather than look at the wider public protection concerns.

The NMC was not the only organisation to blame; the immediate problems of a dysfunctional unit and questionable clinical competency should have been dealt with by the Trust. The CQC must also shoulder some of the blame – it gave the Trust a glowing report, even though problems had arisen at that time, so f urther deaths may have been avoided had a more detailed investigation been undertaken by them. Details of the alleged dishonesty and collusion by various individuals and organisations are contained in this Review.

The Review states *"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 practice. 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."*

The Review has established that changes have been made and continue to be made within the NMC. The High Profile Cases Unit, the Employer Link Service and the Risk and Intelligence Unit will ensure a joined-up response to any high profile allegations. The Public Support Service is in the process of being established and will provide improved support for witnesses.

The Review states *"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."*

The PSA have been very bold in publishing this Review and publically criticising the NMC. The final words in the Review advise the NMC to continue to address its shortcomings. AIMS hopes that the PSA will seriously monitor the new structures and objectives of the NMC to bring about a long-awaited change for the safety of mothers, their babies and midwives.

AIMS' comments on the Review

AIMS has said for many years that there has been a lack of midwifery knowledge and input at the NMC. AIMS is very pleased that this has finally been acknowledged and will be watching for an immediate improvement in this area.

Another important issue for AIMS is the length of time it took to deal with all the cases, which was astonishing. The families and the midwives involved were treated shamefully. It must have been a very difficult place to work in those intervening years and the management of the Trust and the Midwifery Unit must shoulder a great deal of the blame to allow this to fester for so long, putting not only mothers and babies at risk, but also the midwives themselves.

The PSA Review talks about external lawyers which were used by the NMC, and how this became a problem in that they did not have to share information with the External Investigations. AIMS notes that lawyer adverts were placed last year to be employed at the NMC and would be interested to know if all lawyer advice is now internal.

AIMS wonders if this damnation of the NMC's handling of Fitness to Practice will apply to other midwives who had cases brought against them? Will the RCM demand a review of all cases? AIMS knows of and supported many midwives who had cases brought against them during that time and who, in our opinion, were treated very badly by the NMC, eventually having cases dismissed but only after a hugely protracted process which cost the midwives severely, both financially and in their personal lives. Similarly, we supported families in other trusts where the NMC did not deal with their cases appropri ately, leading us to wonder whether there are other "Morecambe Bays" just waiting to be uncovered.

AIMS will be interested to see whether the different structures and departments make a difference. We regularly respond to consultations and are signed upwith Stakeholder interest at the NMC. We will be monitoring their progress, especially in relation to receiving complaints from the public

AIMS has lessons to learn too, as will anyone or any organisation reading this Review:

- We are a lay organisation dedicated to improving maternity services for women.
- We work with, and support midwives who share AIMS' views of supporting women, and in doing so we will improve the maternity services.
- When AIMS comments on something in the future, you will knowthat we have taken time to understand the entire situation as it impacts on maternity services, and that if an AIMS voice can help to make a difference, we will speak.