Nursing and Midwifery Council (NMC) response to the UK Government's consultation on coronial investigations of stillbirths

Introduction

1 We are the independent regulator for nurses and midwives in the UK, and nursing associates in England. We hold a register of 690,000 nurses and midwives and nursing associates.

2 Better and safer care for people is at the heart of what we do, supporting the professionals on our register to deliver the highest standards of care.

3 We make sure nurses, midwives and nursing associates have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

4 Learning does not stop the day nurses, midwives and nursing associates qualify. To promote safety and public trust, we require professionals to demonstrate throughout their career that they are committed to learning and developing to keep their skills up to date and improve as practitioners.

5 We aim to encourage a just culture among health and care professions, prioritising openness and learning to improve care and keep the public safe. On the occasions when something goes wrong and people are at risk, we can step in to investigate an individual's fitness to practise, giving people affected, patients and families a voice as we do so.

Summary

6 We welcome the opportunity to respond to the UK Government's consultation on coronial investigation of stillbirths. Whenever a stillbirth happens it has a devastating impact on the parents and families involved, who above all want to understand what happened, and whether there is anything that could have been done differently. Care providers can often provide these answers, but we recognise that there are times when families have been let down by the process or feel their concerns have not been listened to. In such cases the coroner may have a valuable role in providing an independent investigation into events, which ultimately contributes to improved learning, and better protects patients and members of the public in future.

7 Following a stillbirth, it may be identified that there were failings by nurses, midwives, or nursing associates involved in the care, which may have contributed to the tragic outcome. In such cases the NMC may need to carry out an investigation into the fitness to practise of these healthcare professionals. It is therefore essential we identify all of the relevant concerns with someone's professional practice, so that we can ensure public protection, and encourage

learning and reflection. Investigations by employers and the coroner can play a valuable part in this process.

8 Along with employers, we play an important role in ensuring the public are protected at the earliest opportunity, and at times multiple investigations can cause unexpected delays in our ability to take action. It is therefore essential that any new proposals ensure a streamlined process with a reliable flow of information, to ensure we can take action as soon as necessary.

9 Our response to the consultation is framed within the context of our statutory remit as the UK's independent regulator of nurses, midwives and, in England, nursing associates, in particular our role in investigating the fitness to practise of individual professionals on our register. The consultation raises a number of questions that fall outside our remit, and we do not address these in our response.

Consultation questions

Q1. Do you think coroners should have a role in investigating stillbirths? Please provide reasons.

10 From experience, we understand the importance of independent scrutiny into events that lead to unexpected stillbirths, not just unexpected deaths after birth. Where there have been failures in systems and by healthcare professionals, both before and during delivery, it is important that we learn from this, whether a child is stillborn or dies after birth. We know from our work that coroners play a crucial role in providing answers, and fully support any measure which promotes openness and learning in healthcare.

11 We also recognise that these inquiries can take time, and additional investigations can sometimes cause delays to our own regulatory processes where we aim to manage the risk that individuals may pose. Whilst some cases would benefit with independent investigations by the coroner, it may not be necessary in all cases. We would welcome any proposals which ensure the process of learning from these incidents in streamlined, helping us to take action to protect the public, where needed, as quickly as possible.

12 Some thought should also be given to whether the anticipation of an inquest may have an unintended effect on healthcare professionals' willingness to be open and honest about mistakes. We know there are a number of reasons that professionals are sometimes not open about the mistakes they have made, and the fear of adversarial hearings may be a contributory factor in this. We support any measures which encourage a culture of openness and learning, whilst answering the difficult question of what went wrong.

Q5. Do you agree with the proposal about ascertaining when fetal death occurred or was likely to have occurred and when the baby was delivered stillborn? Do you think there is anything else that should be considered?

13 This is a valuable piece of information in determining what went wrong and why. In addition to this it is often helpful to our own investigations to understand when death became unavoidable / likely (not just the point of death), as closer

examination of the care that was provided up to this point can then be made. This assists with determining how different care failings may have caused or contributed to the overall outcome, which of those had no impact or carried less risk, and what, if anything, could have been done differently to avoid the death.

Q7. Do you agree that, as part of their findings, coroners should identify learning points and issue recommendations to the persons and bodies they consider relevant? If not, how do you think coroners should disseminate learning points?

14 Learning points and recommendations from the coroner play a valuable part in ensuring a culture of openness and learning. They are also an important tool in managing risk, and may provide useful context in our own assessment of individuals' fitness to practise. It is also helpful for us as a regulator to be aware of these learning points and recommendations as a form of intelligence – they may provide useful insights into where there are concerns with standards of care, and we can work more closely with these organisations and monitor risk, through our Employer Link Service and Risk Intelligence Unit.

Q9. Is there anything else you would like to see come out of a coroner's investigation into a stillbirth? What other determinations should be made?

15 Although it is not the role of the coroner to apportion blame, if during the course of an inquest particular incidents or areas of poor nursing or midwifery care are identified, for example by an expert report, then it is of value to us for these to be clearly identified, as this will assist in our assessment of fitness to practise. The coroner may wish to determine whether referrals to the appropriate regulatory bodies (NMC, GMC, CQC etc.) should be made as a result of their findings.

Q10. Do you agree that no consent or permission from the bereaved parents, or anyone else, should be required for a coronial investigation into a stillbirth to be opened? Please give your reasons.

16 The views of bereaved parents and families should be sought, listened to, and respected. However, if a coronial investigation is to serve the public interest, it seems right that consent from bereaved parents should not be required. It will always be essential that bereaved families, especially those who do not want an investigation to be opened, are engaged with sensitively and supported throughout the process.

Q12. Do you agree with the proposals for the links and sequencing between coronial and non-coronial investigations? Please give your reasons.

17 Where there are concerns about the conduct or competence of a nurse, midwife, or nursing associate on our register, it is essential that we undertake our proceedings without delay. If another organisation is also investigating, we will continue with our investigation unless there is a clear and compelling reason for us to delay it and it is in the public interest for us to do so.

18 We recognise and support the need to ensure there is no prejudice to criminal investigations and prosecutions. However, in the interests of the bereaved families, it is essential to guard against unnecessary delay and duplication where multiple organisations are investigating. We would welcome proposals for closer working and better information sharing between relevant organisations.